

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:** _____

BMI: _____

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

Collected by / source: _____

Health Information

Pre-pregnancy weight: _____ **Pre-pregnancy BMI:** _____ **Delivery date:** _____ **Weight at delivery:** _____

Multiple gestation: # of fetuses this pregnancy: _____

Outcome: _____ **Delivery type:** Vaginal Cesarean **Gravida:** _____ **Para:** _____

Health Conditions	Medications and Supplements

Pregnancy-induced Health Conditions

Cigarettes per day: three months prior to pregnancy _____ **Drinks per week: three months prior to pregnancy** _____

last trimester _____

last trimester _____

postpartum _____

postpartum _____

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: Immunizations Tobacco, alcohol and illegal drugs Folic acid Breastfeeding basics/anticipatory guidance
 Other _____

Referrals: _____

Goals: _____

Food Prescription Standard Modified _____

Follow-up / Next Appointment: _____

Certifier/CPA _____
Signature Title

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



Department of Health and Human Services • Division of Public Health • Nutrition Services Branch

www.ncdhhs.gov • www.nutritionnc.com

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