Maryland Vaccines for Children (VFC) Program

Patient Eligibility Screening Record

The provider is **not** required to verify responses by the parent, guardian, or individual of record.

Date:					
D ato					
Child:					
	Last Name		First Name		MI
Date of	Birth:				
	'Guardian/ ual of Record:				
maiviac	iai oi Record	Last Name	First Name		MI
Health (Care Provider:				
The provider's office must keep this form for each child (birth through 18 years of age) who receives immunizations through the Vaccines for Children (VFC) Program in Maryland in the patient's permanent medical record for six years. The health care provider or the parent, guardian, or individual of record may complete this form, and should complete a new form if the child's status changes. The provider may use this record for all subsequent visits as long as there is no change in the child's eligibility status.					
This child qualifies for vaccination through the Maryland VFC Program because he/she (please check only one box):					
(a)	Is covered by o	r enrolled in Medical Ass	istance		or
(b)	does not have h	nealth insurance			or
(c)	is Native Americ	can (American Indian) or	Alaskan Native		or
(d)	has health insu	rance that does not cove	r (pay for) vaccines		
Maryla or the complesubsection (a) (b)	and in the pati parent, guard ete a new forr quent visits as hild qualifies for only one box): Is covered by o does not have h	ient's permanent med lian, or individual of r m if the child's status is long as there is no r vaccination through the r enrolled in Medical Ass health insurance	dical record for six ecord may comple changes. The pro change in the child ne Maryland VFC Pro istance	years. The heatete this form, are ovider may use d's eligibility sta	alth care provided should this record for atus. e/she (please or

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