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: E= Exclusively Breastfeeding **M**= Mostly Breastfeeding **F**= Fully Formula Fed (Circle One)	**E M**	**F**	**E M**	**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?]				
* Dental Problems 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)**		
Date of last time of breastfeeding and/or pumping	**(MM/DD/YYYY)**		

<u>IMMUNIZATION STATUS</u>

Record Screened/Requested? Yes ( ) Requested ( )

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

<u>IMMUNIZATION STATUS</u>

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 Georgia's WIC. 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. Georgia's WIC 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 Georgia's WIC, 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 authorize the disclosure of information about my participation in the WIC program for non-WIC purposes. This information will be used by Georgia WIC, its local WIC agencies and certain public organizations. These organizations include but are not limited to the Immunization Program, Pregnancy Risk Assessment Monitoring Systems (PRAMS), Epidemiology and other Maternal and Child Health Programs, Emergency Preparedness, Environmental Health and Medicaid. I understand that Georgia WIC, its local agencies and the public organizations can only use my information in the administration of their programs that serve persons eligible for WIC. The public organizations that receive my information must assure that it will not disclose my information to another organization or person without my permission.

I further understand that information about my participation in WIC may be used by the organizations that receive it only to:

1. Determine my eligibility for programs that the organization administers
2. Conduct outreach for such programs
3. Enhance the health, education, or well-being of WIC applicants and participants who are currently enrolled in those programs
4. Streamline administrative procedures to ease the burdens on WIC staff and participants
5. Assess the responsiveness of the state's health system to participants' health care needs and health care outcomes.

I have been advised that the decision to share my information is not a condition for eligibility for WIC, and if I decide not to share my information, this will not affect my application or participation in Georgia WIC.

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

Please initial below to indicate your preference:

___In applying for WIC services, I **AUTHORIZE** DISCLOSURE of my WIC applicant or participant information for the purposes referenced above. I understand that my refusal to allow such disclosure does not affect my application for or participation in WIC or my eligibility for WIC services.

___ In applying for WIC services, I **DO NOT AUTHORIZE** DISCLOSURE of my WIC applicant or participant information for the purposes referenced above. I understand that my refusal to allow such disclosure does not affect my application for or participation in WIC or my eligibility for WIC services.