Public Health
IOWA HHS

Bridge Access Program - Patient Eligibility Screening Record for Adults 19 Years of Age or Older

The Bridge Access Program (BAP) is a federally funded program requiring screening and documentation of eligibility status for all patients 19 years of age or older. A record must be kept in the healthcare provider's office reflecting the status of all adults receiving immunizations through the BAP. While verification of responses is not required, it is necessary to retain this or a similar record for each adult patient receiving vaccine. The record may be completed by the patient, guardian or the healthcare provider and should be used for all subsequent visits. It is necessary to retain this or a similar record for each adult receiving vaccine for a minimum of three years.

1. Initial Screening Date: __ __/__ __/__ __ __ __

2. Patient Name:_____
   Last Name First Name MI
3. Date of Birth: __ __/__ __/__ __ __ __

4. Primary Healthcare Provider's Name: _____

Eligibility Status (check only one box):

- ☐ Uninsured – Does not have private insurance, Medicare or Medicaid
- ☐ Underinsured – Has health insurance, but the plan does not cover COVID-19 vaccines or does not provide first-dollar coverage for COVID-19 vaccinations
- ☐ Not eligible for BAP vaccine – Patient has insurance (private insurance, Medicare, Medicaid)

First-dollar coverage: Defined as when COVID-19 vaccines are covered pre-deductible and without any cost-sharing.

Document patient eligibility for all subsequent visits. This record must be retained for a minimum of three years.

Date	Uninsured	Underinsured	Not Eligible

Division of Public Health
Iowa HHS
Lucas State Office Building
Des Moines, IA 50319
800-831-6293

covid19vaccine@idph.iowa.gov
https://hhs.iowa.gov/immtb/immunization

Lee County Health Department
COVID-19 Vaccine Administration Verification & Consent

I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or the person named for whom I am authorized to make this request. I have had a chance to ask questions that were answer to my satisfaction. I verify the information I filled out on the screening form was correct. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature: _____ Date: _____

Relationship to recipient, (if not self): _____

Healthcare Provider Use Only (complete all areas)

Date Vaccine Administered: _____ Injection Site (Deltoid): __ Left __ Right

Manufacturer: _____ Lot Number: _____ Exp: _____

Administered by (print): _____ Signature: _____