APPENDIX
A
Forms

Letter A Ineligibility or Termination

Letter B Sanctions

Letter C No Proof

Letter D Legal Guardian, Foster Parent, Caretaker

Letter E Lost-Stolen Check

Closet Formula Log

Confidentiality

Manual Certification: Infant-Child

Manual Certification: Postpartum-Non-Breastfeeding and Breastfeeding

Manual Certification Prenatal

WIC Signature Page for Certification

INDIANA WIC PROGRAM
INELIGIBILTY OR TERMINATION FORM

_____ _____
(Applicant's Name) (Date)

_____ **You are not eligible for the WIC program at this time for the following reasons:** (If your circumstances change, you may reapply at any time.)**:**

_____Income is too high

_____No nutritional risk was found during this appointment

_____Did not bring proof of income ____ identification ____ residence _____

_____Did not bring the applicant and/or the required written documentation as to why the applicant was not present

_____Minor did not bring parent/guardian/caretaker or adult designee with documentation of consent or proof of legal emancipation

_____Do not live in Indiana (Please contact your State's WIC Program)

_____Indiana is not currently serving applicants in Priority Group _____.

_____ **You are being terminated from the WIC program because:**

_____Member in your household was determined to be over income

_____Certified in error

_____WIC category changed and you no longer have a nutritional risk factor

_____Did not return with proof of custody (foster care) for the minor child

Your termination is effective 15 days from _____. Any checks that have a first-day-to-use date after _____ must not be used, and must be returned to this WIC clinic.

You can appeal any decision affecting your participation in WIC. You must request a hearing by contacting the WIC Coordinator within 60 days of the decision. You will be informed in writing at least ten days prior to the hearing of the time, place, and date your case will be heard. Any positions or arguments may be presented by you or by a representative such as a relative, friend, or legal counsel.

_____ _____
WIC Representative Signature WIC Clinic Phone Number

In accordance with Federal law and USDA policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer. To file a complaint of religious discrimination, send it directly to the Indiana Civil Rights Commission, Indiana Government Center-N103, 100 North Senate Avenue, Indianapolis, IN 46204.

FORMULARIO DE ILEGIBILIDAD O BAJA DEL PROGRAMA WIC DE INDIANA

_____ Fecha_____

(Nombre del solicitante)

_____ **Usted no reúne las condiciones del programa WIC en este momento por las siguientes razones**: (Si sus circunstancias cambian, puede efectuar la solicitud nuevamente en cualquier momento)

_____ Sus ingresos son demasiado elevados

_____ No se encontró ningún riesgo nutricional en esta evaluación

_____ No trajo prueba de sus ingresos ____ identificación ____ residencia _____

_____ No trajo al solicitante ni la documentación escrita de apoyo que justifique la ausencia del solicitante

_____ El menor no trajo al progenitor/representante/cuidador primario o adulto designado con la documentación de consentimiento o prueba de emancipación legal

_____ No vive en Indiana (Por favor contacte el Programa WIC de su estado)

_____ Indiana no está actualmente sirviendo solicitantes de Grupo Prioritario. _____.

_____ **Se le está dando de baja del programa WIC porque**:

_____ Se ha determinado que algún miembro de su domicilio está por encima del ingreso

_____ Fue autorizado por error

_____ La categoría WIC cambió y usted no tiene ya un factor de riesgo nutricional

_____ No regresó con prueba de la custodia (cuidado tutelar) para el menor

Su baja será efectiva en 15 días a partir de _____. Cualesquiera cheques que tengan una fecha "primer día para utilizar" después de _____ no deberán utilizarse y deberán ser devueltos a este centro. Cualquier decisión que afecte su participación en WIC, y que usted considere injusta, puede ser revisada. Deberá solicitar una audiencia con el Coordinador de WIC dentro del lapso de 60 días de la decisión. Será informado por escrito al menos diez días antes de la audiencia de la hora, lugar y fecha donde se ventilará su caso..

_____ _____

Firma del representante de WIC Número de teléfono del Centro WIC

De acuerdo con la ley Federal y la política USDA, esta institución tiene prohibida la discriminación con base a la raza, color, nacionalidad de origen, sexo, edad o discapacidad. Para presentar una queja por discriminación, escriba al Director de USDA, Oficina de Derechos Civiles, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 o llame al (800) 795-3272 o (202) 720-6382 (TTY) USDA es un organismo proveedor y empleador de igualdad de oportunidades. Para presentar una queja por discriminación religiosa, envíela directamente a la Comisión de Derechos Civiles de Indiana, Indiana Government Center-N103, 100 North Senate Avenue, Indianapolis, IN 46204.

FORM LETTER B
Sample Letter--Sanctions Due to Program Abuse

_____
(Date)

Dear _____
(Name)

As a WIC participant you have certain responsibilities as well as rights. It has come to our attention that you have abused those responsibilities in the following way(s):

Check Abuse

_____	1.	Cashed early	_____	5.	Cashed checks at non-WIC store
_____	2.	Cashed late	_____	6.	Altered checks
_____	3.	No signature	_____	7.	Buying Alcoholic or tobacco products
_____	4.	Purchased non-WIC foods with WIC checks or wrong WIC foods	_____	8.	Other _____

Personnel Abuse

_____	8.	Verbal	_____	9.	Physical

Policy Abuse

_____	10.	Provided false information	_____	14.	Sold checks
_____	11.	Participated in more than one WIC Program at the same time	_____	15.	Attempted to sell checks
			_____	16.	Returned WIC foods for cash
_____	12.	Exchanged/sold WIC foods	_____	17.	Attempted to return WIC foods for cash
_____	13.	Attempted to exchange/sell WIC foods		18.	Other _____

According to Indiana State WIC policies, this action on your part results in a:

___ WARNING. Another incident could result in further action or suspension from the WIC Program.

___ SUSPENSION for _____.
(Names)

This suspension is effective on _____.
(Date)

You may return to your WIC clinic on:

_____ for monthly/bimonthly/trimonthly check pickup.
(Date)

or _____ for recertification screening.
(Date)

Any decision affecting your participation in WIC which you think is unfair can be reviewed. You should request a hearing from the WIC Coordinator within 60 days. You will be informed in writing within 10 days upon receipt of request of the time, place, and date your case will be heard.

Sincerely,

_____

In accordance with Federal law and USDA policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202)720-6382 (TTY). USDA is an equal opportunity provider and employer. To file a complaint of religious discrimination, send it directly to the Indiana Civil Rights Commission, Indiana Government Center-N103, 100 N. Senate Avenue, Indianapolis, IN 46204.

INDIANA WIC PROGRAM
NO PROOF FORM

This form is required for applicants unable to produce proof of income, residence (address) or identification because of **homelessness, theft, disaster or being a migrant worker**.

_____
(Name)

Applicant is unable to produce proof of:

_____ Income

_____ Residence (Address)

_____ Identification

I am certifying that this information is true and correct. I understand that intentional misrepresentation may result in paying the state agency, in the form of a cashiers check or money order, the value of the food benefits improperly received.

_____ _____
Applicant/Parent/Guardian/Caretaker Signature Date

_____
WIC Representative Signature

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FORMULARIO PARA CUANDO NO SE PRESENTAN PRUEBAS DEL PROGRAMA WIC DE INDIANA

Este formulario es para solicitantes que no pueden aportar prueba de ingresos, residencia (dirección) o identificación por causa de: ser **personas sin hogar, robo, desastre o por ser trabajador migratorio.**

_____
(Nombre)

El solicitante no puede presentar prueba de:

_____ Ingresos

_____ Residencia (Dirección)

_____ Identificación

Certifico que esta información es verdadera y correcta. Entiendo que la declaración falsa puede resultar en que deba pagar a la oficina estatal, en forma de cheque de gerencia o giro postal, el valor de los beneficios de alimentos recibidos indebidamente.

_____ _____
Firma del solicitante/Progenitor/Representante/Cuidador primario Fecha

_____
Firma del representante de WIC

De acuerdo con la ley Federal y la política USDA, esta institución tiene prohibida la discriminación con base a la raza, color, nacionalidad de origen, sexo, edad o inhabilidad. Para presentar una queja por discriminación, escriba al Director de USDA, Oficina de Derechos Civiles, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 o llame al (800)795-3272 (voz y dispositivo para sordos) o (202)720-6382 (TTY). USDA es un organismo proveedor y empleador de igualdad de oportunidades. Para presentar una queja por discriminación religiosa, envíela directamente a la Comisión de Derechos Civiles de Indiana. Para presentar una queja por discriminación religiosa, envíela directamente a la Comisión de Derechos Civiles de Indiana.

Form Letter C
05/18/07

INDIANA WIC PROGRAM
LEGAL GUARDIAN, FOSTER PARENT, CARETAKER, EMANCIPATED MINOR FORM

Date:_____

1) _____ (applicant)

2) _____ (applicant)

3) _____ (applicant)

4) _____ (applicant)

5) _____ (applicant)

6) _____ (applicant)

☐ **Legal Guardian**

I, _____ (signature of guardian), confirm that I have provided proof of legal guardianship for said child/children.

☐ **Foster Parent**

I, _____ (signature of foster parent), have said child/children in my care through the foster parent program.

I understand that if the minor child is found to be eligible for WIC Program benefits today, only one set of checks will be issued. I also understand that future checks will not be issued and the minor child will be terminated from the WIC Program if proof of custody is not presented by the next scheduled check pick-up.

☐ **Caretaker**

I, _____ (signature of caretaker), have said child/children in my care and am providing them with financial support and daily care.

☐ **Emancipated Minor**

I, _____ (signature of emancipated minor) am under the age of 18 and have provided documented proof of my emancipation.

☐ **Minor Able to Sign for Healthcare**

I, _____ (signature of minor able to sign for own healthcare), am a minor applicant who is able to sign for her own healthcare for the Indiana WIC Program because I am at least 14 years of age; <u>not dependent</u> on a parent for support (i.e., shelter, food, etc.); living apart from my parents or from a guardian/caretaker (loco parentis); and am managing my own affairs.

I, _____ (signature of minor able to sign for own healthcare), am a minor applicant who is able to sign for her own healthcare for the Indiana WIC Program because I am a minor who is or has been <u>married</u>.

I, _____ (signature of minor able to sign for own healthcare), am a minor applicant who is able to sign for her own healthcare for the Indiana WIC Program because am a minor who is in the <u>military</u> of the United States.

FORMULARIO PARA EL MENOR EMANCIPADO, REPRESENTANTE LEGAL, PADRE/MADRE ADOPTIVO, CUIDADOR PRIMARIO
PROGRAMA WIC DE INDIANA

Fecha:_____

1) _____ (solicitante)

2) _____ (solicitante)

3) _____ (solicitante)

4) _____ (solicitante)

5) _____ (solicitante)

6) _____ (solicitante)

☐ **Representante legal**

Yo, _____, confirmo que he suministrado prueba de la representación legal de dichos menores.
(firma del representante legal)

☐ **Padre/Madre adoptivo**

Yo, _____, tengo dicho(s) menor(es) bajo mi cuidado a través del programa de padres adoptivos.
(firma del padre/madre adoptivo)

Entiendo que si el menor reúne los requisitos para recibir los beneficios del Programa WIC hoy, únicamente se emitirá un conjunto de cheques. También entiendo que los cheques futuros no serán emitidos y que el menor será dado de baja del Programa WIC si no se presenta prueba de custodia para la próxima fecha establecida para recoger el cheque.

☐ **Cuidador primario**

Yo, _____, tengo dicho(s) menor(es) bajo mi cuidado y les estoy dispensando el apoyo
(firma del cuidador primario)
financiero y el cuidado diario.

☐ **Menor emancipado**

Yo, _____ tengo menos de 18 años de edad y he suministrado
(firma del[la] menor emancipado[a])
prueba documentada de mi emancipación.

☐ **Menor calificado para firmar por cuidados de salud**

Yo, _____, soy un(a) solicitante de menor edad calificado(a) para suscribir mi propia
(firma del[la] menor calificado[a] para firmar por su propia atención médica)
atención médica en el Programa WIC de Indiana porque tengo al menos 14 años de edad; no dependo de un progenitor para manutención (es decir, para alojamiento, alimentos, etc.); vivo aparte de mis padres o de un representante/cuidador primario (loco parentis); y me encargo de mis propios asuntos.

Yo, _____, soy un solicitante de menor edad calificado(a) para suscribir mi propia
(firma del[la] menor calificado[a] para firmar por su propia atención médica)
atención médica en el Programa WIC de Indiana porque soy un(a) menor que estoy o he estado casado[a].

Yo, _____, soy un solicitante de menor edad calificado(a) para suscribir mi propia
(firma del[la] menor calificado[a] para firmar por su propia atención médica)
atención médica en el Programa WIC de Indiana porque soy un(a) menor que estoy en el ejército de Estados Unidos.

INDIANA WIC PROGRAM
LOST, STOLEN, OR DESTROYED CHECK REPLACEMENT FORM

Name(s) of participant(s) issued checks that were reported lost or stolen: Household ID Number:
Provide details of how WIC checks were lost or stolen. Include relevant information such as police report, date, location, etc. if available.

Participant WIC checks for _____ to _____ (enter date to use and last date to use) have been replaced. Listed below is the first date to use and the check numbers for all original and replacement checks.

FIRST-DATE-TO-USE	ORIGINAL CHECK NUMBER	FIRST-DATE-TO-USE	REPLACEMENT CHECK NUMBER

I certify that the WIC checks reported above were lost and/or stolen from me. If the checks are found, I will return them to the WIC office. If these checks are used by me or my proxy, I understand that I will have to reimburse the INDIANA WIC PROGRAM for food that I should not have received and I will be terminated from the WIC program.

WIC Participant/Parent/Proxy (please print)

SIGNATURE – WIC Participant/Parent/Proxy	Date Signed
SIGNATURE – WIC Coordinator	Date Signed

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

PROGRAMA DE INDIANA WIC
FORMA PERDIDA, ROBADA, O DESTRUIDA DEL REEMPLAZO DEL CHEQUE

Los nombres de participantes publicantes los cheques que fueron divulgados perdido o robados: Número de la identificación de la casa:
Proporcionar los detalles de cómo los cheques de WIC fueron perdidos o robados. Incluir la información relevante tal como policía divulgan, fechan, localización, etc. si está disponible.

Cheques del participante WIC _____ a _____
(incorporar la fecha para utilizar y la fecha pasada para utilizar) se han substituido.
Se enumera abajo la primera fecha a utilizar y el cheque numera para todos los cheques de la original y del reemplazo.

PRIMERA-FECHA-A-UTILIZAR	NÚMERO ORIGINAL DEL CHEQUE	PRIMERA-FECHA-A-UTILIZAR	NÚMERO DEL CHEQUE DEL REEMPLAZO

Certificar que los cheques de WIC divulgados arriba fueron perdidos y/o robados de mí. Si se encuentran los cheques, los volveré a la oficina de WIC. Si estos cheques son utilizados por me o mi poder, entiendo que tendré que reembolsar (parte posteriora del dinero de la paga) al PROGRAMA de INDIANA WIC para el alimento que no debo haber recibido.

FIRMA – WIC Participante/Padre/Poder	Fecha Firmada
Firma – Coordinador de WIC	Fecha Firmada

De acuerdo con ley federal y el Ministerio de Agricultura de los E.E.U.U. la política, prohíben a esta institución de discriminar en base de la raza, del color, del origen nacional, del sexo, de la edad, o de la inhabilidad. Para archivar una queja de la discriminación, escribir USDA, director, oficina de las derechas civiles, 1400 avenida de la independencia, interruptor, Washington, dc 20250-9410 o llamar (800) 795-3272 o (202) 720-6382 (equipo teleescritor). El USDA es abastecedor y patrón de la oportunidad igual.

Form Letter E
08/24/07

State of Indiana Closet Formula Log

DATE	NAME OF PERSON RECEIVING FORMULA	REASON FORMULA WAS ISSUED	AMOUNT OF FORMULA ISSUED	STAFF INITIALS

CONFIDENTIALITY STATEMENT

Handling of Public Health Client Information

Indiana State Health Programs

Ethical and legal considerations require that the names of public health clients and all data collected from them be treated as confidential at all times. This may include medical, financial, and personal information. An assurance of confidentiality is given to all clients. You must uphold this assurance by not discussing client information with anyone other than authorized program employees. You must also safeguard all materials in your possession. Do not permit the review of information by anyone other than authorized program employees by access to files or by observation due to careless record management.

AGREEMENT

I have carefully read and understand the assurance given which pertains to the confidential nature of all records to be handled for Indiana Public Health Programs. I also understand that I am prohibited by law from disclosing any such confidential information under the terms of this contract to any individuals other than authorized program employees and agencies with which the participant has given written permission to share information.

_____ _____

NAME DATE

_____ _____

WITNESS DATE

Participant Manual Certification for
Infant or Child

Date of Certification _____ Name _____
Address _____ Telephone _____
Date of Birth _____ Homeless? _____ Foster Child? _____
Residency Proof _____ ID Proof _____
Mother's Birth Name _____
Household Smoking? _____ Hours TV Watched _____
Disability _____ Insurance _____ Type Medical Home _____
Mother's Marital Status _____ Education Completed _____
Authorized Rep. _____
Proxy 1 _____ Proxy 2 _____
Income Proof_____ HH size _____ Annual Income _____

Health Information
Birth Weight _____ Birth Length _____ Weeks Gestation _____
Birthing Facility _____
Mother's DOB _____ On WIC? _____ Ever Breastfed? _____
Current BF Amount Exclusive More than ½ are BF More than ½ are Formula None
Date Supplemental Foods Offered _____
BF Stop Reason _____ Date Breastfeeding Stopped _____
Current Height _____ Weight _____ Hgb _____

Referral Information
Current used _____
Referral to _____

Nutrition Education
Topics Discussed _____

Food RX
Type of Formula _____ Powder / Concentrate
Gallons of Milk _____ Powder Evap Fluid Lac Reduced
Pounds of Cheese _____ Peanut Butter / Beans
Special Food RX Notes _____

Subsequent CPA Determined Follow-Up

Monthly Issuance Frequency	Trimonthly	Bimonthly	Monthly
Education Frequency	Trimonthly	Bimonthly	Monthly
Education Method	Individual	Group	Goal Setting

Nutrition Education Topic _____

Notes
_____
_____
_____

Participant Manual Certification for
Postpartum or Breastfeeding

Date of Certification _____ Name _____
Address _____ Telephone _____
Date of Birth _____ Homeless? _____ Foster Child? _____
Residency Proof _____ ID Proof _____
Mother's Birth Name _____
Household Smoking? _____Hours TV Watched _____
Disability _____ Insurance _____ Type Medical Home _____
Mother's Marital Status _____ Education Completed _____
Authorized Rep. _____
Proxy 1 _____ Proxy 2 _____
Income Proof_____ HH size _____ Annual Income _____

Health Information
Infant's DOB _____Pregnancy Wt Gain Amt _____ Hospital Discharge Date_____
Wt at EDC _____ C-Section Del? _____ Date of First PN Visit _____
Birthing Facility _____
Inf. Status at Cert. _____ Birth Length _____ Birth Weight _____ Ever BF? _____
Current BF Amount Exclusive More than ½ are BF More than ½ are Formula
Date Supplemental Foods Offered _____
BF Stop Reason _____ Date BF Stopped _____
Cigarette Use Last 3 Months of Preg _____ Current Cig Use _____
Alcohol Use Last 3 Months of Preg _____ Current Alcohol Use _____
Recent Birth was Preterm? _____ LBW? _ _____ Hx of Fetal or Neonatal Loss? _____
Current Height _____ Weight _____ Hgb _____

Referral Information
Current used _____
Referral to _____

Nutrition Education
Topics Discussed _____

Food RX
Gallons of Milk _____ Powder Evap Fluid Lac Reduced Pounds of Cheese_____
Peanut Butter / Beans _____ Special Food RX Notes_____

Subsequent CPA Determined Follow-Up

Monthly Issuance Frequency	Trimonthly	Bimonthly	Monthly
Education Frequency	Trimonthly	Bimonthly	Monthly
Education Method	Individual	Group	Goal Setting

Nutrition Education Topic _____

Notes
_____
_____
_____

Participant Manual Certification for
Prenatal

Date of Certification _____ Name _____
Address _____ Telephone _____
Date of Birth _____ Homeless? _____ Foster Child? _____
Residency Proof _____ ID Proof _____
Mother's Birth Name _____
Household Smoking? _____ Hours TV Watched _____
Disability _____ Insurance _____ Type Medical Home _____
Mother's Marital Status _____ Education Completed _____
Authorized Rep. _____
Proxy 1 _____ Proxy 2 _____
Income Proof_____ HH size _____ Annual Income _____

Health Information
EDC _____ Twins? _____ Planned C-Sec? _____ PN Care? _____
Date of First PN Visit _____ Prepregnancy Weight _____
Number Previous Pregnancies_____ WIC Preg? _____ Number Live Births _____
Number Preg. Past 20 Weeks _____ Date Last Preg. Ended _____
MVI Use 3 Months Prior to Preg. _____ Current MVI Use _____
Cigarette Use 3 Months Prior to Preg. _____ Current Cig. Use _____
Alcohol Use 3 Months Prior to Preg. _____ Current Alcohol Use _____
History of Preterm Birth? _____ LBW? _____ Hx of Fetal or Neonatal Loss?_____
Current Height _____ Weight _____ Hgb _____

Referral Information
Current used _____
Referral to _____

Nutrition Education
Topics Discussed _____

Food RX
Gallons of Milk _____ Powder Evap Fluid Lac Reduced Pounds of Cheese _____
Peanut Butter / Beans _____ Special Food RX Notes_____

Subsequent CPA Determined Follow-Up

Monthly Issuance Frequency	Trimonthly	Bimonthly	Monthly
Education Frequency	Trimonthly	Bimonthly	Monthly
Education Method	Individual	Group	Goal Setting

Nutrition Education Topic _____

Notes
_____
_____
_____

WIC SIGNATURE PAGE FOR CERTIFICATION

Household ID _____

I hereby consent to examinations/tests, consultations, and treatment to me and/or my child/ward. I hereby also consent to the release of personal, financial, and medical records information on the WIC Participant Summary to approved health or welfare agencies such as Head Start, Early Head Start, Healthy Families, EFNEP, FNP for establishing eligibility, and to the Indiana State Department of Health for the purposes of verifying eligibility and performing program evaluation. I understand that the approved health and welfare agencies and the Indiana State Department of Health will maintain confidentiality of this information pursuant to IC 16-39-5, IC 5-14-3-4 (a)(9), 42 CFR 51a, and 7 CFR Part 246.26(d) *Confidentiality of applicant and participant information.*

_____ _____

Printed Name of Applicant/Participant or Parent/Guardian/Caretaker **Date**

_____

Signature of Applicant/Participant or Parent/Guardian/Caretaker

Your rights and responsibilities if you qualify for the program are:

Participants Rights

1. To be treated fairly regardless of race, color, creed, national origin, age, sex or handicap.
2. To request a fair hearing to appeal any decision made by the local agency regarding your eligibility for the program.
3. To receive nutrition education and referrals to other health services or social services.

Participant Responsibilities

1. Using WIC checks correctly.
2. Treating clinic and store employees in a respectful manner.
3. Not selling or exchanging WIC foods or checks.
4. Providing truthful information.
5. Teaching your proxies their role in the WIC Program.
6. Participating in nutrition education activities.

Statement of Agreement:

I have been advised of my rights and obligations under the Program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. 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 or misleading 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.

_____ _____

Signature of participant or parent/guardian/caretaker **Date**

- - - -

PÁGINA DE FIRMA PARA CERTIFICACIÓN WIC

Identificación del domicilio _____

Por la presente doy mi **consentimiento** para los exámenes/pruebas, consultas y tratamiento para mi y/o mi hijo(a)/pupilo(a). También doy mi consentimiento para revelar la información personal, financiera y la contenida en los registros médicos en el Resumen de participante WIC a organismos aprobados de salud o de asistencia pública tales como Head Start, Early Head Start. Healthy Families, EFNEP, FNP para establecer las bases de elegibilidad y al Departamento de Salud del Estado de Indiana con el fin de verificar la elegibilidad y efectuar la evaluación del programa. Entiendo que los organismos aprobados de salud y de asistencia pública y el Departamento de Salud del Estado de Indiana mantendrán la confidencialidad de esta información de acuerdo con IC 16-39-5, IC 5-14-3-4 (a)(9), 42 CFR 51a, y 7 CFR Parte 246.26(d) *Confidencialidad de la información del solicitante y del participante.*

_____ _____

Nombre impreso del Solicitante/Participante o Progenitor/Representante legal/Cuidador primario **Fecha**

_____

Firma del Solicitante/Participante o Progenitor/Representante legal/Cuidador primario

Sus derechos y responsabilidades <u>si califica</u> para el programa son:

<u>Derechos de los participantes</u>

1. Ser tratados de forma justa independientemente de su raza, color, credo, nacionalidad de origen, edad, sexo o incapacidad.
2. Solicitar una audiencia justa para apelar cualquier decisión tomada por la agencia local relativa a su elegibilidad para el programa.
3. Recibir educación nutricional y referidos a otros servicios de salud o sociales.

<u>Responsabilidades del participante</u>

1. Utilizar los cheques de WIC adecuadamente.
2. Tratar a los empleados del organismo y la tienda de forma respetuosa.
3. No vender o intercambiar alimentos o cheques de WIC.
4. Suministrar información veraz.
5. Enseñar a sus representados su rol en el Programa WIC.
6. Participar en actividades de educación sobre nutrición.

Declaración de conformidad:

Se me han informado mis derechos y obligaciones bajo el Programa. Certifico que la información que he suministrado para la determinación de mi elegibilidad es correcta, a mi mejor saber y entender. Este formato de certificación se envía en relación con el recibo de asistencia federal. Los funcionarios pueden verificar la información contenida en esta forma. Entiendo que efectuar intencionalmente una declaración falsa o engañosa o tergiversar intencionalmente, ocultar o no revelar hechos puede tener como consecuencia el pago al organismo estatal, en efectivo, del valor de los beneficios de alimentos indebidamente emitidos en mi favor y puede exponerme a ser objeto de un procedimiento civil o criminal bajo la Ley estatal y federal.

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Firma del participante o padre/representante legal/cuidador primario **Fecha**

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