

**Proxy Signature Form**  
**WIC – 314B**

**Purpose:** To allow a designated alternate to receive nutrition education, food benefit issuance, and / or redeem WIC food benefits for a participant, parent or legal guardian. Signed by the proxy.

**Reference:** PRR 02.0-C

**Procedure:** Complete the form.

1. **Print Name:** Enter name of the participant, parent or legal guardian.
2. **Relationship to Participant:** Enter relationship to participant.
3. **Print Proxy Name:** Enter name of proxy.
4. **State how proxy will share nutrition education and health care referrals:** State on the form what assurances will be given by the proxy to share the nutrition education information, referrals and all other pertinent information with the participant.
5. **Name of Participant / Child / Infant:** Enter name of participant / child / infant.
6. **Client ID Number:** Enter participant's / child's / or infant's Client ID number.
7. **Check Boxes:** The proxy shall read and check each box.
8. **Signature of Proxy and Date:** Enter signature of proxy and date.
9. **Local Agency Signature and Date:** The local agency personnel shall sign and date the form to verify the proxy is acceptable.

**Issuance:** When participant, parent or legal guardian requests a proxy or proxy change.

**Disposition:** File original in participant's record. Provide copy to proxy. If requested, provide a photocopy for the participant, parent or legal guardian.

**Retention:** Three (3) years. Longer if necessary for audit or litigation resolution.

## Proxy Signature Form

### WIC – 314B

I, the proxy of the participant or infants / children (participants) listed below, have been give permission from the participant, parent or legal guardian to be his / her proxy in order to receive and to share nutrition education, to receive and / or redeem the WIC food benefits. I have been given permission to consent, on behalf of the parent or legal guardian, to allow WIC to take height, weight, and blood measurements of the infants / children.

\_\_\_\_\_  
Print Participant's, Parent or Legal Guardian's Name

\_\_\_\_\_  
Relationship to Participant

\_\_\_\_\_  
Print Proxy Name

State how proxy will share nutrition education and health care referrals.

Verbally share the information     Take and share written materials     Other \_\_\_\_\_

You, the proxy must bring this form, the eWIC card, and proof of identification to the WIC Clinic.

\_\_\_\_\_  
Name of Participants

\_\_\_\_\_  
Client ID Number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have Proxy read the following and sign:

- a.  I, the proxy, understand that I am responsible for following all Program rules.
- b.  I, the proxy, understand that I must attend all nutrition education sessions before I receive food benefits.
- c.  I, the proxy, understand that I am responsible for sharing all received nutrition education, and / or other health related and public assistance program information received from WIC with the participant.
- d.  I, the proxy, understand I am responsible for following proper food benefit usage procedures and failure to do so will be considered Program abuse.
- e.  I, the proxy, understand that I may be a proxy for a maximum of (3) three families.
- f.  I, the proxy, understand that I have the right to complain about improper vendor and agency practices.
- g.  I, the proxy, understand that I am required to pick up food benefits in person when scheduled for nutrition education, unless the alternative issuance system is appropriate.
- h.  I, the proxy, understand that my identification will be checked prior to any services being provided.

\_\_\_\_\_  
Signature of Proxy

\_\_\_\_\_  
Date

\_\_\_\_\_  
Local Agency Signature

\_\_\_\_\_  
Date

This institution is an equal opportunity provider.