



SPCC WIC PROGRAM

Canandaigua Office
79 S. Main Street
Canandaigua, NY 14424
Ph: 585.394.9240
Fax: 585.394.9285
Text: 585.481.8488

Visit WICstrong.com

Newark Office
513 W. Union Street
Newark, NY 14513
Ph: 585.394.9240
Fax: 315.573.7158
Text: 585.481.8488



PLEASE CALL THE WIC OFFICE AFTER YOUR BABY IS BORN

Your baby will be added to your household and you will be given an appointment to enroll him/her.
Your baby must be enrolled in WIC in order to receive WIC Foods.

Please bring the following to the appointment:

1. Infant (if infant is unable to attend for medical reasons, please call the WIC office)
2. Proof of Income
 - Documentation to verify proof of income must provide information from within the 30 days prior to the appointment date.

<u>Period Stub Covers</u>	<u># Stubs Required</u>
Weekly	4
Bi-Weekly	2
Twice- Monthly	2
Monthly	1

3. Proof of Address/Residency
4. Proof of Identity for you and your baby
5. Completed Mother/Infant Delivery form (attached) **or** hospital discharge papers **or** WIC Medical Referral form **or** other proof of delivery.
6. Immunization record for your baby (if available)

If you have any questions about what to bring, please call WIC office at (585) 394-9240 or text us at (585) 481-8488.

An individual is income eligible for WIC if he/she is enrolled in Medicaid or a Medicaid Managed Care Plan or if anyone in the household is enrolled in SNAP/Food Stamps or TANF. Proof of enrollment in the program must be shown at certification appointment.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

For other complaints or to request a Fair Hearing contact:

- (1) mail: WIC Program Director
NYSDOH, Riverview Center
Room 650, 150 Broadway,
Albany, NY 12204;
- (2) phone: (800) 522-5006 fax: (518) 402-7348;
- (3) email: NYSWIC@HEALTH.NY.GOV

Authorization to release Information

I authorize the release of the delivery information below to the following NYS WIC Program (_____) and I authorize the WIC Program to release information about me to this healthcare provider for the purposes of coordinating my health care. If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

WIC Participant Signature

Date

WIC Delivery Information (To be completed by MD, PA, RN or RD only)

Mother

Mother's Name: _____

Weeks Gestation: _____ Gravida _____ Para _____

Total Pregnancy Weight Gained _____ pounds

Post Delivery Weight _____ Date taken: ____/____/____

Hgb. _____ and/or Hct. _____ Date taken: ____/____/____

Pregnancy / Labor & Delivery Complications

- Gestational Diabetes
- Hypertension
- Premature Delivery
- Toxemia
- Other: _____

Baby

Date of Birth: ____/____/____ MALE or FEMALE

Baby's FULL Name: _____

Birth Weight: ____lb ____oz Birth Length: _____

Discharge Weight: ____lb ____oz Date: ____/____/____

Hep B Vaccine Given? Y or N Date: ____/____/____

Birth Defects or Medical Conditions

- Medical Condition: _____
- Genetic/Congenital Disorder: _____
- Cardiac: _____
- Hypoglycemia
- Other: _____

Mother / Infant Feeding

Was **Breastfeeding Initiated** at birth? Yes No

Discharge Feeding Method:

- Breastfeeding Fully
- Breastfeeding with Formula Supplement _____
- Formula Feeding with → Contract Formula (Enfamil, Similac Isomil Soy, Gentlease, or Enfamil AR) OR
- Other NYS WIC approved formula (*DOCUMENTATION REQUIRED – DOH -4456*)

Breastfeeding Problems or Concerns Noted: *(Please call the local WIC office ASAP so that we can support a successful breastfeeding experience!)*

Hospital Name:

Infant's Healthcare Provider Name (print):

Signature of MD, PA, RN or RD completing this form:

Date:

Fax Completed Form To:

SPCC-WIC
FAX: 585-394-9285 or 315-573-7158