Illinois Department of Public Health

Patient Eligibility Screening Record

Vaccines for Children Program (VFC)

VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed.

1. Initial Screening Date ___ ___ / ___ ___ / ___ ___ ___ ___
   M M D D Y Y Y Y

2. Child's Name _____ _____ _____
   Last Name First Name MI

3. Child's Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___
   M M D D Y Y Y Y

4. Parent/Guardian/Individual of record: _____ _____ _____
   Last Name First Name MI

5. Is your practice/clinic a federally qualified health center (FQHC) or rural health center (RHC)? Yes ___ No ___
   If you answered "YES", you must have a photocopy or electronic copy of your FQHC or RHC license/certification on file with the Illinois Vaccines for Children program.

6. Primary Provider's Name _____ _____ _____
   Last Name First Name MI

7. Does this patient qualify for immunization through the VFC program because he/she: Check only one box
   - Yes, is enrolled in Medicaid ☐
   - Yes, does NOT have health insurance ☐
   - Yes, is an American Indian or Alaska Native ☐
   - Yes, is underinsured (had health insurance that does not pay for vaccinations* ☐
   - No, this child does not qualify for immunizations through the VFC program because he/she does not meet the eligibility criteria ☐

*To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC. See question 5 above.

Eligibility Changes

Date Eligibility Changed	Medicaid	Uninsured	American Indian / Alaska Native	Underinsured*	Does not meet eligibility criteria

*To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC. See question 5 above.

A record of all children 18 years of age or younger who receive immunizations 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 health care provider. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations as long as the child's eligibility status has not changed. It is necessary to retain this or a similar record for each child receiving vaccine.

The above eligibility status information was provided by me to Jo Daviess County Health Department.

Signature of Parent/Guardian/Individual of Record or Health Care Provider	Date	Signature of Parent/Guardian/Individual of Record or Health Care Provider	Date

JO DAVIESS COUNTY HEALTH DEPARTMENT

A Federally Qualified Health Center / Rural Health Center

Formulario de Elegibilidad del Paciente

Patient Eligibility Screening Record

Programa "Vacunas Para Niños"

Vaccines for Children Program (VFC)

Fecha Inicial:_____
(Initial Screening Date)

Nombre del Niño
(Child's Name)

Apellido Paterno (Last Name, Father)	Apellido Materno (Last Name, Mother)	Nombre (Child's Name)	2do Nombre (Child's 2nd Name)

Fecha de Nacimiento
(Date of Birth)

Mes (Month)	Dia (Day)	Año (Year)

Padre, Madre o Tutor
(Name of Parent/Guardian)

Apellido Paterno (Last Name, Father)	Apellido Materno (Last Name, Mother)	Nombre (Child's Name)	2do Nombre (Child's 2nd Name)

Nombre del proveedor de Primaria _____
(Primary Provider's Name)

Este niño cualifica para recibir vacunas a través del Program "VFC" proqué él o ella: (Marque solo un encasillado)
[This child is eligible for vaccines through the VFC Program. Check only one box.]

- ☐ Si, es participante tiene Medicaid (Reforma de Salud) (Yes, participant has Medicaid [Health Care Reform])
- ☐ Si, No tiene seguro medico (Yes, does not have health insurance)
- ☐ Si, es Indio Americano o Nativo de Alaska (Is American Indian or Alaska Native)
- ☐ *Si, su seguro medico no cubre las vacunas (Yes, is underinsured - Insurance does not cover vaccines)
- ☐ No tiene criterio de elegibilidad para el VFC (No, child does not meet eligibility criteria for VFC)

Cambios en Elegibilidad (Changes in Eligibility)

Fecha de Elegibilidad Cambiado (Date Eligibility Changed)	Medicaid	Sin seguro (Uninsured)	Americano o Nativo de Alaska (American Indian / Alaska Native)	Insuficiente medico (Underinsured*)	No cumple con los criterios de elegibilidad (Does not meet eligibility criteria)

- *Tiene que ser vacunado en un FQHC (Must be vaccinated in an FQHC)
- Este documento sera revisado en cada visita para vacunarse. (This document will be reviewed at each visit for vaccination.)
- Al firmar el padre o tutor Certifica que la elegibilidad marcada es la correcta. Toda persona que ofrezca informacion falsa con la intencion de obtener los beneficios del Programa "Vacunas Para Ninos", sera referida a las autoridades estatales y federales correcpondientes y podra ser procesada criminalmente. (Signing this document by parent/guardian certifies that eligibility is answered correctly. Any person who provides false information with intent of obtaining the benefits of the VFC Program will be referred to state and federal authorities and may be criminally prosecuted.)
- Este documento tiene que mantenerse en el expediente de cada cliente. (This document must be kept on file for each client.)

El estatus de elegibilidad anterior fue proporcionada por mí a la Jo Daviess County Health Department. (The above eligibility status was provided by me to the Jo Daviess County Health Department.)

Firma del padre / madre / tutor o proveedor de atención médica (Signature of Parent/Guardian or Health Care Provider)	Fecha (Date)	Firma del padre / madre / tutor o proveedor de atención médica (Signature of Parent/Guardian or Health Care Provider)	Fecha (Date)