

NEBRASKA WIC CERTIFICATION SIGNATURE FORM

CLIENT'S RIGHTS AND RESPONSIBILITIES

Updated. Streamlined and simplified.

Staff should summarize the R&R after clients read them.

The R&R should be read to anyone who cannot read English or Spanish.

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
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Enrollment Proxy changed to Other.

Client Name: _____

2nd Responsible Party Area
Removed

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: _____

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: _____

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: _____

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.

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	<input type="checkbox"/>									
Minor	<input type="checkbox"/>									

RESIDENCY					
Proof Seen	NoA	Mail	Ck Stub	Lease	Other List
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INCOME							
Proof Seen	MC	Pay Stub	SS/SSI	Tax Form	Child Supp	Income Ltr	Other (list)
	<input type="checkbox"/>						

Zero: Reason why _____

NO PROOF		
<input type="checkbox"/> Res	<input type="checkbox"/> ID	<input type="checkbox"/> Income
Reason: _____		
Client Initials: _____		

CHANGES based on changes to forms and recommendations from LA's.

Staff Signature/Title	Income Assessment	ID/Residency	Nutrition Risk	Food Package	Check Issuance
_____	<input type="checkbox"/>				
_____	<input type="checkbox"/>				
_____	<input type="checkbox"/>				
_____	<input type="checkbox"/>				

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	<input type="checkbox"/>									
Minor	<input type="checkbox"/>									

RESIDENCY					
Proof Seen	NoA	Mail	Ck Stub	Lease	Other List
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INCOME							
Proof Seen	MC	Pay Stub	SS/SSI	Tax Form	Child Supp	Income Ltr	Other (list)
	<input type="checkbox"/>						

Zero: Reason why _____

NO PROOF		
<input type="checkbox"/> Res	<input type="checkbox"/> ID	<input type="checkbox"/> Income
Reason: _____		
Client Initials: _____		

Staff Signature/Title	Income Assessment	ID/Residency Assessment	Nutrition Risk Assessment	Food Package Prescribing	Check Issuance
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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