Ohio Department of Health

WIC Program Application

Please answer all questions on this page.

A.

Parent, guardian or applicant's name		Telephone ☐ Home ☐ Work ☐ Cell ☐ Leave message		
Street address	City	State	ZIP	County
Mailing address (if not the same as street address)	City		State	ZIP

B. In the section below please list everyone who is living in your home, including yourself.

1.

Full name—first, middle, last	Relationship to you	☐ Female ☐ Male	Date of birth / /
Hispanic/Latino ☐ Yes ☐ No ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American		If pregnant: number of unborn babies	Due date / /

2.

Full name—first, middle, last	Relationship to you	☐ Female ☐ Male	Date of birth / /
Hispanic/Latino ☐ Yes ☐ No ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American		If pregnant: number of unborn babies	Due date / /

3.

Full name—first, middle, last	Relationship to you	☐ Female ☐ Male	Date of birth / /
Hispanic/Latino ☐ Yes ☐ No ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American		If pregnant: number of unborn babies	Due date / /

4.

Full name—first, middle, last	Relationship to you	☐ Female ☐ Male	Date of birth / /
Hispanic/Latino ☐ Yes ☐ No ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American		If pregnant: number of unborn babies	Due date / /

5.

Full name—first, middle, last	Relationship to you	☐ Female ☐ Male	Date of birth / /
Hispanic/Latino ☐ Yes ☐ No ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American		If pregnant: number of unborn babies	Due date / /

6.

Full name—first, middle, last	Relationship to you	☐ Female ☐ Male	Date of birth / /
Hispanic/Latino ☐ Yes ☐ No ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American		If pregnant: number of unborn babies	Due date / /

C. If anyone in your home is pregnant, is she under a doctor's care? ☐ Yes ☐ No — If yes, what is the doctor's name?

D. Has anyone in your home had a pregnancy that ended within the last six months? ☐ Yes ☐ No — If so, who?

E. Is anyone in your home breastfeeding a baby less than 12 months old? ☐ Yes ☐ No — If so, who?

F. Please check Yes or No if anyone in your home is receiving any of the following:

Ohio Works First Cash ☐ Yes ☐ No If so, who?	Medicaid ☐ Yes ☐ No If so, who?	Food Assistance ☐ Yes ☐ No If so, who?

For each person in your home who has any income such as wages, self-employment, unemployment, SSI, Social Security, VA pension, workers compensation, alimony, child support, lump-sum payments, please complete the lines below.

Name	Name of income source	Gross amount	How often received
		$	
		$	
		$	

Important! You must sign the back of this application form.

By signing this WIC application, I agree to give proof of eligibility for information entered on this form and any other information asked to meet program rules.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided to me under the Medicaid, WIC, and other medical assistance programs.

I also authorize the Ohio Department of Health, the Ohio Department of Medicaid, and the Ohio Department of Job and Family Services to exchange any information I have provided on this form to enable the departments to determine my eligibility.

I understand that this application is considered without regard to race, color, national origin, sex, age, or disability.

By my signature below, I affirm under penalty of perjury that to the best of my knowledge and belief all the answers on this application are true and complete. I understand that the law provides penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive.

Signature of applicant who completed this form	Date of signature
Signature of person who helped complete this form	Date of signature

AGENCY USE ONLY

Pregnancy Verification ☐ Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephoned (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Name (Circle one— I C P N B)	☐ Present ☐ Exempt	Document type or number
Name (Circle one— I C P N B)	☐ Present ☐ Exempt	Document type or number
Name (Circle one— I C P N B)	☐ Present ☐ Exempt	Document type or number
Name (Circle one— I C P N B)	☐ Present ☐ Exempt	Document type or number
Medical chart location (office name)		

Income Verification ☐ Verification attached (county department of job and family services, employer, other agencies)

Check those that apply					Economic unit size
☐ OWF	☐ Disability Financial Assistance	☐ Food Assistance	☐ Medicaid	☐ Refugee	
Card number			☐ Benefits Notice/Printout ☐ Provider Information Line ☐ MITS or EBT Portal		Effective date

Verification statement used (document/check stub/letter) ☐ Yes ☐ No	Statement date	Income amount $	☐ Weekly ☐ Bi Weekly ☐ Semimonthly ☐ Monthly
Telephoned (name)	Agency/Business		Call date
Confirmed or other information			

Proof of Residence

☐ Ohio License/ID ☐ Utility/credit bill ☐ WIC Reminder Card ☐ Medical card/JFS document ☐ Other_____

WIC personnel signature	Date

This institution is an equal opportunity provider.

Location of CPA

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Children 1–5 Years

Child's name		Today's date
Your name		Your relationship to child (96)
Child's birth date	Birth weight (51, 59)	Birth length
Child's doctor or clinic		Date of last doctor or clinic visit

Please answer the questions below.

Did your child ever breastfeed?
☐ Still breastfeeding ☐ Yes ☐ No ☐ Don't know
Why did you stop? _____ How old was your child when you stopped? _____

Was your child born three or more weeks early?
☐ Yes How many weeks? _____ ☐ No (50)

Please check all the health problems your child has.
☐ Asthma ☐ Depression ☐ Teeth/gums ☐ Birth defects ☐ Lactose intolerant
☐ Other _____ ☐ None (68, 91, 93, 94)

List your child's medicines.
☐ None (93)

Is your child up to date on shots?
☐ Yes ☐ No ☐ Don't know

Has the doctor tested your child's blood for lead?
☐ Yes Results_____ ☐ No ☐ Don't know (21)

Has your child seen a dentist?
☐ Yes ☐ No

Do your child's teeth get brushed?
☐ Yes ☐ No

Where do you get your water?
☐ Well ☐ City ☐ Store bought ☐ Other _____

Check all that your child takes.
☐ Vitamins ☐ Herbs ☐ Iron ☐ Fluoride
☐ Other _____ ☐ None (30)

List your child's food allergies.
☐ None (93)

Is your child on a special diet?
☐ Yes, your choice ☐ Yes, from your doctor ☐ No (30, 35, 91, 93)

Is your child using formula?
☐ Yes Which formula? _____ ☐ No (91, 93)

OVER ☛

Check all that apply to your child.

☐ Drinks from a cup ☐ Drinks from a bottle ☐ Goes to bed with a bottle or sippy cup

☐ Walks around with a bottle or sippy cup ☐ Is fed through a feeding tube (36, 94)

What foods does your child refuse to eat?

☐ None (35)

Please check all the non-food items your child eats.

☐ Printed paper ☐ Paint chips ☐ Dirt ☐ Clay ☐ Ice

☐ Other _____ ☐ None (30)

Check all that apply.

☐ Child feeds self ☐ I run out of money or food stamps to buy food

☐ Child has eating/chewing/swallowing problems ☐ I have a working stove or microwave and refrigerator in my home.

☐ Child usually does not eat at home

☐ Child lives in a shelter, hotel or temporary place. (37, 66, 93, 95)

What do you think about your child's eating habits?

How many hours per day is your child physically active?

☐ Less than one hour ☐ One–two hours ☐ Three or more hours

If anyone in your home smokes, where do they smoke?

☐ Inside ☐ Outside ☐ Car ☐ No one smokes (46)

During the last six months, has your child been physically, verbally or sexually abused or neglected?

☐ Yes ☐ No (67)

Do you have any questions or concerns?

_____

Ohio Department of Health
Welcome to WIC Letter

Dear _____

The Women, Infants, and Children Program (WIC) is a health program funded by the United States Department of Agriculture. WIC provides nutrition education, breastfeeding support, nutritious foods, and referrals to other health and human service agencies. The purpose of the program is to help improve diet during critical times of growth and development. The foods provided by the program are supplemental and are not intended to provide all of your daily food requirements. WIC foods are only for the participant.

The health professional will assess your health and diet information and discuss nutritional risk factors that could affect your health and growth. **Your nutrition risk today is:**

WIC health professionals partner with you to develop nutrition goals to support a healthy pregnancy, breastfeeding and postpartum experience, and growth for infants and children.

I have discussed my nutrition goal with the WIC health professional. I agree to try:

Date	Height	Length	Weight	Blood iron (Hemoglobin)

Benefits are for a specific period of time, usually 6 months, called a certification period. An appointment will be made for you to pick up your benefits and for your next certification appointment. These appointments are made before your certification period runs out so that your benefits are not delayed.

Your next WIC clinic visit is scheduled for:

Nutrition Education and Benefit Pickup Date	Next Certification Visit Date

Keep all WIC appointments or your benefits may end.

Your foods will end on _____ **because**
- ☐ child turns age 5,
- ☐ 6 month postpartum period has ended, or
- ☐ breastfeeding eligibility for WIC has ended.

Information Sharing in the WIC Program

WIC works with many programs to meet your service needs. The *Information Sharing in the WIC Program* pamphlet explains programs that may receive your information for outreach; eligibility; and improving health, education, and well-being for your family.

Sharing information with programs or medical providers not listed in the *Information Sharing in the WIC Program* pamphlet needs your consent. You are not required, but may check or add programs or medical providers below for sharing your information.

☐ Head Start/Early Head Start ☐ Medicaid provider for breast pump _____

☐ Other _____

I have been advised of my rights and responsibilities stated on the back of this letter. I received an *Information Sharing in the WIC Program* pamphlet. I certify that the information I provided is correct to the best of my knowledge. My WIC program application information may be verified. I understand making a false or misleading statement, or misrepresenting, concealing or withholding facts may result in my paying back the cost of benefits issued to me and may result in prosecution under state and federal law.

Signature of Participant or Guardian	Signature of WIC Personnel	WIC Effective Date

Participant Rights and Responsibilities

Participant Rights

1. You have the right to ask for a fair hearing if you are disqualified from the WIC program. You must ask for a fair hearing within 60 days from the date you are notified of disqualification. At the time of the fair hearing, you may be represented and accompanied by a relative, friend, legal counsel, or other spokesperson.
2. You may appeal any decision made by the local agency regarding your eligibility for the program.
3. The local agency will make breastfeeding and nutrition education services available to you or your parent or guardian.
4. Your WIC benefits can be transferred to any WIC clinic in the United States (U.S.) and its territories and to certain other countries where WIC-like services are provided by a U.S. entity.

Participant Responsibilities

I understand that failure to abide by my responsibilities may result in disqualification. I and my alternates must:

1. not sell, trade, or give away WIC foods or formula, breast pumps or WIC Nutrition Cards (WNC). This includes using online outlets such as Craigslist or Ebay to illegally sell or trade WIC benefits;
2. not accept from the vendor cash, credit, unauthorized foods, or other items of value for WIC Nutrition Cards;
3. not physically abuse, threaten physical abuse, or verbally abuse anyone at the WIC clinic or store;
4. notify the clinic if I have difficulty buying WIC foods at the store or if I am treated unfairly by store staff;
5. not make false or misleading statements or misrepresent, hide or withhold facts to obtain benefits;
6. not receive WIC benefits from more than one WIC program at a time;
7. use WIC foods for participants only. Send WIC Nutrition Cards or foods benefits with participants if they leave the household;
8. keep WIC appointments and pick up benefits at assigned times and on a regular basis to avoid termination. WIC benefits stop when benefits are not picked up;
9. notify the clinic of a change in income, address, telephone number, family size and pregnancy due date;
10. use WIC Nutrition Cards during the valid dates;
11. keep WIC Nutrition Cards in a safe place. It can take up to six days to replace WIC Nutrition Cards;
12. return loaned breast pumps when asked; and
13. bring back excess, unopened formula and baby foods to the WIC clinic.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.