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

CLINIC USE ONLY:
TVFC Eligible
☐ Yes ☐ No

Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health-care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: ______________________

Child's Name:

____
Last Name First Name MI

Child's Date of Birth: ____/____/____
mm/dd/yy

Parent/Guardian/Individual of Record:

____
Last Name First Name MI

Provider's/Clinic's Name: CLEBURNE PEDIATRICS

____

Please select one of the following categories (check the first category that applies, check only one) to determine if the child is TVFC eligible:

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance, or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or
- ☐ (f) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage), or
- ☐ (g) is a patient who is served by any type of public health clinic and does not meet any of the above criteria (a-f), or
- ☐ (h) has private insurance, or is paying for services.

Signature: ______________________ Date: ______________

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)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. C-10
Revised 02/09

CLEBURNE PEDIATRICS,P.A. PATIENT INFORMATION FORM **TODAYS DATE** __________

NOTE: ALL NAMES LISTED WILL BE CONSIDERED LEGALLY ABLE TO ATTEND WITH PATIENT AND MAKE DECISIONS IN OFFICE

* ____

PATIENT LAST NAME, FIRST NAME, MIDDLE INITIAL DATE OF BIRTH

* ____

STREET ADDRESS MALE OR FEMALE

* ____

CITY , STATE, ZIP CHILD SSN

* ____

HOME PHONE CELL PHONE

* ____

NAME OF NEAREST FRIEND OR RELATIVE CONTACT NOT LIVING WITH YOU

* ____

THEIR ADDRESS CITY, STATE, ZIP

* ____

THEIR PHONE#

* ____

MOTHER'S LAST NAME, FIRST , MIDDLE INITIAL DATE OF BIRTH DRIVERS LICENSE

* ____

EMPLOYER PHONE#

* ____

OCCUPATION/JOB DESCRIPTION /TITLE MOTHER SSN

* ____

FATHER'S LAST NAME, FIRST , MIDDLE INITIAL DATE OF BIRTH DRIVERS LICENSE

* ____

EMPLOYER PHONE#

* ____

OCCUPATION/JOB DESCRIPTION/ TITLE FATHER SSN

* ____

OR CUSTODIAL GUARDIAN NAME DATE OF BIRTH DRIVERS LICENSE

* ____

ADDRESS GUARDIAN SSN

* ____

GUARDIAN HOME PHONE CELL PHONE WORK PHONE

List any other persons that are authorized to allow this patient to receive medical care and make medical decisions in reference to this patient while at this office :

____

name relationship name relationship

____

name relationship name relationship

signature of parent or Guardian____

NOTE: WE DO NOT FAX INFORMATION TO ANYONE OTHER THAN OFFICES IN RELATION TO CARE OF CHILD WITHOUT PARENT OR GUARDIAN RELEASE OF INFORMATION FORM. PLEASE DO NOT ASK US TO FAX INFO