Georgia Department of Public Health

GEORGIA WIC
EATHEALTHYGROWHEALTHYLIVEHEALTHY

GEORGIA WIC PROGRAM
ASSESSMENT/CERTIFICATION FORM
CHILD

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

NAME LAST	FIRST	MIDDLE INITIAL	BIRTHDATE

ADDRESS	CITY	ZIP CODE	MIGRANT ☐ YES ☐ NO

TELEPHONE	GENDER	HISPANIC/LATINO	RACE (check all that applies)
( )	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

COUNTY OF RESIDENCY	***PROOF OF RESIDENCY***	***PARENT/GUARDIAN*** PROOF OF IDENTIFICATION	***CHILD*** PROOF OF IDENTIFICATION
☐☐☐	UP:	UP:	UP:

EDC DATE:	FOSTER CARE INFORMATION	FOSTER CARE: ☐ YES ☐ NO	FOSTER CARE: ☐ YES ☐ NO

PARENT/GUARDIAN/CAREGIVER/SPOUSE/ALTERNATE PARENT NAME:

INITIAL CONTACT DATE OF FIRST VISIT REQUESTING WIC SERVICES (Must change date if certifications are not consecutive)	Date:	Type:	Date:	Type:
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 CHILD BREASTFED (**00=** 0-6 days, **01=** 7-13 days, **02=** 14-20 days, **03=** 21-27 days, etc.)	wks		wks	
DATE OF MOST RECENT BREASTFEEDING RESPONSE				
MEDICAL DATA DATE (Enter date length/weight measurements were taken)				
Length/Height:	in.		in.	
Weight (Enter Birth weight lbs oz)	lbs.	ozs	lbs.	ozs
Hematocrit/Hemoglobin (Value must be ≤ 90 days) **Hematological Data Date:**	HCT / HGB		HCT / HGB	
Select appropriate risk criteria per State guidelines (See Risk Criteria Handbook for definitions)	**YES**	**NO**	**YES**	**NO**
Low Hgb/Hct (Hgb < 11.0 12-23 months; < 11.1 2-5 year) [HR] 201				
Underweight or *At Risk of Underweight* (≤ 5th percentile 12-23 months; ≤ 10th percentile 2-5 years) [HR?] 103				
Obese (2–5 years) [HR] 113				
Overweight (2-5 years) 114				
High Weight for Length (C < 24 months) **115**				
Short Stature or *At Risk of Short Stature* [HR?] 121				
* **Failure to Thrive** [HR] 134				
Inadequate Growth [HR] 135				
* Low Birth Weight (Children < 24 months of age) 141				
* Prematurity (Children < 24 months of age) (Enter weeks gestation:) 142				
Small for Gestational Age (< 24 months) 151				
Low Head Circumference (< 24 months) 152				
* **Elevated Blood Lead Level** (Blood Lead Level ≥ 5 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				
Other Dietary Risk (< 24 months) 401				
Dietary Risk Associated with Complementary Feeding Practices (< 24 months) 428				
Transfer of Certification 502				
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: 3= (201, 103, 113, 114, 115, 121, 134, 135, 141, 142, 151, 152, 211, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 357, 359, 360, 362, 381, 382, 502, 904) **5=** (400, 401, 428, 502, 801, 802, 901, 902, 903)				
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 Initial

Peachcare **Y**=Yes **N**=No		
Date of last time of breastfeeding and/or pumping **(MM/DD/YYYY)**		
Fruit Intake. **D**=Daily **S**=Some Days **N**=Never		
Household Smoking – Current Visit (1=Yes, someone smokes, 2=No, no one smokes, 9=unknown)		
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		

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 _____ Proxy2 _____

WIC CERTIFICATION STATEMENT

RIGHTS AND RESPONSIBILITIES

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 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 4/17