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.

#	Full name—first, middle, last		Relationship to you		Date of birth
1.	Full name—first, middle, last		Relationship to you **SELF**	☐ 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 ☐ OWF ☐ Disability Financial Assistance ☐ Food Assistance ☐ Medicaid ☐ Refugee			Economic unit size
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

Location of CPA	HT	WT	BMI	HGB

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Breastfeeding Women and Postpartum Women

Name		Today's date	Age (39, 40)
Date this pregnancy ended	What was your due date? (49)	Your weight at delivery	Your weight before pregnancy (11)
Check one ☐ live birth _______pounds _______ounces ☐ stillbirth ☐ miscarriage ☐ abortion ☐ infant death (22, 45, 49)			
Number of past pregnancies (39)	How many ended in live birth? (42)	Date previous pregnancy ended (43)	
Prenatal doctor or clinic		Date of last doctor visit	

If you are currently breastfeeding, fill out Sections 1 and 2. If you are not currently breastfeeding fill out Section 2.

Section 1

My baby breastfeeds

every ________hours or ________times a day and _______times a night   How long on each side? ________________ (70)

If your baby gets bottles

What is in the bottle? ______________________   How often? ________________

Do you have problems with

☐ Let down ☐ Hot, hard breasts ☐ Latch ☐ Pain in your breasts ☐ Sore nipples

☐ Other ______________________ ☐ No problems (74)

How long do you want to breastfeed your baby?

Are you going back to work or school?

☐ Yes When? ________________ ☐ No

What kind of support for breastfeeding do you have at home?

Would you like more breastfeeding help?

☐ Yes ☐ No

Section 2

Did you ever breastfeed your baby?

☐ Still breastfeeding ☐ Yes ☐ No

Why did you stop? ______________________   How old was your baby when you stopped? _______

Did you have a C-section?

☐ Yes ☐ No (93)

List any problems you have had.

With this pregnancy ______________________

With past pregnancies ______________________ ☐ None (44)

Check any health problems you currently have.

☐ Diabetes ☐ Depression ☐ Dental ☐ High blood pressure ☐ Lactose intolerance

☐ Other ______________________ ☐ None (91, 93, 94)

List any medicines you take.

(93)

Has the doctor tested your blood for lead?

☐ Yes Results ______________________ ☐ No ☐ Don't know (21)

Have you ever had a baby with a birth weight of nine pounds or more?

☐ Yes ☐ No (22, 49)

Was your baby born three or more weeks early?

☐ Yes How many weeks? ______________________ ☐ No (49)

Was your baby born with any health problems?

☐ Yes ☐ No

If yes, explain______________________ (23)

Check all supplements you take.

☐ Prenatal vitamins/vitamins ☐ Iron ☐ Herbs ☐ Calcium

☐ Other ______________________ ☐ None (30)

Are you on a special diet?

☐ Yes, your choice ☐ Yes, from your doctor ☐ No (30, 35, 91, 93)

List your food allergies

☐ None (93)

Check any of these non-food items that you **eat** or **crave.**

☐ Paint chips ☐ Ice ☐ Printed paper ☐ Dirt/clay ☐ Starch ☐ Coffee grounds

☐ Other ______________________ ☐ None (30)

Check all that apply.

☐ Someone else shops for food. ☐ I usually shop for food. ☐ I usually do not eat at home.

☐ Someone else does the cooking. ☐ I usually cook. ☐ I live in a shelter, motel, or temporary place.

☐ I have a working stove or microwave and refrigerator in my home.

☐ I run out of money or food stamps to buy food. (66, 95)

What do you think about your eating habits?

Name one or two things you do for physical activity or exercise.

How many cigarettes, pipes, cigars do/did you smoke?

Now	________a day	________a week	☐ None
Last three months of this pregnancy	________a day	________a week	☐ None
Three months before this pregnancy	________a day	________a week	☐ None

(46)

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

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

Check all alcoholic beverages you drink.

☐ Wine ☐ Beer ☐ Coolers ☐ Liquor

Now	________a day	________a week	☐ None
Last three months of this pregnancy	________a day	________a week	☐ None
Three months before this pregnancy	________a day	________a week	☐ None

(47, 66)

Check all drugs you currently use.

☐ Marijuana ☐ Crack ☐ Speed ☐ LSD ☐ Heroin

☐ Crystal meth ☐ Inhalants ☐ Prescription drugs (misuse)

☐ Other ______________________ ☐ None (48, 66, 93)

During the last six months, have you been physically, sexually or verbally abused?

☐ Yes ☐ No (67)

Do you have any questions or concerns?

____

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Infants

Baby's name			Today's date
Your name			Your relationship to baby (96)
Birthdate	Date baby was due (50)	Birth weight (51, 59)	Birth length (52)
Baby's doctor or clinic		Date of last doctor or clinic visit	Were you on WIC during this pregnancy? ☐ Yes ☐ No (61)

Please answer the questions below

My baby breastfeeds

Every ________ hours or ________ times a day and ________ times a night ☐ Not breastfed (71, 75)

Check all that apply to your breastfed baby.

☐ Weak suck ☐ Slow weight gain ☐ Problems latching on ☐ My baby has no problems breastfeeding

☐ Not breastfeeding ☐ Other ________________ (56, 74)

Did you ever breastfeed your baby?

☐ Yes ☐ No

Still breastfeeding?

☐ Yes ☐ No

Why did you stop? ________________ How old was your baby when you stopped? ________

Was your baby born three or more weeks early?

☐ Yes How many weeks? ________ ☐ No (50)

Check any health problems your baby has.

☐ Colic ☐ Reflux ☐ Teeth/gums ☐ Birth defects ☐ Slow weight gain ☐ Jaundice (yellow color)

☐ Other ________________ ☐ None (56, 68, 91, 93, 94)

List your baby's medicines.

☐ None (93)

Is your baby up to date on shots?

☐ Yes ☐ No ☐ Don't know

Has the doctor tested your baby's blood for lead?

☐ Yes Results ________________ ☐ No ☐ Don't know (21)

Do you clean your baby's gums or teeth?

☐ Yes ☐ No

Check all that your baby takes.

☐ Vitamins (vitamin D) ☐ Iron drops ☐ Fluoride drops ☐ Herbs

☐ Other ________________ ☐ None (30)

List your baby's food allergies.

☐ None (93)

How many times a day is your baby's diaper wet or dirty?

(74)

If you give your baby bottles, what is in the bottles?

☐ Breastmilk ☐ Formula Which formula? ______________________ ☐ No bottles used

How many ounces a feeding? ____________ How often are the feedings? ____________ (38)

If you mix formula, what kind of water do you use?

☐ Well ☐ City ☐ Distilled ☐ Spring ☐ Nursery ☐ I don't mix formula

☐ Other ______________________ (38)

Do you have special instructions for mixing your baby's formula from your doctor?

☐ Yes ☐ No (38)

Do you have any questions about mixing your baby's formula?

☐ Yes ☐ No (38)

If you use bottles for your baby, check all that apply.

☐ I wash my hands before fixing the bottle. ☐ I reuse leftover bottles of formula. ☐ I sterilize the bottles and nipples.

☐ I wash the bottles with hot, soapy water. ☐ I use the microwave to warm bottles. ☐ I do not give bottles. (38)

Other than breastmilk or formula, what else do you put into the bottle?

☐ Karo® syrup ☐ Juice ☐ Punch ☐ Cow's milk ☐ Jell-O® water

☐ Sugar ☐ Pop ☐ Sheep/goat's milk ☐ Tea/coffee ☐ Cereal

☐ Honey ☐ Water ☐ Gatorade® ☐ Kool Aid® ☐ Baby foods

☐ Other ______________________ ☐ Nothing (36, 38)

Check all that apply.

☐ Baby is fed with a spoon ☐ Baby uses an infant feeder

☐ Baby drinks from a cup ☐ Baby's pacifier is dipped in ____________

☐ Baby feeds self ☐ Baby goes to bed with a bottle

☐ Baby's bottle is propped when feeding ☐ Baby is usually fed away from home (36, 38)

If your baby has started the following foods, at what age did you start

Cereal _____ Vegetables _____ Fruit _____ Juice _____ Meat _____ Dinners _____ Desserts _____ Cow's milk _____ (36, 38)

Is there a working stove or microwave and refrigerator in your home?

☐ Yes ☐ No (38)

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

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

During the last six months, has your baby been physically, sexually or verbally 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.