CERTIFICATION DATA ENTRY DOCUMENT

Completed by: _____ Date: _____

Demographics

Participant Name: _____
Last First

Participant Number: _____ Clinic: _____

Date of Birth: ___/___/___ Gender: ❑ Male ❑ Female

Home Address: _____
Street City Zip

Mailing Address: _____
Street City Zip

Home Phone: ( ) _____ Options: ❑ Text ❑ Voice Mail

Cell Phone: ( ) _____ Options: ❑ Text ❑ Voice Mail

Email Address: _____

Contact by Phone: ❑ Yes ❑ No Contact by Mail: ❑ Yes ❑ No

Guardian Name: _____ Type: _____

CIRCLE ALL THAT APPLY

Race: American Indian | Alaska Native | Asian | Black or African American | Native Hawaiian | Pacific Islander | White

Ethnicity: Hispanic? ❑ Yes ❑ No

Other than English: Spoken language: _____ Written language: _____

Intake

Other Family on WIC: ❑ Yes ❑ No If yes, who: _____ Clinic: _____

Migrant: ❑ Yes ❑ No Homeless: ❑ Yes ❑ No Voter Registration Offered: ❑ Yes ❑ No

FOR WOMEN ONLY:

EDD _____ or LMP _____ or ADD _____ Marital Status: _____ Education: _____

Proof of ID: _____ Proof of Residency: _____

Number in Family: _____ Number of Unborn: _____

Participates In: ❑ SNAP ❑ OHP ❑ TANF ❑ Eligibility Pending

Income Provider	Interval	Amount	Source	Proof of Income

Rights and Responsibilities Explained: ❑ Yes ❑ No

Participant Signature Form Signed: ❑ Yes ❑ No

Medical Data

Anthropometric Collection Date: ____/____/____ Weight: ____lb____oz

Height / Length: ____in Recumbent: ❑ Standing: ❑

Biochemical Collection Date: ____/____/____ Hemoglobin: _____ Hematocrit: _____

INFANTS

Birth Weight: ____lb____oz Birth Length: ____in Premature: ❑ Yes ❑ No Weeks Gestation: _____

PRENATAL

Pre-pregnancy weight: ____lb Twins or More: ❑ Yes ❑ No

POSTPARTUM

Total pregnancy weight gain: ____lb

NE Plan

Risks: _____

Counseling Topics: _____

Next Steps: _____

Referrals: _____

Progress Notes: _____

_____

_____

FUTURE APPOINTMENT REQUEST High Risk: ❑ Yes ❑ No

Month: _____ Type: _____ Topic: _____ Title: _____

NE Refused: _____ Non-WIC NE: _____

Food Package

Standard Package for Category: ❑ Yes ❑ No

If no, package needed: _____

MEDICAL DOCUMENTATION

Required: ❑ Yes ❑ No If yes, received: ❑ Yes ❑ No

Attach completed Participant Signature form, Health Questionnaire, and Diet Questions form. Attach any additional notes.

Cardholder Information

Cardholder Update Needed: ❑ Yes ❑ No

FIRST CARDHOLDER

Name: _____
Last First MI

Relationship to participant: _____ Date of Birth: ____ / ____ / ____

Address: *same as participant*

SECOND CARDHOLDER

Name: _____
Last First MI

Relationship to participant: _____ Date of Birth: ____ / ____ / ____

Address: same as on front or: _____
Street City Zip

Card Issuance

eWIC Card Needed: ❑ Yes ❑ No If yes, issuance: ❑ Pick up at clinic ❑ Deliver to participant

Who: _____ When: _____