For Healthier

Immunize

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM

Patient Eligibility Screening Form

Initial Screening Date _____

Child's Full Name _____

Date of Birth _____

Parent, guardian, or legal representative's full name _____

Health care provider's full name _____

This form must be completed for all children under 19 years old 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. This form should be completed only once, unless the child's insurance status changes. Please use the back of this form to document changes in status.

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 through Medicaid)
- ☐ does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan)
- ☐ is American Indian (Native American) or Alaska Native

This child is not VFC-eligible

- ☐ has health insurance and is not American Indian (Native American) or Alaska Native

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