

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 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 not 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 boes in this section above is checked, the child is VFC-eligible.