Declared Emergency/Outbreak Name: _____ PHR: _____ Subregion: _____

Texas Vaccines for Children/Adult Safety Net Emergency Eligibility Screening Record

To assess and document eligibility for the DSHS Texas Vaccines for Children (TVFC)/Adult Safety Net (ASN) programs. Eligibility records must be maintained for all children aged 18 and younger, as well as adults receiving DSHS supplied vaccines. These records can be stored in either hard copy by the administering clinic or within an electronic system, with hard copies retained for five years. Eligibility screening and documentation must occur at each immunization visit to confirm continued program eligibility. The record may be completed by the parent, guardian, individual of record, or healthcare provider.

Date of Screening: _____
(mm/dd/yyyy)

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ Gender: ☐ Male ☐ Female Veteran: ☐ Yes ☐ No
(mm/dd/yyyy)

Parent, Guardian, or Individual of Record: _____
(Last Name) (First Name) (Middle Initial)

TVFC Eligibility Criteria (Please select only one):

- ☐ I declare my child qualifies for vaccines through the TVFC program because my child is enrolled in Medicaid.
- ☐ I declare my child qualifies for vaccines through the TVFC program because my child does not have health insurance (uninsured).
- ☐ I declare my child qualifies for vaccines through the TVFC program because my child is American Indian or Alaskan Native.
- ☐ I declare my child qualifies for vaccines through the TVFC program because my child has health insurance that does not include vaccines or only covers specific vaccine types (under-insured).
- ☐ I declare my child qualifies for vaccines through the TVFC program because I have enrolled my child in the State of Texas Children's Health Insurance Program (CHIP).
- ☐ I declare my child qualifies for vaccines through disaster relief/outbreak efforts. The CDC waived insurance status (insured or non-insured) for all disaster relief efforts.

ASN Eligibility Criteria (Please select only one):

- ☐ I declare I qualify for vaccines through the ASN program because I do not have health insurance (uninsured).
- ☐ I declare I qualify for vaccines through disaster relief/outbreak efforts. The CDC waived insurance status (insured or non-insured) for all disaster relief efforts.

☐ Medicaid ☐ CHIP ☐ Private insurance ☐ No insurance

Medicaid number: _____ CHIP number: _____

Private insurance name: _____ Policy number: _____

Primary Provider's Name: _____

Patient or Guardian Signature: _____ Date of Screening: _____
(mm/dd/yyyy)

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 eligible to receive vaccines.

With few exceptions, you have the right to request and to 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 agency to correct any information that is determined to be incorrect. See dshs.texas.gov for more information on Privacy Notification.
(Reference: Government Code, Section 552.021, 552.023, and 559.004)