Proxy Designation Form
WIC – 314A

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 parent or legal guardian.

Reference: PRR 02.0

Procedure: Complete the form.

1. **Name:** Enter name of participant, parent or legal guardian.

2. **Print Proxy Name:** Enter name of proxy.

3. **Relationship to Participant:** Enter relationship to participant.

4. **State how proxy will share nutrition education and health care referrals:** The participant, parent or legal guardian shall 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. **Signature of Participant:** Signature of participant, parent or legal guardian.

6. **Family Number:** Enter participant's, parent's or legal guardian's Family ID number(s).

7. **Date:** Date of signature.

8. **Name of Participant / Child / Infant:** Enter name of participant / child / infant.

9. **Client ID Number:** Enter participant's / child's / or infant's Client ID number(s).

10. **Local agency signature:** 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: Scan original in participant's record. Provide copy to proxy. If requested, provide a copy for the participant / parent or legal guardian.

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

Proxy Designation Form
WIC – 314A

I, _____, the participant, or parent / legal guardian of the infants / children listed below, give permission for the following person to be my proxy in order to receive and to share nutrition education and to receive and to redeem my WIC food benefits. I give permission to the proxy to consent, on my behalf, to WIC taking height, weight, and blood measurements from my infants / children.

I understand that my proxy must attend all nutrition education sessions in order to receive WIC food benefits. I understand that **I am responsible for all actions of the proxy on my behalf. I am responsible for assuring that s/he will follow all program rules. I understand that I will have to repay the program for all losses incurred by my proxy breaking program rules and / or laws.**

Print Proxy Name Relationship to Participant

Local agency personnel shall state the difficulty of obtaining WIC food benefits and the need for a Proxy:

_____

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

_____

Your proxy must bring this form and proof of his/her identification to the WIC clinic. If you would like to change your proxy, you and your new proxy must return to complete another form.

_____

Signature of Participant Family Number Date

Name of Participants Participant WIC Number

_____ _____

_____ _____

_____ _____

_____

Local Agency Signature Date

This institution is an equal opportunity provider.