

# 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:**

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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:**

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Date	Height	Length	Weight	Blood iron (Hemoglobin)
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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
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**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
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# 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 (US) and its territories and to certain other countries where WIC-like services are provided by a US 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

# Ohio Department of Health WIC Program Application

Please answer all questions on this page.

Parent, guardian or applicant's name		Telephone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> 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 <b>SELF</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies / /
2. Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies / /
3. Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies / /
4. Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies / /
5. Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies / /
6. Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies / /
C. If anyone in your home is pregnant, is she under a doctor's care? If yes, what is the doctor's name? <input type="checkbox"/> Yes <input type="checkbox"/> No			
D. Has anyone in your home had a pregnancy that ended within the last six months? If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No			
E. Is anyone in your home breastfeeding a baby less than 12 months old? If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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

Ohio Works First Cash <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?	Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?	Food Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?
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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
		\$	
		\$	
		\$	

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)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> 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	
<input type="checkbox"/> OWF	<input type="checkbox"/> Disability Financial Assistance	<input type="checkbox"/> Food Assistance	<input type="checkbox"/> Medicaid
Card number		<input type="checkbox"/> Benefits Notice/Printout <input type="checkbox"/> Provider Information Line <input type="checkbox"/> MITS or EBT Portal	Effective date
Verification statement used (document/check stub/letter) <input type="checkbox"/> Yes <input type="checkbox"/> No	Statement date	Income amount \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> 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
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Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
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## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (61)

**Please answer the questions below**

<p>My baby breastfeeds</p> <p>Every _____ hours or _____ times a day and _____ times a night <input type="checkbox"/> Not breastfed (71, 75)</p>
<p>Check all that apply to your breastfed baby.</p> <p><input type="checkbox"/> Weak suck    <input type="checkbox"/> Slow weight gain    <input type="checkbox"/> Problems latching on    <input type="checkbox"/> My baby has no problems breastfeeding  <input type="checkbox"/> Not breastfeeding    <input type="checkbox"/> Other _____ (56, 74)</p>
<p>Did you ever breastfeed your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Still breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Why did you stop? _____ How old was your baby when you stopped? _____</p>
<p>Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (50)</p>
<p>Check any health problems your baby has.</p> <p><input type="checkbox"/> Colic    <input type="checkbox"/> Reflux    <input type="checkbox"/> Teeth/gums    <input type="checkbox"/> Birth defects    <input type="checkbox"/> Slow weight gain    <input type="checkbox"/> Jaundice (yellow color)  <input type="checkbox"/> Other _____ <input type="checkbox"/> None (56, 68, 91, 93, 94)</p>
<p>List your baby's medicines.</p> <p style="text-align: right;"><input type="checkbox"/> None (93)</p>
<p>Is your baby up to date on shots? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>
<p>Has the doctor tested your baby's blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know (21)</p>
<p>Do you clean your baby's gums or teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Check all that your baby takes.</p> <p><input type="checkbox"/> Vitamins (vitamin D)    <input type="checkbox"/> Iron drops    <input type="checkbox"/> Fluoride drops    <input type="checkbox"/> Herbs  <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)</p>
<p>List your baby's food allergies.</p> <p style="text-align: right;"><input type="checkbox"/> None (93)</p>
<p>How many times a day is your baby's diaper wet or dirty? (74)</p>

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 • 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 <input type="checkbox"/> live birth _____pounds _____ounces <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion <input type="checkbox"/> 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 <input type="checkbox"/> Let down <input type="checkbox"/> Hot, hard breasts <input type="checkbox"/> Latch <input type="checkbox"/> Pain in your breasts <input type="checkbox"/> Sore nipples <input type="checkbox"/> Other _____ <input type="checkbox"/> No problems (74)
How long do you want to breastfeed your baby?
Are you going back to work or school? <input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
What kind of support for breastfeeding do you have at home?
Would you like more breastfeeding help? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Section 2

Did you ever breastfeed your baby? <input type="checkbox"/> Still breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No Why did you stop? _____    How old was your baby when you stopped? _____
Did you have a C-section? <input type="checkbox"/> Yes <input type="checkbox"/> No (93)
List any problems you have had. With this pregnancy _____ With past pregnancies _____ <input type="checkbox"/> None (44)
Check any health problems you currently have. <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Dental <input type="checkbox"/> High blood pressure <input type="checkbox"/> Lactose intolerance <input type="checkbox"/> Other _____ <input type="checkbox"/> None (91, 93, 94)
List any medicines you take. (93)

Has the doctor tested your blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	(21)
Have you ever had a baby with a birth weight of nine pounds or more? <input type="checkbox"/> Yes <input type="checkbox"/> No	(22, 49)
Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No	(49)
Was your baby born with any health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____	(23)
Check all supplements you take. <input type="checkbox"/> Prenatal vitamins/vitamins <input type="checkbox"/> Iron <input type="checkbox"/> Herbs <input type="checkbox"/> Calcium <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(30)
Are you on a special diet? <input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No	(30, 35, 91, 93)
List your food allergies  <input type="checkbox"/> None	(93)
Check any of these non-food items that you <b>eat</b> or <b>crave</b> . <input type="checkbox"/> Paint chips <input type="checkbox"/> Ice <input type="checkbox"/> Printed paper <input type="checkbox"/> Dirt/clay <input type="checkbox"/> Starch <input type="checkbox"/> Coffee grounds <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(30)
Check all that apply. <input type="checkbox"/> Someone else shops for food. <input type="checkbox"/> I usually shop for food. <input type="checkbox"/> I usually do not eat at home. <input type="checkbox"/> Someone else does the cooking. <input type="checkbox"/> I usually cook. <input type="checkbox"/> I live in a shelter, motel, or temporary place. <input type="checkbox"/> I have a working stove or microwave and refrigerator in my home. <input type="checkbox"/> 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 <input type="checkbox"/> None Last three months of this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None	(46)
If anyone living in your home smokes, where do they smoke? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes	(46)
Check all alcoholic beverages you drink. <input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Coolers <input type="checkbox"/> Liquor Now _____ a day _____ a week <input type="checkbox"/> None Last three months of this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None	(47, 66)
Check all drugs you currently use. <input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroin <input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalants <input type="checkbox"/> Prescription drugs (misuse) <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(48, 66, 93)
During the last six months, have you been physically, sexually or verbally abused? <input type="checkbox"/> Yes <input type="checkbox"/> No	(67)
Do you have any questions or concerns? _____	