System Outage Form for Eligibility Determination
Crossroads-01

Purpose: To gather eligibility data manually when Crossroads is disabled in accordance with ADM 13.0.

Reference: ADM 13.0

Procedure: Have the participant complete the enclosed form, the top part only. Local agency personnel shall verify income, residency, and identity. The method of verification shall be noted in the second part of the form. Comments may be entered in the comments section at the bottom of the form if a proxy is used, or for any other items that may need to be noted in Crossroads.

Issuance: To be used when Crossroads is disabled.

Retention: Forms shall be destroyed once information is entered into Crossroads.
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Today’s Date: ___________________________  Date of next appointment: ___________________________

Client or Family ID: _______________________  Phone Number: ________________________________

Applicant First Name: ______________________  Last Name: _________________________________

Source for proof of ID: ________________________________________________________________

Street Address: _________________________________________________________________

Source for proof of residence: _________________________________

Is the applicant a(n):    _____Infant    _____Child   _____ Pregnant woman
                        Postpartum woman _____Breastfeeding _____Non-Breastfeeding

Is the applicant:    ____  Married   ____  Single

Is the applicant:    ____  Migrant worker   _____ Homeless

Is the applicant a registered voter:  _____ Yes  _____  No, if No, is interested in registering ___Yes ___No

If the applicant is pregnant, if so when is due date?  ________________________

Size of applicant’s economic unit ________   Is applicant in foster care?  ___Yes ___No

Is the applicant adjunctively eligible through current participation in Medicaid, SNAP or TANF?
                        _____ Yes  _____ No    If Yes, what is the certification #:  ___________________________

Monthly income received:  $_______________________

Source of income verification (if not adjunctively eligible) ______________________________________

Is the participant planning to move in the next 6 months? ________________________________

If a new applicant, how did participant hear about WIC? ______________________________________

WIC Staff to verify as needed:

_____  Adjunctive Eligibility (Medicaid, SNAP, TANF)
_____  Income
_____  Identity
_____  Residency

Notes:    ___________________________________________________________________________