GEORGIA WIC PROGRAM
2013 Clinic Staff WIC Forms

1. Batch Control Exception Report
2. Batch Control Form
3. Borrowed Voucher Report Form
4. Clinic VOC Card Inventory Log
5. Computer Systems Issues Problem Report
6. CUR Part 2 Correction Form
7. Daily Roster Monthly Mailed Voucher Report
8. Data Request Form
9. Dual Participation Investigation Form
10. Duplicate Participation Verification Form
11. Form and Voucher Orders
12. Incident Complaint Form
13. Local Agency VOC Card Inventory Log
14. Lost Stolen Destroyed Voided Voucher Report
15. Manual Voucher Inventory
16. Notification Summary of Missing Voucher VOC Cards
17. Property Transfer Form
18. Receiving Report
19. Request for WIC Services Log
20. Request for Investigation Form
21. Request to Establish New Clinic or Change
22. Separation of Duty Form/District Office
23. VOC Card Agreement
24. VOC Card Form
25. Voucher Demand Log Sheet
26. Voucher Investigation Log
27. WIC Ordering Form
28. WIC Logo
29. Dual Participation Report Investigation Form
30. Request for Investigation Form
31. Participant Access Verification Form
32. Office of Inspector General WIC Transaction Report (WTR)

BATCH CONTROL EXCEPTION REPORT

GEORGIA WIC PROGRAM		VOUCHER BATCH EXCEPTION FORM	
DISTRICT/UNIT	CLINIC	DATE	NUMBER

THIS FORM HAS BEEN GENERATED AS A RESULT OF:

_____THE QUANTITY ON THE CLINIC COMPLETED BATCH CONTROL FORM DOES NOT AGREE WITH THE ACTUAL QUANTITY RECEIVED.

_____THE VOUCHERS WERE RECEIVED IN A BATCH OF TADS.

_____ONLY ONE (1) COPY OF THE BATCH CONTROL FORM WAS RECEIVED WITH THE VOUCHERS.

_____NO BATCH CONTROL FORM WAS RECEIVED WITH THE VOUCHERS.

CSC COVANSYS INPUT SECTION	**TYPE OF DOCUMENT**	**APPROXIMATE NUMBER IN BATCH**
	ISSUED MANUAL VOUCHERS	
	VOIDED MANUAL VOUCHERS	

DATE BATCH RECEIVED AT: _____

Revised 3/12

BATCH CONTROL FORM

GEORGIA WIC PROGRAM		BATCH CONTROL FORM	
		DATE	NUMBER
		/ /	/ /
DISTRICT/UNIT	**CLINIC**		

INSTRUCTIONS

1. USE THIS FORM AS A COVER SHEET TO FORWARD ALL TADS (CERTIFICATIONS, UPDATES, TRANSFERS AND TERMINATIONS) AND ISSUED/VOIDED MANUAL VOUCHERS.

2. DO NOT BATCH TADS WITH MANUAL VOUCHERS

3. SUBMIT THIS FORM WITH THE **TADS AND ISSUED MANUAL VOUCHERS** TO:

   CSC COVANSYS
   P.O. BOX 2507
   GREENWOOD, IN 46142

   SUBMIT THIS FORM WITH THE **VOIDED MANUAL VOUCHERS** TO:

   CSC COVANSYS
   1000 COBB PLACE BLVD
   BUILDING 100, SUITE 190
   KENNESAW, GEORGIA 30144

4. **RETAIN A COPY OF THIS FORM IN THE CLINIC WITH COPIES OF THE TADS, ISSUED MANUAL VOUCHERS OR VOIDED MANUAL VOUCHERS, CREATING A BATCH CONTROL MODULE.**

CSC COVANSYS INPUT SECTION	TYPE OF DOCUMENT	NUMBER IN BATCH
	TURNAROUND	
	ISSUED MANUAL VOUCHERS	
	VOIDED MANUAL VOUCHERS	

COMMENTS:

DATE SENT BY DISTRICT/UNIT	PREPARER'S SIGNATURE
DATE RECEIVED AT CSC COVANSYS	SIGNATURE
DATE ENTERED AT CSC COVANSYS	SIGNATURE

Revised 3/12

GEORGIA WIC PROGRAM

BORROWED VOUCHER REPORT FORM

GEORGIA WIC PROGRAM	BORROWED VOUCHER REPORT

BORROWING DISTRICT/UNIT: |_|_|_| CLINIC: __ |_|_|_|

DATE:

INSTRUCTIONS	• USE FORM TO REPORT MANUAL VOUCHERS BORROWED FROM ANOTHER CLINIC • RETURN TO CSC COVANSYS AS SOON AS POSSIBLE. • MAIL TO: CSC COVANSYS GEORGIA WIC PROGRAM 1499 WINDHORST WAY, SUITE 240 GREENWOOD, IN 46142 • OR FAX TO: (317)859-9485

DISTRICT	CLINIC	BEGINNING VOUCHER NO.	ENDING VOUCHER	QUANTITY
|_|_|_|	|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|
|_|_|_|	|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|
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|_|_|_|	|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|_|_|	|_|_|_|_|_|

REASON(S):

☐ INSUFFICIENT QUANT ☐ ORDERED LATE ☐ ORDER NOT RECEIVED FROM CSC COVANSYS ☐ OTHER

COMMENTS: _____

_____

_____

DISTRICT OFFICE APPROVAL DATE_____

Revised 3/12

GEORGIA WIC PROGRAM
CLINIC VOC CARD INVENTORY LOG
VOC CARD INVENTORY LOG

DISTRICT _____ CLINIC _____

Date	Beginning No.	Ending No.	No. Received	Card No. Issued	Participants Name (Print)	WIC ID Number	Signature of Parent, Guardian or Caregiver	City State*	Total No. of Cards on Hand	Staff Signature	Staff Initials

Note: A Physical Inventory of VOC cards must be performed by the local agency and clinics quarterly. One staff member must conduct the inventory (sign the Log) and a second member must verify the accuracy of the inventory (initial the Log).

* If a migrant is issued a VOC card and is not moving, please place “Not Moving” in the column marked City/State.

Revised 3/12

GEORGIA WIC PROGRAM

COMPUTER SYSTEM ISSUES and PROBLEMS REPORT

Date submitted:	Date problem discovered:
Clinic number:	District/unit number:
Name of person reporting issue:	Position:
Telephone number:	Email:
Name of person experiencing issue:	Position:
Telephone number:	Email:

Directions: Type an X next to selections and email to the Systems Information Unit or fax to (404) 657-2910.

Severity of problem (select one)	**Problem type:** (select one and describe below)	
Extremely critical	Batching problem Provide Batch number	Voided voucher numbers (list)
Critical	Incorrect information in system	Multiple copies of same voucher printed ( ) times
Major	Equipment malfunction	Voucher number error
Average	Printer problem	Same voucher number(s) given to different client(s)
Minor	System down (failure)	Vouchers did not print
Enhancement	System slow	Voucher format error
Farmer's Market	Update system information needed	Vouchers printed to wrong destination
	Computer virus (type)	**Other**

Describe the issue and proposed solution (include voucher numbers if applicable):

Did staff report this issue to anyone? Yes____ No___

If yes, provide name and telephone number:_____

Status since report (circle): Resolved Unresolved Pending

Computer report potentially affected: (e.g. CUR) _____

Reason for reporting to state WIC Office (circle): FYI only Take Action

Revised 3/12

GEORGIA WIC PROGRAM
CUR PART 2 CORRECTION FORM

INSTRUCTIONS: Use this form when it is necessary to correct either the issue date and/or the participant ID number appearing on the actual voucher. Complete only the column needing correction. Complete only for a voucher appearing in the first month column on the most recent CUR Part 2 Report. DO NOT USE THIS FORM TO CORRECT CUR PART 1 VOUCHERS.

VOUCHER NUMBER	CORRECTED ISSUE DATE	CORRECTED WIC ID NUMBER (11 DIGITS)	REASON
		| | | | | | | | | |	
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The above ID Numbers and/or Issue Dates were researched and verified by:

_____ _____ _____
Authorized Signature Date D/U Clinic#

Revised 3/12

GEORGIA WIC PROGRAM
DAILY ROSTER/MONTHLY MAILED VOUCHER REPORT

	Participant's Name	I.D. Number	Voucher Number (Range)	Number of Vouchers Returned	Signature of CPA	Date Returned	Replaced Voucher Numbers Lost/Stolen	Redemption Value of Lost Vouchers
D A I L Y								
End of Month Totals Date: _____	**Total # of Participants:** _____		**Total # Issued:** _____	**Total # Returned:** _____			**Total # Replaced:** _____	**Total Redemption Value:** $_____

***Redemption Rate must be completed by the District Office.**

Revised 3/12

GEORGIA WIC PROGRAM

DATA REQUEST FORM

Date of Request:____/___/___ *Date Data Needed: ___/___/___*

Name: _____

D/U/CL: _____

Address: _____

_____

_____

_____

Phone: _____ *Fax:* _____

Type of Requested Data: _____

Description of Data Requested *(Attach additional sheets if necessary)*
(Please be specific)

_____

_____

_____

_____

_____

Format: *(Excel, Access, other-specify)* _____

Media: *(Paper, E-mail, CD ROM, other specify)* _____

For State Office Use Only:
Date Received: _____
Assigned To: _____ *Reviewed By:*_____
Date Complete: _____
Notes: _____

_____

Revised 3/12

GEORGIA WIC PROGRAM
DUAL PARTICIPATION REPORT INVESTIGATION FORM

Please complete and return the following information listed below. Please send the information to the requesting clinic as soon as possible.

DU/Clinic: _____

Name: _____

WIC ID: _____

Birth date: _____

Mother's Name: _____

Date of last voucher pickup: _____

Date of Issue: _____

Is this client active or terminated? _____
(If terminated, indicate term date and term code)

Terminate: _____ Term code: _____

Has the client transferred into your area recently? _____

(If yes, give date; _____)

Date of last certification: _____

Social Security number: _____

Revised 3/12

GEORGIA WIC PROGRAM	Duplicate Participation Verification Form

DISTRICT/UNIT: |__|__|__|__|__| CLINIC: |__|__|__|__|__| DATE: |__|__|__|__|__|__|

INSTRUCTIONS	- USE THIS FORM TO REMOVE PARTICIPANTS FROM THE DUPLICATE PARTICIPATION REPORT - RETURN TO CSC COVANSYS AS SOON AS POSSIBLE. - MAIL TO: GEORGIA WIC PROGRAM 1499 WINDHORST WAY, SUITE 240 GREENWOOD, IN 46142 - OR FAX TO: (317) 889-9485

THE FOLLOWING CLIENT(S) LISTED BELOW ARE LEGITIMATE PARTICIPANTS. PLEASE REMOVE THEM FROM SUBSEQUENT DUAL PARTICPATION REPORTS

PARTICIPANT ID NUMBER											PARTICIPANT NAME

Revised 3/12

GEORGIA WIC PROGRAM
FORM AND MANUAL VOUCHER SUPPLY ORDER FORM

Return to: CSC Covansys
1499 Windhorst Way, Suite 240
P.O. Box 2507
Greenwood, Indiana 46142

Phone 1-800-899-7913

FAX: 1-317-859-7150

Your District/Unit: _____ This order is for clinic #:_____

Clinic name: _____

Address: _____

_____

Contact person:_____ Phone:_____ Date :_____

Mailed/Faxed_____

Note: CSC Covansys processes Georgia WIC Program orders weekly. All orders received at CSC Covansys by the end of the business day on Friday will be processed and shipped the following week.

Manual Voucher Order

Blank Manual Vouchers for Hand Completion

_____	Blank Manual Vouchers for WIC Foods	GAC9-EE
_____	Blank Manual Vouchers for Formula, Infant Foods, and Produce	GAC9-FIP

Preprinted Manual Voucher Package Sets for Hand Completion GAC6

_____	Sets of Prenatal/Mostly Breastfeeding Woman Package (W01)	P,B
_____	Sets of Postpartum/Non-Breastfeeding Woman Package (W21)	N,B
_____	Sets of Exclusively Breastfeeding/Prenatal with Multiples Woman package (W41)	B,P
_____	Sets of Infant Birth - 3 Months Old Fully Formula Fed Package (A17)	I
_____	Sets of Infants 4 – 5 Months Old Fully Formula Fed Package (B17)	I
_____	Sets of Infant 6 – 11 Months Old Fully Formula Fed Package (D17)	I
_____	Sets of Child 1 – 2 Years Old Package (C01)	C
_____	Sets of Child 2 – 5 Years Old Package (C21)	C

Certification Form (TAD) Order

_____ Blank TAD (with no preprinted ID number)
_____ Prenumbered TAD (with preprinted ID number)

Other Forms

_____ Form and Manual Voucher Supply Order Forms
_____ Lost/Stolen/Destroyed/Voided Voucher Report Form
_____ CSC Return Envelopes (for mailing voided vouchers only)
_____ Borrowed Voucher Report Forms

VPOD Supplies

_____ Boxes of Paper Stock
_____ Voucher Serial Numbers

Revised 3/12

GEORGIA DEPARTMENT OF PUBLIC HEALTH
GEORGIA WIC PROGRAM
INCIDENT/COMPLAINT FORM

District/Unit/Clinic:		**County:**	
Date of Incident:		**Date Reported:**	
Follow-Up Date:			

Type of Complaint:

Sub Catorgory 1:

Participant ☐ Proxy ☐
Vendor ☐ Civil Rights ☐
Local Agency/State WIC Office Staff ☐
Anonymous ☐

Sub Catorgory 2:

Wait Time ☐ Stolen Vouchers ☐ Shelf Prices ☐ Customer Service ☐ Fraud(Buy/Sell/Dual) ☐
Vendor ☐ Transfer ☐ Clinic Closing ☐ Appointment ☐ Formula ☐
Food Package Change ☐ Other ☐ Participant ☐

Person Filing Complaint	**Participant information**	**Vendor Information**	**Local Agency/State WIC Office Staff**
Name: **Phone**:	**Name**: **Guardian**: **Phone**:	**Vendor/Vendor #:** **Employee Name:** **Title:** **Phone:**	**Staff Name** : **Phone**: **Staff Name** : **Phone**:

Incident/Complaint:

Local Agency Resolution:	**Can the complaint be closed at the Local Agency?** **Yes** ☐ **No** ☐ **Signature:** **Date:**
State Office of Nutrition and WIC Resolution/Comments:	**Can the complaint be closed at the State Office of Nutrition and WIC?** **Yes** ☐ **No** ☐ **Signature:** **Date:**

Follow-up Report:

Office of Nutrition and WIC, Customer Service Coordinator:
Date:

Rev 4/11/12

GEORGIA WIC PROGRAM
LOCAL AGENCY VOC CARD INVENTORY LOG
VOC CARD INVENTORY LOG

DISTRICT _____

Date	Beginning No.	Ending No.	No. Received	No. Issued	Clinic Name (Print)	Name of Clinic Representative	Total No. of Cards on Hand	Staff Signature	Staff Initials

Note: A Physical Inventory of VOC cards must be performed by the local agency and clinics quarterly. One staff member must conduct the inventory (sign the Log) and a second member must verify the accuracy of the inventory (initial the Log).
Revised 3/12

GEORGIA WIC PROGRAM
LOST/STOLEN/DESTROYED
VOIDED VOUCHER REPORT

GEORGIA WIC PROGRAM	LOST/STOLEN/DESTROYED VOIDED VOUCHER REPORT

DISTRICT/UNIT/CLINIC: _____ **DATE:** _____

INSTRUCTIONS	• USE THIS FORM TO REPORT VOUCHERS (COMPUTER OR MANUAL) WHICH HAVE BEEN LOST, STOLEN, OR DESTROYED BY EITHER THE PARTICIPANT OR THE CLINIC. • SUBMIT AT LEAST MONTHLY. • MAIL TO CSC COVANSYS • GEORGIA WIC PROGRAM • P.O. BOX 2507 • GREENWOOD, IN 46142	**STATUS CODES** LOST/STOLEN/DESTROYED - 2 VOIDED - 3

BEGINNING VOUCHER NO.	ENDING VOUCHER NO.	QUANTITY	WIC I.D. NUMBER	STATUS	COMMENTS

GEORGIA WIC PROGRAM
MANUAL VOUCHER INVENTORY

STANDARD MANUAL_____ CLINIC_____ BALANCE BROUGHT FORWARD_____

DATE	BEGINNING NO.	ENDING NO.	NO.RECEIVED	NO. ISSUED	NO. VOID	NO. ON HAND	INITIALS	INITIALS

Revised 3/12

GEORGIA WIC PROGRAM

Please use INK

NOTIFICATION SUMMARY OF MISSING VOUCHERS/VOC CARDS

COMPLETE: When 25 or more WIC vouchers; 5 or more VOC cards; are missing.
(A lost/stolen/voucher report must be completed for all missing vouchers)
IMMEDIATELY: Notify Supervisor; Nutrition Services Director; and the Police.
Complete the following information: **(ALL SECTIONS MUST BE COMPLETED)**

SECTION I

Name of person who discovered the vouchers/VOC cards missing_____ D/U/C____

Name of person completing this form, if different from above _____

SECTION II

Name of person(s), who is responsible for vouchers/VOC cards at this clinic.

_____ _____

_____ _____

SECTION III

Number of Missing Voucher(s)_____Number of Missing VOC Cards _____
NOTE: A separate form must be completed if both Vouchers and VOC cards are missing
Discovered missing: Date _____ Time _____ am ____ pm _____
Supervisor notified: Date _____ Time _____ am ____ pm _____
Coordinator notified: Date_____ Time _____ am ____ pm _____
VOUCHER'S Beginning #_____ Ending #_____
VOC CARDS Beginning #_____ Ending # _____

SECTION IV

Complete a detailed summary of how vouchers/VOC cards were discovered missing._____
_____

Use additional sheets of paper if needed, and attach

SECTION V

List any additional information that would apply to this case.
_____
_____Use additional sheets of paper if needed, and attach

SECTION VI

Signature of person completing report:

_____
_____
(Submit completed report to Nutrition Services Director /Person in charge)
Person receiving the report: _____ Title: _____ Date: _____
(This signature is to verify receipt of this report, not to verify information on report)

Nutrition Services Director or designee, shall submit a copy of this report to the State WIC Office within three (3) working days.

Routing: Copy - SWO Copy - District Copy - Clinic

Note: In the event that unused vouchers are lost or stolen as a result of an unsecured food instrument environment, thus resulting in USDA sanctions to repay the value of the lost or stolen vouchers in question, the Local Agency will be responsible for repaying the value of those food instruments.

Revised 3/12

Georgia Department of Administrative Services
Surplus Property Division
2072 N. Bibb Drive
Tucker, GA 30084-6233

Property Transfer Form

Date: _____

Fields with * are required

*Transfer from Agency:	* Transfer to Agency:	**DOAS Use:**
*Unit:	* Unit:	
*Address 1:	* Address 1:	
*Address 2:	* Address 2:	**Transaction #**
*Point of Contact:	* Point of Contact:	
*Email:	* Email:	
*Phone:	* Phone:	

Action Requested: ☒ Intra Agency Transfer ☐ Surplus Center Transfer ☐ Destruction ☐ On-Site Sale ☐ Vendor Return ☐ DNS

*Line	*Quantity	*Description (Model, Serial #, Inventory #, etc.)	*Condition	*Funding Information (Funded or Non-Funded)	*Final Disposition (DOAS use only)
1			Select	Make Selection	
2			Select	Make Selection	
3			Select	Make Selection	
4			Select	Make Selection	
5			Select	Make Selection	
6			Select	Make Selection	
7			Select	Make Selection	
8			Select	Make Selection	
9			Select	Make Selection	
10			Select	Make Selection	
11			Select	Make Selection	
12			Select	Make Selection	
13			Select	Make Selection	
14			Select	Make Selection	
15			Select	Make Selection	
16			Select	Make Selection	
17			Select	Make Selection	
18			Select	Make Selection	
19			Select	Make Selection	
20			Select	Make Selection	

DOAS Surplus Representative Signature	Property Release Signature	Property Receipt Signature
Title	Title	Title
Date	Date	Date

Releasing signature certifies that ORIGINAL asset funding is accurate and that all software and data have been removed from all computers prior to their transfer.

"I hereby declare that the item(s) purchased through the Surplus Property Section, DOAS, shall not be resold within one (1) year of such transfer without the written consent of the Surplus Property Section, and the Surplus Property Section shall have the right which shall be exercised at their discretion, to supervise the resale of such property at public outcry to the highest responsible bidder is such property is within one (1) year after such transfer. All proceeds derived from that sale of such transferred item will revert to the State of Georgia through the Surplus Property Section."

GEORGIA WIC PROGRAM
RECEIVING REPORT

Unit Name	Purchase Order No.
Unit Location	**Purchase Order Date**

We have received the item(s) listed below in **Good / Bad** condition

From	**Name of Vendor (Company)**
Address	**Vendor's Address**

Item No.	Quantity	
		1. WIC ID CARDS----------
		ENGLISH
		SPANISH
		2. BAGS----------

This is to certify receipt of item(s) listed on this receiving report and that I have personally examined these and found them to meet our specifications in the Purchase Order numbered above.

Date Received	Signature

After signing, send the completed form to DCH Office of Financial Services Accounts Payable Section

Revised 3/12

GEORGIA WIC PROGRAM

REQUEST FOR WIC SERVICES LOG

PHONE CALLS/WALK-INS

Name	Address/Telephone Number	P/B/PP Infant/ Child	Date Service Requested	Date of Appointment	Prenatal Re-Appointments	Date Appointment Rescheduled

Revised 3/12

GEORGIA WIC PROGRAM

REQUEST TO ESTABLISH NEW CLINICS/CLINIC CHANGE

PURPOSE OF REQUEST: EST. NEW CLINIC ☐ CLINIC CHANGE ☐
CLINIC NUMBER ☐

EFFECTIVE DATE OF CHANGE _____

TYPE OF CHANGE _____

DIST/UNIT _____ DATE SUBMITTED _____

COUNTY# _____ COORDINATOR _____

CONTRACT # (IF LOCATED OUTSIDE OF HEALTH DEPT.) _____

CONTACT PERSON _____

NEW CLINIC NAME _____

MAILING ADDRESS (not a Post Office Box) _____

PHONE# _____ ATTENTION: _____

CLINIC DAYS AND HOURS OF OPERATION _____

PURPOSE OF PROPOSED CLINIC (circle) initial certification re-certification nutrition education voucher issuance

Other (specify) _____

SCHEDULE OF VOUCHER ISSUANCE (circle) monthly bi-monthly odd bi-monthly even

PLEASE INDICATE IF TADS & VOUCHERS ARE TO BE SHIPPED TO ANOTHER LOCATION OTHER THAN THIS CLINIC _____

VOUCHER ORDERS	
SPECIAL VOUCHERS	_____
BLANK VOUCHERS	_____

TAD ORDERS	
BLANK TADS	_____
PREPRINTED TADS	_____

PREPRINTED VOUCHER PACKAGES

WOMEN (P&B)	_____	PACKAGES	WOMEN (N)	_____	PACKAGES
INFANTS	_____	PACKAGES	CHILDREN	_____	PACKAGES

PLEASE INDICATE A BEGINNING TAD NUMBER (EXAMPLE: CLINIC #123 WOULD BE 123000001 FOR THE BEGINNING TAD NUMBER) _____

CSC COVANSYS WILL ASSIGN A MAXIMUM NUMBER OF INDIVIDUAL VOUCHERS TO BE PRINTED. THIS NUMBER WILL EQUATE TO 100 PACKAGES FOR WOMEN, 100 PACKAGES FOR INFANTS AND 100 PACKAGES FOR CHILDREN. IF YOU WISH TO INCREASE THIS NUMBER, PLEASE INDICATE: YES _____ NO _____

FOR GEORGIA WIC PROGRAM USE

APPROVED_____ DISAPPROVED_____

FOR CSC COVANSYS USE

NEW CLINIC # ASSIGNED _____

EFFECTIVE DATE _____

COMPLETED BY _____

SYSTEM MAINTENANCE REPORT # _____

Revised 3/12

Georgia WIC Program
Separation of Duty Form/District Office

Type of Certification (Home, Hospital, etc.)	Date of Certification	Was Any Information Missing? (Cert. , Voucher Receipt, Nutrition Information)	Name of Person who performed Certification	Nutrition Services Director or Designee's Name	Approved or Disapproved	Completion Date

(This form must be kept on file for 3 years plus current year)

Revised 3/12

GEORGIA WIC PROGRAM

VOC CARD AGREEMENT

District _____, Unit _____ would like to have a clinic representative order VOC Cards directly from the Georgia WIC Program.

In order to accommodate this request, please complete the **VOC CARD FORM,** located in the Certification Section of the Georgia WIC Program Policy and Procedures Manual.

Signed_____ Date_____
Nutrition Services Director

IN SIGNING THIS FORM, I REALIZE THAT IF THE CLINIC REPRESENTATIVE CHANGES, I MUST CONTACT THE GEORGIA WIC PROGRAM TO INFORM THEM OF THE CHANGE.

Revised 3/12

GEORGIA WIC PROGRAM
VOC CARD FORM

District ____, Unit ____

In an effort to begin sending VOC cards directly to the clinic from the Georgia WIC Program, the following form must be on record at the Georgia WIC Program.

1. Please list the information requested below:

CLINIC NAME/#	# OF VOC CARDS ISSUED (Three Month Period)	STAFF PERSON Clinic Representative

2. How many cards do you currently have on hand at the District Office? _____

Revised 3/12

GEORGIA WIC PROGRAM
VOUCHER PRINTED ON DEMAND LOG SHEET

DATE RECEIVED #_____BEGINNING #_____ENDING #_____TOTAL # REC'D_____

DATE (when vouchers were printed.)	**BEGINNING** (the number of the first voucher printed for that day.)	**ENDING** (the number of the last voucher printed for that day.)	**ISSUED** (the number of vouchers issued for that day.)	**VOIDED** (the number of vouchers that were voided for that day.)	**ON HAND** (total amount of numbers on hand)	**INITIALS** (always sign your initials for that day.)

GRAND TOTAL OF NUMBERS REMAINING IN STOCK. (After completing this form.)

REMAINING STOCK _____

INITIALS _____

Revised 3/12

GEORGIA WIC PROGRAM
VOUCHER INVESTIGATION LOG

DISTRICT/UNIT: _____ DATE: _____

REASON FOR INVESTIGATION: _____

			STATE WIC OFFICE USE ONLY		
VOUCHER NUMBER	**ISSUE DATE**	**CLINIC #**	**BOX #**	**PAID YES/NO**	**COMMENTS**

COMPLETED BY: _____ **DATE:** _____

Revised 3/12

GEORGIA WIC

EATHEALTHYGROWHEALTHYLIVEHEALTHY

GEORGIA WIC PROGRAM
WOMEN INFANT AND CHILDREN (WIC)
ORDERING FORM

SEND TO:_____
(NAME OF OFFICE)

_____
(STREET ADDRESS)

_____
(CITY) **(STATE)** **(ZIP CODE)**

COUNTY:_____ _____
(NAME) **(NUMBER)**

DATE:_____

Name of Form	Form #	Quantity	Description

COMMENTS SECTION: _____

_____

ORDERED BY:_____

TELEPHONE: _____

SIGNATURE OF STATE REPRESENTATIVE:_____

DATE:_____

Revised 3/12

Please use Ink

Georgia WIC Program
NOTIFICATION SUMMARY OF MISSING VOUCHERS/VOC CARDS

COMPLETE: When 25 or more WIC vouchers; 5 or more VOC cards; are missing.
(A lost/stolen/voucher report must be completed for all missing vouchers)
IMMEDIATELY: Notify Supervisor; Nutrition Services Director; and OIG.
Complete the following information: **(ALL SECTIONS MUST BE COMPLETED)**

SECTION I

Name of person who discovered the vouchers/VOC cards missing____ D/U/C_____

Name of person completing this form, if different from above_____

SECTION II

Name of person(s), who is responsible for vouchers/VOC cards at this clinic.

_____ _____

_____ _____

SECTION III

Number of Missing Voucher(s)_____ Number of Missing VOC Cards _____
NOTE: A separate form must be completed if both Vouchers and VOC cards are missing
Discovered missing: Date _____ Time ___ am _____ pm _____
Supervisor notified: Date _____ Time ___ am _____ pm _____
Coordinator notified: Date_____ Time _____ am ____ pm _____
VOUCHER'S Beginning # _____ Ending # _____
VOC CARD'S Beginning # _____ Ending # _____

SECTION IV

Complete a detailed summary of how vouchers/VOC cards were discovered missing: _____
_____

Use additional sheets of paper if needed, and attach

SECTION V

List any additional information that would apply to this case.
_____
_____

Use additional sheets of paper if needed, and attach

SECTION VI

Signature of person completing report:

_____
_____

(Submit completed report to the District Nutrition Services Director/Person in charge)
Person receiving the report: _____ Title: _____ Date: _____
(This signature is to verify receipt of this report, not to verify information on report)

District Nutrition Services Director or designee shall submit a copy of this report to the State WIC Office and the Office of Inspector General within three (3) working days.

Note: In the event that unused vouchers are lost or stolen as a result of an unsecured food instrument environment, thus resulting in USDA sanctions to repay the value of the lost or stolen vouchers in question, the Local Agency will be responsible for repaying the value of those food instruments.

GEORGIA WIC PROGRAM

PARTICIPANT ACCESS VERIFICATION FORM

District/Unit_____Vendor Number _____

Name of Vendor under Investigation _____
Address (Street/Hwy) _____
_____

WIC Vendor(s) within ten (10) miles of Investigated Vendor

Vendor Name _____
Address _____
_____

Distance in Miles_____

List any Geographical Barriers

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Comments_____
_____
_____
_____
_____

Investigator's Signature_____Date_____

Revised 06/12

Georgia Department of Public Health

Office of Inspector General

Voucher Number

Vendor

WIC TRANSACTION REPORT (WTR)

Store Name and Address:-	WTR Returned to WIC Agency:

1. At the Check-out counter there (was/were) person(s) in line ahead of me. On _____ , at about _____. I entered the subject's store. I selected the item(s) specified below. The food instrument indicated above was used for this transaction. The clerk sold the item(s) below at a total cost of (if available) $ _____. During checkout, the voucher was in plain view of the clerk who served the investigator. The price of the items(s) were marked on the item(s) or shelf, for item(s) not marked, they were verified by:

2.

Time Entered Store:		Time Approached Checkout:		Time Left Store:	

3.

Check List	Y / N		Y / N		Y / N	
Prices Marked on Foods or Shelf			Rang up Sale		Adequate Supply of WIC Foods on Shelf	
Recorded Price on Voucher			Checked ID Cards		Gave Receipt to Investigator	

4. Comments

5. Description of Clerk (Approximate)

SEX	RACE	AGE	HEIGHT	WEIGHT	HAIR COLOR

6. Other Identifying Information:

7. Identified During Transaction as (Title/Name):

ELIGIBLE ITEMS SUMMARY OF PURCHASE

QUANTITY	BRAND NAME	ITEM	PRICE

INELIGIBLE ITEMS

QUANTITY	ITEM	PRICE

ITEMS REFUSED

QUANTITY	ITEM

I_____ , an investigator with the Office of Inspector General makes the above statement freely and voluntarily knowing that this statement may be used as evidence.

Name:	Date:
Title:	Investigator Signature:

GEORGIA WIC PROGRAM
REQUEST FOR INVESTIGATION FORM

GEORGIA WIC PROGRAM **WIC REQUEST FOR INVESTIGATION**	DATE

TO:	FROM:
NAME AND ADDRESS OF STORE *(INCLUDE STREET, CITY, STATE AND COUNTY)*	VENDOR NUMBER
NAME OF OWNER OR MANAGER	
ETHNIC MAKEUP OF STORE'S CLIENTELE	
HAS STORE BEEN PREVIOUSLY INVESTIGATED? YES ☐ NO ☐	
ARE THERE OTHER STORES UNDER THE SAME OWNERSHIP WHICH ARE AUTHORIZED FOR PARTICIPATION? YES ☐ NO ☐ If Yes, fill in their names and address.	
TYPES OF ABUSES FOR WHICH INVESTIGATION IS REQUESTED.	
OTHER INFORMATION USEFUL TO THE INVESTIGATOR *(PROVIDE ADDITIONAL SHEETS IF NECESSARY)*	

Revised 3/12

REQUEST FOR INVESTIGATION FORM

OFFICE OF INSPECTOR GENERAL
REQUEST FOR INVESTIGATION

DATE:

TO: Ondray Jennings, Deputy Inspector General 2 Peachtree Street NW, 9th Floor Atlanta, GA 30303 onjennings@dhr.state.ga.us	FROM:
NAME AND ADDRESS OF STORE or PARTICIPANT *(INCLUDE STREET, CITY, STATE AND COUNTY)*	VENDOR NUMBER WIC ID/PARTICPANT DOB/SSN
NAME OF OWNER OR MANAGER	
ETHNIC MAKEUP OF STORE'S CLIENTELE	
HAS STORE BEEN PREVIOUSLY INVESTIGATED? YES ☐ NO ☐	
ARE THERE OTHER STORES UNDER THE SAME OWNERSHIP WHICH ARE AUTHORIZED FOR PARTICIPATION? YES ☐ NO ☐ If Yes, fill in their names and address.	
TYPES OF ABUSES/ALLEGATIONS FOR WHICH INVESTIGATION IS REQUESTED:	
OTHER INFORMATION USEFUL TO THE INVESTIGATOR *(PROVIDE ADDITIONAL SHEETS IF NECESSARY)*	

Revised 06/12