

Hunterdon County Childhood Vaccine Program



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

Hunterdon County Department of Health

Division of Public Health Nursing

Physical address:

6 Gauntt Place

Flemington, NJ 08822

Mailing address:

PO Box 2900

Flemington, NJ 08822



Public Health
Prevent. Promote. Protect.

“ Childhood vaccines are one of the great triumphs of modern medicine. Indeed, parents whose children are vaccinated no longer have to worry about their child's death or disability from whooping cough, polio, diphtheria, hepatitis, or a host of other infections.”

- Ezekiel Emanuel



To support and encourage childhood immunizations, the Hunterdon County Department of Public Safety provides free vaccinations to children under age of 18 years-old who meet certain guidelines. Children who qualify to the program will be eligible for annual health and physical exam and age-appropriate vaccinations by selected primary care providers of Hunterdon Healthcare System valid for one year.

This program does not include lab tests and sick child services.

Please note that this program is **NOT** for children who are qualified and currently enrolled in NJ Family Care, Medicaid, or other health insurance options. Children enrolled above programs can receive vaccine through VFC program.

Questions?

Call

Public Health Nursing

(908) 806-4570



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

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

Gross family income: Add all sources of income, such as wages, unemployment, child support etc.):250%FPL

Family Size	Maximum Annual Income
2	\$41,150
3	\$51,950
4	\$62,750
5	\$73,550

◆ **TO PARTICIPATE:**



1. **Fill out this application form**, (must use the legal name).



2. **Proof of income** eligibility i.e. tax return, paystub...etc.



3. **Proof of address** i.e. 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. Submit your application to our office for processing.

*** Completed application will be processed in one week.***

APPLICATION (PLEASE PRINT)

Parent / Guardian Name:

Last Name: _____

First Name: _____

Address: _____
(Street Address)

(Town) _____ (Zip) _____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Email: _____

The following questions MUST be answered:

(Incomplete applications will not be considered)

- Does your child have health insurance? **YES NO**
- Does your child health insurance cover immunizations? **YES NO**
- Do you meet the income guidelines? **YES NO**
- How many members are in your household?

Children in need of program assistance:

Last Name: _____

First Name: _____

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

Last Name: _____

First Name: _____

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

Last Name: _____

First Name: _____

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

I understand that the information I submit is subject to verification and certify that the above information regarding family size and income is accurate.

(Signature) (Date)