



Washington State Department of Health
Immunization Program CHILD Profile



Patient VFC Status Screening Form

Child's Full Name: _____

Date of Birth: _____

Full name of Parent, Guardian, or Legal Representative: _____

Health Care Provider's Full Name: _____

INSTRUCTIONS:

- Form must be completed for every child under age 19 years
- Complete only once, unless the child's VFC Eligibility Status changes.
- Use the back of form to document any changes in VFC Eligibility status.
- Form can be completed by the child's parent, guardian, or legal representative, or by a health care provider.
- Verification of responses is not required.
- Keep this form in the child's medical record or on file in the provider office.
- This form must be made available on request at site review as required by CDC guidance
- Documentation of VFC Eligibility Status must be kept for a minimum of 6 years after the child has left this practice (as per CDC and Washington State guidelines).

Initial Screening Date: _____

Patient's Vaccine for Children (VFC) Status Is: *(Choose one)*

- American Indian or Alaska Native
- Medicaid: Department of Social and Health Services (DSHS) - Healthy Options or Fee for Service
- No health insurance
- Underinsured (the child has health insurance coverage that has limited or no coverage for administration of vaccines)
- Private insurance

Please note: The private insurance category includes private health plans and children in state sponsored health plans [e.g. Health Care Authority Basic Health Plan (BCP), and DSHS CHIPRA (formerly SCHIP), CHP or other non-Medicaid DSHS health plans.]

**If this patient's VFC Eligibility Status changes,
please document his or her new status in the table on the back of this form.**

