



Texas Department of State
Health Services

Adult Safety Net (ASN) Program

ADULT ELIGIBILITY SCREENING RECORD

PURPOSE: To determine and record eligibility for the DSHS ASN Program. A record of the eligibility status of adults receiving vaccine supplied by DSHS must be maintained either in hard copy by the clinic providing the service or in an electronic system such as TWICES. Hard copies must be maintained for five (5) years. ASN eligibility screening and documentation of eligibility status must take place at each immunization visit to ensure eligibility status for the program.

19 years and older - no insurance

Date of Screening: / /
(mm/dd/yy)

Name: _____
(Last) (First) (Middle initial)

Date of Birth: / /
(mm/dd/yy) Gender: Male Female Veteran: Yes No

Important Information for Former Military Service Members: Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at <https://texvet.org/partners/texasgov>.

Eligibility Criteria (Please check only one (1) box below):

- I declare that I qualify for vaccines through the ASN Program because I do not have health insurance.
- I am 19 years of age and I have been referred to finish a vaccine series that I began when I was 18 years of age or younger and eligible under the Texas Vaccines for Children (TVFC) Program. This option is only available as long as I have not reached my 20th birthday. "Vaccine series" applies to Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Mumps, Measles, & Rubella (MMR), Varicella, and Meningococcal vaccines.
- I declare that I qualify for vaccines through Disaster Relief/Outbreak efforts. The CDC waived insurance status (insured or non-insured) for all disaster relief efforts.
- I declare that I qualify for ASN vaccines under a Special Initiative Program. The CDC waived insurance status (insured or non-insured) to allow for co-administration with ASN vaccines for a specific population.

Referring Provider: _____

Patient Signature: _____ Date: / /
(mm/dd/yy)

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is eligible to receive ASN vaccines.

With few exceptions, you have the right to request and to be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct any information that is determined to be incorrect. See <http://www.dshs.texas.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, and 559.004)