

**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]							
* Dental Problems				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, 361, 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 _____

Peachcare	Y=Yes	N=No		
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	
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 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

Name of WIC Official (please print)

Date

UP:

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.

Revised 6/12