Glacier Pediatrics, LLC
Amy Dressel, MD • Kim Gardner, FNP • Mary Ellen Arvold, PNP
Mary Ellen Arvold, PNP • Lauren Hopson, PNP
Phone: (907) 586-1542 • Fax: (907) 586-1849 • 1600 Glacier Ave • Juneau AK, 99801

PATIENT INFORMATION

CHILD'S FULL NAME: _____
(First) (Middle) (Last)

NICKNAMES:_____ GENDER: M / F DATE OF BIRTH:_____
CHILD'S HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIPCODE:_____
CHILDS MAILING ADDRESS: _____ CITY:_____ STATE:_____ ZIPCODE:_____
PRIMARY PHONE:_____ MOTHER'S MAIDEN NAME:_____

HOW DID YOU HEAR ABOUT GLACIER PEDIATRICS: INTERNET FRIENDS ADVERTISEMENT OTHER:_____

GUARDIAN INFORMATION

GUARDIANS FULL NAME**:** _____
(First) (Middle) (Last)
DATE OF BIRTH:_____ RELATIONSHIP TO CHILD:_____ SOCIAL SECURITY:_____
PRIMARY PHONE:_____ SECONDARY PHONE:_____ EMAIL: _____
HOME ADDRESS:_____CITY:_____ STATE:_____ ZIPCODE:_____
MAILING ADDRESS:_____CITY:_____ STATE:_____ ZIPCODE: _____

GUARDIANS FULL NAME: _____
(First) (Middle) (Last)
DATE OF BIRTH:_____ RELATIONSHIP TO CHILD:_____ SOCIAL SECURITY:_____
PRIMARY PHONE:_____ SECONDARY PHONE:_____ EMAIL: _____
HOME ADDRESS:_____CITY:_____ STATE:_____ ZIPCODE:_____
MAILING ADDRESS:_____CITY:_____ STATE:_____ ZIPCODE: _____

OTHER CHILDREN IN HOUSEHOLD (FULL NAMES):_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP TO CHILD: _____ PRIMARY PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance company: _____
Policy #:_____Group Number:_____
Subscriber Name: _____
Social Security: _____Date of Birth: _____
Relationship to Patient:_____

SECONDARY INSURANCE
Insurance company:_____
Policy #:_____Group Number:_____
Subscriber Name: _____
Social Security: _____ Date of Birth:_____
Relationship to Patient:_____

I understand and agree that my co-payment is due at the time of visit and that regardless of my insurance status; I am ultimately responsible for the balance of my account for any professional services rendered. I will notify you of any changes in my child's status to the above information. I consent to the care including diagnostic procedures, examinations and treatment that the physician designates and considers to be necessary to treat my child's condition. I certify that I have read all information on this sheet and have answered all questions to the best of my knowledge.

LEGAL GUARDIAN SIGNATURE:_____ DATE:_____

Family Profile

Who lives in your home? (Include yourself and any significant others)

Full Name	Birth Year	Relationship to Patient	Occupation

Are there any smokers in the house? ☐No ☐Yes If yes, do they smoke ☐Inside ☐Outside

Are there any pets in the house? ☐No ☐Yes If yes, what type and how many?

Current housing situation: ☐ Single Family Home ☐Apartment/Condo ☐ Group Home ☐Shelter ☐Other

Utilities available in current housing: ☐Electricity ☐Running Water ☐Internet ☐Telephone ☐Natural Gas/Propane/Heat

Are there any cultural or religious beliefs that may affect healthcare choices? ☐No ☐Yes If yes, explain:

Family Health History

Please let us know who in the child's family has any of the conditions listed below

☐**History is Unknown- The Patient is Adopted or in Foster Care**

	Paternal Codes:	Dad (DAD) Grandfather (PGF) Grandmother (PGM)	**Maternal Codes:**	Mom (MOM) Grandfather (MGF) Grandmother (MGM)	**Sibling Codes:**	Brother (BRO) Sister (SIS)

YES	NO	Condition	Who: DAD	PGF	PGM	MOM	MGF	MGM	BRO	SIS
☐	☐	Asthma	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Blood Disorders (Anemia, Sickle Cell, Hemophilia)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Bone Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Cancer (Specify what type:_____)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Digestive or Intestinal Problems (Specify:_____)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Eczema	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Hearing Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Joint Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Kidney or Bladder Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Mental Health (Ex: Depression, Anxiety, Bipolar, Schizophrenia)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Seizures or Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Substance Abuse (Drugs or Alcohol)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Thyroid Problems / Auto-Immune Conditions	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Other:_____	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name: _____ Date of Birth: _____

Signature of Legal Guardian: _____ Date: _____

Patient Health history	
Delivery Method: ☐Vaginal Birth ☐Cesarean Born at _____ Weeks	
Birth Place: ☐Hospital ☐Birth Center ☐Home Birth ☐Other:_____	
Birth Length:_____ Birth Weight:_____ Feeding: ☐Breastfed ☐Formula	
Problems During New Born Stage? ☐No ☐Yes If yes, Explain:_____	
What age did your child sit alone:	What age did your child crawl:
What age did your child walk alone:	What age did your child say specific words:
For Children Under 5 years old:	
What style car seat are you currently using? ☐Rear Facing ☐Forward Facing ☐Booster Seat ☐None	
Is the child in childcare? ☐No ☐Yes If yes, what type: ☐Daycare Facility ☐In-home Daycare ☐Family ☐Other	
For Children Over 5 years old:	
What grade is the child currently in and what school are they attending? Grade: School:	
How would you describe their performance in school? ☐No Problems ☐Academic Difficulties ☐Social Issues ☐Behavioral Concerns	

For Adolescents (9 years – 19 years)	
Age of onset puberty:	*Females only*, age of onset menstrual cycle:

ALL AGES: Please Circle Any Problems Your Child Has Been Diagnosed With:

ADHD	Cancer	Hearing Loss	Migraines
Acne	Chicken Pox	Heart Disease	Seasonal Allergies
Anemia	Chronic Constipation	High Blood Pressure	Seizure
Anxiety	Depression	High Cholesterol	Sexual Transmitted Disease
Asthma	Diabetes	Incontinence	Skin Problems
Autoimmune Disease	Eczema	[Inherited]Metabolic Disease	Tuberculosis or +TB Test
Behavioral Problems	Frequent Ear Infection	Insomnia	Urinary Tract Infections
Birth Defects	Food Allergies	Kidney Disease	Warts
Bleeding or Clotting Disorders	Gastrointestinal Problems	Learning Difficulties	Weight Concern
Bone and Joint Disease	Headaches	Mental Illness	Vision Problems
Broken Bone(s)	Head Injury or Concussion	Menstrual Problems	Other:_____

Surgeries & Hospitalizations

☐ **No Surgical or Hospitalization History**

Year	Reason	Hospital

Patient Name: _____ Date of Birth: _____

Signature of Legal Guardian: _____ Date: _____

Patient Allergies & Medication Summary

Allergies to **Medication**	
☐**No Known Allergies**	
Medication Name:	Reaction (Ex: Hives, Rash, Wheezing, Facial Swelling)

Allergies to **Foods/Other**	
☐**No Known Allergies**	
Foods/Other Name:	Reaction (Ex: Hives, Rash, Wheezing, Facial Swelling)

Current Medications, Vitamins & Supplements		
☐**No Current Medications** ☐**No Current Vitamins or Supplements**		
Medication/Vitamin/Supplement Name:	Dosage:	Frequency/How Often:

Patient Name: _____ Date of Birth: _____

Signature of Legal Guardian: _____ Date: _____

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Financial Policy

Thank you for choosing Glacier Pediatrics (GP) to meet your child(ren)'s health care needs. We are committed to providing the best care possible and appreciate your trust. Please understand that payment of your bill is considered part of your child(ren)'s treatment. The following document is our Financial Policy. Please read it carefully; we will require that you agree to and sign this policy prior to receiving treatment.

I. Responsible Party

a. GP will gladly submit to your health insurance for the services provided. However, any charges accrued on the account are your responsibility. You will be expected to follow up on any unpaid or incorrectly paid charges, regardless of insurance coverage. We will be happy to assist you in any way we can, but you are ultimately responsible for timely payment of your account.
b. In divorce situations, the person bringing the child into the office is the responsible party. A divorce decree is a document that involves only you, your ex-spouse and the courts. Although a divorce decree may state that an ex-spouse is responsible for medical bills, GP has no authority to enforce compliance.
c. You will be responsible for the charges accrued by minor (under age 18) that come into the office unaccompanied, or in the presence of another caregiver (ie. grandparents, baby sitter, friend, etc...)
d. You will be responsible for charges accrued by minor who have turned 18 until such time as you notify GP in writing, prior to services being provided, that you no longer accept financial responsibility.

II. Billable Services

a. GP will charge for healthcare services and all follow up services, as well as supplies used for the care of your children.
b. GP will charge for all scheduled, walk-in, home visits, and after hour appointments. We will also charge for patients who are not scheduled (ie. siblings of a scheduled patient) that the healthcare provider is asked to see.
c. Occasionally a patient will be scheduled for one type of service but the provider may diagnose and treat another problem in addition to the scheduled service (ie. immunizations, lab work, procedures). GP will charge accordingly.

III. Portion Due at Time of Service

a. *Unless prior arrangement is made, payment is due at the time of service*. Your payment options are: cash, check, or Visa and Master Card credit/debit cards.
b. If you have insurance coverage, all co-pays are due at the time of service.
c. Payment in full is due from self-party patients at the time of service. A 15% discount will be given if charges are paid in full on the date of service.
d. *Payment is due at the time of service for non-GP patients* (ie. Tourists, etc), regardless of insurance coverage.
e. Payment in full is due at the time of service if accounts have a history of collections status.

IV. Insurance Coverage

a. It is your responsibility to provide accurate insurance information to GP at the time of service.
b. GP will create and submit claims to your health insurance on your behalf. However, we reserve the right to refuse insurance and collect payment in full from you (ie out-of-state Medicaid, insurance information provided after claim filing deadlines, etc).

c. *It is your responsibility to verify benefits* and that the health care providers you have chosen are covered under your plan, prior to receiving services. You will be responsible for any non-covered services and services considered to be over "usual, responsible, and customary." *You will also be responsible for amounts not paid by your insurance for any reason.*
d. In a divorce situation, it is your responsibility to provide us with your ex-spouse's correct insurance information, necessary to bill your child(ren)'s visit, not ours.
e. Your signature on this policy authorizes GP to release health information to insurance carriers when necessary for payment.

V.Statements

a. Account statements will be sent on a monthly basis for accounts that have balances owing. Payment is due within 30 days of the statement date.
b. *Statements can only be sent to the responsible party at one address.* We cannot and will not bill to more then one address/party.
c. It is your responsibility to provide GP with your correct address and phone number. If a statement is returned for an invalid address and no contact can be made with you, your account may be turned over to an outside collections agency.

VI.Past Due Accounts

a. If you cannot pay your families account balance in full, then *a monthly payment is expected*. Additionally, we require you to stay on top of your *co-payments at every visit,* if you have no co-payment then you must make a payment at each visit.
b. *Accounts greater that 6 months old with no payment will be sent to a collections agency.* If anyone in your family is sent to collections we would not be able to see you in the clinic until the balance is paid off with the agency

VII.Payment Plan Options

a. When appropriate and at GP's discretion, GP will offer monthly payment plans to help you manage your health care costs.
b. We are happy to keep your credit card information on file, for automatic processing
c. Payment plans are intended to help bring past-due amounts current.

VIII.Credits

a. Any insurance credits or over-adjustments will be returned to the appropriate insurance company.
b. Any patient credits or overpayments will either be applied to past-due balances or left on the account to be used for future co-pays and/or deductibles.

IX.Collections

a. Your account may go to collections for the following reasons that include, but are not limited to:
    1. Invalid patient information (address, phone, etc.) which prevents us from contacting you regarding your account.
    2. Failure to provide timely, accurate insurance information.
    3. Failure to pay patient balances.
    4. Failure to follow through with payment plan agreements.
    5. Failure to follow through with statement discrepancies, insurance denials or any other items on your account.
    6. Failure to follow through with any other correspondence from GP.

b. GP makes every effort to work with you to keep your account out of collections. However, in the event that your account is referred to a collection agency, you will be responsible to pay your balance before you can schedule

appointments at GP for your child(ren). You will also be required to pay cash or credit (no checks) at each visit and you will be given a super bill to take with you so that you may bill your insurance if you choose.

X. Returned Checks

a. Checks returned unpaid by your bank, regardless of the reason, will be posted back to your account in the original amount, in addition to a $25.00 return check fee.

XI. Dismissal from Practice

a. GP reserves the right to dismiss patients from our practice for non-payment. If you have a history of non-payment on your account, you may be eligible for dismissal.
b. Missed Appointments: GP is here to meet the needs of you and your family. Our policy is 24-hours notice on appointment changes. We understand emergencies happen. If an emergency keeps you from keeping your appointment, please contact us as soon as you know you will not be able to keep you regularly scheduled appointment. *Please help us to serve you better by keeping your regularly scheduled appointments. After 3 no show appointments, then we reserve the right to allow your family only same day scheduling*.

XII. Divorced and Seperated Parents

a. Please see Glacier Pediatrics' in-depth '*Divorced and Seperated Parents Policy*' to understand our requirements and expectation for families who are divorced or separated. A copy of the policy is in this new patient packet and is available upon request from the front desk.

XIII. Questions or Concerns

a. If you have any questions regarding your account or need clarification on any of the items listed in this financial policy, please contact Front Desk Staff.
b. GP Staff are available 9:00 – 5:00 Monday – Friday. You can contact them at (907) 586-1542, by e-mail reception@glacierpediatricsllc.com, or in person at the office.

Thank you for trusting Glacier Pediatrics with the care of your children. We are dedicated to making your experience a positive one, help us help you. Please do not hesitate to contact us with any questions regarding your account, payment options or financial responsibilities.

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Acknowledgment of Receipt of Financial Agreement

I acknowledge that I have received a copy of the Glacier Pediatrics' (GP) Financial Agreement for my child, _____, which describes how his/her account will be handled.

I have read, understand and agree to the policies described above. I understand that these policies are subject to change without notice at any time and that I may obtain a current copy of the agreement by contacting GP.

Printed Name:_____ Relationship to Child:_____

Signature: _____ Date:_____

Glacier Pediatrics Employee/Witness Signature:_____

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Separated & Divorced Parent Policy

We believe that such matters should not enter into a child's medical treatment. The following policy ensures that your child's care is minimally impacted.

- We will assume that both parents have legal custody of the child, unless we receive an original court document to the contrary, and as such, each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results. We cannot guarantee that copies of medical records will be free of all demographic information, such as home phone numbers and addresses.
- Appointments must be made and attended by ether legal guardian unless permission is given to a step-parent. We are unable to release medical records to step-parents unless they have legal authority to request them.
- We will not call the non-accompanying parent for consent prior to office visits and treatment. We will communicate our findings and plans to the parent or legal guardian who is present and will assume that any information will be shared with the non-present parent. We cannot routinely call non-present parents to share findings, but if we are contacted, we will certainly make every attempt to respond to the caller and answer questions, unless we are prohibited from doing so by court order.
- We will assume that any treatment and/or medication that we prescribe will be given as directed, as failure to do so may jeopardize your child's health. We cannot write prescriptions for separate bottles of the same medication to be used at separate homes. Doing so may result in over dosage.
- If you utilize more than one office for your child's medical care, it is your responsibility to ensure our notes are delivered.
- One parent will be designated the financial guarantor and will receive statements unless it is indicted elsewhere legally, we will collect co-payments from the accompanying legal guardian. The guarantor will be ultimately responsible for the amount owed.
- We are here to provide medical care to your child, but we are not in a position to provide legal advice. Child custody concerns must be directed to your attorney and proper legal channels followed.
- Should the issues that come between parents become disruptive to our clinic, we will discharge the patient from further treatment.

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Privacy Policy

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Please continue to further understand the details of your information, your rights and our responsibility.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-bas

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting Glacier Pediatrics and speaking to our Business Manager, Thea Paddleford.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- Treat you. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: hhs.gov/ocr/privacy/hipaa/ understanding/consumers/index.html

Help with public health and safety issues.

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research
We can use or share your information for health research.

Health Information Exchange Mission Health
Participates in electronic health information exchanges which allow the sharing of your medical information for appropriate purposes. Your information will be included unless you choose to opt-out.

Comply With The Law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. When North Carolina law gives more protection to your health information than included in this notice or required by federal law, we will give that additional protection.

Respond To Organ And Tissue Donation Requests
We can share health information about you with organ procurement organizations.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond To Lawsuits And Legal Actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:

hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htm

Glacier Pediatrics reserves the right to change these terms of Privacy Policy at any time. The new notice will be available in our office, upon request.

These terms are effective as of April 1, 2015. Revised June 18, 2018.

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Acknowledgment of Receipt of Privacy Policy

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My signature below constitutes my acknowledgement that I have received, read and understand this Privacy Policy as it applies to the patient, _____.
Patient Name

_____ _____
Signature of parent or legal representative Date

Relationship to Patient: ☐ Mother ☐ Father ☐ Other:_____

If signature is not obtained, reason why? _____
_____
_____

Signature of Glacier Pediatrics Employee/Witness:_____

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Medicaid Eligibility Questionnaire

Effective October 17, 2011 Glacier Pediatrics is required by Alaska Medicaid to provide this questionnaire on ethnicity and race to its patients, **regardless of their status with Alaska Medicaid.** Please note that while we are required to provide you with this questionnaire you are not required to answer any of the following questions. **If you choose to decline, please check the box at the bottom of this form.**

I. Please check any of the following which applies to you child:

☐ **American Indian** ☐ **Asian** ☐ **Black/African American**

☐ Hispanic ☐ **White** ☐ **Native Hawaiian**

☐ Other ☐ **Other Pacific Islander**

II. Please check any of the following which applies to your child:

☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino** ☐ **Other**

III. Please Write any languages, ***other than English***, spoken in your home. If there are no other languages spoken in your home, please leave this field blank:

_____

_____

CHECK HERE IF YOU WISH TO DECLINE:

☐ **I am declining participation for the Medicaid eligibility questionnaire.**

Thank you for helping our office keep in accordance with Medicaid eligibility.

Patient Eligibility Screening Record
Vaccine for Children (VFC) Program

VFC eligibility screening must be conducted whenever a child age 18 year and younger receives state-supplied vaccines. Although screening must take place during EACH immunization visit to ensure the child's eligibility status has not changed, documentation on this form is required only during the initial visit of a VFC-eligible child and during any subsequent visit in which it is determined the child's eligibility status has changed. The screening record may be completed by the parent/ guardian/ individual of record or by the health care provider. Verification of responses is not required. This form (or similar information) must be maintained in the child's medical record.

Primary Medical Provider's Name:_____

Initial Screening Date:_____/_____/_____ Child's Date of Birth:_____/_____/_____

Child's Name:_____
Last Name Middle First

Parent/Guardian of Record: _____
Last Name Middle First

Does this patient qualify for the VFC program: ☐ Yes ☐ No

If YES, check one eligibility box:
☐ Medicaid
☐ American Indian/Native Alaskan
☐ Uninsured

---------- **Below For Nurse Use Only** ----------

Eligibity Changes

Although VFC eligibility status must be reviewed EVERY time a vaccine is administered, documentation is required on the table below ONLY when changes in VFC eligibility occur.

Date	VFC Eligibility Status (Place an 'x' under the appropriate category)				
	Medicaid	American Indian/ Native Alaskan	Uninsured	Underinsured*	Does not meet eligibility criteria