



TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM  
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:	
TVFC Eligible:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Screener's Initials	

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC 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 has not changed. If patient eligibility changes, a new form must be completed. 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.

Date of Screening: \_\_\_\_\_  
mm/dd/yyyy

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

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

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

Provider's Name/Clinic's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
Area Code + number

Please check the first category that applies; check only one.

(a)  Is enrolled in Medicaid, or

Medicaid Number: \_\_\_\_\_ Date of Eligibility (mm/dd/yyyy) \_\_\_\_\_

(b)  Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or

CHIP Number: \_\_\_\_\_ Date of Eligibility (mm/dd/yyyy) \_\_\_\_\_

(c)  Is an American Indian, or

(d)  Is an Alaskan Native, or

(e)  Does not have health insurance (uninsured), or

(f)  Is underinsured:

- 1) has commercial (private) health insurance, but coverage does not include vaccines; or
- 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or
- 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g)  Has private insurance that covers vaccines:

Name of Insurer: \_\_\_\_\_ Insurer Contact Number: (\_\_\_\_\_) \_\_\_\_\_  
Area Code + number

Policy/Subscriber Number: \_\_\_\_\_ Group Number (if applicable): \_\_\_\_\_

**NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
(mm/dd/yyyy)

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)