

Texas Vaccines for Children Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

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

2. Child's Date of Birth: ___/___/_____

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

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

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC program, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-F is marked, the child is eligible for the TVFC program. If column G is marked the child is not eligible for TVFC vaccine.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are eligible for vaccines through the TVFC program as long as the provider bills CHIP for the administration of the vaccine.*

**** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*



Texas Vaccines for Children Program
Patient Eligibility Screening Record
(Continued)

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicaid: Medicaid Number: _____ Date of Eligibility: _____	CHIP: CHIP Number: _____ Group Number: _____ Date of Eligibility: _____
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Private Insurance:	
Name of Insurer: _____	Insurer Contact Number: _____
Insurance Name: _____	Policy/Subscriber Number: _____

Programa de Vacunas para los Niños de Texas (TVFC) Registro de determinación del derecho a la participación del paciente

En el consultorio de un proveedor de salud debe mantenerse un registro de determinación del derecho a la participación de todos los niños de 18 años de edad o menos que reciban inmunizaciones por medio del Programa TVFC. Dicho registro lo puede rellenar el padre o la madre, el tutor, el individuo cuyo nombre consta en el registro o el proveedor de salud. En cada visita de inmunización debe determinarse y documentarse el derecho a la participación en el programa TVFC para asegurarse de que la persona tenga derecho a participar en el programa. Aunque no se requiere verificar las respuestas, es necesario conservar este registro, o uno similar, por cada niño que reciba vacunas bajo el Programa TVFC.

1. Nombre del niño o niña: _____
Apellido Primer nombre Inicial del 2.º nombre

2. Fecha de nacimiento del niño o niña: _____
mm/dd/aaaa

3. Padre o madre, tutor o individuo cuyo nombre consta en el registro: _____
Apellido Primer nombre Inicial del 2.º nombre

4. Nombre del proveedor primario: _____
Apellido Primer nombre Inicial del 2.º nombre

5. Para determinar si un niño o niña (de 0 a 18 años de edad) cumple los requisitos estatales o federales para recibir las vacunas mediante el Programa TVFC, en cada inmunización o visita médica anote la fecha y marque la categoría apropiada de derecho a la participación. *Si se ha marcado una columna de la A a la F, el niño o niña tiene derecho a participar en el programa TVFC. Si se ha marcado la columna G, el niño o niña no reúne los requisitos para participar en el programa TVFC.*

	Con derecho a participar en el Programa de vacunas VFC				Con derecho a participación estatal		No cumple los requisitos para participar
Fecha	A	B	C	D	E	F	G
	Inscrito en Medicaid	No tiene seguro médico	Indio americano o nativo de Alaska	*Con seguro insuficiente, recibe atención de un FQHC, una RHC o un proveedor autorizado	**Inscrito en el CHIP	***Otras situaciones de seguro insuficiente	Tiene seguro médico que cubre las vacunas
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*El seguro insuficiente incluye a los niños cuyo seguro médico no incluye las vacunas o solo cubre ciertos tipos específicos de vacunas. Los niños solo tienen derecho a recibir las vacunas que no están cubiertas por un seguro. Además, para recibir las vacunas del Programa VFC, los niños con seguro insuficiente deben ser vacunados en un Centro de Salud Federalmente Calificado (FQHC) o en una Clínica de Salud Rural (RHC), o por un proveedor aprobado y autorizado. El proveedor autorizado debe tener un acuerdo por escrito con un FQHC o una RHC y con el programa de inmunización estatal, local o territorial para poder vacunar a los niños con seguro insuficiente.

**Niños inscritos en el Programa estatal separado de Seguro Médico Infantil (CHIP). Estos niños se consideran asegurados y tienen derecho a recibir vacunas mediante el programa TVFC siempre y cuando el proveedor facture al CHIP el importe de la administración de la vacuna.

*** Otros niños con seguro insuficiente son aquellos cuyo seguro es insuficiente pero que además no tienen derecho a recibir vacunas federales por medio del programa VFC porque el proveedor o el centro no es un FQHC o una RHC, o no es un proveedor autorizado. Sin embargo, estos niños pueden ser atendidos si las vacunas son proporcionadas por el programa estatal para dar cobertura a aquellos niños que no tienen derecho a beneficiarse del programa VFC.

Programa de Vacunas para los Niños de Texas (TVFC)
Registro de determinación del derecho a la participación del paciente
(Continuación)

	Con derecho a participar en el Programa de vacunas VFC				Con derecho a participación estatal		No cumple los requisitos para participar
	A	B	C	D	E	F	G
Fecha	Inscrito en Medicaid	No tiene seguro médico	Indio americano o nativo de Alaska	*Con seguro insuficiente, recibe atención de un FOHC, una RHC o un proveedor autorizado	**Inscrito en el CHIP	***Otras situaciones de seguro insuficiente	Tiene seguro médico que cubre las vacunas
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicaid: Número del Medicaid: _____ Fecha en que adquirió el derecho a la participación: _____	CHIP: Número del CHIP: _____ Número del grupo: _____ Fecha en que adquirió el derecho a la participación: _____
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Seguro privado: Nombre de la aseguradora: _____ Nombre del seguro: _____	Número de contacto de la aseguradora: _____ Número de póliza o del asegurado: _____
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____
Signature of Minor Individual DATE

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §§ 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii)); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.