

VFC Recertification Instructions 2026



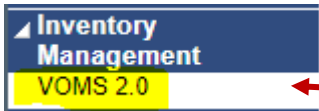
① USERNAME

🔒 PASSWORD

LOG IN

[Forgot Password?](#)

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

- Home
- Inventory >
- Orders & Returns >
- Cold Storage
- Provider Agreement**
- Pandemic Agreement
- Reports
- Admin & Settings

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

Provider Agreements

Show 10 entries Search:

Select	PDF-Full	PDF Signature Page	Facility Name	PIN	Approval Status	Date	Approval Date	Expiration Date	Create Organization (IRMS)
No data available in table									

Showing 0 to 0 of 0 entries

First Previous Next Last

Add Export Agreement Export Provider Export Provider/Practice Profile

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 x
Agreement Signatory:	MRS. PIGGY
Agreement Signatory Title:	MD
Facility Address:	
Street Address:	123 ABC
Street Address2:	
City:	METAIRIE
State:	LOUISIANA v
Parish:	JEFFERSON v
Zip Code:	70001
Vaccine Delivery Address:	
Check if vaccine delivery address is the same as facility address:	<input type="checkbox"/>
Street Address:	123 ABC
Street Address2:	
City:	METAIRIE
State:	LOUISIANA v
Parish:	JEFFERSON v
Zip Code:	70001
Mailing Address:	
Check if mailing address is the same as facility address:	<input type="checkbox"/>
Street Address:	123 ABC
Street Address2:	
City:	METAIRIE
State:	LOUISIANA v
Parish:	JEFFERSON v
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 <input type="text"/>
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:	<input checked="" type="radio"/> Yes <input type="radio"/> No
Type Of Training Received1:	Online Training <input type="text"/>
Type2:	Primary Vaccine Coordinator <input type="text"/>
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:	<input checked="" type="radio"/> Yes <input type="radio"/> No
Type Of Training Received2:	Online Training <input type="text"/>
Type3:	Back-up Vaccine Coordinator <input type="text"/>
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:	<input checked="" type="radio"/> Yes <input type="radio"/> No
Type Of Training Received3:	Online Training <input type="text"/>
Type4:	--select-- <input type="text"/>
Contact Name 4:	
Phone Number4:	
Phone Number Extension4:	
Fax Number4:	
Email Address4:	
Completed Annual Training4:	<input type="radio"/> Yes <input type="radio"/> No
Type Of Training Received4:	--select-- <input type="text"/>
Type5:	--select-- <input type="text"/>
Contact Name 5:	
Phone Number5:	
Phone Number Extension5:	
Fax Number5:	
Email Address5:	
Completed Annual Training5:	<input type="radio"/> Yes <input type="radio"/> No
Type Of Training Received5:	--select-- <input type="text"/>

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:

Vaccines Offered

Is this provider a specialty provider? Yes No

All ACIP Recommended Vaccines
 Offers Selected Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A "Specialty Provider" is defined as a provider that only serves

A defined population due to practice specialty (e.g. OB/GYN; STD Clinic; family planning). Please specify:
 (e.g. We are an STD clinic)

or

A specific age group within the general population of children ages 0-18. Please specify:
 (e.g. We serve children ages 0-6 years)

Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

<input type="checkbox"/> COVID	<input type="checkbox"/> Meningococcal Conjugate	<input type="checkbox"/> TD
<input type="checkbox"/> DTaP	<input type="checkbox"/> MMR	<input type="checkbox"/> Tdap
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Nirsevimab	<input type="checkbox"/> Varicella
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Hib	<input type="checkbox"/> Pneumococcal Polysaccharide	
<input type="checkbox"/> HPV	<input type="checkbox"/> Polio	
<input type="checkbox"/> Influenza	<input type="checkbox"/> Rotavirus	

Document days and times that you are able to receive vaccines:

Monday:	<input checked="" type="checkbox"/>	08:00	17:00	--select--	--select--
Tuesday:	<input checked="" type="checkbox"/>	08:00	17:00	--select--	--select--
Wednesday:	<input checked="" type="checkbox"/>	08:00	17:00	--select--	--select--
Thursday:	<input checked="" type="checkbox"/>	08:00	17:00	--select--	--select--
Friday:	<input checked="" type="checkbox"/>	08:00	17:00	--select--	--select--

Provider Type:

Provider Type Other:

If applicable, please indicate the specialty of the provider/practice (Select all that apply):

<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Preventive Medicine
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> N/A
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Pediatrics	

Is this provider site part of a hospital/healthcare system: Yes No N/A or don't know

Facility Type:

Is this facility a mobile facility, or does this facility have mobile units: Yes No

Facility Comments:

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.

Select	PDF-Full	PDF Signature Page	Facility Name	PIN	Approval Status	Date	Approval Date	Expiration Date	Create Organization (IRMS)
-->	PDF	PDF Signature	TEST CLINIC SITE	001900	PENDING	02/15/2016			

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First Previous **1** Next Last

Add Export Agreement Export Provider Export Provider/Practice Profile

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

Last Name	First Name	Middle Initial	Title	Specialty
<input type="text" value="Piggy"/>	<input type="text" value="Mrs."/>	<input type="text"/>	<input type="text" value="MD"/>	<input type="text" value="Pediatrics"/>
Active with this Practice	Medical License Number	Medicaid Provider Number	NPI Number	Medical Director or Equivalent
<input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="text" value="L12565878"/>	<input type="text" value="2688954667"/>	<input type="text" value="1236549871"/>	<input checked="" type="radio"/> Yes <input type="radio"/> No

Sort By: Last Name Status

- 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.

Current LINKS Users

Below is a list of current LINKS users for your practice. Please indicate if they are still active with your practice.

User Name	First Name	Last Name	Active with this Practice?
CTEST	CTEST	TESTER	<input type="radio"/> Yes <input checked="" type="radio"/> No
CTEST1	CTEST1	TESTER	<input checked="" type="radio"/> Yes <input type="radio"/> No
CTEST2	CTEST2	TESTER	<input type="radio"/> Yes <input checked="" type="radio"/> No
CTEST3	CTEST3	TESTER3	<input checked="" type="radio"/> Yes <input type="radio"/> No

- 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	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0
VFC eligible - Uninsured	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0
VFC eligible - American Indian/Alaskan Native	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0
VFC eligible - Underinsured at FQHC/RHC	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0
Total VFC:	0	0	0	0	0	0	0
# of children who received non-VFC Vaccine by Age Category							
Non-VFC Vaccine Eligibility Categories	< 1 Year	Estimate	1-6 Years	Estimate	7-18 Years	Estimate	Total (Estimate)
Not VFC Eligible	0	<input type="text" value="0"/>	1	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0
317	0	<input type="text" value="0"/>	0	<input type="text" value="0"/>	0	<input type="text" value="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

- 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.

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

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

- 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.

- 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.

Follow instructions below to submit completed application

Facility Display Name:

Thank you

Thank you for your interest in the Louisiana Vaccines for Children Re-Enrollment 2024 campaign. Your enrollment is almost complete. Mail or fax signed original signature page (5) to State of Louisiana Immunization Program at 1450 Poydras St., Suite 1938, New Orleans, LA 70112. Fax number is (504) 568-2659

Fax number: (504)568-2659
Email address: Adrienne.Mercadel@la.gov
Please contact the help desk at (504)568-2600 if you have any questions.

PDF-Full

PDF Signature Page

- 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 Agreements									
Select	PDF-Full	PDF Signature Page	Facility Name	PIN	Approval Status	Date	Approval Date	Expiration Date	Create Organization
-->	PDF	PDF Signature	TEST FACILITY	88TEST	SUBMITTED	09/25/2024			

Showing 1 to 1 of 1 entries

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****