

Head Start and WIC

January 23, 2019

Presenting To

WIC Partners Meeting
Brittany Howard, MS, RDN, CSP, CLC | WIC Nutrition Services Manager





Supporting Head Start quality today, impacting Arizona's tomorrow!



WIC and Head Start

Partners in Promoting Health and Nutrition for Young Children and Families

WIC Nutrition Services

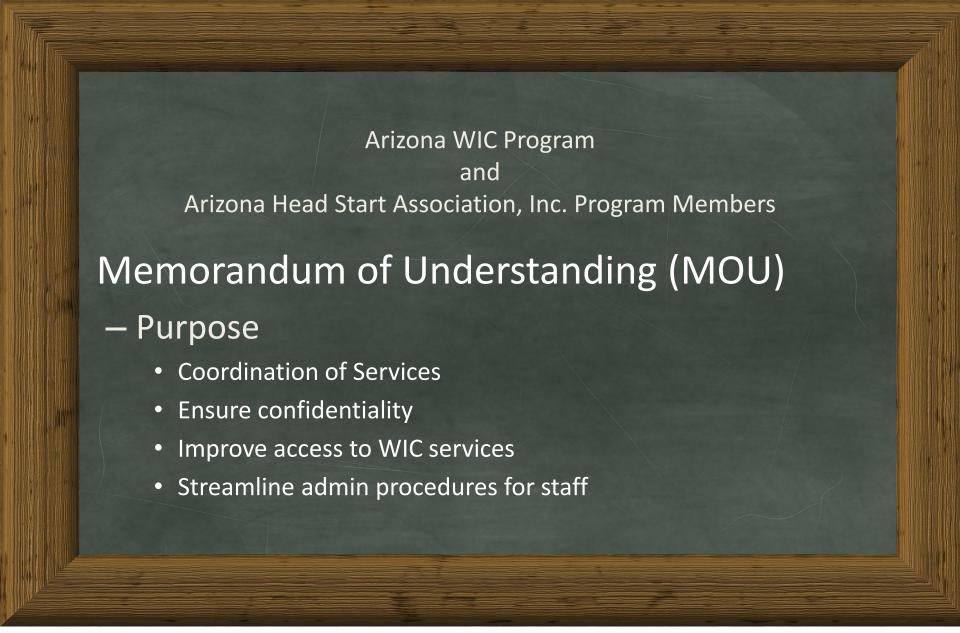
Adjunct to Preventive Healthcare Health & Nutrition Education Provide Nutritious Foods





Head Start Comprehensive Child Development Services







MOU Key Points

- Signees
- Effective Dates
- Updates!
 - Guide for Data Sharing
 - Referral Form



Who is Participating?

- 1. Catholic Charities Westside Head Start
- 2. Chicanos Por La Causa
- 3. Child Crisis Arizona
- 4. Child Parent Centers, Inc.
- 5. City of Phoenix
- 6. Maricopa County
- 7. Northern Arizona Council of Governments
- 8. Pinal Gila Community Child Services, Inc.
- 9. Southwest Human Development
- 10. Western Arizona Council of Governments
- 11. Urban Strategies





Effective Dates



- 5 years
- January 2, 2019
- Expires January 1, 2024



Guide for Data Sharing Agreement

Guide for Data Sharing Between the Arizona Head Start Association Program Members and the Arizona WIC Program



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Referral Form







Head Start and WIC Referral Form



This referral form is for sharing client information between Arizona Head Start Programs and the Arizona WilC Program. This form is to be completed and shared with the requesting agency within two (2) weeks from the Date of Referral.

If the client is due back for measurements within 2 weeks, please hold this form to complete at that time. If not, complete with the most recent measurements.

Please complete ALL sections noted with a ".	
Participation Status*	
Currently Participating in Head Start	Currently Not Participating in Head Start
Currently Participating in WIC	Currently Not Participating in WIC
Date of Referral (MM/DD/YYYY)*	Quality and the second of the
Date of Referral (MM/DD/1111)	
Child's Full Name (First, Middle Initial, Last)*	
Child's Date of Birth (MM/DD/YYYY)*	
Authorized Representatives//Caregivers/ Full	Name (First, Middle Initial, Last)*
Family's Contact Phone Number*	
raminy 5 contact Priorie Number	
Helght	Date Taken
2500	
Weight	Date Taken
	Date Taken
Hgb	Date Taken
Referring WIC/Head Start Clinic Contact Infor	rmation"
	WT-100
Name of Staff Member Completing the Refer	ral*
	28
Optional: To Be Completed By Participants	Marconord and the second second second
	acted by the programs for outreach and enrollment beyond the information horized Representative/Caregivers. The selected program below will be the
agency receiving this referral form.	The second secon
agency receiving this referral form. Would you like to be contacted by [circle one]	WIC or Head Start to learn more about the program? (Please check one)
agency receiving this referral form.	WIC or Head Start to learn more about the program? (Please check one)

Next Steps

- Ongoing feedback as process is implemented
- Utilize referral form for referrals and data requests
- Outreach to Head Start
- Send in your suggestions!

THANK YOU

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