

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 or 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.

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

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

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or

write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised Date: 11/2015

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/ZIP CODE:	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	

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THERE IS NO CHARGE FOR WIC SERVICES



GEORGIA WIC PROGRAM

PROMOTING HEALTHY NUTRITION FOR WOMEN, INFANTS AND CHILDREN SINCE 1974 1-800-228-9173

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Georgia Department of Public Health

Georgia WIC Program

Rights and Obligations

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 will assist you as well as notify the proper authorities if necessary. ANY COMPLAINT You may call Georgia WIC about any complaints at the toll free phone number below: 1-800-228-9173 and/or write about your complaint to the address below: Georgia WIC Program Office of Integrity & Strategy 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 Georgia WIC by calling the toll free number 1-800-228-9173, and/or write about your complaint to the address below: Georgia WIC Program, Office of Program Integrity & Strategy 2 Peachtree Street, 10th Floor 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 In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they	<u>Your Responsibilities:</u> ▪ To keep your appointments and be on time. If you cannot keep your appointment, call your local WIC office to reschedule as soon as possible. ▪ To bring all documentation requested to each appointment. ▪ To treat WIC and store staff with courtesy and respect. ▪ To participate in only one WIC clinic at a time. If I move, I can ask for a transfer card. ▪ Choose WIC or CSFP (Commodity Supplemental Food Program) to participate in. A person cannot be on both programs at the same time. ▪ Follow the rules when using WIC benefits. WIC staff will tell me how to use the WIC Vouchers when I am put on the program. ▪ To buy only the foods listed on my WIC Vouchers. I will use the foods only for the person on the program. ▪ I understand that if my WIC vouchers are lost or stolen, they may not be replaced. ▪ To report any changes in my income, family size, or eligibility for Medicaid, Food Stamps, or TANF. <u>You may be taken off the WIC Program if:</u> ▪ You do not tell the truth about all the information you give to WIC. ▪ You get benefits from more than one clinic at a time. ▪ You/child participate in CSFP and WIC at the same time. ▪ You do not follow the rules when using your WIC Vouchers. ▪ You use abusive language or are physically violent with clinic staff, store personnel, or other WIC clients. ▪ If you attempt to sell WIC foods, breast pumps, benefits and/or WIC vouchers by making a verbal offer of sale to another person or posting the items for sale in print or online, or allow someone else to do it for you. ▪ You miss appointments for two consecutive months. ▪ 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 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
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applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the <u>USDA Program Discrimination Complaint Form</u>, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider. This institution is an equal opportunity provider. Revised, November, 2105	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 proxy engages in any of the listed items above
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Brenda Fitzgerald, MD, Commissioner

Nathan Deal, Governor

2 Peachtree St NW, 15th Floor
Atlanta, Georgia 30303-3142
www.health.state.ga.us

Dear WIC Alternate:

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

1. An alternate is a person who acts on behalf of the participant. Authorized alternates may pick-up and/or redeem vouchers and may bring a child in for subsequent certifications.
2. An alternate 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. An alternate is a responsible person who the participant/parent/guardian/spouse/caregiver depends on
4. When an alternate picks up vouchers or brings a child in for subsequent certification, the alternate must attend any required nutrition education classes and be able to provide health information for the participant(s).
5. An alternate must be at least sixteen (16) years old unless prior approval is obtained from the WIC staff.
6. An alternate must not pick up vouchers for more than two (2) families in the state of Georgia.
7. When redeeming vouchers at the grocery store, the alternate must have the WIC ID card and additional ID for themselves.

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

Please contact the WIC participant if you can no longer serve as an alternate. The WIC participant must notify the WIC clinic of this change. If you have any questions pertaining to your new role, please ask the participant you are representing as an alternate.

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

Sincerely,

Georgia WIC Program Staff

The alternate must provide the following documentation and have knowledge of the below information when present for recertification appointments:

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

Note: Alternates must also have additional ID when using vouchers at the grocery store.

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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.

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**GEORGIA 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

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**Georgia WIC Program
Participant Repayment Schedule
SAMPLE LETTER**

Date _____

CERTIFIED MAIL RETURN
RECEIPT REQUESTED

Participant Name
Participant Street Address
City, State Zip Code

RE: NOTICE OF ASSESSMENT OF A PARTICIPANT CLAIM

Dear Participant:

Per Federal Regulation 7 CFR 246.23(c)(1)(i), a claim must be established against a participant when it has been determined that a participant has received benefits as a result of a participant violation.

On (date) , you received a Notice of Assessment of Claim, assessing a claim in the amount of \$ for programmatic violations committed by you. On (date) , you requested that a repayment schedule be established. This letter confirms your proposal to repay the total amount of the assessed claim, \$, to the Georgia WIC Program in monthly installments of \$. The following is the payment schedule that we will require you to follow until the full amount is recovered:

<u>DATE</u>	<u>AMOUNT</u>	<u>DATE</u>	<u>AMOUNT</u>
-------------	---------------	-------------	---------------

Total

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

[INSERT ADDRESS]

If you fail to make the payments on time, the full amount will be due immediately. If you fail to repay the full amount of the claim within the time frame provided above, you may be disqualified from the Georgia WIC Program for up to one year. See 7 CFR §246.23(c)(1)(i).

If you have any questions concerning this matter, please call (insert name and title), at (enter phone number), or (enter alternate contact person and contact information), between the hours of (enter days and time of availability).

Sincerely,

District Nutrition Services Director
District _____ Unit _____

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**GEORGIA WIC PROGRAM
NOTICE OF TERMINATION / INELIGIBILITY / WAITING LIST**



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 Georgia WIC 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). _____ Fund are not available to serve postpartum non-breastfeeding women. Other _____	
SUSPENSION SECTION: ☐ You are being suspended from the Georgia WIC Program for three (3) months because you broke the following 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 Georgia WIC 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 REPRESENTATIVE SIGNATURE/TITLE

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Georgia WIC Referral Form

Referrals for Breastfeeding Support and WIC Services

Patient's First & Last Name: _____ Date of Birth (MM/DD/YY): _____

(For Infants/Children) Parent/Caregiver's First & Last Name: _____

Clinic/Hospital/Medical Office

Name: _____

Street Address: _____

City: _____

Zip Code: _____

Phone Number: _____

To locate your County Health Department, please visit www.WIC.GA.GOV (select "Clinic Listing") OR call 1-800-228-9173

Infants/Children Referral Data: (Complete Applicable Information)

Length/Ht: _____ in. Wt: _____ lbs. _____ oz. Date: _____
Date: _____

(Valid within 60 days of measurement)

Hgb/Hct: _____

(Valid within 90 days of measurement)

Birth weight: _____ lbs. _____ oz. Birth Length: _____ in. If premature, weeks gestation at birth: _____

Breastfeeding?: ☐ Yes ☐ No

Referral data provided by: (signature) _____ Date: _____

Women Referral Data: (Complete Applicable Information)

Length/Ht: _____ in. Wt: _____ lbs. _____ oz. Date: _____
Date: _____

(Valid within 60 days of measurement)

Hgb/Hct: _____

(Valid within 90 days of measurement)

EDC: _____
☐ Yes ☐ No

Last Wt Prior to Pregnancy: _____ lbs.

Multiple Gestation?: ☐

Delivery Date: _____
Yes ☐ No

Last Wt Prior to Delivery: _____ lbs.

Breastfeeding?: ☐

If Currently Breastfeeding: ☐ Exclusively ☐ Partially ☐ Unknown
needed: ☐ Yes ☐ No

Breastfeeding follow-up

☐ Mother/baby separation ☐ Latch-on issues ☐ Milk supply concerns
☐ Other _____

Additional Comments/Details

Referral data provided by: (signature) _____

Date: _____

Instructions & Resources for Use of This Form:

This form is intended for use as...

- A medical data referral form for infants, children and women for the Georgia WIC Program
- A breastfeeding support referral form for the Georgia WIC Program
- A proof of identification for hospitalized newborn infants

To prescribe a special formula or medical food for an infant, child, or woman please refer to Georgia WIC Form #1 (*Medical Documentation Form for WIC Special Formulas and WIC Foods*). This form can be found at www.WIC.GA.GOV (select "Health Care Provider Information").

We appreciate your cooperation and partnership in serving the Georgia WIC population.

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- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

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Revised, November, 2015

**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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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
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 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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**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: _____

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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's 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
VMARS Dual Participation Sample Warning Letter**

(Date)

Dear Participant:

The Federal Regulations that govern the administration of the Georgia WIC Program consider dual participation a participant violation that will result the assessment of claims and/or a sanction against a participant. See 7 CFR §§ 246.2, 246.7(l)(3), and 246.12(u). However, in instances where the dual participation is the result of an intentional misrepresentation by a participant, that individual will be assessed a claim for improperly issued WIC benefits and may be disqualified from the Georgia WIC Program for a period of one (1) year. See 7 CFR §§ 246.7(l)(4).

Our records indicate that you intentionally made misrepresentations and/or falsified your information in an attempt to participate in two Georgia WIC Programs at the same time. Specifically, our records show that you were certified and enrolled in the Georgia WIC Program at (clinic) _____ on (date) _____, and you were also certified at (clinic) _____ on (date) _____.

As indicated in the Federal Regulations and on your Georgia WIC Program ID card, participating in more than one Georgia WIC Program constitutes a violation of the Georgia WIC Program regulations and policies. Information concerning our findings has been forwarded to the Office of Inspector General at the Department of Public Health for further investigation. Upon conclusion of the investigation, we will notify you of any action we decide to take to address this violation, including assessment of a claim to repay the amount of the WIC benefits you improperly received, termination from all but one of the WIC Programs you are enrolled in, suspension, and/or disqualification from the Georgia WIC Program for up to one year.

If you have any questions concerning this matter, please call (insert name and title), at (enter phone number), or (enter alternate contact person and contact information), between the hours of (enter days and time of availability).

Sincerely,

District Nutrition Services Director

District _____ Unit _____

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**Georgia WIC Program
Participant Repayment Schedule
SAMPLE LETTER**

Date _____

Participant Name
Participant Street Address
City, State, Zip Code

RE: NOTICE OF ASSESSMENT OF A PARTICIPANT CLAIM FOR VIOLATIONS

Dear Participant:

Georgia's Special Supplemental Nutrition Program for Women, Infants & Children (Georgia WIC) has determined that, as a responsible party, you have committed one or more of the following violations against the Program:

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

Federal Regulation 7 CFR 246.23(c)(1)(i), provides that a claim will be assessed when it is determined that a participant violation has resulted in the improper issuance of benefits. Based upon the information above and pursuant to the federal regulations, the Georgia WIC Program is assessing a claim against you in the amount of \$_____, which reflects the full amount of the WIC benefit that you were improperly issued based upon the violation committed. The claim amount is based on the value of the WIC benefit improperly issued 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 period cannot exceed 90 days from receipt of the letter. If restitution is not made within 30 days or in accordance with the agreed upon repayment schedule, the participant may be disqualified from the Georgia WIC Program, or. See 7 CFR §246.23(c)(1)(i).

Your repayment must be in the form of a cashier's check or money order, made payable to _____, and be submitted to:

[INSERT ADDRESS]

If you have any questions concerning this matter, please call (insert name and title), at (enter phone number), or (enter alternate contact person and contact information), between the hours of (enter days and time of availability).

Sincerely,

District Nutrition Services Director
District _____ Unit _____

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**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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GEORGIA WIC PROGRAM
How to File a Complaint (Flyer)



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

ANY COMPLAINT

You may call 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 number 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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Caregiver's Statement of Change Form

Georgia State WIC Caregivers Statement of Change Form

When a parent, guardian, caregiver of a WIC participant **changes during** a certification period, the clinic may issue up to three (3) months of Food Benefits to the infant / child if **ALL** of the five (5) following conditions are met:

1. The changed caregiver must bring the infant / child participant to the WIC appointment. If they do not bring the infant / child to the clinic, they are to be rescheduled.
2. The caregiver must show proof of the infant / child's ID or the WIC ID Folder. If ID is not available, the staff must issue one month of food Benefits and have the caregiver return the following month with the appropriate documents.
3. The new caregiver must SIGN the statement below in the WIC office declaring that they are caring for the infant / child and an explanation of the circumstances that led them to becoming the caregiver.
4. The WIC staff will assist in making the written statement if the new caregiver is unable to write, and he or she must sign the statement or make their identifying mark.
5. The income of the new caregiver must meet the WIC eligibility criteria.

Statement of Change in Caregiver for Infants/Children

I, _____ (name), hereby declare that I am currently the caregiver of _____ (infant/child), date of birth _____. The previous caregiver, _____ (name) is no longer the caregiver of this child as of _____ (date).

Reason for change (optional) _____ If this situation changes, I will immediately notify the WIC clinic.

Rights and Obligation Statement:

I have been informed of my rights and obligations to the WIC Program. The information I have provided is correct and the WIC staff may verify any of the information. I understand that if I have intentionally lied or if I violate the program rules that (1) I or my child can be taken off WIC for up to one year, (2) I can face legal charges, and/or (3) I will have to pay money back to the program for the foods or formula I should not have received.

Signature: _____ Date: _____

WIC Staff Member Signature: _____

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

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

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

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised November, 2015

**GEORGIA WIC PROGRAM
INCOME CALCULATION FORM**

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

WIC ID NUMBER: _____

First

Last

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.

<u>Use This Section to Calculate Income</u>			
First Certification Date _____			
Relationship and Name Each Family Member's Income? (circle one)	Income Source		What Is
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)

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

_____	_____	\$ _____
-------	-------	----------

Weekly/Bi-Weekly/Monthly/Yearly

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

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

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

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

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

_____	_____	\$ _____
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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.

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

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