2014 GEORGIA WIC PROGRAM
Clinic Staff to WIC Clients/Applicants WIC FORMS

1. Appellant's Georgia's WIC Record Summary
2. Disclosure Statement
3. Georgia WIC Program Referral Form
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30. WIC Certification Statement (English)
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Georgia WIC Program
Abuse Claims Payment Report

Name of Participant:_____ **ID#**_____**DU#**_____

Name of Vendor_____ **Vendor #**_____**DU#**_____

Reason for claim:_____

Amount of claim:_____

Date of notification to participant:_____ **Date fair hearing requested:**_____

Date of final disposition of fair hearing/court mandate: _____

Repayment Schedule Agreement

Due Date:_____ Amount Due:_____

Payment to be submitted by : Clerk of Court [ ] Participant [ ] Vendor [ ]

Date Paid:	Amount Paid:	Balance Due:	Initials

COLLECTED FUNDS ARE DEPOSITED IN A GENERAL ACCOUNT FOR FARMER'S MARKET MATCH FUND

Collection ceased due to:

[ ] No longer cost effective Date:_____ Initials_____
[ ] Unable to locate participant Date:_____ Initials_____
[ ] Other_____ Date:_____ Initials_____

Was In-kind Service performed: **YES [ ]** **NO [ ]**

If yes explain:_____
_____
_____

Revised 6/12

Georgia WIC Program
Department of Public Health
APPELLANT'S GEORGIA WIC RECORD SUMMARY

SECTION I - IDENTIFICATION

District/Unit _____ WIC ID # _____

Applicant/Participant: _____

Appellant (if different from above): _____

Address: _____
Street Number and Name

_____
City State Zip Code

Phone Number: _____

Representative: _____

Applicant/Participant's Race/Sex: (Circle item #)

Ethnicity:
(1) Hispanic or Latino
(2) Non Hispanic or Latino

Sex:
(1) Male
(2) Female

Race:
(1) American Indian or Alaskan Native
(2) Asian
(3) Black or African-American
(4) Native Hawaiian or Other Pacific Islander
(5) White

County: _____ Date of Request: _____

Date of Appointment: _____ Date of Notification: _____

FOR STATE OFFICE USE ONLY:
Request number: _____ Date request filed: _____

Time limits Hearing shall be held within three (3) weeks from the date the State or local agency receives the request for hearing 7 C.F.R Section 246.9(j). The fair hearing decision shall issue within 45 (forty-five) days (7 C.F.R. Section 246.9 (k)(3)) of the date the request for hearing was received by the State or local agency.

SECTION II - TYPE OF AGENCY ACTION OR INACTION

A. Agency Action (Circle item number)
Participation denied/terminated because WIC applicant/participant:

1. Is not income eligible. _____ Date
2. Does not live in local WIC service. _____ Date
3. Has reached expiration of regulatory eligibility. _____ Date
4. Is not pregnant, postpartum, breastfeeding woman or an infant/child under five (5) years old. _____ Date
5. Does not meet nutritional risk criteria. _____ Date
6. Failed certification appointment on: _____. _____ Date
7. Did not pick up vouchers for two (2) consecutive months. _____ Date
8. Violated WIC rules and was suspended for three (3) months for: _____. _____ Date
9. Is in Priority ___ and WIC has funds to serve only Priority(ies) _____. _____ Date
10. Other _____. _____ Date

B. Agency Inaction (Circle item number):

1. Failure of local agency to meet processing standards: (specify)
_____
_____

2. Other:(specify)
_____
_____
_____
_____
_____

SECTION III - NARRATIVE SUMMARY OF AGENCY'S ACTION OR INACTION AND PRINCIPAL ISSUES INVOLVED IN THE REQUEST FOR FAIR HEARING

A. Basis for local agency's action or inaction (specify briefly):

B. WIC regulations applied by local agency:

C. Participant's income eligibility information:

_____ _____
Signature/Title of WIC Personnel Signature of Nutrition Services Director

_____
Name

_____ _____
Address City State Zip Code

_____
Telephone Number

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GEORGIA DEPARTMENT OF PUBLIC HEALTH

NAME OF INDIVIDUAL/CONSUMER/PATIENT/APPLICANT	
DATE OF BIRTH	
Requesting Agency ID #	**Releasing Agency ID #**

AUTHORIZATION TO RELEASE INFORMATION

I hereby request and authorize: _____
(Name of Person or Agency Requesting Information)

_____
(Address)

to obtain from: _____
(Name of Person or Agency Holding the Information)

_____
(Address)

the following type(s) of information from my records (and any specific portion thereof):

_____

_____

for the purpose of: _____

_____

I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: ***(PLEASE CHECK ONE)***

- ☐ *ninety (90) days unless I specify an earlier expiration date here:* _____
- ☐ *one (1) year*
- ☐ *the period necessary to complete all transactions on matters related to services provide to me.*

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ _____
(Date) (Signature of Individual/Consumer/Patient/Applicant)

_____ _____
(Date) (Signature of Parent or other legally Authorized Representative, where applicable)

_____ _____
(Signature of Witness) (Title or Relationship to Individual)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ _____
(Date this authorization is revoked by Individual) (Signature of Individual or legally authorized Representative)

Form Effective 7/1/2011

WIC CERTIFICATION STATEMENT

RIGHTS AND OBLIGATIONS

I have been advised of my rights and obligations for participation in Georgia's WIC. I certify that the information I will provide, or have provided, is correct to the best of my knowledge. The income information that I have provided is my total gross household income (all cash income before deductions). This certification form is being submitted in connection with the receipt of Federal assistance. Georgia's WIC officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying to Georgia's WIC, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

NOTICE OF DISCLOSURE

I understand that the chief state health officer for Georgia may authorize the disclosure of information about my participation in the WIC program for non-WIC purposes. This information will be used by Georgia WIC, its local WIC agencies and certain public organizations. These organizations include but are not limited to the Immunization Program, Pregnancy Risk Assessment Monitoring Systems (PRAMS), Epidemiology and other Maternal and Child Health Programs, Emergency Preparedness, Environmental Health and Medicaid. I understand that Georgia WIC, its local agencies and the public organizations can only use my information in the administration of their programs that serve persons eligible for WIC. The public organizations that receive my information must assure that it will not disclose my information to another organization or person without my permission.

I further understand that information about my participation in WIC may be used by the organizations that receive it only to:

1. Determine my eligibility for programs that the organization administers
2. Conduct outreach for such programs
3. Enhance the health, education, or well-being of WIC applicants and participants who are currently enrolled in those programs
4. Streamline administrative procedures to ease the burdens on WIC staff and participants
5. Assess the responsiveness of the state's health system to participants' health care needs and health care outcomes.

I have been advised that the decision to share my information is not a condition for eligibility for WIC, and if I decide not to share my information, this will not affect my application or participation in Georgia WIC.

_____	_____	_____	_____
Name of WIC Applicant/Participant/Guardian/ Caregiver/Spouse/Alternate Parent (please print)	Date	Name of WIC Official (please print)	Date
	_____ UP:		
_____	_____	_____	_____
Signature of WIC Applicant/Participant/Guardian/ Caregiver/Spouse/Alternate Parent	Date	Signature of WIC Official	Date

Please initial below to indicate your preference:

___In applying for WIC services, I **AUTHORIZE** DISCLOSURE of my WIC applicant or participant information for the purposes referenced above. I understand that my refusal to allow such disclosure does not affect my application for or participation in WIC or my eligibility for WIC services.

___ In applying for WIC services, I **DO NOT AUTHORIZE** DISCLOSURE of my WIC applicant or participant information for the purposes referenced above. I understand that my refusal to allow such disclosure does not affect my application for or participation in WIC or my eligibility for WIC services.

WIC CERTIFICATION STATEMENT

DERECHOS Y OBLIGACIONES

He sido informado(a) acerca de mis derechos y obligaciones para participar en el programa WIC de Georgia. Certifico que la información que voy a dar o he dado, es correcta según mi conocimiento. La información de ingresos que he proporcionado es el total de los ingresos brutos de mi hogar (todos los ingresos en efectivo, antes de las deducciones). Este formulario de certificación se presenta en conexión con la recepción de asistencia federal. Los funcionarios del programa WIC de Georgia pueden corroborar la información provista en este formulario. Entiendo que declarar información falsa o engañosa de manera intencional, o tergiversar, ocultar o no revelar hechos de manera intencional puede resultar en el pago en efectivo, al programa WIC de Georgia, del valor de los beneficios alimenticios expedidos a mi persona de manera indebida y puede someterme a un proceso civil o criminal según las leyes estatales y federales.

AVISO DE DIVULGACIÓN

Entiendo que el superintendente estatal de salud de Georgia puede autorizar la divulgación de información acerca de mi participación en el programa WIC, por motivos no relacionados con este programa. Esta información será utilizada por el programa WIC de Georgia, las agencias locales de WIC y ciertas organizaciones públicas. Estas organizaciones incluyen, pero no se limitan, al Programa de Inmunización, el Sistema de Monitoreo de Evaluación de Riesgo en el Embarazo (PRAMS, por sus siglas en inglés), Epidemiología y otros programas de Salud Materno-Infantil, Preparación para Emergencias, Salud Ambiental y Medicaid. Entiendo que el programa WIC de Georgia, sus agencias locales y las organizaciones públicas, solo podrán usar mi información en la administración de sus programas que benefician a personas elegibles para WIC. Las organizaciones públicas que reciban mi información, deberán asegurar que la misma no será divulgada a otras organizaciones o personas sin mi permiso.

Además, entiendo que la información de mi participación en WIC puede ser utilizada por las personas que la reciben, solo para:

1. Determinar mi elegibilidad para los programas que dicha organización administra.
2. Promover la participación en dichos programas.
3. Mejorar la salud, educación o bienestar de los solicitantes y participantes de WIC que se encuentran actualmente inscritos en esos programas.
4. Simplificar los procedimientos administrativos para aliviar la carga de los empleados y participantes de WIC.
5. Evaluar la capacidad de respuesta del sistema de salud del estado, a las necesidades de atención de los participantes y a los resultados de su salud.

He sido informado que la decisión de compartir mi información no es una condición de elegibilidad para WIC y, si decido no compartir mi información, esto no afectará mi solicitud o participación en el programa WIC de Georgia.

_____ Nombre del solicitante de WIC /participante/representante/ proveedor de cuidados/cónyuge/representante alternativo (letra de imprenta)	_____ Fecha _____ UP:	_____ Nombre del funcionario de WIC (letra de imprenta)	Fecha
_____ Firma del solicitante de WIC /participante/representante/ proveedor de cuidados/cónyuge/representante alternativo	_____ Fecha	_____ Firma del funcionario de WIC	Fecha

Favor de colocar sus iniciales abajo indicando su preferencia:

___Al solicitar los servicios de WIC, YO **AUTORIZO** LA DIVULGACIÓN de la información sobre mi solicitante o participante de WIC para los propósitos arriba mencionados. Entiendo que el rehusarme a permitir dicha divulgación, no afectará mi solicitud de participar en WIC o mi elegibilidad para los servicios de WIC.

___ Al solicitar los servicios de WIC, YO **NO AUTORIZO** LA DIVULGACIÓN de la información sobre mi solicitante o participante de WIC para los propósitos arriba mencionados. Entiendo que el rehusarme a permitir dicha divulgación, no afectará mi solicitud de participar en WIC o mi elegibilidad para los servicios de WIC.

GEORGIA WIC PROGRAM
Custody /Termination Form

This Custody/Termination Form allows you to remain on the Georgia WIC Program for thirty (30) days only. This period will be extended if the required documentation is brought back to the clinic within 30 days and proof of custody is confirmed.

DATE_____

NAME:	**DATE OF BIRTH:**
ADDRESS:	
CITY/ZIPCODE:	**PHONE NUMBER**

____You will be terminated from the Georgia WIC Program if you fail to bring Proof of Custody to the clinic information by_____.
(date)

WIC Representative Name_____ **Date** _____

FAILURE TO BRING THIS DOCUMENTATION BACK THE WIC CLINIC ON OR BEFORE THE ABOVE DATE WILL RESULT IN TERMINATION FROM THE GEORGIA WIC PROGRAM.

FAIR HEARING SECTION:

You have the right to a fair hearing if you do not agree with the reason for your termination. A request for a fair hearing must be made within 60 days of the date of this notice. Fair hearing requests should be addressed to:

_____
Georgia WIC Program

_____
Address

_____
City/Zip Code Phone Number

_____ _____
Participant Signature/Parent/Caregiver/Guardian **WIC Representative Signature/Title**

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Dual Participation Sample Warning Letter

Dear Participant:

Our records show that you have participated in two Georgia WIC Programs. You were certified and enrolled on _____ Georgia WIC Program on (date) _____, and you were also certified and enrolled on _____Georgia WIC Program on (date) _____.

As indicated on your Georgia WIC Program ID card, participating in more than one Georgia WIC Program violates programs regulations. Information concerning this will be forwarded to the Office of Inspector General to determine if you will be required to repay money back to the Georgia WIC Program.

Should you have any questions, contact me at _____.

Sincerely,

District Nutrition Services Director

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GEORGIA WIC PROGRAM
REFERRAL FORM

Name: _____ Date of Birth: _____

Address:_____ Telephone Number:_____

Measurements Obtained: _____ Hematological Data Date: _____

Current Height: _____ Hematocrit: _____

Current Weight: _____ Hemoglobin: _____

Any nutritionally related medical conditions? Yes No

If yes, specify: _____

_____

Any clinical manifestations of malnutrition? Yes No

If yes, specify: _____

_____

Any dental problems severe enough to interfere with mastication? Yes No

If yes, specify: _____

_____

Any evidence of lead poisoning?Yes No

If yes, specify: _____

_____

WOMEN ONLY

EDC/Delivery Date: _____ Currently Breastfeeding:Yes No

Blood Pressure: _____ Date Taken: _____

Number of Previous Pregnancies: _____Live Births: _____Miscarriages:_____ Abortions: _____Pregravid Weight :_____

INFANTS ONLY

Breastfeeding: Yes No

Birth weight:_____ Birth length: _____

Weeks Gestation:_____

HEALTH PROFESSIONAL

Signature/Title: _____ Agency Telephone: _____

Agency Address: _____

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GEORGIA WIC PROGRAM
GENERAL APPOINTMENT LETTER

Date: _____

(Insert Responsible Party name) __
(Insert mailing address) _____
(Insert city, state & zip) _____

Dear _____

Your record was selected for review as it pertains to your WIC benefits eligibility. Therefore, on __(insert day, date, and time) _____, you are hereby requested to report to __(insert clinic or interview location name & address) _____ in order to resolve any discrepancies. You must bring your WIC ID card/folder to the appointment.

Please contact me at __(insert phone #) _____ if you have any questions.

Sincerely,

_____
Nutrition Services Director
District _____ Unit_____

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To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish)."
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GEORGIA WIC PROGRAM
Health Department Staff
DISCLOSURE STATEMENT

All Health Department Staff who performs WIC services must complete this form.

County_____

Name(Please print)_____, Title_____

Are you a WIC Participant? _____Yes _____No

Do any of the following relatives or household members participate in Georgia WIC?

Children, grandchildren, sisters, brothers, nieces, nephews, aunts, uncles, parents, spouses, first cousins, in-laws or any person who lives in your household.

_____Yes _____No

Name of your relative or household member	Relationship*	Date of Cert.

(If more space is needed, list on back)

I certify that the above information is correct.

_____ _____
Signature/Title **Date**

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GEORGIA WIC PROGRAM
How to File a Complaint

If you feel you have been treated unfairly, please let us know by using the information listed below. Georgia WIC Program will assist you as well as notify the proper authorities if necessary.

ANY COMPLAINT

You may call the Georgia WIC Program about any complaints at the toll free phone number: **1-800-228-9173** and/or write about your complaint to the address below:

Georgia WIC Program Policy Unit
2 Peachtree Street, Suite 10-293
Atlanta, GA 30303

DISCRIMINATION AND/OR CIVIL RIGHTS

If you feel that you have been discriminated against or that your civil rights have been violated, you may contact the Georgia WIC Program by calling the toll free number **1-800-228-9173**, and/or write about your complaint to the address below:

Georgia WIC Program Policy Unit
2 Peachtree Street, Suite 10-293
Atlanta, GA 30303

And/or you may contact the Federal Office of Adjudication directly by calling the phone numbers below:

1-866-632-9992
and/or you may write the Office of Adjudication at the address below:

Office of Adjudication
1400 Independence Avenue, SW
Washington, DC 20250-9140

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To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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PROGRAMA WIC de GEORGIA
Cómo presentar una queja

Si usted cree que le han tratado injustamente, sírvase hacérnoslo saber usando la información que aparece más abajo. Georgia WIC Program le ayudará y notificará a las autoridades correspondientes si es necesario.

CUALQUIER QUEJA

Puede llamar gratis a Georgia WIC Program sobre cualquier queja que tenga al número de teléfono: **1-800-228-9173** o escribir sobre su queja a la dirección siguiente:

Georgia WIC Program Policy Unit
2 Peachtree Street, Suite 10-293
Atlanta, GA 30303

DISCRIMINACIÓN Y DERECHOS CIVILES

Si usted cree que le han discriminado o que se han violado sus derechos civiles, puede comunicarse con Georgia WIC Program llamando gratis al número **1-800-228-9173**, o escribiendo sobre su queja a la dirección siguiente:

Georgia WIC Program Policy Unit
2 Peachtree Street, Suite 10-293
Atlanta, GA 30303

También puede ponerse en contacto con la Oficina Federal de Arbitraje (Federal Office of Adjudication) directamente llamando al número de teléfono que aparece más abajo:

1-866-632-9992
o escribir a la Oficina de Arbitraje (Office of Adjudication) a la siguiente dirección:

Office of Adjudication
1400 Independence Avenue, SW
Washington, DC 20250-9140

De acuerdo con la ley federal y las politicas del Departamento de Agricultura de los EE.UU. (USDA, sigla en ingles), se le prohibe a esta institucion que discrimine por razon de raza, color, origen, sexo, edad, o discapacidad.

Para presentar una queja sobre discriminacion, escriba a USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 o llame gratis al (866) 632-9992 (voz). Personas con discapacidad auditiva o del habla pueden contractar con USDA por medio del Servicio Federal de Relevo (Federal Relay Service) al (800) 845-6136 (espanol) o (800) 877-8339 (ingles)."

USDA es un proveedor y empleador que ofrece oportunidad igual para todos**.**

Revised 3/12

GEORGIA WIC PROGRAM

INCOME CALCULATION FORM

(This form must be completed if applicant does not qualify for Adjunctive eligibility)

WIC ID NUMBER: _____

NAME _____
Last **First** **Middle Initial** **Date of Birth**

ADDRESS_____
City Zip Code

Documentation of Income must be completed for an applicant who does not qualify for adjunctive eligibility.

Use This Section to Calculate Income

First Certification Date_____

Relationship and Name	Income Source	What Is Each Family Member's Income? (circle one)
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly

Other Income – Is there other regular income or contributions received by the family (i.e., unemployment, child support)?

_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly

$_____Total Applicant's Income (Weekly/Bi-Weekly/Monthly/Yearly) No. In Family_____

IS THE CLIENT INCOME ELIGIBLE? YES ☐ NO ☐ (Transfer total to the Certification Form)

Use This Section to Calculate Income

First Certification Date_____

Relationship and Name	Income Source	What Is Each Family Member's Income? (circle one)
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly

Other Income – Is there other regular income or contributions received by the family (i.e., unemployment, child support)?

_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly

$_____Total Applicant's Income (Weekly/Bi-Weekly/Monthly/Yearly) No. In Family_____

IS THE CLIENT INCOME ELIGIBLE? YES ☐ NO ☐ (Transfer total to the Certification Form)

I have been advised of my rights and obligations under the Program. I certify that the information I will provide, or have provided is correct, to the best of my knowledge. The income I have given is my total gross income (all cash income before deductions). This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making a false statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. I understand that the WIC Program may give my certification information to other health or public assistance agencies to see if my family is eligible for their services. I understand that these agencies may contact me, but they may not give my information to anyone else without asking my permission.

PARENT/GUARDIAN/CAREGIVER SIGNATURE	DATE	SIGNATURE OF WIC OFFICIAL (Who assessed income)

Please place this form in the Client's Medical Record behind the Certification Form

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GEORGIA WIC PROGRAM
INCOME VERIFICATION LETTER

Date

Dear Mr/Ms:

It has been brought to the attention of the Georgia WIC Program that the income reported in the clinic may not be accurate. In order to qualify for the Georgia WIC Program, you must meet the income guidelines of the program.

Please bring in proof of family income on your next clinic appointment on _____at _____ a.m./p.m. At that time, you may bring either a copy of your most recent pay stub, a letter from your employer verifying your current wages, a copy of your most recent federal tax return, or a verification letter from the local welfare office. Failure to do so will result in termination from the program, an investigation and may require you to pay the State Agency in cash the value of the benefits improperly issued to you or your family member(s).

Sincerely,

_____
Title

c:

In accordance with Federal Law and Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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Revised 3/12

GEORGIA WIC PROGRAM
NO PROOF FORM

The Georgia WIC Program requires each applicant to show documentation of identification, residence (address), and income to be eligible for the Georgia WIC Program. This form is to be completed by those who cannot get documentation, such as paycheck stub. Please read the following statement before completing this form.

I understand that by completing, signing, and dating this form, I am certifying that the information I am providing below is correct. I understand that intentional misrepresentation may result in paying the state agency, in cash, the value of the food benefits improperly received.

1. **Completion of this form is for: Income Address Identification**
   (circle the appropriate proof (s))

2. **Who do you work for?** **How much did you make last month?**

_____ $_____

List working family members: **How much did they make last month?**

_____ $_____
_____ $_____
_____ $_____
_____ $_____

(Family means related or non-related individuals living together)

3. **Reason for No Documentation:**

_____
_____
_____

List family members applying for WIC:

_____

_____
(Signature of Applicant) (Date)

_____ _____
(Signature of Clinic Staff) (Date)

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PROGRAMA WIC de GEORGIA
FORMULARIO DE AUSENCIA DE PRUEBA/DOCUMENTOS

WIC De Georgia requiere a cada solicitante el proveer y mostrar documentación de identificación, residencia (dirección) e ingresos para ser elegibles al Programa WIC. Este formulario deberá ser completado por aquella persona que no pueda conseguir documentación tales como talonarios de cheques. Favor de leer la declaración siguiente antes de completar.

Entiendo que completando, firmando y al fechar este formulario, estoy certificando que la información aquí provista es correcta. Entiendo que cualquier mal representación intencionada podría resultar en el tener que pagar en efectivo a la agencia estatal, el valor de los beneficios de alimentos que recibí impropiamente.

1. La cumplimentación de este formularioes por:
   (Circule la prueba(s) apropiada(s) Ingresos Dirección Identificación

2. ¿Para quién usted trabaja? ¿Cuánto dinero ganó el mes pasado?

   _____ $_____

   Enumere otros miembros familiares trabajando ¿Cuánto dinero ganaron el mes pasado?

   _____ $_____

   _____ $_____

   _____ $_____

3. Razón por la ausencia de pruebas/documentos:

   _____

   _____

   Enumere miembros familiares solicitando WIC:_____

   _____

   _____ _____
   (Firma del Solicitante) (Fecha)

   _____ _____
   (Firma del empleado de la clinica) (Fecha)

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Revised 3/12

GEORGIA WIC PROGRAM
NOTICE OF TERMINATION / INELIGIBILITY / WAITING LIST

DATE:_____

NAME:	**DATE OF BIRTH:**
ADDRESS:	
CITY/ZIP CODE:	**PHONE NUMBER:**

TERMINATION/INELIGIBILITY SECTION:

☐ You are not eligible for the Georgia WIC Program because you:

☐ You are being terminated from the Georgia WIC Program because you:

_____have an income that is too high for the Georgia WIC Program.
_____do not live in the area served by the Georgia WIC Program.
_____are not pregnant, postpartum, or breastfeeding woman; child under five (5) years.
_____do not have a medical/nutritional health problem.
_____ did not return to the clinic for your recertification appointment on_____ (date).
_____did not pick-up your food vouchers for two (2) months. You will be terminated on _____(date).
Other _____ Funds are not available to serve postpartum non-breastfeeding women.
_____ _____.

SUSPENSION SECTION:

☐ You are being suspended from the Georgia WIC Program for three (3) months because you broke the following the Georgia WIC Program rule(s)

WAITING LIST SECTION:

☐ You are being placed on a waiting list. Funds are not available to serve priority(ies)_____ . You are in priority_____.

- You may still receive nutritional education and other services provided by the Health Department.
- If you need information or would like to discuss this decision, please contact the Georgia WIC Program at the address below:

FAIR HEARING SECTION:

You have a right to a fair hearing if you do not agree with the reason for your termination/ineligibility or waiting list placement. A request for a fair hearing must be made within 60 days of the date of this notice. Fair hearing requests should be addressed to:

_____
Georgia WIC Program
_____
ADDRESS
_____/_____
CITY/ZIP CODE **PHONE NUMBER**

_____ _____
SIGNATURE/PARENT/CAREGIVER/GUARDIAN **WIC RESPRENTATIVE SIGNATURE/TITLE**

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PROGRAMA WIC de GEORGIA
AVISO DE BAJA, INCUMPLIMIENTO DE LOS REQUISITOS O LISTA DE ESPERA

FECHA:_____

NOMBRE:	**FECHA DE NACIMIENTO:**
DIRECCIÓN:	
CIUDAD Y CÓDIGO POSTAL:	**NÚMERO DE TELÉFONO:**

SECCIÓN DE TERMINACIÓN E INCUMPLIMIENTO DE REQUISITOS:

☐ Usted no puede participar en Georgia WIC Program porque:

☐ Se le está dando de baja del programa Georgia WIC Program porque usted:

_____tiene un ingreso demasiado alto para Georgia WIC Program.
_____no vive en el área de servicio de Georgia WIC Program.
_____no está embarazada, en etapa de posparto ni amamantando; el niño es menor de cinco (5) años.
_____no tiene problema de salud médico ni nutricional.
_____ no regresó a su cita en la clínica para fines de recertificación el_____ (fecha).
_____no recogió sus cupones de alimentos durante dos (2) meses. El programa terminará para usted el _____(fecha).
Otro _____ No hay fondos disponibles para prestar servicio a mujeres en etapa de posparto que no están amamantando.
_____ _____.

SECCIÓN DE SUSPENSIÓN:

☐ Se le está suspendiendo del programa Georgia WIC Program durante tres (3) meses porque no cumplió con las siguientes reglas de Georgia WIC:

SECCIÓN DE LISTA DE ESPERA:

☐ Usted está en lista de espera. No hay fondos disponibles para dar servicio a la(s) prioridad(es)_____. Usted está en prioridad_____.

- Usted puede seguir recibiendo educación sobre nutrición y otros servicios prestados por el Departamento de Salud.
- Si necesita información o desea conversar sobre esta decisión, sírvase comunicarse con Georgia WIC a la dirección que figura más abajo:

SECCIÓN DE AUDIENCIA JUSTA:

Usted tiene derecho a una audiencia justa si no está de acuerdo con la razón de su baja, incumplimiento de requisitos o colocación en lista de espera. La solicitud de audiencia justa debe hacerse en un plazo de 60 días a partir de la fecha de este aviso. Las solicitudes de audiencia justa deben dirigirse a:

_____
Georgia WIC Program
_____
DIRECCIÓN
_____/_____
CIUDAD Y CÓDIGO POSTAL **NÚMERO DE TELÉFONO**

_____ _____
FIRMA DEL PADRE O LA MADRE, CUIDADOR O TUTOR **FIRMA DEL REPRESENTANTE DE WIC Y CARGO**

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Revised 3/12

Georgia WIC Program
Participant Repayment Letter
SAMPLE LETTER

Date:

Name
Address
City, State, Zip

Dear _____:

Georgia Women, Infants & Children (WIC) determined as a responsible party you have _____:

A. Participated in dual clinics/counties/states
B. Intentionally made a false or misleading statement or intentionally misrepresented, concealed, or withheld facts
C. Sold or exchanged vouchers or WIC food items with other individuals or parties
D. Received cash from food vendors or credit toward other non-WIC items
E. Other: _____

The total amount you owe is $_____ during the time period from _____ to _____. If you are unable to make restitution for this amount within 30 days of receipt of the letter demanding repayment, then please adhere to the attached repayment agreement. The repayment agreement cannot extend more than 90 days.

You will be disqualified from the WIC program for __12__ months during the time period of _____ to _____.

Please send a cashier's check or money order payable to:

Georgia WIC Program
(Insert Your Address)

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Sincerely,

District Nutrition Services Director's

Name

Address

Revised 06/12

Georgia WIC Program
Participant Repayment Schedule
SAMPLE LETTER

Date _____

CERTIFIED MAIL RETURN
RECEIPT REQUESTED

Ms.

Dear Ms. :

This letter confirms your proposal to repay $_____ to the Georgia WIC Program in monthly installments of $_____. If you fail to make payments on time, the full amount will be due immediately. The following is the payment schedule that we will require you to follow until the full amount is recovered:

DATE	AMOUNT	DATE	AMOUNT

Total

Please send a cashier's check or money order payable to the Georgia WIC Program and mail it to the following address:

Georgia WIC Program
Your address

If you have any questions, please call me at _____.

Sincerely,

District Nutrition Services Director's Name
Address

Revised 03/12

Participant Violation Sample Warning Letter

Date:

Participant Name
Parent/Guardian
Address
City, State, Zip

It has come to the attention of the Georgia WIC Program that your behavior in (clinic name) on (Date) was in violation of the rules and Rights and Obligations of the Georgia WIC Program.

This letter serves as a warning for your behavior. **Use of abusive language and/or physical abuse with WIC staff, other WIC clients, or store personnel is not an acceptable behavior**. Failure to comply with the rules and Rights and Obligations of the program may cause you and your family members to be terminated from the program. Attached please find a copy of the Rights and Obligations. Please review this document.

If you have any questions, please contact Name of Nutrition Services Director at phone number.

Sincerely,

District Nutrition Services Director
Title

cc: Participant's record
Ondray Jennings, Deputy Inspector General

Revised 6/12

GEOGIA WIC PROGRAM
IDENTIFICATION, RESIDENCY & INCOME PROOF LIST

Help WIC help you!

"Proof of ID, residency and income is needed for each applicant/participant/guardian/caregiver and infant/child". Please call your local WIC department for any questions you may have. Whenever your child, infant or you need be certified for WIC, you must present proof of each of the following categories:

Proof of Identifications

(One form of proof required)

Infant:
Birth Certificate
Confirmation of birth letter
Hospital ID bracelet (mom & baby)
Immunization Record
Military ID
Health Records
Social Security Card
Discharge of hospital papers
EVOC/VOC Card (with Additional ID)
Passport Card/Passport

Child:
Birth Certificate
Immunization Record
Health Records
Social Security Card
Military ID
EVOC/VOC Card (with Additional ID)
Passport Card/Passport

Women:
Birth Certificate
Driver's License
Immunization Record
Military ID
Health Records
Hospital ID bracelet (mom & baby)
Social Security Card
State ID/School ID
EVOC/VOC Card (with Additional ID)
WIC ID (Voucher Pick Up Only)
Work ID
Passport Card/Passport

Proof of Residency (Address)

(One form of proof required)

Cable TV Bill
Electric Bill
Medicaid (address must be visible during swipe or internet access)
Gas Bill
Water Bill
Health Record
Telephone Bill
Rent/Mortgage Receipt

(P.O. Box address is not acceptable)

Proof of Income

(Bring proof of Income for each household member)

Alimony
Pay Stub
Annuities
Pensions
Basic Allowance from Private Pensions
Child Support Payments
Public Assistance/Welfare Payments (TANF)
Contribution from people
Current Tax Return
Rental Income (Net)
Dividends or Interest on Bonds
Self Employment (Net Income)
Estate Income
Social Security
Financial Records
Supplemental Social Security
Food Stamps Documentation
Trust
Government Retirement
Unemployment Compensation
Letter from your Employer
Unemployment Notice
Medicaid
Military Retirement
Veteran's Payment
Monetary Compensation
Net Royalties

Revised 3/12

PROGRAMA WIC de GEORGIA
LISTA DE PRUEBAS DE IDENTIFICACIÓN, RESIDENCIA E INGRESO

¡Ayude a WIC a ayudarle a usted!

"Para cada solicitante, participante, tutor o cuidador, así como también para cada bebé o niño, se necesitan pruebas de identificación, residencia e ingresos". Sírvase llamar a su departamento local de WIC si tiene alguna pregunta Siempre que su niño, bebé o usted tengan que ser certificados para recibir WIC, deben presentar prueba de cada una de las siguientes categorías:

Prueba de identificaciones
(es requisito presentar una prueba)

Bebé:
Acta de nacimiento
Carta de confirmación de nacimiento
Pulsera de identificación del hospital (madre y bebé)
Certificado de vacunaciones
Identificación militar
Expedientes médicos
Tarjeta del Seguro Social
Documentos del alta del hospital
Tarjeta de EVOC o VOC (con identificación adicional)
Tarjeta de pasaporte/pasaporte

Niño:
Acta de nacimiento
Certificado de vacunaciones
Expedientes médicos
Tarjeta del Seguro Social
Identificación militar
Tarjeta de EVOC o VOC (con identificación adicional)
Tarjeta de pasaporte/pasaporte

Mujeres:
Acta de nacimiento
Licencia de conducir
Certificado de vacunaciones
Identificación militar
Expedientes médicos
Pulsera de identificación del hospital (madre y bebé)
Tarjeta del Seguro Social
Identificación del estado o la escuela
Tarjeta de EVOC o VOC (con identificación adicional)
Identificación de WIC (solamente para recoger los cupones)
Identificación del trabajo
Tarjeta de pasaporte/pasaporte

Prueba de residencia (dirección)
(es requisito presentar una prueba)

Factura de TV por cable
Factura de electricidad
Factura del gas
Factura del agua
Factura del teléfono
Recibo de renta o hipoteca
Medicaid (la dirección tiene que ser visible cuando se pasa la tarjeta o mediante acceso a Internet)
Expediente médico

(No se aceptan direcciones de apartados postales)

Prueba de ingreso
(Traiga una prueba de ingreso para cada miembro del hogar)

Pensión de divorcio
Comprobante de sueldo
Anualidades
Pensiones
Cuotas básicas de Pensiones privadas
Pagos para manutención de niños
Asistencia pública o pagos de bienestar social (TANF)
Contribución de personas
Declaración de impuestos actual
Ingreso por renta (neto)
Dividendos o intereses de bonos
Empleo por cuenta propia (ingreso neto)
Ingreso de patrimonio
Seguro Social
Estados financieros
Complemento del Seguro Social (SSI)
Documentación de cupones de alimentos
Fideicomiso
Jubilación del gobierno
Compensación por desempleo
Carta de su empleador
Aviso de desempleo
Medicaid
Jubilación militar
Pago de los Veteranos
Compensación monetaria
Derechos de autor netos

Revised 3/12

GEORGIA WIC PROGRAM
PROOF OF RESIDENCY FORM FOR
APPLICANTS WITH P.O. BOX ADDRESS

The WIC applicant must complete this form when giving a post office box address:

Directions to House

_____

_____

_____

_____

_____

_____

_____

_____

_____

Participant Signature Date

_____ _____

Participant Signature Date

_____ _____

Participant Signature Date

This form must be filed in the applicant/participant's health record.

Revised 3/12

PROGRAMA WIC de GEORGIA

FORMULARIO DE PRUEBA DE RESIDENCIA PARA
SOLICITANTES CON UN APARTADO POSTAL COMO DIRECCIÓN

El solicitante de WIC debe completar este formulario si da un apartado postal como su dirección:

Direcciones a la Casa

_____

_____

_____

_____

_____

_____

_____

_____

_____

Firma del Participante Fecha

_____ _____

Firma del Participante Fecha

_____ _____

Firma del Participante Fecha

Este formulario debe ser archivado en el registro de salud del participante

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Revised 3/12

Brenda Fitzgerald, MD, Commissioner Nathan Deal, Governor
2 Peachtree St NW, 15th Floor
Atlanta, Georgia 30303-3142
www.health.state.ga.us

Dear WIC Proxy:

The Georgia WIC Program appreciates your help, respects your time and effort in assisting the Georgia WIC Program participants. As a proxy, it is vital that you follow the rules below:

1. A proxy is a person who acts on behalf of the participant. Authorized proxies may pick-up and/or redeem vouchers and may bring a child in for subsequent certifications in restricted situation.

2. A proxy is a person who is named by the WIC participant and given the participants WIC ID card when redeeming WIC Approved food item at the grocery store.

3. A proxy is a responsible person who the participant/parent/guardian/spouse/ caregiver/alternate parent depends on.

4. If a proxy picks up vouchers or brings a child in for subsequent certification, the proxy may sometimes have to remain for nutrition education classes and be able to provide health information for the participant(s).

5. A proxy must be at least sixteen (16) years old unless prior approval is obtained from the WIC staff.

6. A proxy **must not** pick up vouchers for more than two (2) families in the state of Georgia.

Documentation of proxy is recorded on the Georgia WIC Program ID card. The name of the proxy is placed in the WIC participants file. The local agency will notify the WIC participant if the proxy is not listed within the WIC participants file.

Please contact the WIC participant if you can no longer serve as a proxy. The WIC participant must notify the WIC clinic of this change. If you have any questions pertaining to your new role, please ask the person who asked you to serve as a proxy.

Thank you in advance for what you will do to help the Georgia WIC Program.

Sincerely,

Georgia WIC Program Staff

Revised 3/12

Georgia Department of Public Health
Georgia WIC Program
Rights and Obligations

RIGHTS AND OBLIGATIONS

1. The rules for signing up and taking part in the Georgia WIC Program are the same for everyone, regardless of race, color, national origin, sex, age, or disability.
2. You may appeal any decision made by the WIC clinic about your eligibility for WIC or disqualification from WIC by asking for a fair hearing.
3. The WIC clinic will give you information about food that is healthy for you. Health service referrals are also available to you. The clinic would like you to use these services.
4. Information on your WIC form will be used to review WIC services and tell us how many people are on WIC.
5. The food you get from WIC is only for WIC participant(s).
6. You may be taken off WIC if:
   - You do not tell the truth about eligibility criteria.
   - **You get vouchers from more than one (1) WIC clinic <u>at the same time.</u>**
   - You do not keep your certification appointments. (Rescheduling WIC appointments may take from 7 to 20 days depending on the clinic schedule).
   - You do not get your vouchers for two (2) months in a row.
   - You sell or trade your WIC vouchers or WIC food for money or any product, good, or service not authorized by the Georgia WIC Program.
   - You use your vouchers to buy food that is not on the authorized WIC food list.
   - You exchange your WIC food items after purchase for any item(s) not listed on the voucher.
   - You use abusive language with WIC clinic staff, store clerks, or managers.
   - You are physically violent with WIC clinic staff, other WIC clients, or store personnel.
   - You threaten clinic staff, state staff, store manager or cashiers and or/security in the clinic. Your threat will lead to possible termination or you losing the privileged of coming to the clinic. If you lose that privilege, a proxy will act on your behalf for your child.
   - You solicit other participants to violate program rules, including the selling of their vouchers.
   - You commit any crime in the WIC clinic or on the grounds of the clinic.
   - Your designated <u>proxy</u> engages in any of the listed items in #6 above.
7. If you do not keep your appointments, the number of vouchers issued to you or your child(ren) will be reduced.
8. A proxy cannot provide services for more than two families.
9. Lost and destroyed/stolen vouchers will not be replaced.

10. The WIC program does not participate in home delivery of WIC foods. If you or your proxy participates in such activities, you will be terminated from the program.

VOUCHER INFORMATION

- Failure to keep appointments will reduce the number of vouchers you receive.
- The fruit and vegetable/cash value voucher can not be prorated. It must always be issued and must be issued in full value (e.g., $6, $10, $15).
- Food packages will be prorated based on the total number of vouchers in the package.

Revised 7/12

Departamento de Salud Pública
Programa WIC de Georgia
Derechos Y Obligaciones

DERECHOS Y OBLIGACIONES

1. Las reglas para inscribirse y participar en el programa WIC de Georgia son las mismas para todos, sin distinción de raza, color de piel, nacionalidad de origen, sexo, edad o discapacidad.
2. Usted puede apelar cualquier decisión tomada por la clínica de WIC acerca de su elegibilidad para el programa WIC o descalificación de WIC pidiendo una audiencia imparcial.
3. La clínica de WIC le dará información acerca de los alimentos que son saludables para usted. También hay a su disposición referencias de servicios de salud. La clínica desea que usted use dichos servicios.
4. La información en el formulario de WIC será utilizada para revisar los servicios de WIC y decirnos cuántas personas están en el programa WIC.
5. Los alimentos que recibe de WIC son solamente para quienes participan en WIC.
6. Usted puede ser suspendido del programa WIC si:
   - No dice la verdad acerca de los criterios de elegibilidad.
   - **Recibe cupones de más de una (1) clínica de WIC <u>al mismo tiempo.</u>**
   - No acude a las citas de certificación. (Cambiar las citas de WIC puede tardar de 7 a 20 días, dependiendo del horario de la clínica).
   - No obtiene sus cupones por dos (2) meses consecutivos.
   - Vende o intercambia sus cupones de WIC o alimentos de WIC por dinero o algún producto, bien o servicio no autorizado por el programa WIC de Georgia.
   - Utiliza sus cupones para comprar alimentos que no está en la lista de alimentos autorizados por WIC.
   - Intercambia sus alimentos de WIC después de comprarlos por algún(os) artículo(s) que no figura(n) en el cupón.
   - Utiliza un lenguaje abusivo con el personal de la clínica de WIC, los dependientes de las tiendas o los gerentes.
   - Emplea violencia física contra el personal de la clínica de WIC, otros clientes de WIC o el personal de las tiendas.
   - Amenaza al personal de la clínica, personal estatal, gerente de la tienda, cajeros o personal de seguridad en la clínica. Su amenaza dará lugar a una posible cancelación o a perder el privilegio de venir a la clínica. Si usted pierde ese privilegio, un representante actuará por usted en nombre de su niño(a).
   - Solicita a otros participantes que violen las reglas del programa, incluyendo la venta de sus cupones.
   - Comete cualquier delito en una clínica local de WIC o en propiedad de la clínica.
   - Su <u>apoderado(a)</u> designado(a) se involucra en cualquiera de los puntos mencionados arriba en el no. 6.
7. Si no mantiene sus citas, se reducirá el número de cupones que se emitan para usted o su(s) niño(s).
8. Un apoderado no puede prestar servicios para más de dos familias.

9. Los cupones extraviados, destruidos o robados no serán reemplazados.
10. El programa de WIC no participa en entrega a domicilio de los alimentos. Si usted o su apoderado(a) participa en dichas actividades, usted será expulsado(a) del programa.

INFORMACIÓN DEL CUPÓN

- No acudir a las citas reducirá la cantidad de cupones que usted reciba.

- El valor en efectivo del cupón de frutas y vegetales no se puede prorratear. Siempre se debe emitir y emitirse por su valor completo (p. ej., $6, $10,$15).

- Los paquetes de alimentos se pueden prorratear según la cantidad total de cupones que haya en el paquete.

Revisado 7/12

GEORGIA WIC PROGRAM
SIGNED STATEMENT OF INCOME, RESIDENCY AND IDENTIFICATION

PROXY LETTER

I (Parent/guardian) _____, cannot come in to apply for WIC services for my child (ren) _____. I have given permission to (name of proxy) _____ to apply for WIC for my child (ren). The number of people in my family is _____ ("Family" means related or non-related individuals living together), and the monthly household income is _____.

The requested documentation listed below is attached.

Parent/guardian signature **Date**

The proxy must provide the following documentation for recertification appointments:

1. Proxy Form
2. The Participant's WIC ID card
3. Participant's ID **(Birth Certificate, Immunization record, e.g.)**
4. Parent/Guardian or Participant's current Medicaid, SNAP (formally Food Stamps) Letter or TANF Letter
5. If there is no proof of Medicaid, please provide proof of income **(Pay Stubs, Alimony, Social Security, Child Support, Current Year Income Tax, e.g.)**
6. Proof of Residency
7. Proxy Identification **(Current)**
8. Knowledge of child(ren) health and diet
9. Knowledge of proxy responsibilities

Revised 3/12

PROGRAMA WIC de GEORGIA
DECLARACIÓN FIRMADA DE INGRESOS, RESIDENCIA E IDENTIFICACIÓN

CARTA DE PODER

Yo, (padre/guardián) _____, no puedo venir a solicitar los servicios de WIC para mi(s) hijo/a(s) _____; por lo tanto, autorizo a (nombre del apoderado) _____ para que solicite WIC para mi(s) hijo/a(s). El número de personas en mi familia es _____ ("Familia" significa todos los individuos, relacionados o no, que viven juntos) y los ingresos mensuales del hogar son _____.

La documentación solicitada a continuación, se encuentra adjunta.

Firma del padre/guardián **Fecha**

El apoderado deberá traer la siguiente documentación para las citas de recertificación:

1. Formulario de Poder.
2. Tarjeta de identificación de WIC del participante.
3. Documento de identificación del participante **(por ejemplo, certificado de nacimiento o registro de vacunas).**
4. Carta que muestre si el padre/guardián o el participante reciben actualmente Medicaid, SNAP (Cupones de Alimentos, anteriormente conocido como Food Stamps) o TANF (Asistencia Temporal para Familias Necesitadas).
5. Si no puede comprobar que tiene Medicaid, por favor presente una prueba de ingresos **(por ejemplo, talones de pago, pensión alimenticia, seguro social, manutención de menores o impuesto sobre la renta del año actual).**
6. Prueba de residencia.
7. Documento de identificación del apoderado **(vigente).**
8. Conocimiento acerca de la salud y el régimen de alimentación del(de los) niño(s).
9. Conocimiento acerca de las responsabilidades del apoderado.

Revised 3/12

THERE IS NO CHARGE FOR WIC SERVICES

GEORGIA WIC

EATHEALTHYGROWHEALTHYLIVEHEALTHY

GEORGIA WIC PROGRAM

PROMOTING HEALTHY NUTRITION FOR WOMEN, INFANTS AND CHILDREN SINCE 1974

1-800-228-9173

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NO SE LES COBRA POR LOS SERVICIOS DE WIC

GEORGIA WIC

EATHEALTHYGROWHEALTHYLIVEHEALTHY

EL WIC DE GEORGIA HA ESTADO

PROMOVIENDO HABITOS SALUDABLES PARA LA NUTRICION

DE MUJERES, INFANTES Y NINOS DESDE 1974

1-800-228-9173

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Revised 3/12

GEORGIA WIC PROGRAM
Thirty (30) Day Certification/Termination Form

This Thirty (30) Day Certification Form allows you to be on the Georgia WIC Program for thirty (30) days only. The certification period will be extended if the required documentation is brought back to the clinic within 30 days and eligibility is confirmed.

DATE_____

NAME:	**DATE OF BIRTH:**
ADDRESS:	
CITY/ZIPCODE:	**PHONE NUMBER:**

____You will be terminated from the Georgia WIC Program if you fail to bring in the following information by_____.
(date)

Proof of:

_____ **Family Income** or _____**Medicaid, TANF or Supplemental Nutrition Assistance Program (SNAP) Documentation** (check one)

_____**Identification – Client** _____ **Identification – Parent/Guardian**
_____**Residency**

WIC Representative _____ **Date** _____

FAILURE TO BRING THIS DOCUMENTATION TO THE HEALTH DEPARTMENT ON OR BEFORE THE ABOVE DATE WILL RESULT IN TERMINATION FROM THE GEORGIA WIC PROGRAM

_____You are being terminated from the Georgia WIC Program because you have been found to be over income.

WIC Representative_____ Date_____

FAIR HEARING SECTION:

You have the right to a fair hearing if you do not agree with the reason for your termination. A request for a fair hearing must be made within 60 days of the date of this notice. Fair hearing requests should be addressed to:

_____
Georgia WIC Program

_____
Address

_____
City/Zip Code Phone Number

_____ _____
Participant Signature/Parent/Caregiver/Guardian **WIC Representative Signature/Title**

Revised 3/12

PROGRAMA WIC de GEORGIA
Certificación de treinta (30) días y formulario de baja

Esta certificación de treinta (30) días le permite estar en Georgia WIC durante treinta (30) días solamente. El período de certificación se extenderá si trae a la clínica la documentación exigida en un plazo de 30 días y se confirma que usted cumple con los requisitos.

FECHA_____

NOMBRE:	**FECHA DE NACIMIENTO:**
DIRECCIÓN:	
CIUDAD Y CÓDIGO POSTAL:	**NÚMERO DE TELÉFONO:**

____Si no trae la siguiente información a más tardar el _____, se le dará de baja de Georgia WIC.
(fecha)

Prueba de:

_____ **Ingreso familiar** o **_____Medicaid, TANF o Documentación del Programa de Asistencia Suplementaria de Nutrición (SNAP)** (marque uno)

_____**Identificación – Cliente** _____ **Identificación – Padres o tutores**
_____**Residencia**

Representante de WIC _____**Fecha** _____

SI NO TRAE ESTOS DOCUMENTOS AL DEPARTAMENTO DE SALUD A MÁS TARDAR EN LA FECHA QUE FIGURA ARRIBA SE LE DARÁ DE BAJA DE GEORGIA WIC

_____Se le está dando de baja de Georgia WIC porque hemos comprobado que sus ingresos están por encima de lo permitido.

Representante de WIC_____ Fecha_____

SECCIÓN DE AUDIENCIA JUSTA:

Usted tiene derecho a una audiencia justa si no está de acuerdo con la razón por la que le dieron de baja. La solicitud de audiencia justa debe hacerse en un plazo de 60 días a partir de la fecha de este aviso. Las solicitudes de audiencia justa deben dirigirse a:

_____
Georgia WIC

_____
Dirección

_____
Ciudad y código postal Número de teléfono

_____ _____
Firma del participante, padre, madre, cuidador o tutor **Firma y cargo del representante de WIC**

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Revised 3/12

Georgia WIC Program
VERIFICATION OF RESIDENCY AND/OR INCOME

Household Section:

I,_____, have the person(s) listed below living with me.
Print Name

Name of WIC Applicant(s): **Address:**

_____ _____

_____ _____

Including the applicant(s) listed above, I have _____of people in my family. ("Family" means related or non-related individuals living together.)

I give the above listed applicant(s) permission to bring my family's documentation of income (example: pay stub) and residency to the Georgia WIC Program. This information is attached.

_____
Signature Date

Address:_____

City:_____State:_____ZipCode:_____

Telephone No.:_____

Clinic Section:

This form must be returned
on_____to_____

_____
WIC Official **Date**

_____
WIC Official **Date Received**

WE RESERVE THE RIGHT TO VERIFY THIS INFORMATION, IF NECESSARY.

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Revised 3/12

Georgia WIC Program
VMARS Dual Participation Sample Warning Letter
(Date)

Dear Participant:

Records indicate you have intentionally misrepresented your information in an attempt to participate in two Georgia WIC Programs. You were certified and enrolled on (clinic) _____ Georgia WIC Program on (date) _____, and you were also certified and enrolled on (clinic) _____Georgia WIC Program on (date) _____.

As indicated on your Georgia WIC Program ID card, participating in more than one Georgia WIC Program violates program regulations. Information concerning this action will be forwarded to the Office of Inspector General for further investigation to determine if you will be required to repay money back to the Georgia WIC Program.

If you have any questions, contact me at _____.

Sincerely,

District Nutrition Services Director

Revised 06/13

GEORGIA DEPARTMENT OF PUBLIC HEALTH
WAIVER OF RIGHTS TO FREE INTERPRETER SERVICES

Free interpreter services are available through agencies or programs of the Georgia Department of Public Health (DPH). DPH will call an interpreter after identifying the primary language in which you are able to communicate. You are entitled to bring your own interpreter, however, DPH or its representative agencies will not authorize payment for interpreter services not secured or approved by DPH.

I, _____ have been informed of my right to receive free interpretive
(Client Name)

services from _____. I understand that I am entitled to interpretive
(Agency or Program)

services at no cost to myself or to other family members, but do not wish to receive DPH's free services at this

time. I choose _____ to act as my interpreter from _____
(Interpreter's Name) **(Start Date)**

until _____. I understand that I may withdraw this waiver at any time and request the services
(End Date)

of an interpreter, which will be paid for by _____.
(DPH Agency or Program)

To the best of my knowledge, the person I am using to act as my own interpreter is over the age of 18. I understand that this waiver pertains to interpreter services only and does not entitle my interpreter to act as my Authorized Representative. I also understand that the service agency may secure a qualified or certified interpreter to observe the interpreter of my choice during the interpreting session to ensure the accuracy of the communication and follow-up instructions.

The Interpreter indicated below orally translated this form to me.

_____ _____
(Client's Signature) **(Date)**

_____ _____
(Interpreter's Signature) **(Date)**

_____ _____
(Interpreter Printed or Typed Name) **(Date)**

_____ _____
(Staff Person's Signature) **(Date)**

Georgia WIC Program
Interview Script

The Georgia WIC Program is a nutrition program for Women, Infants and Children who have nutritional needs and are income eligible. Eligible program enrollees receive:

- Nutrition assessment
- Nutrition education
- Healthy foods (milk, eggs, cheese, juice, cereal, peanut butter, dried beans or peas, carrots, tuna and infant formula)
- Support for breastfeeding moms
- Referral to other health and social services

You may qualify for WIC if you:

- **are** pregnant, just had a baby, is breastfeeding a baby, or have small children under age 5;
- **have** a moderately low family income, even if you work; and
- **have** a documented nutrition-related medical need:
- **and live** in the State of Georgia.

The following information is being asked for statistical purposes and the answers will have no effect on the receipt of WIC services

Are you a Migrant Farmworker*? _____Yes _____ No
***A Migrant Farmworker is an individual whose principal employment is in agriculture on a seasonal basis, who has been employed within the last twenty-four (24) months and who establish for the purpose of such, a temporary abode.**

Are you Hispanic/Latino? _____Yes _____ No
(**Yes** = A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race.)

What is your RACE ? ***You may choose more than one race or all that apply.***

1._____ **White** – A person having origins in any of the original people of Europe, the Middle East of North Africa.

2._____ **Black or African American** – A person having origins in any of the Black racial groups of Africa.

3._____ **Asian** – A person having origins in any of the original people of the Far East, Southeast Asia, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

4._____ **American Indian/Alaska Native** – A person having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

5._____ **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

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Programa WIC de Georgia

Guión para entrevistas

WIC de Georgia es un programa de nutrición para mujeres, bebés y niños que tienen necesidades nutricionales y son elegibles por sus ingresos. Los afiliados elegibles del programa recibirán:

- Evaluación nutricional
- Educación nutricional
- Alimentos saludables (leche, huevos, queso, jugos, cereales, mantequilla de maní, frijoles o guisantes, zanahorias, atún y fórmula infantil para lactantes)
- Apoyo a las madres lactantes
- Remisión a otros servicios médicos y sociales

Usted puede calificar para WIC si:

- **está** embarazada, acaba de tener un bebé, está amamantando a un bebé o tiene niños pequeños menores de 5 años;
- **tiene** un ingreso familiar moderadamente bajo, incluso si usted trabaja, y
- **tiene** una necesidad médica documentada relacionada con la nutrición:
- **y vive** en el estado de Georgia.

La siguiente información se solicita con fines estadísticos y las respuestas no tendrán ningún efecto en el recibo de los servicios de WIC

¿Es usted un trabajador agrícola migrante*? _____Sí _____ No

*** Un trabajador agrícola migrante es un individuo cuyo empleo principal es en la agricultura sobre una base estacional, que ha estado empleado en los últimos veinticuatro (24) meses y que establecen una morada temporal con tal propósito.**

¿Es usted hispano / latino? _____Sí _____ No

(**Sí** = Una persona de origen cubano, mexicano, puertorriqueño, de América del Sur o Central, o de otra cultura u origen español, independientemente de su raza.)

¿Cuál es su RAZA? *Usted puede elegir más de una raza o todo lo que corresponda.*

1._____ **Blanco**: Una persona con orígenes en cualquiera de los pueblos originarios de Europa, el Oriente Medio o el norte de África.

2._____ **Negro o afroamericano**: Una persona con orígenes en cualquiera de los grupos raciales negros de África.

3._____ **Asiático**: Una persona con orígenes en cualquiera de los pueblos originarios del Lejano Oriente, el sudeste asiático, Malasia, Pakistán, Filipinas, Tailandia y Vietnam.

4._____ **Indio americano / Nativo de Alaska**: Una persona con orígenes en cualquiera de los pueblos originarios de América del Norte y América del Sur (incluida América Central), y que mantiene afiliación tribal o lazo comunitario.

5._____ **Nativo de Hawai u otra isla del Pacífico**: Una persona con orígenes en cualquiera de los pueblos originarios de Hawai, Guam, Samoa u otras islas del Pacífico.

Revised 3/12