CALIFORNIA WIC
WOMEN, INFANTS & CHILDREN

Request for WIC Program Enrollment

Santa Clara County Public Health Dept.
Main - WIC Office
725 E. Santa Clara Street
San Jose, Ca. 95112
Suite 200

(408) 792 – 5101 Phone
(408) 294 – 6315 Fax

Applicants' Name: _____
If pregnant: **Date of Birth:** _____ **Mother's First Name:** _____

Child's Name: _____ **Date of Birth:** _____
If applicant is NOT child's mother> **Mothers first name:** _____

Address: _____ Phone: _____

_____ Language: _____

MediCal: N/A Gross Monthly Income: _____ Family Size: _____

Is this client or another family member receiving WIC? _____

If yes, where? _____ Date of last WIC visit? _____

WIC Family ID #: _____ Source of Health Care: _____

EDD: _____ If already delivered, is mom breastfeeding? _____

Was infant delivered preterm? N/A If so, how many weeks: ____ Birth weight: _____

If this is a high risk individual or family, please specify high risk conditions: _____

Name of Referring Party: _____

Program/Agency: _____

Address & Phone: _____

Date of Referral: _____

This form is for referral by agency or provider. The WIC Program will provide the client with an appointment, directions to the WIC office and forms to be completed.

This institution is an equal opportunity provider.

WIC Program Use Only:
Date & Time of Enrollment: _____
Version: 7/2017