VFC PIN: ___ ___ ___ ___

Montana Immunization Program
VACCINE ELIGIBILITY FORM - for FQHC/RHC Clinics

Accountability Period

From: _____ /_____ /_____

To: _____ /_____ /_____

PATIENT ELIGIBILITY STATUS
(Check ONE BOX for each service date. Circle the checkmark for the first visit of the year or whenever eligibility status changes.)

VACCINE DOSES ADMINISTERED
Check all doses administered at each visit.

Name	Date of Birth	Date of Service (mo / day)	Age is under 1 Year: MEDICAID	NO INSURANCE	AMER. INDIAN or ALASKA NATIVE	VFC - UNDERINSURED	INSURED-NOT ELIGIBLE	Age is 1 through 6 Years: MEDICAID	NO INSURANCE	AMER. INDIAN or ALASKA NATIVE	VFC - UNDERINSURED	INSURED-NOT ELIGIBLE	Age is 7 through 18 Yrs: MEDICAID	NO INSURANCE	AMER. INDIAN or ALASKA NATIVE	VFC - UNDERINSURED	INSURED-NOT ELIGIBLE	Adult: CDC NO INSURANCE or UNDERINSURED	INSURED-NOT ELIGIBLE	DTaP (or Ped DT *)	Hep B	HIB: Pedvax (or ActHIB * [A]) (or Hiberix [H])	IPV	Pediarix (DTaP + Hep B + IPV)	Pentacel (DTaP + IPV + ActHIB)	Pneumococcal PCV (or PPSV *)	Rotavirus RotaTeq (or Rotarix* [RR])	MMR	VAR	ProQuad (MMRV)	Hep A	Influenza - .25 dose	Influenza - .5 dose	Influenza - Flumist	Kinrix - for 4-6 yr olds only (DTaP + IPV)	Tdap (or Td *)	Meningococcal-MCV4 Menactra (or Menveo*[O])	Human Papillomavirus (HPV) Gardasil
1		/																																				
2		/																																				
3		/																																				
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To determine provider profile number for re-enrollment, count the circled checkmarks in each column for the entire year.																																						

Total these columns for vaccine doses administered - Use these numbers to determine vaccine need and order quantities.

Provider's Signature: **Date:**

This form must be retained for three years. MT IZ VFC Form 245.1 (revised 12/13/13)