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.

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

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

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

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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Revised December, 2015

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
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
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**

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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

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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Revised December, 2015

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

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Your Responsibilities:

- 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.

You may be taken off the WIC Program if:

- 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

applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider. This institution is an equal opportunity provider. Revised, December, 2015	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

I understand all the information I have given will be protected. Information about my participation in WIC may be shared with other state of Georgia Department of Public Health programs. This information will only be used to help me get other health services and to learn how well these services meet my needs. My child's shot records may be shared with the statewide immunization registry. If I move to a different WIC service area, the eligibility information I have given will be shared with the WIC clinic in my new area so I can keep getting WIC benefits. WIC may release information about me or my child to me (the participant/caretaker).

I understand my rights and responsibilities to the WIC Program. The information I have provided is correct and the WIC family 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.

_____ _____

Participant/Caretaker Signature *Date*

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
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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Revised December, 2015

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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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:

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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 RESPRENTATIVE SIGNATURE/TITLE

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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
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

_____

City Zip Code

*ADDRESS*_____

_____

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?
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly (circle one)
_____	_____	$_____ 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?
_____	_____	$_____ Weekly/Bi-Weekly/Monthly/Yearly (circle one)
_____	_____	$_____ 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
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
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
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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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: _____

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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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