Procedure: Certification Forms

Functional Area: VIII Certification, Eligibility & Coordination of Services

Section: A 1 | Approval Date: 8/2013

Citation: 246.7(i) | Revised Date:

Certification Forms/ Minimum Requirements

The minimum requirements for the WIC Certification Form, as established by 246.7 (i) are:

1. Name and address of applicant
2. Date of initial visit to apply for benefits
3. An indication of whether the applicant was physically present at certification and if not, the reason why an exception was granted
4. Information regarding income eligibility
5. A description of the document(s) used to determine residency
6. A description of the document(s) used to determine identity
7. A description of the document(s) used to determine income eligibility OR that the applicant has no income
8. Date of certification and medical data
9. Height/length, weight, and hematological test results. Pregnant women may be temporarily certified in the absence of blood work under special circumstances.
10. Pregnant women may be certified as presumptive eligible.
11. Nutritional risks which established eligibility
12. Signature and title of the Competent Professional Authority making the nutrition risk determination and if different, the signature and title of the person responsible for determining income eligibility
13. The following statements, with a space for the applicant or responsible party to sign after reading or having the statements read to them.

    I have been advised and received a copy of my rights and responsibilities. The information that I provided to WIC is correct and current.

    To provide the most current and truthful information (WIC staff may verify this information is correct).

Certification Forms/ Minimum Requirements (cont.)

14. The statement – That if I intentionally lie to receive WIC benefits or if I violate the program rules that 1) My family can be taken off the program 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 foods or formula, I should not have received.

15. A statement regarding release of information if the State Health Officer has authorized disclosure of information to specific public organizations.

WIC Certification Forms

The Nebraska WIC Program uses two forms to meet the above requirements. The forms are:

WIC Certification Data Form -- this form is printed directly from the computer system and contains all of the demographic, medical, and assessment information for the WIC client.

WIC Certification Signature Form – this form contains the client rights and responsibilities, fair hearing information, dual participation statement, WIC fraud statements, voter registration, client or guardian signature, income, residency and identification documentation, applicant presence in clinic, staff signatures, and documentation of notice of expiration of benefits and program ineligibility.

These forms also serve as data collection instruments, in the event of computer system failure, for the following:

1. The National WIC Minimum Data Set as established by USDA

2. Client food prescription and subsequent generation of WIC checks

3. Information used in program management and evaluation

When to Print Certification Data Form

Certification Data Forms must be printed at the initial visit.

Using the Signature Form

The Certification Signature Form must be read and signed by each client/ guardian at each certification before the process begins. The steps to complete the Certification Signature Form follow.

Step	Action
1	Have client read the Rights & Responsibilities as you verbally review them

Step	Action
2	**RELATIONSHIP TO APPLICANT (Check One)** SIGNATURE: Maria Lopez — Self ☐ Guardian/Custodial Parent ☒ Foster Parent ☐ Other ☐ Date: 7/3/13 The applicant/responsible party should sign and date the area located at the bottom of the first page after reading the Rights & Responsibilities. They should check his/her relationship to the applicant.
4	Have client read and then initial and date the dual participation statement. If they are unable to read the statement, staff should read it to them. **DUAL PARTICIPATION** By initialing below I agree that the person who is being certified for WIC today is not currently receiving and will not receive for the same time period: • WIC benefits from another WIC clinic **OR** • benefits from Commodity Supplemental Food Program (CSFP). My initials indicate that I understand that this is considered fraud. Initials: SR Date: 3/05/13 | Initials: Date: | Initials: Date: Initials: Date: | Initials: Date: | Initials: Date: Initials: Date: | Initials: Date: | Initials: Date:
5	Have client read and then initial and date the WIC Fraud box. If they are unable to read, staff should read the statement to them. **WIC FRAUD** I understand that: 1) selling, attempting to sell or giving away WIC checks, food or formula is not allowed; 2) if I sell, attempt to sell or give away WIC checks, food or formula I can be asked to repay the value of the items and I may be subject to legal charges; 3) posting WIC items on any media, including radio, newspaper, Facebook, Craigslist, and E-bay is considered an attempt to sell. My initials indicate that I understand that this is considered fraud. Initials: SR Date: 3/05/13 | Initials: Date: | Initials: Date: Initials: Date: | Initials: Date: | Initials: Date:

Step	Action
6	Complete voter registration box according to guidelines found in the Voter Registration procedure.

VOTER REGISTRATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
If you are already registered to vote at your current address check "NO".

☐ YES ☒ NO DATE: 3/05/09	☐ YES ☐ NO DATE:	☐ YES ☐ NO DATE:
☐ YES ☐ NO DATE:	☐ YES ☐ NO DATE:	☐ YES ☐ NO DATE:
☐ YES ☐ NO DATE:	☐ YES ☐ NO DATE:	☐ YES ☐ NO DATE:

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by WIC.

If you believe that someone has interfered with your right to register, or to decline to register to vote, you may file a complaint with the Nebraska Secretary of State, State Capital Building, Lincoln, Nebraska, 68509, (402) 471-2554.

7	Complete the Client Name and ID Number areas at the top of pages 2, 3 or 4. The name & ID number only needs to be written on the form in one location. Client Name: _____ ID:_____ Family ID: _____
8	The documentation area should be completed by WIC staff for each certification visit. Information to assist staff in completing this area follows as steps 8 through 18.

☐ New Cert ☐ ReCertification ☐ ReEnroll ☐ InState Transfer ☐ Out of State Transfer ☐ Presumptive ☐ Custody Change
Date Cert Expires:_____

Date of Certification: _____ Client Present: ☐ YES ☐ NO, Reason:_____

IDENTIFICATION

Proof Seen	DL	NE WIC Fldr	SS Card	MC	Work/ School ID	BC	WIC ID Card	Frgn/ State ID	Other (list)
Adult	☐	☐	☐	☐	☐	☐			
Minor		☐	☐	☐	☐	☐	☐	☐	

RESIDENCY

Proof Seen	NoA	Mail	Ck Stub	Lease	Other List
	☐	☐	☐	☐	

INCOME

Proof Seen	MC	Pay Stub	SS/ SSI	Tax Form	Child Supp	Income Ltr	Other (list)
	☐	☐	☐	☐	☐	☐	

☐ Zero: Reason why

NO PROOF

☐ Res ☐ ID ☐ Income
Reason:
Client Initials

Staff Signature/Title	Income Assessment	ID/Residency Assessment	Nutrition Risk Assessment	Food Package Prescribing	Check Issuance
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Notification That Benefits Are About to Expire Was Given On: _____ By: _____

Ineligibility Documentation Given On:_____ Staff Initials:_____ Termination Code/Reason:_____

Step	Action
9	a. Check type of visit the client is being seen for today. b. For Transfers; the date their certification ends is placed here. c. For custody changes begin a new form and check this box. ☐ New Cert a ☐ ReCertification ☐ ReEnroll ☐ InState Transfer ☐ Out of State Transfer ☐ Presumptive c ☐ Custody Change Date Cert Expires:____b_____
10	The date of the certification should be placed here. Date of Certification: _____
11	Document if the applicant was present in the clinic at the certification by checking yes or no. If the applicant was not present in clinic during the visit staff should document the reason why. Client Present: ☐ YES ☐ NO, Reason:_____
12	The type of identification seen for clients and guardians (for minors) should be documented by checking the type of ID seen in the Identification box. If the ID seen is not represented by a box, list what type of proof was seen in the "other" box. Refer to the Client/Guardian Identification procedure for acceptable identification. **IDENTIFICATION** Proof Seen: DL; NE WIC Fldr; SS Card; MC; Work/School ID; BC; WIC ID Card; Frgn/State ID; Other (list) Adult: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ I94 Card Minor: ☐ ☐ ☐ ☐ ☐ ☐ ☒

Listed below are the abbreviations used in the Identification box and what each represents:

- **DL:** Driver's License
- **NE WIC Folder:** Nebraska WIC ID Folder
- **SS Card:** Social Security Card
- **MC:** (Medicaid) Notice of Action or NMES line verification
- **BC:** Birth Certificate (certified)
- **WIC Infant Card:** Card sent with mom for hospital or physician's office to complete
- **Frgn/St ID:** Foreign or State Identification Card

Step	Action
13	The proof seen for residency should be documented by checking the appropriate box. If the proof seen is not represented by a check box, list what was seen in the "other"box. **RESIDENCY** Proof Seen: NoA ☐ Mail ☒ Ck Stub ☐ Lease ☐ Other List: utility bill
14	The proof shown for income should be checked. If the proof seen is not represented by a check box, list what was seen in the "other" box. **INCOME** Proof Seen: MC ☒ Pay Stub ☐ SS/SSI ☐ Tax Form ☐ Child Supp ☐ Income Ltr ☐ Other (list): Bank Statement ☐ Zero: Reason why Listed below are the abbreviations used in the Income box and what each represents: ➢ **MC:** Medicaid Notice of Action or NMES line ➢ **Pay Stub**: Paystub from employment ➢ **SS/SSI:** Social Security or Supplemental Security Income ➢ **Tax Form:** Most recent 1040 or other tax form showing income ➢ **Child Support:** Documentation showing child support actually received ➢ **Income Letter:** Completed WIC Income Letter
15	When clients are seen who have no (Zero) or Negative income the zero box must be marked in the Income box. The reason why the person's income is zero or negative must also be written in the Income box. **INCOME** Proof Seen: MC ☐ Pay Stub ☐ SS/SSI ☐ Tax Form ☐ Child Supp ☐ Income Ltr ☐ Other (list): ☒ Zero: Reason why: Lost job/unemployed For more information on what is appropriate documentation for proof of income refer to the Income Determination & Documentation procedure.

Step	Action
16	When a client is unable to provide proof of either, residency, identification or income the "No Proof Box" must be completed. The corresponding box that indicates what proof (identification, residency or income), the client is unable to provide should be marked. The reason why proof cannot be provided is written on the "Reason" line. The client/responsible party must initial the line title "Client Initials". An example of a completed box is shown below: NO PROOF ☐ Res ☐ ID ☒ Income Reason: Paid in Cash Client Initials MB
17	The signature(s) and title(s) of staff who participate in the certification of the client are placed here. Staff should check the box(es) to indicate the part(s) they completed for the certification visit. **Staff who make more than one determination need to only sign one line and check the appropriate boxes indicating the actions they took.** An example is shown below: Staff Signature/Title — Income Assessment — ID/Residency Assessment — Nutrition Risk Assessment — Food Package Prescribing — Check Issuance Anna Sanchez — ☐ — X — ☐ — ☐ — X Lori Johnson, RN — X — ☐ — X — ☐ — ☐ ~~Marla Lewandowki, RD~~ — ☐ — ☐ — X — X — ☐ _____ — ☐ — ☐ — ☐ — ☐ — ☐
18	Fill in the date and staff initials when clients are given notification their benefits are about to expire in the locations shown below. **Notification That Benefits Are About to Expire Was Given On:** 6/26/10 By: SB
19	Fill in the date and staff initials when a client is found to be ineligible for the program and given an ineligibility letter documenting the reason for termination. List the termination code for this client. **Ineligibility Documentation Given On:** 7/30/10 Staff Initials: SB Termination Code/Reason: D

Certification Form Revisions	The Certification Forms are designed and produced by the State WIC office in consultation with the Local Agencies. Revisions to the Certification Forms are made as necessary.
Translated Form	The Certification Signature Form is available in Spanish. The Spanish version of the form may be ordered from the State WIC Office using the WIC Materials Order Form.
Retention of Forms	The Certification Signature Form with the original signature of the applicant/ responsible party is retained in the applicant's file as the official documentation of application and eligibility determination. The Certification Data Form is to be printed and retained in the applicant's file for each person applying for the program.
Completing Certification Information In The Computer System	At the time of the certification visit, all applicable information on the computer screens is to be completed. Detailed descriptions for completing this may be found in the Participant Processing User's Guide.
Sample of Forms	A sample of the Certification Data Form, Certification Signature Form, and Spanish translation of the signature form follow.

NEBRASKA WIC CERTIFICATION DATA FORM

Agency	Clinic	Client ID	Family ID	Action Date	Initial Visit	Transaction	WL	Term	Term Date

1st Auth. Rep. Last Name	First Name	Phone Number	Alternate Phone Number

Address, Street, RFD, PO Box	City	State	Zip Code

Client Last Name	Client First Name	MI	Client Maiden Name

ADJ Elg.	HH Size	Annual Income	Int	PU Day	Status	Foster Child	Other Programs	Date of Birth	Social Security Number	Sex	Lang

Race		R M H	SRC Care	H S
H	Race			

A L L W	LMP	Est. Due Date

I C	Birth Wt.	Infant Food Package		
		4 mo. pkg	6 mo. pkg	12 mo. pkg

Status	Date of Cert.	Medical Date	Age		Height	Weight	HGB	HCT	Nutrition Risk Factors	P R	H R
			Yr.	Mo.							

Food Pkg.

397-013

NUTRITION DATA

A L L W	Grade Compl	M S	Month Pren Care	A + D Risk	3 mo. Before Preg.		
					Cig/D	D/W	Dr/D

A L L W	LMP	Est Due Date	Wks Gest	Pre-Preg. Weight	# Prev. Preg.	# Prev. Live Births	Date Last Preg. Ended	At Initial Preg Visit				BF Prom (before PG)
								Cig/D	Chg	D/W	Dr/D	
	/ /	/ /										

BF PP	WIC During Preg	Not on WIC During Pregnancy			At Initial PP Visit				Weight Change	BF Support	BF How Long	Form Start	Why Stop BF
		Cig/D	D/W	Dr/D	Cig/D	Chg	D/W	Dr/D					

BF PP	Birth Information						
	Inf Seq.	Infant DOB	Birth Cond	Sex	PP Cond	DOD	Birth Weight
	1	/ /				/ /	:
	2	/ /				/ /	:
	3	/ /				/ /	:

I C	BF Now	BF Ever	BF How Long	Date of Last Breastfeeding Response	Birth Wt.
				/ /	

LA Use	LA ID	Referral		Optional Health Data					
		To	From	1st Check			2nd Check		
				Cig/D	D/W	Dr/D	Cig/D	D/W	Dr/D

Nutrition Education		Immunizations		
NE Code	Pres. Code	Antigen	Date	P/V
			/ /	
			/ /	
			/ /	

NEBRASKA WIC CERTIFICATION SIGNATURE FORM

CLIENT'S RIGHTS AND RESPONSIBILITIES

Your Rights:

- WIC will provide you with information about nutrition, breastfeeding, and healthy foods.
- WIC will help you in getting other services, like Immunizations, SNAP and Medicaid
- All information you give WIC will be kept private.
- If you disagree with a decision regarding your WIC eligibility, you may request a fair hearing. Your request must be made within 60 calendar days of when the written denial or termination of benefits was mailed or given to you. WIC staff can give you the steps to request a hearing.
- If you feel you have been discriminated against you may file a complaint.
- Standards for eligibility for WIC are the same for everyone, regardless of race, color, national origin, age, disability or sex.

Your Responsibilities:

- Provide the most current and truthful information (WIC staff may verify this information is correct)
- Be the legal guardian, custodial parent, step parent married to the minor's parent, or foster parent of any minor you enroll in WIC.
- Keep your appointments and be on time. If you cannot keep your appointment, call your local WIC office to reschedule as soon as possible.
- Bring all documentation requested to each appointment
- Treat WIC and store staff with courtesy and respect.
- Buy only the foods listed on your WIC checks. Use the WIC foods only for the person on the program.
- Report address and/or phone changes at your next scheduled appointment.
- Keep your WIC checks safe; lost/stolen checks may not be replaceable

I Understand:

- My signature on this form allows staff of the SNAP and SNAP Nutrition Education Program; Medicaid; Perinatal, Child and Adolescent Health Unit; CSFP; and Immunization programs to see the information for purposes of outreach, referral, eligibility, and for administrative processes. They cannot share the information with a third party.
- That if I intentionally lie to receive WIC benefits or if I violate the program rules that 1) my family can be taken off the program 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 foods or formula I should not have received.
- Presumptive eligible pregnant women found to have no nutritional risk within the first 60 days of certification will no longer be eligible for the Program and will receive no additional benefits.
- WIC may ask for social security number as allowed by law to verify Medicaid participation when applicable and for administrative purposes, such as, to prevent participation in more than one WIC program at the same time. Providing your number is optional.

I have been advised and received a copy of my WIC rights and responsibilities. The information that I provided to WIC is correct and current.

RELATIONSHIP TO APPLICANT (Check One)

SIGNATURE	Self	Guardian/ Custodial Parent	Foster Parent	Other	Date
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

Revised 7/13

Client Name: _____ ID: Family ID:

DUAL PARTICIPATION

By initialing below I agree that the person who is being certified for WIC today is not currently receiving and will not receive for the same time period:

- WIC benefits from another WIC clinic OR
- benefits from Commodity Supplemental Food Program (CSFP).

My initials indicate that I understand that this is considered fraud.

Initials: Date:	Initials: Date:	Initials: Date:
Initials: Date:	Initials: Date:	Initials: Date:

WIC FRAUD

I understand that: 1) selling, attempting to sell or giving away WIC checks, food or formula is not allowed; 2) if I sell, attempt to sell or give away WIC checks, food or formula I can be asked to repay the value of the items and I may be subject to legal charges; 3) posting WIC items on any media, including radio, newspaper, Facebook, Craigslist, and E-bay is considered an attempt to sell.

My initials indicate that I understand that this is considered fraud.

Initials: Date:	Initials: Date:	Initials: Date:
Initials: Date:	Initials: Date:	Initials: Date:

VOTER REGISTRATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you are already registered to vote at your current address check "NO".

☐ YES ☐ NO Date:	☐ YES ☐ NO Date:	☐ YES ☐ NO Date:
☐ YES ☐ NO Date:	☐ YES ☐ NO Date:	☐ YES ☐ NO Date:

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by WIC.

If you believe that someone has interfered with your right to register, or to decline to register to vote, you may file a complaint with the Nebraska Secretary of State, State Capital Building, Lincoln, Nebraska, 68509, (402) 471-2554.

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all protected bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at program.intake@usda.gov

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

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Client Name: _____ **ID:** _____ **Family ID:** _____

☐ New Cert ☐ ReCertification ☐ ReEnroll ☐ InState Transfer ☐ Out of State Transfer ☐ Presumptive ☐ Custody Change
Date Cert Expires: _____

Date of Certification: _____ Client Present: ☐ YES ☐ NO, Reason: _____

IDENTIFICATION									
Proof Seen	DL	NE WIC Fldr	SS Card	MC	Work/ School ID	BC	WIC ID Card	Frgn/ State ID	Other (list)
Adult	☐	☐	☐	☐	☐	☐			
Minor		☐	☐	☐	☐	☐	☐	☐	

RESIDENCY					
Proof Seen	NoA	Mail	Ck Stub	Lease	Other List
	☐	☐	☐	☐	

INCOME							
Proof Seen	MC	Pay Stub	SS/ SSI	Tax Form	Child Supp	Income Ltr	Other (list)
	☐	☐	☐	☐	☐	☐	
☐ Zero: Reason why							

NO PROOF	
☐ Res ☐ ID ☐ Income	
Reason:	
Client Initials	

Staff Signature/Title	Income Assessment	ID/Residency Assessment	Nutrition Risk Assessment	Food Package Prescribing	Check Issuance
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Notification That Benefits Are About to Expire Was Given On: _____ By: _____

Ineligibility Documentation Given On: _____ Staff Initials: _____ Termination Code/Reason: _____

☐ New Cert ☐ ReCertification ☐ ReEnroll ☐ InState Transfer ☐ Out of State Transfer ☐ Presumptive ☐ Custody Change
Date Cert Expires: _____

Date of Certification: _____ Client Present: ☐ YES ☐ NO, Reason: _____

IDENTIFICATION									
Proof Seen	DL	NE WIC Fldr	SS Card	MC	Work/ School ID	BC	WIC ID Card	Frgn/ State ID	Other (list)
Adult	☐	☐	☐	☐	☐	☐			
Minor		☐	☐	☐	☐	☐	☐	☐	

RESIDENCY					
Proof Seen	NoA	Mail	Ck Stub	Lease	Other List
	☐	☐	☐	☐	

INCOME							
Proof Seen	MC	Pay Stub	SS/ SSI	Tax Form	Child Supp	Income Ltr	Other (list)
	☐	☐	☐	☐	☐	☐	
☐ Zero: Reason why							

NO PROOF	
☐ Res ☐ ID ☐ Income	
Reason:	
Client Initials	

Staff Signature/Title	Income Assessment	ID/Residency Assessment	Nutrition Risk Assessment	Food Package Prescribing	Check Issuance
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Notification That Benefits Are About to Expire Was Given On: _____ By: _____

Ineligibility Documentation Given On: _____ Staff Initials: _____ Termination Code/Reason: _____