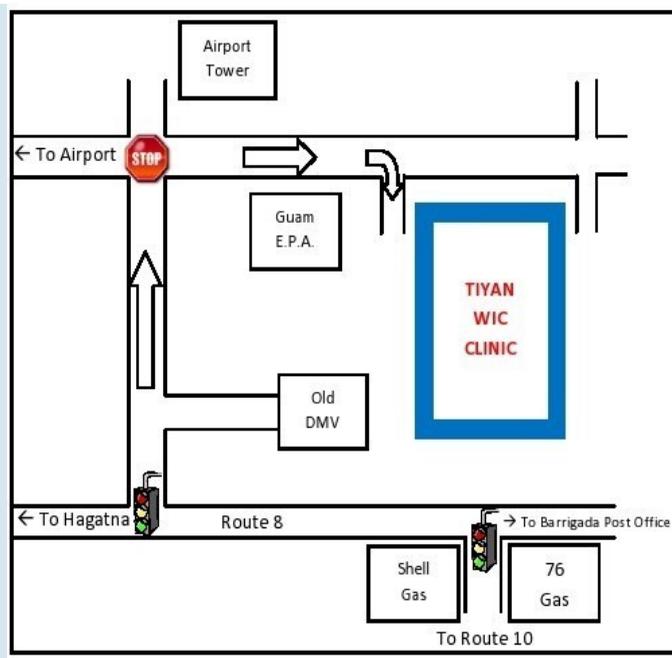


WIC Clinic Locations

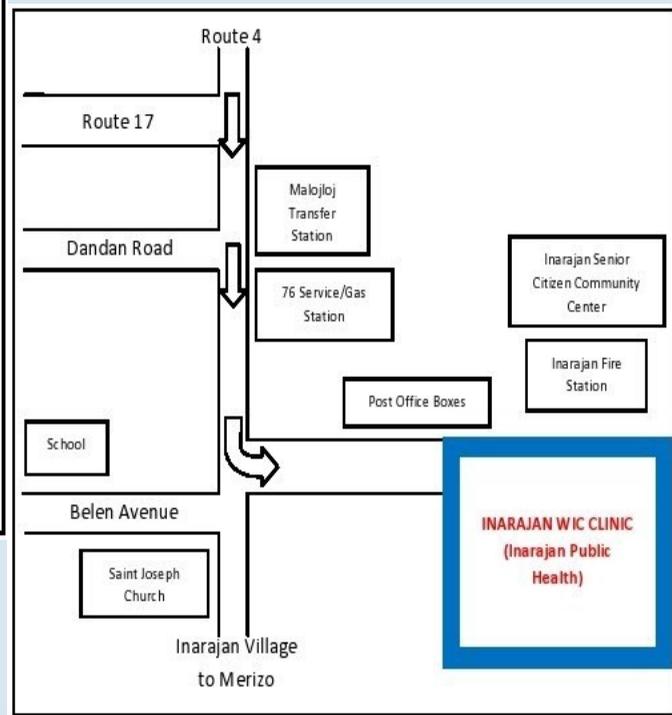
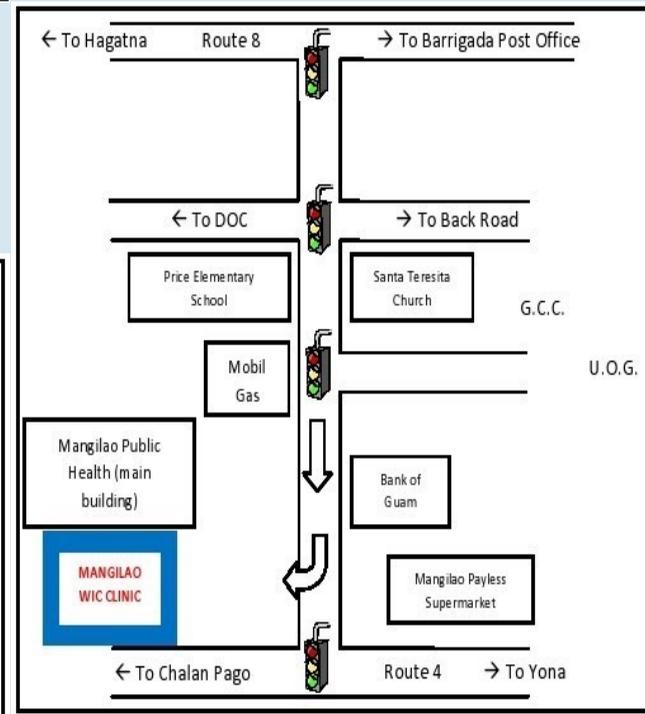
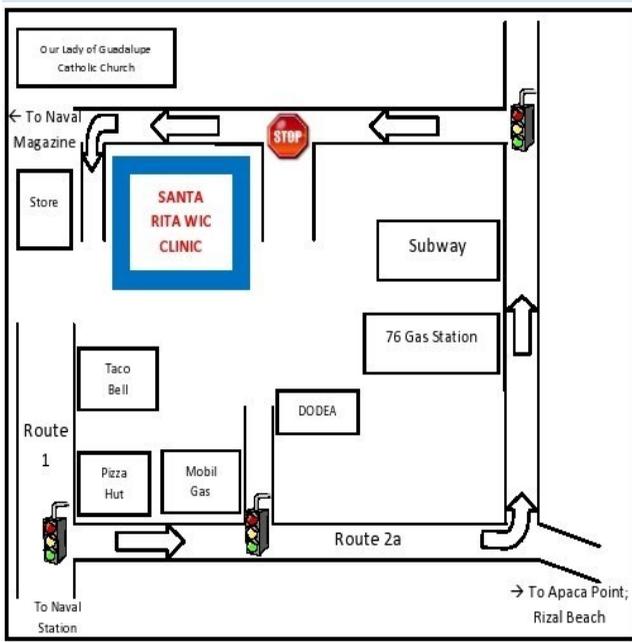


WIC Clinic (circle one):
Dededo • Tiyan • Mangilao • Santa Rita • Inarajan

WIC Appointment Date & Time

Family ID #

Authorized Representative's Name



WELCOME GUAM WIC PROGRAM
The Special Supplemental Nutrition Program for Women, Infants, and Children (up to 5 years old)

Helping Families Grow Healthy

(ENGLISH)



WHAT IS WIC?

The GUAM WIC PROGRAM is a special supplemental nutrition and education program for women, infants, and children (up to 5 years old).

It is a Health Promotion Program, not a welfare program. It teaches you and your family to be aware of your nutritional needs and to practice good eating habits. The Guam WIC Program helps you to be healthy during times of rapid growth. It promotes and supports breastfeeding, helps you prevent medical problems, and helps lower your health costs.



WHAT DOES WIC PROVIDE?

- Nutritional group classes.
- Personalized nutrition counseling.
- Breastfeeding information and support, including hospital and home visits, if needed.
- Food guides for feeding yourself, your infants, and your children.
- Referrals to other federal and local programs.
- Supplemental foods, such as milk, eggs, fortified cereals, 100% fruit and vegetable juices, dry beans, peanut butter, whole wheat bread, brown rice, vegetables, and fruits.
- Infant cereal, infant vegetables, and fruits.
- Infant formula (if needed).



WHO CAN APPLY?

You can apply if you are:

1. Pregnant, a new mom, or a breastfeeding woman;
2. A parent/guardian of a child under 5 years old;
3. A parent/guardian of an infant (0-11 months old).



WHAT DO YOU NEED TO BRING TO YOUR APPOINTMENT?

Bring the following to your certification or first appointment:



Most recent paycheck stubs of everyone working and/or retired in the household. Any proof of cash income, such as child support, tips, or LES document.

John Doe's Check Stub

Metro Services		27155	
po756	John Doe	123-45-6789	02/02/98
Emp. No.	Employee Name	Social Security No.	Period Start
Earnings	Hrs	Current Amount	Year to Date
\$6.00	80	\$480.00	\$1,440.00
		Deductions	Current Amount
		Federal	\$4.81
		FICA	\$29.78
		Medicare	\$6.96
		State	\$13.55
		City	\$4.80
		County	\$2.40
		Health	\$71.05
		Disability	\$2.25
			\$213.15
			\$6.75
\$6.00	\$480.00	\$135.58	\$344.42
Pay Rate	Current Earnings	Current Deductions	Net Pay
			\$1,440.00
			YTD Earnings
			\$406.74
			YTD Deductions
			\$1,033.26
			YTD Net Pay



Eligibility Certification for Medicaid, SNAP (formerly Food Stamp), or TANF, if applicable.



Proof of Residency. Any document with the caretaker's name and physical address.



Valid Picture I.D. of the person applying for WIC.

Valid ID Card,
Passport, or
Driver's License



Birth Certificate of children under 5 years old.

U.S. STANDARD
CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER: _____ BIRTH NUMBER: _____

1. CHILD'S NAME (First, Middle, Last) _____ 2. DATE OF BIRTH (Month, Day, Year) _____ 3. TIME OF BIRTH _____

4. SEX: Male Female 5. CITY, TOWN, OR LOCATION OF BIRTH _____ 6. COUNTY OF BIRTH _____

7. PLACE OF BIRTH: Hospital Free-standing Birthing Center Child-Breeder's Office Residence Other (Specify) _____ 8. FACILITY NAME (if not institution, give street and number) _____

9. I certify that this child was born alive at the place and time and on the date stated. _____ 10. DATE SIGNED (Month, Day, Year) _____ 11. ATTENDANT'S NAME AND TITLE (if other than certified) (Type/Print) _____
Name: _____
 M.D. D.O. C.N.M. Other Midwife
Signature: _____

12. CERTIFIER'S NAME AND TITLE (Type/Print) _____ 13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) _____
 M.D. D.O. Hospital Admin. C.N.M. Other Midwife

14. REGISTRAR'S SIGNATURE _____ 15. DATE FILED BY REGISTRAR (Month, Day, Year) _____

16a. MOTHER'S NAME (First, Middle, Last) _____ 16b. MOTHER'S SURNAME _____ 17. DATE OF BIRTH (Month, Day, Year) _____

18a. BIRTHPLACE (State or Foreign Country) _____ 18b. RESIDENCE—STATE _____ 18c. COUNTY _____ 18d. CITY, TOWN, OR LOCATION _____

19a. STREET AND NUMBER _____ 19b. INSIDE CITY LIMITS? (Yes or No) _____ 20. MOTHER'S MAILING ADDRESS (if other than residence, enter Zip Code on _____)

21. FATHER'S NAME (First, Middle, Last) _____ 22. DATE OF BIRTH (Month, Day, Year) _____ 23. BIRTHPLACE (State or Foreign Country) _____

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.
Signature of Parent or Other Informant: _____



Bring the infant and/or child under 5 years old.



Shot record or Immunization card for each infant and/or child under 5 years old.

IMMUNIZATION RECORD
Comprobante de Inmunización

Name (nombre) _____
Birthdate (fecha de nacimiento) _____
Allergies (alergias) _____
Vaccine Reactions (reacciones a cualquier vacuna) _____

RETAIN THIS DOCUMENT — CONSERVE ESTE DOCUMENTO



For legal guardians (if not natural parents), **bring court documents.**



WHERE CAN I APPLY?

For more information and to make an appointment, please call any of our clinics:

MANGILAO

Tel: 735-7180/1

Monday-Friday 8:00am to 6:00pm

Saturday 8:00am-12:00pm

DEDEDO

Tel: 635-7471/2

Monday-Thursday 8:00am-6:00pm

Friday 8:00am-5:00pm

Saturday 8:00am-12:00pm

TIYAN

Tel: 475-0295/6

Monday-Friday 8:00am-6:00pm

Walk-in Clinic (First Come, First Serve Basis) for New Applicants and Missed Appointments.

SANTA RITA

Tel: 565-3537

Tuesday & Thursday 8:00am-5:00pm

INARAJAN

Tel: 828-7550

Wednesdays only 9:00am-4:00pm

All locations are CLOSED every LAST FRIDAY of the month for staff training.

Department of Public Health & Social Services
15-6100 Mariner Avenue, Barrigada, Guam 96913-1601

CHECK TO SEE IF YOU MAY BE ELIGIBLE FOR WIC BENEFITS
<https://stars.fns.usda.gov/wps/>

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all of part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.