

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:

**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 given 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

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## 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 Tam 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.

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### Signature of Proxy

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Date

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Local Agency Signature

Date

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

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To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

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