For Healthier Lives



Immunize

MASSACHUSETTS IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Patient Eligibility Screening Form

Date _____

Child's full name _____

Date of birth _____

Parent, guardian, or legal representative's full name _____

Health care provider's full name _____

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. This form should be completed only once, unless the child's insurance status changes. Verification of responses is not required.

Check only one box below

This child:

☐ is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)

☐ does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan)

☐ is Native American (American Indian) or Alaskan Native

☐ has health insurance and is not Native American (American Indian) or Alaskan Native

Please note that all children seen in Massachusetts practices get the same free vaccines. This form tells us which children get vaccines paid for by the federal VFC Program (first three boxes) and which get vaccines paid for by state and other federal funds (last box).