

**WEST VIRGINIA WOMEN, INFANTS & CHILDREN (WIC) PROGRAM
PRE-CERTIFICATION FORM**

Date: _____

Local WIC Address/Phone:
(Stamp)

Applicant: (Last)_____ (First)_____ (M)____ SSN:_____

Parent/Guardian: (Last)_____ (First)_____ (M)____ SSN:_____ (infant/child applicant)

Address: _____ (City) _____ WV (Zip)_____

Telephone: _____ Residence County: _____

Date of Birth:_____ Pregnant __ Breastfeeding__ Postpartum__ Infant__ Child__ Sex: Male__ Female__

Due Date: _____ Delivery Date: _____ Referred From: _____ Household Size : _____

Family Income: \$ _____ Check if receiving: TANF _____ Food Stamps _____ Medicaid _____

Best time/day of the week for an appointment: _____

This institution is equal opportunity provider and employer.

WIC-31 (08/00) West Virginia Department of Health and Human Resources