

**VIRGIN ISLANDS DEPARTMENT OF HEALTH  
WIC PROGRAM  
ELIGIBILITY CHECKLIST**

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

Location: \_\_\_\_\_

Telephone: \_\_\_\_\_

**To receive or continue to receive WIC benefits, you will need to bring in the items checked below:**

**PROOF OF ALL APPLICANTS' IDENTITY:**

- |                                      |  |
|--------------------------------------|--|
| _____ WIC Appointment Card (valid)   | _____ Nursery Book/Infant Card         |
| _____ Birth Certificate (not a copy) | _____ Passport or Passport ID/Visa     |
| _____ Baptismal Record (not a copy)  | _____ Photo ID (school, health, other) |
| _____ Driver's License               | _____ Marriage Certificate             |
| _____ Voter's Registration Card      | _____ Immunization Record (child)      |

**PROOF THAT YOU LIVE IN THE VIRGIN ISLANDS:**

- |   |   |
|---|---|
| _____ VI WIC Appointment Card (valid)       | _____ WAPA Bill                           |
| _____ VI Driver's License (valid)           | _____ Telephone/Cable Bill                |
| _____ VI Voter's Registration Card (valid)  | _____ Institution Letter/Notice           |
| _____ Rent Receipt/Lease Contract (current) | _____ Photo ID with Local Address (valid) |

**PROOF OF HOUSEHOLD'S CURRENT INCOME:**

- |  |   |
|--|---|
| _____ SNAP (Food Stamps) Action Statement (with cert period) | _____ Foster Care Stub (most recent)    |
| _____ MAP (Medical Assistance) CARD                          | _____ Receipts of Payment Received      |
| _____ TANF (Welfare) Statement                               | _____ Social Security Letter/Statement  |
| _____ VOC (Valid WIC Verification of Certification)          | _____ TAX Forms (most recent filed)     |
| _____ Verification of Support                                | _____ LES (Military Earning Statement)  |
| _____ Check Stub/Statement (most recent)                     | _____ Bank Book/Statement (most recent) |
| _____ Verification of Employment Letter                      | _____ Other _____                       |

**MEDICAL INFORMATION:**

- |                                       |  |
|---------------------------------------|--|
| _____ Bring _____ for Weight & Height |  |
| _____ WIC Referral                    | _____ Other Hospital/Medical Documents |
| _____ Hematology Results for _____    |  |

**OTHER:**

- |                                     |                           |                   |
|-------------------------------------|---------------------------|-------------------|
| _____ Notarized Guardianship Letter | _____ Immunization Record | _____ Other _____ |
|-------------------------------------|---------------------------|-------------------|



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- |   |  |
|---|--|
| (1) mail: U.S. Department of Agriculture<br>Office of the Assistant Secretary for Civil Rights<br>1400 Independence Avenue, SW<br>Washington, DC. 20250-9410. | (2) fax: (202) 690-7442<br>OR<br>(3) email: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a> |
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**This institution is an equal opportunity provider**