

INCOME DETERMINATION (income must be documented)

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

Is the Client Income Eligible? YES () NO () UP _____ Staff Initials _____

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 _____

DATA NEEDED FOR PREGNANCY SURVEILLANCE

Marital Status (0=Married 1=Not Married 9=Unknown)	
Years of Education completed (e.g. 1 st grade = 01, 2yrs. College = 14, Unknown = 99)	
Month of gestation at time of first prenatal exam (0=o Prenatal Care, 1=1 st . mo., 8=8 th or 9 th mo., 9=Unknown)	
Parity (00= None 01-29 = Number of previous pregnancies)	
Date previous pregnancy ended (000000 = No Previous Pregnancy 01-12 (all four digits) = Month/Year)	
Maternal Smoking – Current Visit (00=no, 01-96=#cigs/day, 97=97 or more, 98=quantity unknown, 99=refused)	
Household Smoking – Current Visit (1=Yes, someone smokes, 2=No, no one smokes, 9=unknown)	
Drinks/week – Current Visit (00=No, 01=1 drink, 02-20=drinks, 21=21 or more, 98=quantity unknown, 99=refused)	
Fruit Intake. D =Daily S =Some Days N =Never	
Vegetable Intake. D =Daily S =Some Days N =Never	
Dairy Intake. D =Daily S =Some Days N =Never	
Daily Activity. V =Very Active S =Active Some of the Time N =Not Active	
Screen time. Hours = 00 through 24	

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

Name of WIC Official (please print)

UP:

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.