

**State of Connecticut WIC Program-DEPARTMENT OF PUBLIC HEALTH  
CERTIFICATION/MEDICAL REFERRAL FORM - INFANTS AND CHILDREN**

Participant ID #: \_\_\_\_\_ Family ID #: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth (DOB): \_\_\_/\_\_\_/\_\_\_ Sex: M / F

Parent/Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Health Plan \_\_\_\_\_

<b>DATE COLLECTED:</b>	<b>DATE COLLECTED:</b>	<b>FOR INFANTS AND CHILDREN &lt; 2:</b>
<b>Weight:</b>	<b>Hemoglobin:</b>	<b>Birth Weight:</b>
<b>Length or Height:</b>	<b>Hematocrit:</b>	<b>Birth Length:</b>
<b>Body Mass Index (BMI):</b>	<b>Lead test done? Y or N</b>	<b>Birth Head Circ. (optional):</b>
<b>Head Circ. (optional):</b>	<b>Date: _____ Result: _____</b>	<b>Immunizations Up-to-date? Y N</b>
<b>Medications/Medical Problems/Concerns:</b>		

**ANTHROPOMETRIC**

**Weight, length/height measurements must be within 60 days of WIC certification appointment.**

- 1a.  Weight for length  $\leq$  10<sup>th</sup> percentile (infants and children <2 years of age)
- 1b.  Body Mass Index (BMI)  $\leq$  10<sup>th</sup> percentile (children 2 to 5 years of age)
- 2a.  Body Mass Index (BMI)  $\geq$  95<sup>th</sup> percentile (children 2 to 5 years of age)
- 2b.  Body Mass Index (BMI)  $\geq$  85<sup>th</sup> or <95<sup>th</sup> percentile (children 2 to 5 years of age) or parent with BMI  $\geq$  30 (infants and children)
3.  Length or height-for-age  $\leq$  10<sup>th</sup> percentile
4.  Failure to thrive
5.  Inadequate growth
6.  Low birth weight (infants and children <2 years of age with birth weight < 5.5 pounds or < 2500 grams)
7.  Prematurity: Specify \_\_\_\_\_ weeks gestation. (Infants and children <2 years of age born < 38 weeks gestation)
- 8a.  Small for gestational age (based on medical diagnosis) (infants and children <2 years of age)
- 8b.  Large for gestational age ( $\geq$  9 lbs) (infants up to one year of age)
9.  Head circumference < 5<sup>th</sup> percentile (infants up to one year of age)

**BIOCHEMICAL (1998 CDC Standards)**

10.  Anemia (**6-23 Mos:** Hgb < 11g/dl, Hct < 32.9%; **2-5 yrs:** Hgb < 11.1 g/dl, Hct < 33%)
11.  Elevated blood lead level ( $\geq$  10ug/dl in last 12 months)

**CLINICAL/ HEALTH/ MEDICAL**

12.  Nutrient deficiency disease. Specify \_\_\_\_\_
13.  Gastrointestinal disorder. Specify \_\_\_\_\_
14.  Nutritionally significant genetic or congenital disorder. Specify \_\_\_\_\_
15.  Nutrition related infectious disease. Specify \_\_\_\_\_
16.  Nutrition related non-infectious chronic disease. Specify \_\_\_\_\_
17.  Food allergy. Specify \_\_\_\_\_
18.  Other nutrition related medical conditions. Specify \_\_\_\_\_
19.  Oral health problems. Specify \_\_\_\_\_
20.  Fetal Alcohol Syndrome
21.  Infant born of a woman with mental retardation
22.  Infant born of a woman who abused alcohol or drugs during most recent pregnancy
23.  Breastfeeding complications or potential complications. Specify \_\_\_\_\_
24.  Breastfeeding infant of woman at nutritional risk  non-dietary;  dietary

**DIETARY** (Document in SWIS or on WIC Nutrition Questionnaire and Assessment form)

25.  Specify code(s) \_\_\_\_\_  
 Improper use of bottle/cup or (pacifier-Child only)  Potentially harmful microorganisms/toxins  Feeding sugar containing fluids

**OTHER NUTRITIONAL RISKS**

26.  Infant (0-6 months) of a WIC mother or of a woman who would have been WIC eligible during pregnancy
27.  Possible regression in nutritional status if removed from the program  non-dietary;  dietary
28.  Homelessness or migrancy
29.  Entering or moving within the foster care system during the previous 6 months
30.  Other risks. Specify \_\_\_\_\_

Health Care Provider Signature and Title: \_\_\_\_\_ Date: \_\_\_\_\_

Location: \_\_\_\_\_

<b>WIC OFFICE USE:</b>	<b>Physical Presence:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Date:</b> _____	<b>Waiver Code:</b> MC/ ND/ OHC/ WPC
<b>Priority group:</b> 1 2 3 4 5 6	<b>Signature/Initials of WIC CPA:</b> _____	<b>WIC Certification Date:</b> _____	

**WIC Participant Rights and Responsibilities:**

- Information collected on your child may be used for program evaluation, and your name and address will not be given to anyone outside the WIC Program without your special permission.
- WIC participants who fail to pick up checks for two (2) consecutive months will be automatically removed from the program. You will need to reapply (recertify) to restart/receive WIC benefits.**
- Standards for participation in the WIC Program are the same for everyone, regardless of race, color, or national origin.
- You may appeal any decisions made by the local agency regarding your eligibility for the WIC Program.
- The local agency will make health services and nutrition education available to you and you are encouraged to participate in these services.

I have been advised of my rights and obligations under the Program. I certify that the information I have provided for my eligibility is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that knowingly making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, 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 laws.

Date	Signature of Parent or Guardian
1.	Los datos colectados acerca de mi niño pueden ser usados en la evaluación del programa. Mi nombre y dirección no serán dados a ninguna persona fuera del programa WIC sin mi autorización.
2.	<b>Los participantes de WIC que no recojan sus cheques durante dos meses consecutivos serán terminados automáticamente del programa.</b>
3.	Las reglas para participar en el programa WIC son las mismas para todos. No importa la raza, el color, u origen nacional.
4.	Usted puede apelar cualquier decisión hecha por la agencia local referente a su elegibilidad para el programa WIC.
5.	La agencia local tendrá servicios de salud y educación sobre nutrición disponibles para usted y le aconsejamos participar en estos servicios.

Yo he sido informada de mis derechos y obligaciones bajo el Programa. Certifico que la información dada para la determinación de mi elegibilidad es correcta según mi entender. Este formulario de certificación es sometido en conexión con el recibo de asistencia Federal. Oficiales del programa pueden verificar la información provista en este fomulario. Tengo entendido que el dar falso testimonio, ocultar o falsificar hechos intencionalmente, puede resultar en el pago en enefectivo a la agencia Estatal por el valor de los beneficios alimenticios impropriamente entregados a mí y puedo ser sujeta a persecución civil o criminal bajo las leyes Estatales y Federales.

Fecha	Firma de Padre o Guardián
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**WIC OFFICE USE ONLY:**

Date of Application \_\_\_\_\_  Subsequent Certification

Income determined by the following:  
 HUSKY I.D. # (MEDICAID) \_\_\_\_\_  Pay Stub  Other \_\_\_\_\_

Number in family/household \_\_\_\_\_ Total gross income of household \$ \_\_\_\_\_  wk.  mo.  yr.

Applicant income eligible based on WIC guidelines?  Yes, WIC Income Eligible  No, WIC Income Ineligible

Signature/Initials of WIC Staff verifying income, residency and identity	Date
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Would you like to register to vote today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Initials: _____
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