eWIC card # ____________________________

Application Date: ______________________

Continuity of Services Form

WIC: PREGNANT WOMAN

☐Certification

Demographics

Applicant ☐ Client Present ☐ Not Present Justification______________________

Name: ______________________ (Last, First, MI)

DOB:______________________

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

Telephone #: (____) ______________________

Preferred method of contact:______________________ ☐Home ☐Work ☐Cellular

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

Height: ____________ **Weight:**____________ **Date:**____________ Collected by / source: ______________________

Weeks gestation:__________ **Expected weight gain:**__________ **Actual weight gain:**__________

☐**Hgb** / ☐**Hct:** ____________ **Deferred/Exempt Reason:**______________________ **Date:**____________

Collected by / source:______________________

Health Information

Pre-pregnancy weight:_________ **Pre-pregnancy BMI:**_________

Expected Delivery date:___________ **First Prenatal Visit Date:**__________ **Medical Home:**______________________

☐**Multiple Gestation: # of fetuses this pregnancy:**______ **Gravida:**______ **Para:** ______

Health Conditions	Medications and Supplements

Pregnancy-induced Health Conditions

Cigarettes per day: 3 months prior to pregnancy ______ **Drinks per week: 3 months prior to pregnancy** ______

Today: ______

Name:______________________ Date of Birth:______________________

Health Info

Pregnancy History

Date (mm/yy)										
Outcome										
Weeks gestation										
Birth weight/length										

Dietary & Health

____

____

____

____

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

Care Plan

Nutrition Education: ☐ Tobacco, alcohol and illegal drugs ☐ Folic acid ☐ Breastfeeding basics/anticipatory guidance ☐ Healthy eating during pregnancy ☐ 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

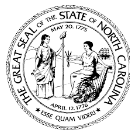
The following is to be completed for certifications when proof of identity, residency, and/or income does not exist, obtaining proof places undue burden to or harm on applicant, or an individual declares that their economic unit has no income.

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 ______



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