NYC Department of Health and Mental Hygiene
Immunization Program
Vaccines For Children Program

ELIGIBILITY SCREENING FORM

Provider Name: _____ Date of Screening: _____/_____/_____
MM DD YYYY

HEALTH CARE PROVIDER: A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NYC VFC program. The record may be completed by the **parent, guardian, individual of record, or healthcare provider.** The same record may be used for all subsequent visits as long as the child's health insurance status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

PATIENT INFORMATION:

Child/Patient Date of Birth: ____ /____/_____
MM DD YYYY

_____ _____ _____
Child/Patient Last Name First Name M.I

_____ _____ _____
Parent/Guardian's Last Name First Name M.I

Check the appropriate eligibility category line below for children (up to their 19th birthday) who receive publicly purchased vaccine in New York.

1. Medicaid/Medicaid managed care enrolled _____ Date
2. Uninsured (no insurance) _____ Date
3. Underinsured (insurance does not cover vaccines) _____ Date
4. Native American/Alaskan Native _____ Date
5. Not Eligible (insurance covers immunization) _____ Date
6. Child Health Plus B (CHPlus B) _____ Date

EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK