NH WIC Program MANUAL FORM - CHILD & INFANT

TYPE OF WIC SERVICE PROVIDED ☐ **Recertification** ☐ **Certification** ☐ **Nutrition Follow up**

Date WIC Service Provided:	Is the client physically present? ☐ Yes ☐ No, reason stated

CLIENT / GROUP DEMOGRAPHICS

Client Name:	Category	Gender	DOB / /

Hispanic/Latino? ☐ Yes ☐ No ☐ Declined	American Indian/Alaskan Native _____ Asian _____ Black or African American_____ White or Caucasian_____ Native Hawaiian or Other Pacific Islander _____

If the client is an INFANT choose one of the following:

	Mother is Family Member Mother's Name
	Mother is Non-Family Member Mother's name
	Mother is a WIC Participant in Another Program
	Mother is not a WIC Participant

Caregiver Name	DOB / /	Alternate/2nd Payee Name	
Telephone Number		Telephone Notes/Message Telephone	
Telephone Number (Cell Phone)		Email	Receive appointment reminders ☐ email ☐ text (phone)
Street Address		City	Zip Code
Mailing Address		City	Zip Code
Proof of Caregiver ID	Proof of ID Infant/Child	Proof of Residence	Homeless? ☐ Yes ☐ No
Special Needs	Interpreter	Primary Language	Migrant? ☐ Yes ☐ No

INCOME and PROOFS

Adjunctive Eligibility ☐ TANF ☐ Medicaid ☐ SNAP		_____ # in Household	
Medicaid #	☐ Proof Pending	☐ Zero Income	☐ Self-declared income
Total Income Amount $	☐ Monthly ☐ Weekly ☐ Twice/Month ☐ Every 2 Weeks ☐ Annually ☐ Hourly ☐ Intermittent ☐ Multiple Incomes		
Income Source Description	Rights & Rules Reviewed ☐ Yes ☐No Rights & Rules provided ☐ Yes ☐No		

☐ Yes Is the applicant a member of a family in which there is a pregnant woman receiving or participating in Medicaid?
☐ Yes Is the applicant a member of a family in which there is an infant who is receiving or participating in Medicaid?

Proof of Income Shown ☐ Yes, Type _____ ☐ No	**WIC Staff Signature/Title**
Other Income Eligibility Information	

INFANT CERTIFICATION

Was Mom on WIC During Pregnancy? (Both Infant/Child) ☐ Yes ☐ No	Is Infant Breastfed? ☐ Exclusively ☐ Mostly ☐ Limited ☐ Stopped ☐ Never	Date BF Stopped	Reason Formula Introduced
Date Formula/Milk Introduced	Date Solids Introduced	Does child live in a house built before 1978? ☐ Yes ☐ No ☐ Unsure Blood lead test in the last 12 months? ☐ Yes ☐ No ☐ Unsure	

Household Smoking ☐ No one in household smokes ☐ Yes, someone smokes ☐ Unknown
Does anyone use a vaping device inside your home or vehicle? ☐ Yes ☐ No

CHILD CERTIFICATION

Was Child Breastfed? ☐ Exclusively ☐ Mostly ☐ Limited ☐ Stopped ☐ Never	Date BF Stopped	# of Hours TV/Video Viewing

Household Smoking (Both Infant/Child) ☐ Yes, someone smokes ☐ No one in household smokes ☐ Unknown Does anyone use a vaping device inside your home or vehicle? ☐ Yes ☐ No	Does infant live in a house built before 1978? ☐ Yes ☐ No ☐ Unsure Blood lead test in the last 12 months? ☐ Yes ☐ No ☐ Unsure

MEDICAL PROVIDER/MEDICATION SUPPLEMENTS/ IMMUNIZATIONS

Medical Provider and Facility Name	
Supplemental Use ☐ Vitamins/Minerals ☐ Iron ☐ Fluoride ☐ Other Any medications (prescribed or over the counter) ☐ Yes ☐ No Notes	Immunizations ☐ Current for age ☐ Behind for age ☐ Record not available ☐ Referral given

MEASUREMENTS (Include date of measurement if different from visit/certification date)

Birth Length	Birth Weight	Gestational Age	Proof of measurements provided or verbal:	
Height/Length	Current Weight	Head Circumference	HCT/ HGB	Lead
Measurement Notes				

RISK FACTORS- To be completed with WIC CPA

Assigned Risks Notes	
☐ Professional Discretion High Priority, include reason:	☐ Doctor Diagnosed Medical Condition (please list)

REFERRALS MADE	**REFERRALTO WIC FROM**
☐ SNAP ☐ TANF ☐Medicaid ☐ Other	☐ Healthcare provider ☐ Head Start ☐ On WIC Before ☐ Family/ friend ☐ SNAP ☐ Medicaid
BASIC CONTACT COMPLETED. ☐ Yes ☐ No	

CARE PLAN/ NUTRITION ED CLIENT GOALS

Parent or caretaker's concerns	Nutrition topics reviewed
Handouts given	Counselor comments
Nutrition Education Client Goals/Follow-up Plan	

To be completed by WIC Staff
BENEFIT PACKAGE_____

Tailored benefit package ☐ No ☐ Yes
Reason: _____

Request for Special Formula attached ☐ Yes ☐ No	MD Prescription attached ☐ Yes ☐ No
eWIC Card #: **6107 3000** _ _ _ _ _ _ _ _	Caregiver Signature for card:

NEXT APPOINTMENT

Next Appointment ☐ FUN- low priority in person ☐ FUN- on line education ☐ FUN- high priority with nutritionist Date/Time:	**Date participant contacted that benefits are available:**
Form Completed By **Print Name**: **Staff Signature**:	Data Entered into StarLINC:
Participant Signature:	Date: