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 <u>within the 30 days</u> prior to the appointment date.

Period Stub Covers	# Stubs Required
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.

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	**Baby**
Mother's Name:_____	Date of Birth: _____/_____/_____ MALE or FEMALE
Weeks Gestation: _____ Gravida _____Para_____	Baby's FULL Name: _____
Total Pregnancy Weight Gained _____pounds	Birth Weight: _____lb _____oz Birth Length: _____
Post Delivery Weight _____ Date taken:____/____/____	Discharge Weight: ____lb ____oz Date: ____/____/____
Hgb. ____ and/or Hct. ____ Date taken:____/____/____	Hep B Vaccine Given? Y or N Date: ____/____/____
Pregnancy / Labor & Delivery Complications ☐ Gestational Diabetes ☐ Hypertension ☐ Premature Delivery ☐ Toxemia ☐ Other:_____	**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