eWIC card # _____ **Continuity of Services Form** ☐**Certification**

Application Date: _____ **WIC: BREASTFEEDING/POSTPARTUM WOMAN** ☐**Mid-Certification Assessment (Breastfeeding)**

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:_____

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_____
last trimester_____
postpartum_____

Drinks per week: three months prior to pregnancy _____
last trimester _____
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 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
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