## **Vaccines For Children (VFC) & Wyoming Vaccinates Important People (WyVIP) Programs**

## **Vaccine Eligibility Screening Form**

The VFC and WyVIP Programs provide vaccines for eligible patients from birth through the age of 18. If this patient is aged **18 years or younger**, please complete this form to determine eligibility. VFC & WyVIP eligibility **must** be screened and documented at every immunization encounter.

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| **Screening Date:** | | |
| **Patient Information** | | |
| Patient’s Full Name: | Date of Birth: | Age: |
| Full Name of Parent, Guardian, or Legal Representative: | | |

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| --- | --- | --- | --- | --- |
| **VFC Eligibility Screening Circle Response** | | | | **Details & Documentation** |
| 1. Is this patient covered by Medicaid? | YES | NO | **If No,** proceed to number 2**.**  **If Yes**, STOP*.* Patient is *VFC Eligible – Medicaid/Medicaid Managed Care*. | |
| 2. Is this patient uninsured (has **no** insurance or is self-pay)? | YES | NO | **If No,** proceed to number 3**.**  **If Yes**, STOP*.* Patient is *VFC Eligible – Uninsured*. | |
| 3. Is this patient American Indian or Alaskan Native? | YES | NO | **If No,** proceed to number 4**.**  **If Yes**, STOP*.* Patient is *VFC Eligible – American Indian/Alaskan Native*. | |
| 4. **If this facility is a Rural Health Clinic, Federally Qualified Health Center, or a Delegated Authority/Deputized Provider:** Does this patient have insurance that does not cover the vaccines needed (underinsured)? | YES | NO | **If No,** proceed to WyVIP Screening**.**  **If Yes**, STOP*.* Patient is *VFC Eligible – Underinsured at a FQHC/RHC/Deputized Provider*. | |

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| **WyVIP Eligibility Screening Circle Response** | | | | **Details & Documentation** |
| 1. Is this patient a Wyoming resident? | YES | NO | **If No,** the patient is *Not VFC Eligible* and cannot receive publicly-supplied vaccine.  **If Yes,** the patient is *State Program Eligible. \*See Note* | |
| **\*NOTE**: The following vaccines are **not** provided by the WyVIP Program; providers must administer **privately-purchased** vaccine and document eligibility as *Not VFC Eligible*.  • Hepatitis A • Meningococcal conjugate  • Influenza • Human papillomavirus | | | | |

In certain situations, a patient may have a different eligibility status for different vaccines. In these situations, specify patient eligibility for each vaccine below.

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| **Vaccine** | **Eligibility** | **Comments** |
| *Ex: Influenza* | *Ex: Not VFC Eligible* | *Ex: Patient is WyVIP eligible for all vaccines except flu* |
|  |  |  |
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If you have any questions about VFC and WyVIP policies and/or eligibility screening or documentation, please contact the Immunization Unit at 307-777-7952.

*\* Eligibility Screening Forms must be maintained with the patient’s record for no less than 3 years.*

*\*\*Any provider changes to this form must be approved by the Immunization Unit*. Rev. 02.2020