

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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