

**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
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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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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**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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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 REPRESENTATIVE SIGNATURE/TITLE	

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**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:

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

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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 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

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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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**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
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

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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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REVISED 04/14

GEORGIA WIC PROGRAM
INCOME CALCULATION FORM
(This form must be completed if applicant does not qualify for Adjunctive eligibility)

WIC ID NUMBER: _____

Last	First	Middle Initial	Date of Birth
NAME _____			
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	Income Source	Date	_____
Relationship and Name			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
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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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

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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
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 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 at the same time.**
 - 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 proxy 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.

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**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

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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 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.

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PROGRAMA WIC de GEORGIA

Cómo presentar una queja



Si usted cree que le han tratado injustamente, sírvase hacérselo 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
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
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**

El Departamento de Agricultura de los Estados Unidos (por sus siglas en inglés "USDA") prohíbe la discriminación contra sus clientes, empleados y solicitantes de empleo por raza, color, origen nacional, edad, discapacidad, sexo, identidad de género, religión, represalias y, según corresponda, convicciones políticas, estado civil, estado familiar o paternal, orientación sexual, o si los ingresos de una persona provienen en su totalidad o en parte de un programa de asistencia pública, o información genética protegida de empleo o de cualquier programa o actividad realizada o financiada por el Departamento. (No todos los criterios prohibidos se aplicarán a todos los programas y/o actividades laborales).

Si desea presentar una queja por discriminación del programa de Derechos Civiles, complete el USDA Program Discrimination Complaint Form (formulario de quejas por discriminación del programa del USDA), que puede encontrar en internet en http://www.ascr.usda.gov/complaint_filing_cust.html, o en cualquier oficina del USDA, o llame al (866) 632-9992 para solicitar el formulario. También puede escribir una carta con toda la información solicitada en el formulario. Envíenos su formulario de queja completo o carta por correo postal a U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, por fax al (202) 690-7442 o por correo electrónico a program.intake@usda.gov.

Las personas sordas, con dificultades auditivas, o con discapacidad del habla pueden contactar al USDA por medio del Federal Relay Service (Servicio federal de transmisión) al (800) 877-8339 o (800) 845-6136 (en español).

El USDA es un proveedor y empleador que ofrece igualdad de oportunidades.

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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”. Sírvese 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
Medicaid (la dirección tiene que ser visible cuando se pasa la tarjeta o mediante acceso a Internet)
Expediente médico

Factura del gas
Factura del agua

Factura del teléfono
Recibo de renta o hipoteca

(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
Añualidades
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

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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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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 al mismo tiempo.**
 - 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 apoderado(a) 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.

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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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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.

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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.

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DECLARACIÓN DE CERTIFICACIÓN DE WIC

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 proporcionaré, o que he proporcionado, es correcta según mi leal saber y entender. 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 podrían 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 oficial principal de salud estatal de Georgia podría permitir que alguna información sobre mi participación en WIC de Georgia sea divulgada con propósitos no relacionados a WIC para determinar elegibilidad con otros servicios del programa. Entiendo que esta información podría ser usada por WIC de Georgia, compartida con las agencias locales de WIC, o compartida con otras organizaciones públicas que sirven a personas elegibles a WIC. Además, entiendo que los que reciben esta información solo la usarán para establecer elegibilidad a programas administrados por otras organizaciones públicas; para realizar programas de alcance administrados por otras organizaciones públicas; para mejorar la salud, la educación o bienestar de los solicitantes y participantes de WIC de Georgia; para reestructurar los procedimientos administrativos para minimizar la carga en los participantes y empleados(as) del programa; y para evaluar el sistema de salud del estado en cuanto al grado de reacción y sensibilidad a las necesidades de cuidado de salud de los participantes y los resultados. Las organizaciones públicas que reciban mi información, no podrán divulgar la información a otras organizaciones o personas sin mi permiso.

También entiendo que si no quiero que mi información sea compartida, esa decisión no afectará mi participación en Georgia WIC.

Nombre del Solicitante/Participante de WIC
Tutor/Cuidador/Cónyuge/Padre(Madre) Alterno
(escriba en letra de molde)

Fecha

Nombre del Oficial de WIC (escriba en letra de molde)

UP:

Firma del Solicitante/Participante de WIC
Tutor/Cuidado/cónyuge/Padre(Madre) Alterno

Fecha

Firma del Oficial de WIC

Favor de colocar sus iniciales abajo indicando su preferencia:

___ Al solicitar los servicios de WIC, **AUTORIZO** la divulgación de mi información para los propósitos arriba mencionados. Entiendo que si no quiero que mi información sea compartida, esa decisión no afectará mi participación en el Programa WIC de Georgia.

___ Al solicitar los servicios de WIC, **YO NO AUTORIZO** la divulgación de mi información para los propósitos arriba mencionados. Entiendo que si no quiero que mi información sea compartida, esa decisión no afectará mi participación en el Programa WIC de Georgia.