GEORGIA WIC PROGRAM
ASSESSMENT/CERTIFICATION FORM
INFANT

CLINIC ☐☐☐ FAMILY NUMBER ☐☐☐☐☐☐☐☐☐☐☐ WIC ID NUMBER ☐☐☐ ☐☐☐ ☐☐☐ ☐☐

NAME LAST	FIRST	MIDDLE INITIAL	BIRTHDATE
ADDRESS	CITY	ZIP CODE	MIGRANT ☐ YES ☐ NO
TELEPHONE ( )	GENDER ☐ MALE ☐ FEMALE	HISPANIC/LATINO ☐ YES ☐ NO	RACE (check all that applies) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
COUNTY OF RESIDENCY ☐☐☐	***PROOF OF RESIDENCY*** UP:	***PARENT/GUARDIAN*** PROOF OF IDENTIFICATION UP:	***INFANT*** PROOF OF IDENTIFICATION UP:
PARENT/GUARDIAN/CAREGIVER/SPOUSE/ALTERNATE PARENT NAME	FOSTER CARE: ☐ YES ☐ NO	FOSTER CARE: ☐ YES ☐ NO	
MOTHER'S WIC ID#	LAST WEIGHT BEFORE DELIVERY: lbs.	EDC DATE:	

INITIAL CONTACT DATE OF FIRST VISIT REQUESTING WIC SERVICES			Date:	Type:	Date:	Type:	
INFANT FEEDING METHOD: (Circle One) **E**= Exclusively Breastfeeding **M**= Mostly Breastfeeding **S**= Some Breastfeeding **F**= Fully Formula Fed			**E M S F**		**E M S F**		
Check Each Question Yes or No or Write N/A (per state guidelines)			**YES**	**NO**	**YES**	**NO**	
BREAST FED NOW							
BREASTFED EVER							
RECORD THE NUMBER OF WEEKS INFANT BREASTFED (**00=** 0-6 days, **01=** 7-13 days, **02=** 14-20 days, **03=** 21-27 days, etc.)			wks				
DATE OF MOST RECENT BREASTFEEDING RESPONSE							
MEDICAL DATA DATE (Enter date length/weight measurements were taken)							
Length:			in		in		
Weight (Enter Birth weight lbs ozs)			lbs.	ozs.	lbs.	ozs.	
Hematological Data Date:							
Hematocrit/Hemoglobin (Value must be ≤ 90 days)					HCT / HGB		
Select appropriate risk criteria per State guidelines (See Risk Criteria Handbook for definitions)			**YES**	**NO**	**YES**	**NO**	
Low Hgb/Hct (Hgb ≤ 10.9 6-11 month)	[HR]	201					
Underweight or At Risk of Underweight (≤ 5th percentile weight/length)	[HR?]	103					
High Weight for Length (≥ 98th percentile weight for length)		115					
Short Stature or At Risk of Short Stature	[HR?]	121					
* **Failure to Thrive**	[HR]	134					
Inadequate Growth	[HR]	135					
* **Low Birth Weight** (Birth weight ≤ 5 ½ lbs. or ≤ 2500 gms)	[HR]	141					
* Prematurity (Enter weeks gestation:)		142					
Small for gestational Age		151					
Low Head Circumference (≤ 2nd percentile)		152					
* Large for Gestational Age [Birth weight ≥ 9 lbs. (4000 gms)]		153					
* **Elevated Blood Lead Level** (Blood Lead Level ≥ 10 µg/dl)	[HR]	211					
* **Nutrition Related Medical Conditions** (List code(s):)	[HR?]						
* Oral Health Conditions		381					
* **Fetal Alcohol Syndrome**	[HR]	382					
* Inappropriate Nutrition Practices		400					
Dietary Risk Associated with Complementary Feeding Practices (Infant > 4 months)		428					
Transfer of Certification		502					
* **Breastfeeding Complications or Potential Complications**	[HR]	603					
Infants (up to 6 months old) of a WIC Mother or a woman who would have been eligible during pregnancy		701					
* Breastfeeding Infant of a Woman at Nutritional Risk (Enter mother's risk factors:)		702					
* Infants born to Mother with Mental Retardation, or Alcohol or Drug Abuse During Most Recent Pregnancy		703					
Homelessness		801					
Migrancy		802					
* Recipient of Abuse		901					
* Primary Caregiver with Limited Ability to make Feeding Decisions and/or Prepare Food		902					
Foster Care		903					
* Environmental Tobacco Smoke Exposure		904					
HIGH RISK (Yes or No)							
ELIGIBLE FOR WIC							

PRIORITY: **1=** (201, 103, 115, 121, 134, 135, 141, 142, 151, 152 ,153, 211, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 359, 360, 362, 381, 382, 502, 603, 702, 703, 904)
2= (502, 701, 702)
4= (400, 428 ,502, 702, 801, 802, 901, 902, 903)

(NEVER DOWNGRADE INFANTS PRIORITY)

FOOD PACKAGE: (Specify Tailoring Instructions)		
SERVICES: CH (A), Health Check (B), CMS (C), Immun (G), Lead Screen (H), Dental Health (I), STD (J), Private MD (K), SNAP (L), Medicaid (M), TANF (N), Mental Health (O), Head Start (P), NA/None (Q), Refused (R), Community Health Center (S), Children 1st (T), Other-Specify (U), Dietitian (V), Breastfeeding (W), Breastfeeding Peer Counselor (X)	Enrolled In: Referred To:	Enrolled In: Referred To:
TODAY'S DATE		
SIGNATURE AND TITLE OF HEALTH PROFESSIONAL		

***Additional Documentation Required**

Do you have a medical home? ☐ Yes ☐ No M.D. Name

INCOME DETERMINATION (income must be documented)

DATE	PHYSICAL PRESENCE	MEDICAID CURRENT Y/N/U	MEDICAID I.D. NUMBER VERIFY	TANF Y/N/U COPY AND FILE	SNAP Y/N/U	NO. IN FAMILY	GROSS INCOME (CURRENT/ANNUAL)
	Y ( ) N ( ) * * N ( ) R ( ) D ( ) W ( )	Y ( ) U ( ) N ( ) UP (_____)		Y ( ) U ( ) N ( ) UP (_____)	Y ( ) U ( ) N ( ) UP (_____)		C ( ) A ( ) UP (_____)

* See Procedures Manual (CT - Physical Presence) for a list of applicable reasons:
(MUST Document in Health Record)

Source of Income Code _____ Other _____
(Write in type)

UP: _____

No Proof ( ) How is food, shelter, clothing and Medical Care obtained?_____

_____ _____
Staff Initials

Is the Client Income Eligible? YES ( ) NO ( ) UP _____ Check Here if Only One Income Reported ( )

NOTE: The Income Calculation Form must be completed and filed in the Client's Medical Record if more than one income was calculated. UP: _____
Staff Initials

Peachcare	**Y**=Yes **N**=No		
Date breastfeeding began	**(MM/DD/YYYY)**		
Household Smoking – Current Visit (1=Yes, someone smokes, 2=No, no one smokes, 9=unknown)			
Date of last time of breastfeeding and/or pumping	**(MM/DD/YYYY)**		

IMMUNIZATION STATUS

Record Screened/Requested? Yes ( ) Requested ( )

Adequate for Age/Referred: Yes ( ) Doctor ( ) Health Dept. ( )

IMMUNIZATION STATUS

Record Screened/Requested? Yes ( ) Requested ( )

Adequate for Age/Referred: Yes ( ) Doctor ( ) Health Dept. ( )

Comments:(Date/Sign/Title):_____

Proxy 1 _____ Proxy 2 _____

WIC CERTIFICATION STATEMENT

RIGHTS AND OBLIGATIONS

I have been advised of my rights and obligations for participation in the Georgia WIC Program. I certify that the information I will provide, or have provided, is correct to the best of my knowledge. The income information that I have provided is my total gross household income (all cash income before deductions). This certification form is being submitted in connection with the receipt of Federal assistance. The Georgia WIC Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying to the Georgia WIC Program, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

NOTICE OF DISCLOSURE

I understand that the chief state health officer for Georgia may allow information about my participation in Georgia WIC to be shared for non-WIC purposes to determine eligibility with other program services. I understand that this information may be used by Georgia WIC, shared with its local WIC agencies, or shared with other public organizations that serve persons eligible for WIC. Further, I understand that the recipients of this information will only use it to establish the eligibility for programs administered by other public organizations; to conduct outreach for programs administered by other public organizations; to enhance the health, education or well-being of Georgia WIC applicants and participants; to streamline administrative procedures to minimize burdens on program participants and staff; and, to assess and evaluate the State's health system in terms of responsiveness to participants' health care needs and outcomes. The public organizations that receive my information cannot share my information with another organization or person without my permission.

I also understand that if I do not want my information shared, that decision will not affect my participation in Georgia WIC.

_____ Name of WIC Applicant/Participant/ Guardian/Caregiver/Spouse/Alternate Parent (please print)	_____ Date _____ UP:	_____ Name of WIC Official (please print)
_____ Signature of WIC Applicant/Participant/ Guardian/Caregiver/Spouse/Alternate Parent	_____ Date	_____ Signature of WIC Official

Please initial below to indicate your preference:

___ In applying for WIC services, I **AGREE** to allow my information to be shared for the purposes referenced above. I understand that if I do not want my information to be shared, this decision will not affect my participation in the Georgia WIC Program.

___ In applying for WIC services, I **DO NOT AGREE** to allow my information to be shared for the purposes referenced above. I understand that if I do not want my information to be shared, this decision will not affect my participation in the Georgia WIC Program.

Revised 6/15