

## Texas Vaccines For Children (TVFC) Program Patient Eligibility Screening Record

A screening record of all children 18 years of age or younger who receive immunizations through the TVFC Program must be kept in the health-care provider's office. The record may be completed by the parent, guardian, or individual of record or by the healthcare provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: \_\_\_\_\_  
Last Name
First Name
MI

2. Child's Date of Birth: \_\_\_\_\_  
mm/dd/yyyy

3. Parent/Guardian/Individual of Record: \_\_\_\_\_  
Last Name
First Name
MI

4. Provider's/Clinic's Name: \_\_\_\_\_

5. To determine if a child (0 through 18 years of age) is eligible to receive state or federal vaccine through the TVFC Program, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for TVFC Program.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Medicaid:**  
 Medicaid Number: \_\_\_\_\_  
 Date of Eligibility: \_\_\_\_\_

**CHIP:**  
 CHIP Number: \_\_\_\_\_  
 Group Number: \_\_\_\_\_  
 Date of Eligibility: \_\_\_\_\_

**Private Insurance:**  
 Name of Insurer: \_\_\_\_\_ Insurer Contact Number: \_\_\_\_\_  
 Insurance Name: \_\_\_\_\_ Policy/Subscriber Number: \_\_\_\_\_