Washington State Department of HEALTH

DOH 962-1007 June 2025

WIC BENEFIT REPLACEMENT FORM

Parent Guardian/Caretaker Name:	**Clinic:** **Date:**
Participant Name:	**Participant ID:**
Participant Name:	**Participant ID:**

Please describe what happened:

_____

_____

_____

Please describe which foods and formula need replacing (*for example: pasta, 16 oz; fresh produce, $8; 2% milk, 1.5 gal*):

_____

_____

_____

BENEFIT REPLACEMENT AGREEMENT:
Please read the information below. You must sign before you can receive replacement food or formula benefits.

- Reason benefits are being replaced:
  - ☐ Fire ☐ Flood ☐ Natural Disaster
  - ☐ Not available for use (please describe) _____
  - ☐ Not given to me by the previous caregiver _____
    (previous caregiver's name)
- I will bring any original formula back to the clinic if I am able to reclaim it or it is given to me by the previous caregiver.
- I understand if I give false information to receive more food or formula than allowed per month, I have broken WIC rules. I will have to pay the money back to WIC and I can be taken off the Program.

"I certify, with my signature below, under penalty of perjury under the laws of the State of Washington that the above statement is true and correct to the best of my knowledge."

Parent Guardian/Caretaker Signature: _____ Date: _____

Signature of WIC staff: _____ Date:_____

Form Distribution: Scan form into Cascades and give original to the participant, parent guardian or caretaker.