Newcomer Health Program

Follow-Up Vaccine Form

Affix a patient label, or complete the information below:

Name: _____ **Web Vision /Patient ID#**_____
(Last name, First name)

DOB: _____ **Alien ID#**_____

Health District:_____

Date of Arrival to US _____ (use date asylum granted for aylees)

****Reminder reimbursement is only available for 1 year from the date of admission/date asylum granted

Date vaccines administered: _____

Vaccines administered: ☐Td/Tdap ☐MMR ☐Varicella ☐Flu ☐Pneumococcal

Did your district complete the initial health screening for this patient? ☐Yes ☐No

If no, was the initial health screening completed in VA? ☐Yes ☐No

If the initial health screening was NOT completed in VA, where was it completed? _____

This form should be used whenever districts are providing additional vaccines (after the initial health screening) to refugees or other qualified individuals (asylees, etc.). Please provide all of the requested information above and fax to the NHP at (804)864-7913 along with your other documentation.

****Reminder: The Newcomer Health Program is unable to provide reimbursement for the following vaccines or associated costs: Hepatitis A or B, HPV, Meningococcal, Zoster.**

***Costs associated with vaccines for children, including administration fees, should be billed to Medicaid.**