State of Illinois
Department of Human Services - Division of Community Health and Prevention - Bureau of Central and Field Operations

SUPPLEMENTAL NUTRITION PROGRAM QUARTERLY REPORT (WIC)

Person Completing Report: _____

Telephone: _____ Ext. _____ Date Submitted: _____

Email: _____

Agency Name: _____

FEIN: _____

Contract Number: _____ Document Number: _____

Amount		
_____	◯ Quarter 1 (☐ July, ☐ Aug, ☐ Sept)	**DUE BY NOVEMBER 1**
_____	◯ Quarter 2 (☐ Oct, ☐ Nov, ☐ Dec,)	**DUE BY FEBRUARY 1**
_____	◯ Quarter 3 (☐ Jan, ☐ Feb, ☐ Mar,)	**DUE BY MAY 1**
_____	◯ Quarter 4 (☐ Apr, ☐ May, ☐ June,)	**DUE BY AUGUST 1**
_____	Total Year to Date	

☐ Revised

Title/Purpose	Components (Specify)					
	Total Claimed	Breast Feeding Promotion	Client Services	General Administration	Nutrition Education	Breast Feeding Peer Counseling
Personal Services/Fringe						
Contractual Services						
Travel						
Supplies						
Equipment						
Match (if required)						
Total						

Certification

The undersigned hereby certifies that the good and/or services claimed above are necessary expenditures for the program, that appropriate purchasing procedures have been followed, that payment has been made as indicated and that reimbursement has not previously been requested or received.

Authorized Agency Official: _____ Date: _____

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