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

Patient Eligibility Screening Form

Wareham Pediatrics
Boston Children's Primary Care Alliance
warehampeds.com
508-295-8622

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

Initial Screening Date:_____

Child's Full Name:_____

Date of Birth:_____

Parent, Guardian, or legal representative's full name:_____

Health Care Provider's Full Name:_____Wareham Pediatrics Associates, P.C._____

This Form must be completed for all children under 19 years old and kept in the child's medical record of on file in the offices. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. Verification of responses is <u>not</u> required. This form should be completed only once, unless the child's insurance status changes. Please us 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
- ◯ is American Indian (Native America) of 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 identifies which children are eligible for vaccines through the federal Vaccines for Children (VFC) program. If one of the three boxes in this section above is checked, the child is VFC-eligible.