Breastfeeding/Postpartum Women Application

Today's Date _____

1. Name (First, Middle, Last)	2. Birth Date

3. If receiving Medicaid, please provide Medicaid number:

4. Is this person Hispanic or Latino? ☐ Yes ☐ No

5. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacifc Islander ☐ White

To Be Completed by Health Care Provider (HCP)

Name of HCP verifying applicant lives in Alaska

ID Verifed by:

Name of CPA reviewing WIC application

Eating & Feeding

28. What concerns, if any, do you have about having enough food to feed your family?

Additional

Yes No