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|  | **VFC Eligible** | | | | **Not VFC Eligible** |
| Date | Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid) | Is underinsured (has health insurance that does not pay for vaccinations) | Does not have health insurance | Is American Indian (Native American) or Alaska Native | Has health insurance |
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Check only one box below:

**This child is eligible for immunizations through the federal VFC program because he/she\*:**

* is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled in Medicaid)
* is underinsured (has health insurance that does not pay for vaccinations)
* does not have health insurance
* is American Indian (Native American) or Alaska Native

**This child is not VFC-eligible because he/she:**

* has health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

**Screening at each subsequent visit (documentation required)**

\*This form identifies which children are eligible for vaccines through the federal Vaccines for Children (VFC) program. If one of the first four boxes in the section above is checked, the child is VFC eligible.

VFC Eligibility Screening Form FQHC 2015

**This form must be completed for all children under 19 years old at their initial visit, updated every time a vaccine is given and kept in the child’s medical record or on file in the office.**

**The form may be completed by the parent, guardian, or legal representative, or by the health care provider.**

**Verification of responses is not required.**

Initial screening date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s full name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent, guardian or legal representative’s full name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health care provider’s full name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial screening**

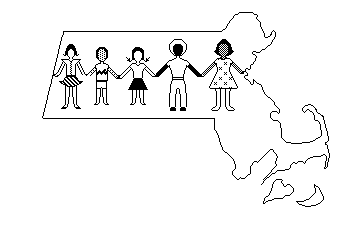
Patient Eligibility Screening Form

For use in Federally Qualified Community Health Centers

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**IMMUNIZATION PROGRAM**

**VACCINES FOR CHILDREN PROGRAM (VFC)**



For Healthier Lives

Immunize

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|  | **VFC Eligible** | | | | **Not VFC Eligible** |
| Date | Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid) | Is underinsured (has health insurance that does not pay for vaccinations) | Does not have health insurance | Is American Indian (Native American) or Alaska Native | Has health insurance |
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VFC Eligibility Screening Form FQHC 2015

**Screening at each subsequent visit (documentation required)**