eWIC card # _____

Application Date: _____

Continuity of Services Form

WIC: INFANT

☐Certification

☐Mid-Certification Assessment

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 completer, 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:_____ **Weight:**_____ **Date:**_____

Collected by / source:_____

☐**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: _____

☐< 6 wet diapers per day ☐Inadequate stooling (as determined by physician/health professional)

☐Difficulty latching on to mother's breast ☐Jaundice ☐Weak or ineffective suck

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 _____

Do you give your baby any formula? ☐ No ☐ Yes Amount in 24-hr period: _____

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 completer, 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.

	Reason for lack of proof OR zero income declaration
ID	
Residence	
Income	

Applicant/Participant/Caretaker Signature/Firma Date/Fecha Staff Signature Date

Department of Health and Human Services • Division of Public Health • Nutrition Services Branch
www.ncdhhs.gov • www.nutritionnc.com
This institution is an equal opportunity provider.
20,000 copies of this public document were printed at a cost of $821.48 or $0.0411 per copy. 07/19