

**GEORGIA WIC PROGRAM
ASSESSMENT/CERTIFICATION FORM
CHILD**

CLINIC FAMILY NUMBER WIC ID NUMBER

NAME LAST		FIRST		MIDDLE INITIAL		BIRTHDATE	
ADDRESS				CITY		ZIP CODE	
				MIGRANT <input type="checkbox"/> YES <input type="checkbox"/> NO			
TELEPHONE ()		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		HISPANIC/LATINO <input type="checkbox"/> YES <input type="checkbox"/> NO		RACE (check all that applies) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
COUNTY OF RESIDENCY <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		PROOF OF RESIDENCY		PARENT/GUARDIAN PROOF OF IDENTIFICATION		CHILD PROOF OF IDENTIFICATION	
UP:		UP:		UP:			
EDC DATE:		FOSTER CARE INFORMATION		FOSTER CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO		FOSTER CARE: <input type="checkbox"/> YES <input type="checkbox"/> 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:		Recumbent (R) or Standing (S)		Circle One	in.	R	S
Weight (Enter Birth weight		lbs	oz)	lbs.	ozs	lbs.
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 ≤ 10.9 12-23 months; ≤ 11.0 2-5 year) [HR] 201							
Underweight or At Risk of Underweight (≤ 5 th percentile 12-23 months; ≤ 10 th 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 ≥ 10 µg/dl) [HR] 211							
* Nutrition Related Medical Conditions (List code(s):) [HR] 381							
* 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:	Enrolled In:		
				Referred To:	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	SNAP Y/N/U	NO. IN FAMILY	GROSS INCOME (CURRENT/ANNUAL)
				COPY AND FILE			
	Y () N ()*	Y () U () N () UP (_____)		Y () U () N () UP (_____)	Y () U () N () UP (_____)		C () A () UP (_____)
	* N () R () D () W ()						

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

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

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

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

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 _____

	Y=Yes	N=No		
Peachcare				
Date breastfeeding began.	(MM/DD/YYYY)			
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 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.