South Carolina Vaccines for Children (VFC) Program
Dis-Enrollment Form

All fields required

VFC PIN (6-Digit)	**County**	**Dis-enrollment Effective Date***
Provider Name of Physician's Office, Practice, Clinic, etc.		**Today's Date**
Address (Number and Street)		
City*	**County**	**Zip Code**
Contact Person / Role		
Telephone	**Fax**	

***The Immunization Division's VFC Program must be notified one (1) month prior to dis-enrollment from the VFC Program in South Carolina.**

Reason for Dis-enrollment (Choose all that apply)

Provider Inactivity:

☐ Provider did not order vaccines for the last 12 consecutive months
☐ Physician retired/deceased (the provider who enrolled in the VFC program no longer works at practice [e.g. no longer practicing, retired, deceased, etc])
☐ Provider did not complete recertification

Change in Practice Status:

☐ Provider no longer offering vaccination services
☐ Practice closed
☐ Provider merged with another provider
Please specify provider _____
☐ Practice merged with another facility
☐ Provider no longer a Medicaid provider
☐ Change in ownership

Other:

☐ Provider entered in error (i.e. duplicate or not a VFC Provider)
☐ Did not reenroll (reason unknown)
☐ Lost contact with provider
☐ Not (Never) a VFC provider (accidental entry)
☐ Stores but does not administer vaccine
☐ Temporary outbreak
☐ Natural disaster prevents clinic from re-opening
☐ _____

Do any VFC doses remain on-site? :

☐ No
☐ Yes

Awardee (SC DHEC) Initiated:

Reduction in VFC-Eligible Children Served by the Practice/Provider

☐ Provider's population has changed (e.g. became adult-only provider)
☐ The office has a low volume of VFC-eligible patients and therefore does not wish to continue to participate in the VFC program. If so, please explain/elaborate:

Awardee (SC DHEC) Initiated:

Provider non-compliance with VFC Program Requirements

☐ Provider was non-compliant with Awardee and/or Federal VFC requirements for eligibility screening, documentation, inventory management, ands/or vaccine storage and handling.

VFC Provider Initiated:

Related to Perceived Operational or Financial Burden of VFC Program

☐ Provider indicated that participation in the VFC program is too costly and/or takes too much time for them or their staff. Please elaborate:

Certifying Provider/Provider of Record Name (Print): _____

Certifying Provider/Provider of Record (Signatory): _____ **Date:** _____

Attn: VFC Operations Section

Email Completed Form to: scvfc@dhec.sc.gov

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INSTRUCTIONS

Purpose: The purpose of this form is to capture all information necessary from the Vaccines For Children (VFC) program provider's office regarding their dis-enrollment from the VFC and/or SC State Vaccine programs. The Certifying Provider/Provider of Record (Signatory) who signed the Federal VFC Program Provider Agreement (DHEC 1144) must sign this disenrollment form.

Item-by-Item Instructions:

1. Complete Demographic information: VFC PIN, Name of Provider, Address, Contact Person, County, Date, and Reason for Dis-enrollment, Date dis-enrollment is to be effective.
2. Complete Reason for Dis-Enrollment (choose all that apply).
3. Signature of ESA and Date ESA signed form.
4. Submit form via email to the Immunization Division at scvfc@dhec.sc.gov **one (1) month before** the date of your dis-enrollment.
5. If you indicated that VFC doses will remain on site, SC DHEC personnel will contact you to arrange pick-up of these doses.

Office Mechanics and Filing:

1. Form Retention:

   -DHEC Immunization Program: retain providers' copies for (3) three years as required by the Federal Immunization Program.

Under Retention schedule 15726
Record Group Number 169
Retention: 3 years, destroy