To support and encourage childhood immunizations, the Hunterdon County Division of Public Health Nursing and Education provides free vaccinations to children under age of 19 years-old who meet certain guidelines. Children who are enrolled in and have pending NJ FamilyCare applications will be eligible for an interim annual health and physical exam and age–appropriate vaccinations. Children enrolled will be able to receive vaccines at selected primary care providers who participate with the County for reduced-fee services.

HCCVP service does not include lab tests or sick visit. Families are encouraged to apply for NJ FamilyCare if eligible.

Questions?
Call
Public Health Nursing

(908) 806-4570

Your child **may** be eligible for this county-funded program if:

- Your family is currently without health insurance **AND**
- Your children live in Hunterdon County and meet the income eligibility guidelines below

Financial Eligibility will be based on household Modified Adjusted Gross Income (MAGI). Children under 19 are eligible when the household income is up to 355% of the Federal Poverty Level (FPL). https://njfamilycare.dhs.state.nj.us/who_eligbl.aspx

♦ **TO PARTICIPATE:**

1. **Fill out this application form**, (must use the legal name).
2. **Proof of income** eligibility ie. tax return, paystub...etc.
3. **Proof of address** ie. driver license, utility or credit card bill...etc.
4. A copy of parent/guardian's **photo ID and child's birth certificate or passport.**
5. **Past vaccination record** (if applicable).
6. **NJ FamilyCare Eligibility Survey form** (complete at Board of Social Services).

Public Health
Prevent. Promote. Protect.

Hunterdon County Childhood Vaccine Program

Free immunizations for Hunterdon County Children who have no insurance and meet income guidelines

Revised 08/27/2025

APPLICATION (PLEASE PRINT)

Parent / Guardian Name:

Last Name:_____

First Name:_____

Address: _____
(Street Address)

_____
(Town) (Zip)

Home Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____

Email: _____

Children in need of program assistance:

Last Name: _____

First Name:_____

Date of Birth (mm/dd/yy):_____

School:_____

Last Name: _____

First Name:_____

Date of Birth (mm/dd/yy):_____

School:_____

Last Name: _____

First Name:_____

Date of Birth (mm/dd/yy):_____

School:_____

ELIGIBILITY

The following questions MUST be answered:
(Incomplete applications will not be considered)

1. How many members in your household? ☐
2. How many earn income? ☐
3. What is gross monthly income? ☐
4. List all jobs and wages:
   _____
   _____
   _____
5. Do the children live in Hunterdon County? **Y / N**
6. Do the children have health insurance? **Y / N**
   If yes, circle which one:
   PRIVATE MEDICAID YELLOW CARD (HOSPITAL ASSIST.)

Insurance Active Date: _____

Initial here to confirm you have been given the *NJ FamilyCare Eligibility Survey.* _____

The form must be signed by staff in the Board of Social Services. Once you obtain the signature, return the survey to Public Health Nursing in person or by mail at the following location:

Hunterdon County Department of Health
Division of Public Health Nursing

Physical address:
1 Walter E Foran Blvd
Flemington, NJ 08822

Mailing address:
PO BOX 2900
Flemington, NJ08822

AGREEMENT AND CONSENT

1. I understand this program does NOT cover for sick visits or lab tests. _____ *(initial)*

2. I understand prior authorization letter is required for all of the appointments covered by the program; otherwise, I will be responsible for the cost of the visit. _____ *(initial)*

3. I give my consent to the HCCVP staff to share my past immunization record and health information with the school, doctor office(s), and Social Services staff. _____ *(initial)*

4. I was given the opportunity to review and ask questions about my civil rights for HIPPA Privacy Disclosures. _____ *(initial)*

5. I give my permission to PHN to communicate with me via phone, email and text messaging. _____ *(initial)*

I understand that the information I submit is subject to verification and certify that the information regarding family size and income is accurate. I have reviewed program info and above statements and consent to participate.

_____
(Parent/Guardian Signature) (Date)

Official Use Only

REVIEWED BY:_____ _____
(HCCVP Program Staff Signature) *(Date)*

DECISION:

☐ **Immunizations transcribed by _____ and _____**