

Date: _____ Provider/Physician: _____

**Patient Eligibility Screen Record
Vaccines for Children Program**

This provider participates in the Vaccines for Children Program (VFC). If you meet the requirements of this program we can provide your child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance.

Child: _____ Date of Birth: _____
Last Name First Name MM/DDYY

Parent/Guardian: _____
Last Name First Name

<p><u>INELIGIBLE FOR STATE-SUPPLIED VACCINE</u> <i>(Check if applicable)</i></p> <p><input type="checkbox"/> The child has insurance that pays for immunizations. (Fully or partially insured)</p> <p><u>ELIGIBLE FOR STATE-SUPPLIED VACCINE</u></p> <p>This child qualifies for vaccination with state-supplied vaccine because <i>(check only one box)</i></p> <p><input type="checkbox"/> The child is enrolled in Medicaid</p> <p><input type="checkbox"/> The child is American Indian or Alaskan Native</p> <p><input type="checkbox"/> The child does not have health insurance (Not Insured)</p>
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Note To Providers:

A record must be kept in the healthcare's office that reflects the status of children 18 or younger, who receive immunizations with vaccines supplied by state programs. While verification is not required it is necessary to retain this or a similar record for each child receiving vaccine.

**SREENING UPDATES
Check Only One Category**

Date Screened	Medicaid Enrolled	American Indian of Alaskan Native	Uninsured
/ /			
/ /			
/ /			