

Demographics

Applicant Client Present Not Present Justification _____

Name: _____
Last First MI

DOB: _____ **Sex:** Male Female

Proof of identification _____

Ethnicity: Declared Observed Hispanic/Latino Not Hispanic/Latino

Race: American Indian or Alaskan Native Asian Black or African American

Address: _____
Street

City Zip Code

Proof of residence _____
 Foster care Homeless Migrant

Parent/Guardian 1 2 Caretaker

Name: _____
Last First MI

DOB: _____

Relationship to applicant: _____

Proof of identification: _____

Telephone #: (____) _____
 Home Work Cellular

Preferred method of contact: _____

Language: Read: _____ Spoken: _____

Voter Registration:
 Declined Form provided Ineligible Registered

Family Assessment:
Does anyone smoke inside the home? Yes No

Income

Adjunct program participation: SNAP Medicaid TANF **Family size:** _____ **Number of expected infants:** _____ **TOTAL family size:** _____

Self-declared income or range: \$ _____ Zero-Income Declaration

Source	Amount	Frequency
	\$	
	\$	
	\$	

Verification Document: _____

Income Eligible Yes No

Income Verification completed _____
Staff Signature/Title Date

Certification Signature

I understand that by signing and dating this form, I am certifying that the information I am providing is correct, that I understand my rights and responsibilities as related to the WIC program, and that I understand my right to a fair hearing.

Entiendo que al completar, firmar y fechar en esta forma, certifico que la información que proveo es correcta; que entiendo mis derechos y responsabilidades en relación con el programa WIC; y que entiendo mi derecho a una audiencia justa.

Applicant/Parent/Guardian/Caretaker Signature

Date

Anthro/Lab

Length / Height: _____ **Weight:** _____ **Date:** _____ Collected by / source: _____

BMI (\geq age 2) _____ **% BMI / Age:** _____ **OR % Weight / Length** (< age 2) _____

Hgb / Hct: _____ **Deferred/Exempt reason:** _____ **Date:** _____

Collected by / source: _____

Health Information

Birth weight: _____ **Birth length:** _____ **Weeks gestation:** _____ Multiple gestation

Hospital discharge weight: _____ **Date:** _____

Medical Conditions	Medications and Supplements

Immunizations: Up-to-date Not up-to-date Unknown Referred

Feeding complications: _____

Name: _____ Date of Birth: _____

Health Info

Are you breastfeeding? No Yes Breastfeeding Frequency: _____

If no, have you ever breastfed? No Yes Age infant stopped breastfeeding _____

Reason infant stopped breastfeeding _____

Dietary & Health

WIC Nutrition Risk Criteria Codes (Identify all that apply) _____

Care Plan

Nutrition Education: Tobacco, alcohol and illegal drugs Other _____

Referrals: _____

Goals: _____

Food Prescription Standard Modified _____

Follow-up / Next Appointment: _____

Certifier/CPA _____

Signature/Title

Date

AFFIDAVIT FOR PROOF OF IDENTITY, RESIDENCY, and / or INCOME

The following is to be completed for certifications when proof of identity, residency, and/or income does not exist, obtaining proof places undue burden to or harm on applicant, or an individual declares that their economic unit has no income.

I understand that by completing, signing and dating this form, I am certifying that the information I am providing is correct. I understand that intentional misrepresentation may result in paying the state agency, in cash, the value of the food benefits improperly received.

Entiendo que al completar, firmar y fechar en esta forma, certifico que la información que proveo es correcta. Entiendo que proveer información incorrecta intencionalmente puede resultar en tener que devolver a la agencia estatal, en efectivo, el valor de los beneficios de comida recibidos indebidamente.

	<i>Reason for lack of proof OR zero income declaration</i>
ID	
Residence	
Income	

Applicant/Participant/Caretaker Signature/Firma

Date/Fecha

Staff Signature

Date



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