COLLIN COUNTY HEALTH CARE SERVICES ELIGIBILITY SCREENING APPLICATION--PLEASE PRINT LEGIBLY

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Date of Birth: MONTH DAY YEAR	Gender: ☐ Male ☐ Female	Contact Phone #:
Social Security # - last 4 (or NA):	Email:	
Address:	Apt #:	City:
State: Zip Code:	County:	Mother's Maiden Name:

Race: Alaskan Native/American Indian (SEE BELOW) White Black/African American Pacific Islander Asian Other

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Does the patient have a primary physician (medical home)? ☐ Yes ☐ No

Is the patient a Veteran? ☐ Yes ☐ No

If the patient is under 18 years list name of parent/guardian: _____
(Parent/Guardian Last Name) (Parent/Guardian First Name)

CHILDREN 0-18 YEARS - TVFC ELIGIBILITY I DECLARE THE PATIENT IS:		HOUSEHOLD INFORMATION FOR CHILDREN 0-18 YEARS	
☐	Uninsured: has no health insurance	How many people live in the household? _____	
☐	Medicaid Enrolled: Medicaid Number_____ Eligibility Date:_____	Monthly Income	TVFC Eligible Vaccine Administration Fee
☐	CHIP Enrolled: CHIP Number:_____ Eligibility Date: _____	☐ $0 - $1,335	No Charge
☐	American Indian or Alaskan Native	☐ $1,336 - $2,025	$5 Each Vaccine
☐	Underinsured: patient's insurance only covers selected vaccines.	☐ $2,026 - $2,715	$10 Each Vaccine
☐	Underinsured: patient has commercial/private health insurance, but coverage doesn't include vaccines	☐ $2,715+	$13 Each Vaccine

ADULTS AGED 19+ - ASN ELIGIBILITY - I DECLARE THE PATIENT IS:		ADULTS AGED 19+ - ASN Eligible Vaccine Administration Fee
☐	Uninsured: has no health insurance	$20 Each Vaccine

ADULTS AGED 19+ - ASN – COVID-19 VACCINE ELIGIBILITY – I DECLARE THE PATIENT IS:		ADULTS AGED 19+ - ASN Eligible COVID-19 Vaccine Administration Fee
☐	Uninsured: has no health insurance	$0 COVID-19 Vaccine
☐	Underinsured: not covered by insurance or co-pays apply	

ALL AGES WITH INSURANCE - PRIVATE PAY ELIGIBILITY - I DECLARE THE PATIENT IS:		ALL AGES WITH INSURANCE
☐	Insured: patient's insurance covers vaccines.	PRICES AND AVAILABILITY VARY, SEE FRONT DESK STAFF MEMBER FOR ASSISTANCE

ACKNOWLEDGEMENTS

By signing this form, the applicant or legally authorized representative, is authorizing CCHCS or its authorized representative, to submit a claim for reimbursement and collect payment for any benefit, service or assistance that was received. The patient/parent/guardian, CCHCS (or authorized representative), as applicable, will submit the claim and collect payment from any private or group health insurance company, Medicaid, Medicare or any health plan providing coverage to the applicant. The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about the applicant's eligibility. I understand giving false information could result in disqualification and repayment.

I understand that as part of the provisions of healthcare services, Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Collin County reserves the right to change its notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment of healthcare operations, but that Collin County is not required to agree to the requested restrictions.

Print Name of Person who completed application (matches ID)	Signature of Person who completed application	Relationship to Patient	Date

FOR OFFICE USE ONLY—VACCINATIONS REQUESTED						
PP VACCINES						
ASN VACCINES						
VFC VACCINES						

INFECTIOUS DISEASE SCREENING?	MEDICAL HM PACKET:	CLERK INITIALS:
☐ YES ☐ NO - DONE BY:	☐ Y ☐ N	

FOR OFFICE USE ONLY—PAYMENT DETAILS

$_____TOTAL PAID BY ☐CC ☐CASH ☐CHECK

Revised: 9/26/2023

CCHCS HEALTH HISTORY & SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

PERSON RECEIVING VACCINATIONS (PATIENT) NAME	DATE OF BIRTH
	MONTH DAY YEAR

Disclaimer: We **DO NOT** offer the following travel vaccines: Anthrax, Cholera, Japanese Encephalitis, Smallpox, Typhoid, and Yellow Fever. If you are interested in receiving a travel vaccine(s), please discuss with your primary care provider.

THE FOLLOWING QUESTIONS WILL HELP US DETERMINE WHICH VACCINES THE PERSON RECEIVING VACCINATIONS MAY BE GIVEN TODAY. IF YOU ANSWER "YES" TO ANY QUESTION, IT DOES NOT NECESSARILY MEAN THAT THE PERSON RECEIVING VACCINES SHOULD NOT BE VACCINATED. IT JUST MEANS ADDITIONAL QUESTIONS MAY BE REQUIRED. IF A QUESTION IS NOT CLEAR, PLEASE DISCUSS WITH YOUR HEALTHCARE PROVIDER.

	QUESTIONS			**COMMENTS**
1.	Does the patient have allergies to medications, food, a vaccine component, or latex?	Yes ☐	No ☐	
2.	Has the patient had a serious reaction to a vaccine in the past?	Yes ☐	No ☐	
3.	If the patient is of child bearing age, when was the first day of last menstrual period? (please specify in the comments)		N/A ☐	
4.	Is the patient pregnant or is there a chance they could become pregnant during the next month?	Yes ☐	No ☐	
5.	Does the patient have a long-term health problem with heart, lung, kidney or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak?	Yes ☐	No ☐	
6.	Is the patient on long-term aspirin therapy or taking blood thinners?	Yes ☐	No ☐	
7.	Has the person receiving vaccinations been told that they had wheezing or asthma in the past 12 months?	Yes ☐	No ☐	
8.	Has the patient ever been told or had intussusception (bowel obstruction)?	Yes ☐	No ☐	
9.	Has the patient, the patient's child, sibling, or parent ever had a seizure, brain, or other nervous system problem (e.g. Guillain-Barre Syndrome)?	Yes ☐	No ☐	
10.	Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes ☐	No ☐	
11.	In the past 3 months, has the patient taken medications that affect their immune system, such as prednisone, cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or has the patient had any radiation treatments?	Yes ☐	No ☐	
12.	During the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes ☐	No ☐	
13.	Has the patient received any vaccinations in the past 4 weeks?	Yes ☐	No ☐	
14.	Has the patient had the Chicken Pox Disease?	Yes ☐	No ☐	If yes, what age?
15.	Would the patient like the COVID-19 Vaccine? If yes, please fill out the document below.	Yes ☐	No ☐	

For all women of child bearing age: By signing below I acknowledge and understand that if I receive any live virus vaccine during my visit that I should practice birth control of choice for the next four weeks after receiving any live vaccine.

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I understand that giving false information could result in serious injury or even death. I acknowledge and agree that signing this screening checklist for contraindications to vaccines is a voluntary act on my part and that I have signed this document of my own free will and act.

Print Name of Person who completed application	**Signature of Person who completed application**	**Relationship to Patient**	**Date**

FOR OFFICE USE ONLY

Form Reviewed By		Date	

Notes: _____

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Revised: 9/26/2023