DELAWARE BRIDGE PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			Pin# (if applicable):
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT		
Instructions: *The official Delaware Bridge Program registered health care provider signing the agreement must be a practitioner authorized to administer vaccines under state law who will also be held accountable for compliance by the entire organization and its Delaware Bridge Program providers with the responsible conditions outlined in the provider enrollment agreement. For the purposes of this agreement, a vaccine is defined as any vaccine or vaccine-like product recommended by the Advisory Committee on Immunization Practices (ACIP). The individual listed here must sign the provider agreement.*		
Last Name, First, MI:		Title:
Specialty:	License No:	Medicaid or NPI No:
Employer Identification Number:		Email:

Delaware Bridge Program VACCINE COORDINATOR	
Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training (mandatory): O Yes O No	Type of training received (mandatory):
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training (mandatory): O Yes O No	Type of training received (mandatory):

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN (Optional)

PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or practice administrator or equivalent:

(Items 2, 11b, and 12 are specifically required for the Bridge Access Program)

1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of patients served changes or 2) the status of the facility changes during the calendar year.
2.	I will screen patients and document eligibility status at each immunization encounter and administer publicly purchased and Bridge Access Program vaccines only to adults who are at least 19 years of age and meet one of the following categories: a) Uninsured: A person who does not have health insurance. b) Underinsured: A person who has health insurance, but the insurance does not include any vaccines; a person whose insurance covers only selected vaccines; a person whose insurance does not provide first-dollar coverage for vaccines.
3.	For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the Delaware Bridge Program unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the person; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the Delaware Bridge Program for a minimum of three years, or longer if required by state law, and upon request make these records available for review. Delaware Bridge Program records include, but are not limited to, Delaware Bridge Program screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will administer vaccine to eligible persons with publicly purchased vaccine at no charge to the patient for the cost of the vaccine.
6.	I will not deny administration of a publicly purchased vaccine to an established patient because the individual of record is unable to pay the administration fee.
7.	I will distribute the current Vaccine Information Statements (VIS) or Emergency Use Authorization (EUA) fact sheet (if applicable) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Delaware Immunization Program storage and handling recommendations and requirements;

	d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
9.	I agree to operate within the Delaware Bridge Program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the Delaware Bridge Program: **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. **Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
10.	I will participate in Delaware Bridge Program compliance site visits including unannounced visits, and other educational opportunities associated with Delaware Bridge Program requirements as recommended by Delaware Immunization Program.
11a.	I agree to submit vaccine administration data for all publicly purchased vaccines using Section 317 and state/local funds to the jurisdiction's Immunization Information System (IIS) in accordance with Delaware Immunization Program regulations and reporting timelines.
11b.	I agree to submit vaccine administration data for all Bridge Access Program purchased vaccines to the jurisdiction's Immunization Information System (IIS) in accordance with CDC documentation and data requirements.
12	I agree to update Vaccines.gov to indicate Bridge Access Program vaccine availability and to make my profile public facing, according to CDC data guidance and timelines
13.	I understand this facility, or the Delaware Immunization Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Delaware Immunization Program.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Delaware Bridge Program enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN