

PATIENT ELIGIBILITY FORMS

Immunization Section—Vaccines for Children Program

Patient Eligibility Screening Record Florida Vaccines for Children Program

1. Initial Screening Date: _____
M M D D Y Y Y Y

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

3. Child's Date of Birth: _____
M M D D Y Y Y Y

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

5. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC):

- Yes No

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

7. This patient qualifies for immunization through the VFC Program because he/she (check only one box):

- a) Is enrolled in Medicaid
- b) Does not have health insurance
- c) Is an American Indian or Alaskan Native
- d) Is underinsured (has health insurance that does not pay for vaccinations)*
- e) This child does not qualify for immunizations through the VFC Program because he/she does not meet the eligibility criteria

Eligibility Criteria					
Date	Is enrolled in Medicaid	Does not have health insurance	Is an American Indian or Alaskan Native	Underinsured (has health insurance that does not pay for vaccinations)*	Does not meet eligibility criteria

The health care provider must keep in the office a record of all children 18 years of age or younger who receive immunizations. The record may be completed by the parent, guardian, 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.** While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

***To be supported with VFC Program-purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC or under a deputized agreement with an approved provider.**

**Comprehensive Certification Form
for American Indians and Alaskan Natives**

This form may be substituted for individual VFC Program screening records when 100% of the persons to be immunized at this facility are American Indians or Alaskan Natives.

Provider enrollment and Provider Profile forms for this practice must be on file with the State Health Department or public health agency of record. Certification must be re-issued annually when provider profile is submitted.

Date: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ Fax: () _____

Email: _____

Authorizing Official: _____

(Please Print the Authorizing Official's Name)

(Signature of Authorizing Official)

**Retain a copy of this form at your facility and send the original to the
State Health Department or state public health agency of record.**

**Comprehensive Certification Form
for Children Who Are Enrolled in Medicaid**

Provider Enrollment and Provider Profile forms for this practice must be on file with the State Health Department or public health agency of record. Certification must be re-issued annually when provider profile is submitted.

Date: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ Fax: () _____

Email: _____

Authorizing Official: _____
(Please Print the Authorizing Official's Name)

(Signature of Authorizing Official)

**Retain a copy of this form at your facility and send the original to the
State Health Department or state public health agency of record.**

Family Planning Clinic
Unaccompanied Minor without Insurance Information VFC Vaccine Log

Directions: This log must be completed and submitted to the state immunization program on a monthly basis. To prevent duplication of patient count, please record all vaccines administered to one patient on a single line. This report is in addition to other VFC Program reports required by the state immunization program. In completing this log, document only the administration of any VFC Program vaccine to unaccompanied minors (through 18 years of age) who present without insurance information. Please keep one copy for your clinic's records and send one to the state immunization program at the address below:

Florida Vaccines for Children (VFC) Program
 4052 Bald Cypress Way, BIN A-11
 Tallahassee, Florida 32399-1700
 Attention: VFC Program Coordinator

Clinic name: _____

Person completing this log: _____

Phone number of person completing this log: _____

Log for: Month _____ Year _____

Patient	Date VFC vaccine was administered	List names of VFC vaccines administered	Total number of VFC vaccines administered to this patient
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Total number of VFC vaccines, by type, administered this month:

Maximum Regional Charges for Vaccine Administration by State

State	Regional maximum charge
Alabama	\$19.79
Alaska	\$27.44
Arizona	\$21.33
Arkansas	\$19.54
California	\$26.03
Colorado	\$21.68
Connecticut	\$23.41
Delaware	\$22.07
District of Columbia	\$24.48
Florida	\$24.01
Georgia	\$21.93
Guam	\$23.11
Hawaii	\$23.11
Idaho	\$20.13
Illinois	\$23.87
Indiana	\$20.32
Iowa	\$19.68
Kansas	\$20.26
Kentucky	\$19.93
Louisiana	\$21.30
Maine	\$21.58
Maryland	\$23.28
Massachusetts	\$23.29
Michigan	\$23.03
Minnesota	\$21.22
Mississippi	\$19.79
Missouri	\$21.53
Montana	\$21.32
Nebraska	\$19.82
Nevada	\$22.57
New Hampshire	\$22.02
New Jersey	\$24.23
New Mexico	\$20.80
New York	\$25.10
North Carolina	\$20.45
North Dakota	\$20.99
Ohio	\$21.25
Oklahoma	\$19.58
Oregon	\$21.96
Pennsylvania	\$23.14

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State	Regional maximum charge
Puerto Rico	\$16.80
Rhode Island	\$22.69
South Carolina	\$20.16
South Dakota	\$20.73
Tennessee	\$20.00
Texas	\$22.06
Utah	\$20.72
Vermont	\$21.22
Virginia	\$21.24
Virgin Islands	\$21.81
Washington	\$23.44
West Virginia	\$19.85
Wisconsin	\$20.83
Wyoming	\$21.72