



HANDS CERTIFICATION FORM



FAMILY INFORMATION

Family ID

AUTHORIZED REPRESENTATIVE 1

*Last Name

*First Name

MI

*Proof of Identity

AUTHORIZED REPRESENTATIVE 2

Last Name

First Name

MI

Proof of Identity

*Education

*Register to Vote?

Disability

*Proof of Address

Email Address

Do Not Email

STREET ADDRESS

Do Not Send Mailing

*Street 1

Street 2

*City, State, ZIP Code and County

MAILING ADDRESS

Same as Street Address

*Street 1

Street 2

*City, State, ZIP Code and County

FAMILY PHONE(S)

Does not have a phone

*Phone Number

Ext.

Phone Type

Do Not Call

Do Not Text

Priority

Appointment Reminder Preference

Phone

Email

Text

*Primary Language

Secondary Language

Interpreter Required

PROXY 1

Last Name

First Name

MI

Proof of Identity

PROXY 2

Last Name

First Name

MI

Proof of Identity

How did you hear about WIC?



HANDS CERTIFICATION FORM



CLIENT REGISTRATION

Client ID	*Last Name	*First Name	MI	*Date of Birth
<input type="text"/>				

Gender Male Female

Mother's ID	or	Mother outside of Family	*Proof of Identity
<input type="text"/>		<input type="text"/>	<input type="text"/>

FOSTER CARE Yes No

Has the child entered into foster care, or changed foster care homes, within the last 6 months?

Yes No

ETHNICITY AND RACE

*Choose one of the following: Hispanic or Latino Not Hispanic or Latino

*Choose one or more of the following:

- American Indian or Alaskan Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White

*Choose one of the following: Observed by Staff Provided by Client

Ineligibility Reason



HANDS CERTIFICATION FORM



INCOME ELIGIBILITY

HOUSEHOLD

Income Date *Family Size Unborn Counted

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ADJUNCT ELIGIBILITY

Member AHCCCS FDPIR SECTION 8 SNAP TANF

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INCOME

Providers *Zero Income*

*Income Provider *Amount *Interval

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Hours Per Week *Documentation

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Migrant Homeless Group Home Military Refugee

Foster Children

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CERTIFICATION

*Category

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Client Not Present

Reason Client Not Present

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Last Menstrual Period

Expected Delivery Date

Actual Delivery Date

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*Cert Start Date

*Cert Created By

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HANDS CERTIFICATION FORM



MEDICAL

Date

Weight

Height or Length

Hemoglobin

Recumbent Standing

Birth Weight

Birth Length

Pre-Pregnancy Weight

Delivery Weight

Pending Lab Codes:

1. Less than 4 weeks Post-partum (Hgb only, 1 mo FB)
2. Hgb not required
3. Medical Condition
4. Safety Concern (1 mo FB)
5. Religious Belief
6. Ht/Wt Pending Outside Documentation (1 mo FB)
7. Hgb/Hct Pending Outside Documentation (2 mo FB)



HANDS CERTIFICATION FORM



IMMUNIZATION

All Certifications Ages 0-2 Years

IMMUNIZATION VERIFICATION

Are DTaP dosages correct for age?

2-3 month old should have 1 dose of DTaP

4-5 month olds should have 2 doses of DTaP

6-17 month olds should have 3 doses of DTaP

18 month olds should have 4 doses of DTaP

**Based on standard immunization schedule*

***DOSES CORRECT?**

Yes No Unsure

What was used to assess the child's immunization status?

Immunization Database Hand Held Shot Record

REFERRAL ORGANIZATION

Referral Organization Code

BREASTFEEDING SURVEILLANCE

All Certifications Ages 0-2 Years

Most Recent Surveillance Date

Is this infant/child currently breastfeeding?

YES NO

Has this infant/child ever been breastfed?

YES NO

How old was this infant/child when he/she completely stopped breastfeeding?

Days Weeks Months

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Why did you stop breastfeeding?

How old was this infant/child when he/she was first fed something other than breast milk?

Days Weeks Months

Not Applicable, Nothing Given

<input type="text"/>	<input type="text"/>	<input type="text"/>
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HANDS CERTIFICATION FORM



PG Assessment (required fields)

Clinical

7. Number of Previous Pregnancies

8. Number of Doctor visits

9. No Prenatal Care (checkbox)

10. Date prenatal care began

P Assessment (required fields)

Clinical

6. Number of Previous Pregnancies

PN/EN Assessment(required fields)

Clinical

6. Number of Previous Pregnancies



HANDS CERTIFICATION FORM



IFF Assessment (required fields)

Diet and Nutrition

6. Scoops of powder to ounces of water

7. Ounces of concentrate to ounces of water

8. Number of ounces of formula in 24 hours

IPN/IPN+ Assessment (required fields)

Diet and Nutrition

7. Ounces of concentrate to ounces of water

8. Scoops of powder to ounces of water

9. Number of ounces of formula in 24 hours

10. Number of breastfeeding's in 24 hour period

Exclusively Nursing Assessment (required fields)

Diet and Nutrition

6. Number of breastfeeding's in 24 hour period



HANDS CERTIFICATION FORM



EZ-TGIF

- 1) = **T** Used _____ tool
- 2) = **G** Family/Mom will _____
- 3) = **I** Discussed _____.

Assigned Codes _____ due to _____

***Food Package Changes (IPN Tailoring) _____ because _____**

- 4) = **F** Referrals made: _____

Ask about _____

Next appointment remember to: _____