Massachusetts Department of Public Health Immunization Program
PATIENT ELIGIBILITY SCREENING FORM

Vaccines for Children Program

Wakefield Pediatrics
Boston Children's
Primary Care Alliance

wakefieldpedi.com
781-245-2203 | *fax* 781-245-7303

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.

Initial screening

Initial screening date: _____

Patient last name:_____

First name: _____ MI: _____

Date of birth: _____

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)

❍ is underinsured (has health insurance that does not pay for vaccinations)

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

For use in federally qualified community health centers.