Public Health
Delta & Menominee Counties

WIC Application / Pre-Cert Scheduling

Date of Application _____
Date of Appointment _____

Authorized Person			
Last Name:		Birth Date:	
First Name:	MI:	Clinic:	
Street Address		Mailing Address ☐Same as Street Address ☐Prefer no mailing	
Line 1:		Line 1:	
Line 2:		Line 2:	
Zip Code:	City/State:	Zip Code:	City/State:
County:		County:	

Applicant

Last Name	First Name	MI	Birth Date	Due Date	M/F	Foster

Area Code	Phone #	Home, cell, work, msg?	Prefer	No calls	Total household income (before deductions):	
					Family Size:	Migrant: ☐ Yes ☐ No
					Special Needs:	☐ Homeless
					Language:	☐ Translator required

Applicant Name	Appointment Type	Appt Date/Time	Been on WIC program before? Where?

Does your child have Children's Special Health Care Services (CSHCS)? ☐ Yes ☐ No
Do you or your child have Healthy Kids (Medicaid)? ☐ Yes ☐ No
Did you apply for Healthy Kids (Medicaid)? ☐ Yes ☐ No

This institution is an equal opportunity provider.