eWIC card # ____________________

Application Date: ____________________

# Continuity of Services Form
# WIC: INFANT

☐Certification
☐Mid-Certification Assessment

## 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 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

**Length:**__________ **Weight:**__________ **Date:**__________

Collected by / source:____________________

☐**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:** ____________________

☐< 6 wet diapers per day ☐Inadequate stooling (as determined by physician/health professional)

☐Difficulty latching on to mother's breast ☐Jaundice ☐Weak or ineffective suck

**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:** ☐ 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 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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