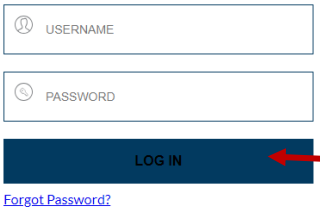
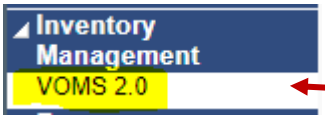
VFC Recertification Instructions 2026

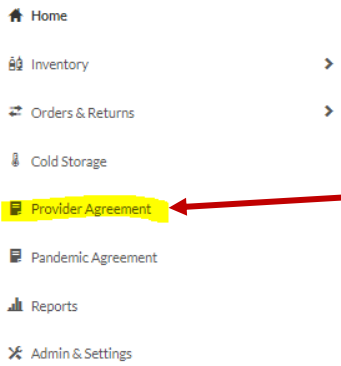


Go to: https://lalinks.org/linksweb/login.jsp

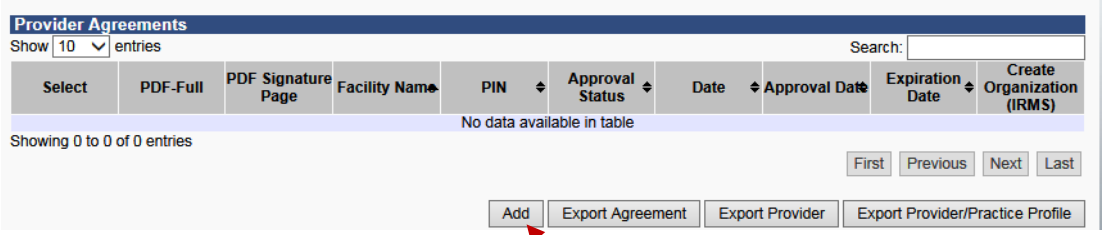
Log into LINKS with provided username & password



Once logged in, click on VOMS 2.0 under Inventory Management



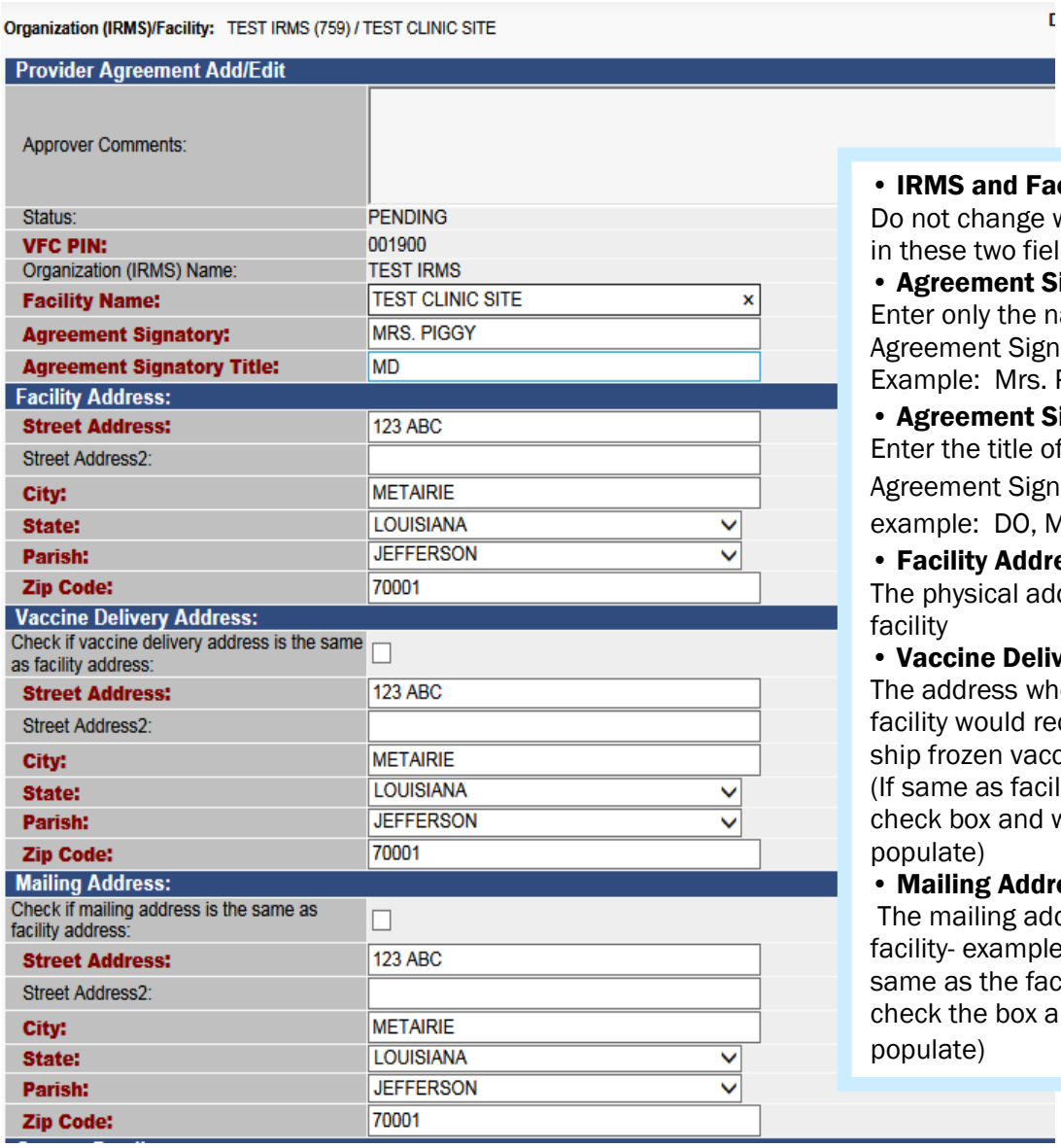
Once in VOMS 2.0, you will select "Provider Agreement" tab on the left hand menu, which will lead you back to IWeb.



Click the "Add" button to create a new Provider Agreement

Please note: If you filled out a Provider Agreement last year, the information will populate in this year's Provider Agreement. Review all of the information for accuracy and make any changes if necessary.

First Page of the Provider Agreement – *Contacts:*



Organization (IRMS)/Facility: TEST IRMS (759) / TEST CLINIC SITE

Provider Agreement Add/Edit

Approver Comments:	
Status:	PENDING
VFC PIN:	001900
Organization (IRMS) Name:	TEST IRMS
Facility Name:	TEST CLINIC SITE
Agreement Signatory:	MRS. PIGGY
Agreement Signatory Title:	MD
Facility Address:	
Street Address:	123 ABC
Street Address2:	
City:	METAIRIE
State:	LOUISIANA
Parish:	JEFFERSON
Zip Code:	70001
Vaccine Delivery Address:	
Check if vaccine delivery address is the same as facility address:	☐
Street Address:	123 ABC
Street Address2:	
City:	METAIRIE
State:	LOUISIANA
Parish:	JEFFERSON
Zip Code:	70001
Mailing Address:	
Check if mailing address is the same as facility address:	☐
Street Address:	123 ABC
Street Address2:	
City:	METAIRIE
State:	LOUISIANA
Parish:	JEFFERSON
Zip Code:	70001

- **IRMS and Facility Name:** Do not change what populates in these two fields
- **Agreement Signatory:** Enter only the name of the Agreement Signatory- Example: Mrs. Piggy
- **Agreement Signatory Title:** Enter the title of the Agreement Signatory- example: DO, MD, NP
- **Facility Address:** The physical address of your facility
- **Vaccine Delivery Address:** The address where your facility would receive direct ship frozen vaccine deliveries (If same as facility address check box and will auto populate)
- **Mailing Address:** The mailing address of your facility- example: PO Box (If the same as the facility address, check the box and will auto-populate)

Contact Details:

Contact Details:	
Type1:	Signatory
Contact Name 1:	MRS. PIGGY
Phone Number1:	(504)838-5300
Phone Number Extension1:	
Fax Number1:	(504)838-5206
Email Address1:	PIGGY@TEST.NET
Completed Annual Training1:	Yes No
Type Of Training Received1:	Online Training
Type2:	Primary Vaccine Coordinator
Contact Name 2:	KERMIT T FROG
Phone Number2:	(504)838-5300
Phone Number Extension2:	
Fax Number2:	(504)838-5206
Email Address2:	KERMIT@TEST.NET
Completed Annual Training2:	Yes No
Type Of Training Received2:	Online Training
Type3:	Back-up Vaccine Coordinator
Contact Name 3:	DONALD T DUCK
Phone Number3:	(504)838-5300
Phone Number Extension3:	
Fax Number3:	(504)838-5206
Email Address3:	DONALD@TEST.NET
Completed Annual Training3:	Yes No
Type Of Training Received3:	Online Training
Type4:	--select--
Contact Name 4:	
Phone Number4:	
Phone Number Extension4:	
Fax Number4:	
Email Address4:	
Completed Annual Training4:	Yes No
Type Of Training Received4:	--select--
Type5:	--select--
Contact Name 5:	
Phone Number5:	
Phone Number Extension5:	
Fax Number5:	
Email Address5:	
Completed Annual Training5:	Yes No
Type Of Training Received5:	--select--

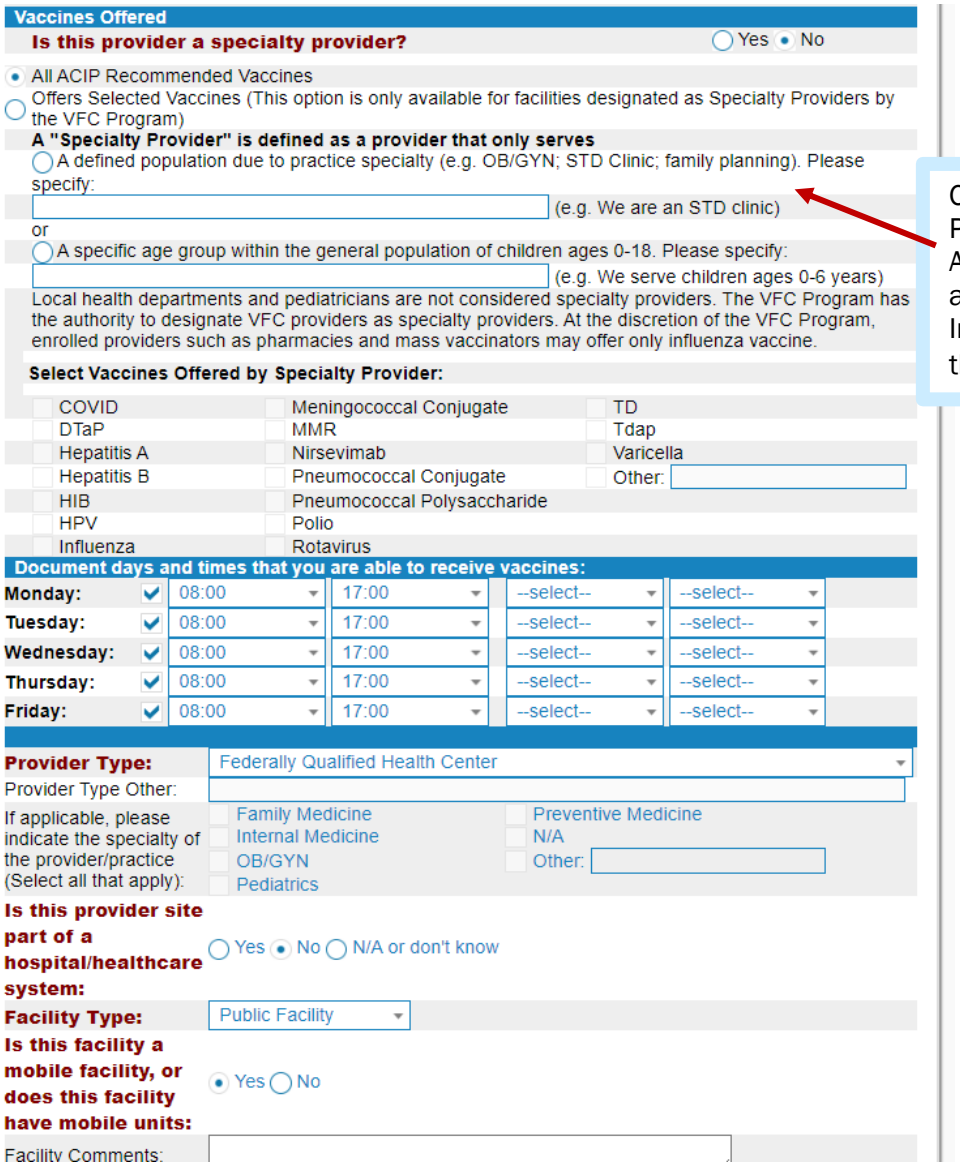
Contact Details: Three contacts are mandatory. Contacts should appear in the following order:

1. Signatory (is required to match "Agreement Signatory" field above)
2. Primary Vaccine Coordinator
3. Back-up Vaccine Coordinator

You may enter two additional contacts if desired. Click the drop down arrow to select the contact type.

- All Fields in **RED** are required Fields
- Fill out **Name, Phone, Fax & Email** fields for each contact type.
- Indicate if **Annual Training** was completed and the **type of training received** for each contact.

Vaccines Offered:



Only select "Specialty Provider" if you do not offer all ACIP Recommended Vaccines and are a Specialty Provider. Indicate what type and select the vaccines offered.

- **Shipping Information:**

Use military time. Select the drop downs for each day and **choose the hours that you can receive shipments**. You can choose both morning and afternoon hours to reflect a lunch hour. It must be more than one day of the week and delivery times should be in increments of 4 hours.

- **Facility Type:**

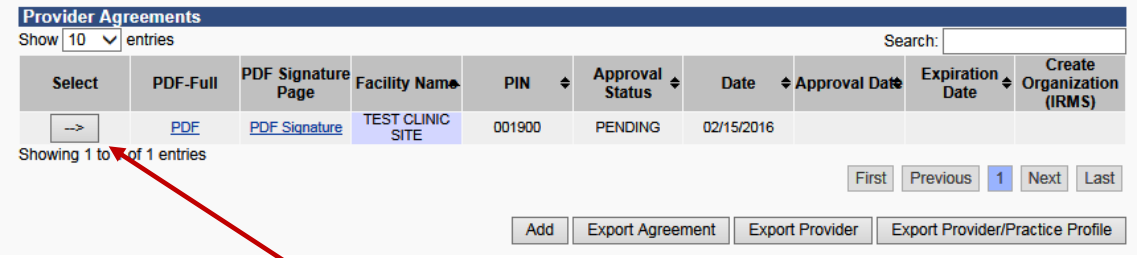
Click the drop down arrow to select facility type.

- **Facility Comments:**

Enter special delivery instructions if you have them, i.e. "Deliver to clinic behind school"

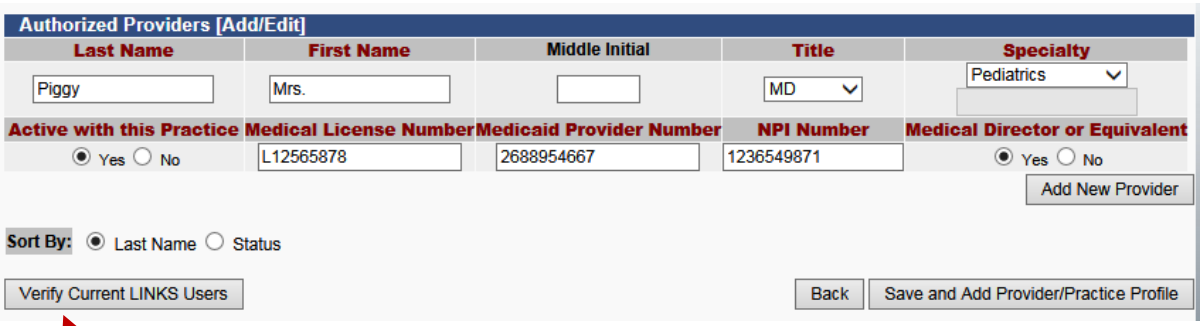
If you need to exit the Provider Agreement before completion, you can save it and return to it later, but you must complete the page you are working on before the system will allow you to save your work.

Complete the first page and Click Save and Add Provider at the bottom of the page. This will take you to the next page, but will also save your work if you need to exit the Provider Agreement.

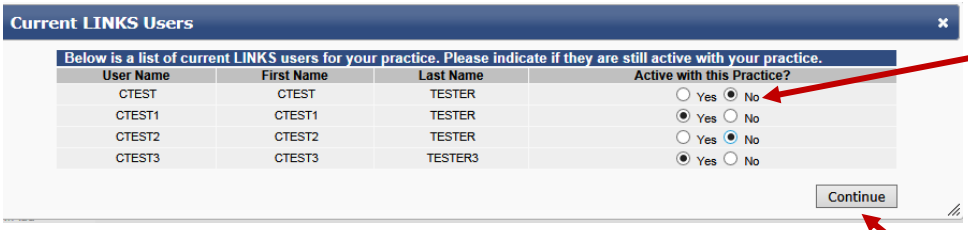


To continue working on a saved Provider Agreement: Login → Inventory Management → VOMS 2.0 → Provider Agreement, then select the arrow to continue.

Page 2 of Provider Agreement – *Authorized Providers*



- List the **Name, Title, Specialty, Active status, Medical license number, and NPI number for your facility** for all healthcare providers that have prescriptive authority and may provide state-supplied immunizations. Include the certifying provider as well.
- **Add New Provider** Click here to add additional providers to your list.
- **Verify Current LINKS Users.** After you have entered all of your providers, click here view your current LINKS Users for your practice.



- **Bullet "No" on any users that are no longer active with your practice.** Once you have checked all no longer active, click on continue (by clicking continue you are saving your work and can move to the next section).

Page 3 of the Provider Agreement – *Provider/Practice Profile*

1) Report the number of children who received state supplied vaccinations for calendar year **(May 02, 2023 to May 01, 2024)** by age group, insurance type and demographics. This is based on your patient records. Billing staff may be best equipped to respond to this section of the survey. Only count a child once - no matter the number of visits. Retain a copy of this survey for your records for audit purposes. Please provide the best data possible.

Provider Estimates

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category						
	< 1 Year	Estimate	1-6 Years	Estimate	7-18 Years	Estimate	Total (Estimate)
VFC eligible - Medicaid/Medicaid Managed Care	0	0	0	0	0	0	0
VFC eligible - Uninsured	0	0	0	0	0	0	0
VFC eligible - American Indian/Alaskan Native	0	0	0	0	0	0	0
VFC eligible - Underinsured at FQHC/RHC	0	0	0	0	0	0	0
Total VFC:	0	0	0	0	0	0	0

Non-VFC Vaccine Eligibility Categories	# of children who received non-VFC Vaccine by Age Category						
	< 1 Year	Estimate	1-6 Years	Estimate	7-18 Years	Estimate	Total (Estimate)
Not VFC Eligible	0	0	1	0	0	0	0
317	0	0	0	0	0	0	0
Total Non-VFC:	0	0	1	0	0	0	0
Total Patients (must equal sum of Total VFC + Total Non-VFC):	0	0	1	0	0	0	0

2) What data source (or type of data) was used: (check all that apply)

- [ ] Benchmarking
- [ ] Medicaid Claims
- [ ] Doses Administered
- [ ] Provider Encounter Data
- [ ] Billing System
- [x] Louisiana Immunization Network for Kids Statewide (LINKS)
- [ ] Other

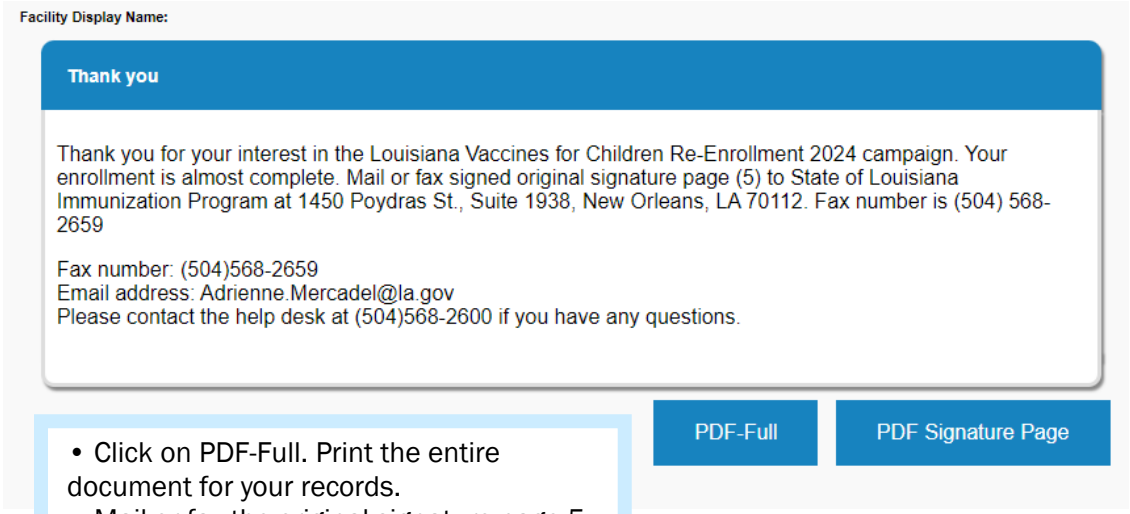
- [ ] By checking this box, I certify on behalf of myself and all immunization providers in this facility, all information entered in this agreement is accurate and complete
- [ ] I understand that Louisiana Immunization Program has a "No Borrowing" Policy. This includes failing to separate private stock vaccine from VFC funded vaccine and borrowing on VFC/private pay vaccine with the intent to "repay the doses".
- [ ] I have received and reviewed the Louisiana VFC Provider Manual.

Back | Save | Submit to State

- Review the numbers in each category for accuracy, or if necessary, fill in the numbers in each category.
- Choose what data source (or type of data) was used to obtain the numbers in each category.

- Check box to certify all info is correct
- Check box that you understand Louisiana has a "No Borrowing" Policy and that Private Stock and VFC Stock will be separate
- Check box that states that you have reviewed & received the LA VFC Provider Manual
- **Submit to State:** Click here only if the Provider Agreement is complete and you are ready to submit for approval.

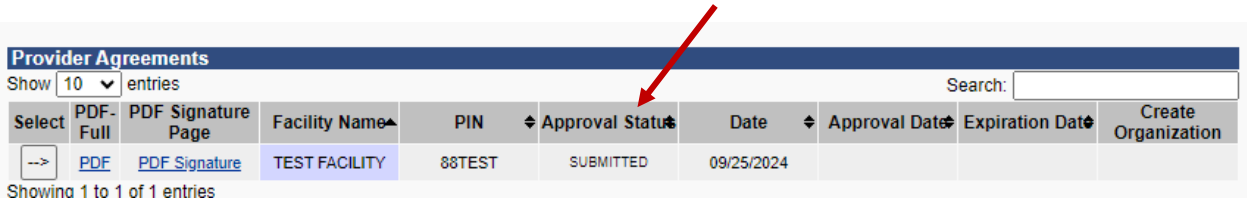
Follow instructions below to submit completed application



- Click on PDF-Full. Print the entire document for your records.
- Mail or fax the original signature page 5 of this document to:

Louisiana Immunization Program
1450 Poydras St. Suite 1938,
New Orleans, LA 70112
or Fax: (504)568-2660

You can check the status of your Application at any time by going to Inventory Management → VOMS 2.0 → Provider Agreement and check the *Approval Status*



Provider Agreement Status

- **Pending:** The Provider Agreement is saved and is not complete. You can open and continue working.
- **Submitted:** The Provider Agreement was submitted and is waiting for the Immunization Program's review and approval.
- **Returned:** You need to make corrections within the Provider Agreement. Click on the Select arrow to view comments made by Immunization Program staff. Make the requested corrections and re-submit the Provider Agreement.
- **Approved:** Immunization Program staff approved the Provider Agreement and has received all signed pages. *****Only when the Provider Agreement shows an Approved status is your facility officially enrolled in the program. If not approved by the deadline date of May 29, 2026, you will not be able to make a VFC vaccine order*****