



**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH  
IMMUNIZATION PROGRAM  
VACCINES FOR CHILDREN PROGRAM (VFC)**

# Patient Eligibility Screening Form

For use in all Provider Sites, except Federally Qualified Community Health Centers

**Initial screening**

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 \_\_\_\_\_

**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)
- 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

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

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

Date	VFC Eligible			Not VFC Eligible
	Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)	Does not have health insurance	Is American Indian (Native American) or Alaska Native	Has health insurance

