

eWIC card # _____

Continuity of Services Form
WIC: PREGNANT WOMAN

Certification

Application Date: _____

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 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

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 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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 20,000 copies of this public document were printed at a cost of \$896.72 or \$0.0448 per copy. 07/19