NEBRASKA WIC PROGRAM REQUEST FOR CLINIC APPROVAL

Local Agency Name	Local Agency Number	Date

Local Agency Contact Person – name/title	Telephone Number

☐ Opening New Clinic	☐ Relocating Current Clinic Clinic Number:	Anticipated Date of Opening/ Relocation:

New/Relocating Site Information

Name:	Building Name	Clinic Telephone Number
Number/Street	City/Zip Code	Participant Line (This # will be given to clients)
List other WIC Agency's that serve this area:	Closest WIC Clinics: (list with distance)	Anticipated or Current Caseload: Number of Days Clinic will be Open Each Month:
Is this Clinic Located in or Affiliated with a Hospital? ☐ Yes ☐ No	Will or Does this Clinic Serve a Special Group? ☐ Yes * ☐ No *Specify group:	Days and hours clinic will be open each month:
Will the clinic be co-located with other health services? ☐ Yes ☐ No		
Is There a Breastfeeding Room or Other Designated Space Available? ☐ YES ☐ NO		
Describe available transportation and parking:		Are restrooms available? ☐ Yes ☐ No
Language(s) Spoken at clinic:	Staffing planned at clinic: (indicate # of each) Clerks Nurse BFPC RD Nutritionist Interpreters	Is this new site handicap accessible? ☐ Yes ☐ No * *Attach a reason for site selection and a plan for providing WIC services to disabled clients at this site.
Space Cost/Month: Square footage of clinic space:	Will the clinic be ready to move-in, with no pending repairs or renovations needed, on the first day of clinic? ☐ Yes ☐ No * *list the repairs or renovations needed and the date to be completed as an attachment	
Will new equipment need to be purchased? ☐ Yes * ☐ No *Complete & submit a Equipment Purchase Request	Internet Access Available at this Site: ☐ Yes ☐ No (If yes, specify type of internet available and provider)	

Reasons for opening/relocating clinic (use extra pages if needed)

REQUIRED ATTACHMENTS (New & Relocating Clinics)
Local Agencies shall include the following with this form when opening or relocating a clinic: **1. A floor plan that identifies entrances, exits and the location of work areas.** **2. Digital images of the site interior and exterior** **WHEN APPLICABLE:** **3. Equipment Purchase Request** **4. A copy of the "Notification Letter of Proposed New/Relocating Clinic" sent to other local agencies serving the same county** **5. Local agency responses to the "Notification Letter of Proposed New/Relocating Clinic"** **6. A plan to provide WIC services to disabled clients** **7. Pending repairs/renovations and date of completion**

☐ Closing Current Clinic	Clinic Name:	Clinic Number:	Anticipated Date of Closing:
Caseload Served:	**Estimated Cost Savings from closing clinic:**	**List closest clinics & distance:**	
Where will current participants go for WIC Services?		**How will current participants be notified of closing?**	
Reasons for closing clinic (use extra pages if necessary):			
When Completed, please submit this form and all supporting documentation to State Clinic Services Coordinator to allow for state approval at least 60 days prior to the anticipated effective date of the clinic opening/relocation or closing. The timing of the request submission must allow for a review of civil rights, participation, funding and IT impacts.			

COMPLETE FOR ALL REQUESTS TO RELOCATE OR CLOSE A CLINIC					
White/Non-Hispanic	Black/Non-Hispanic	Hispanic/White	Amer. Ind./Non-Hispanic	Asian/Non-Hispanic	Mixed Race/Unknown

STATE USE ONLY		
☐ Approved ☐ Not Approved ☐ Conditional Approval	**Date conditional approval met:**	
Reason not approved:		Date request received from L/A:
		If new equipment, date referred to Admin Op:
Conditions for Approval:		Date Local Agency notified:
		Date System updated:
		Site Number Assigned:
		Date Website Updated:
Clinic Services Coordinator signature:	**Date**	Date clinic lists updated:
		Date original placed in L/A file:

INSTRUCTIONS FOR COMPLETING REQUEST FOR WIC CLINIC APPROVAL

Please save the form to your computer as a blank document before you enter information: this allows you to retain the original copy for future reference.

- **Local agency name:** Name of local agency
- **Local agency number:** Number for local agency
- **Date:** Date you are completing the form
- **Local agency contact person:** Name and title of the person to contact for questions related to this clinic
- **Telephone Number:** Number where the contact person may be reached
- **Opening New Clinic:** Check here if you are opening a new WIC clinic in an area not previously served by your agency or are expanding to a new site.
- **Relocating Current Clinic:** Check here if you are relocating a site and are still serving the same population and/or geographical service area.
- **Clinic Number:** Clinic number for clinic you would like to relocate
- **Anticipated Date of Opening/Relocation:** Anticipated date of opening new or relocated site for WIC services
- **New/Relocating Site Information:** Complete this for all new and relocating clinics
    - *Name:* The name you wish to use for the new clinic
    - *Building Name:* Name of the building where the clinic will be located
    - *Number/Street:* Street address where the clinic will be located
    - *City/Zip Code:* City and zip code where the clinic is planned
- **Clinic Telephone Number:** The telephone number of the new/relocated clinic
- **Participant Line:** Telephone number you would like the state office to provide to clients who call with questions or to make or change an appointment at this clinic.
- **List *all* other WIC Agency's that serve this area:** List *all* WIC local agencies whose service area includes the same county as the proposed/relocated clinic
- **Closest WIC Clinics:** List the closest WIC clinics to the proposed/relocated site. Indicate the distance in miles/blocks from the proposed site to the listed clinic.
- **Anticipated or Current Caseload:** For new clinics - anticipated number of participants served at this clinic. For relocation clinics – current caseload
- **Number of Days Clinic will be Open Each Month:** List the number of days this clinic will be open each month
- **Is This Clinic Located in or Affiliated with a Hospital:** Indicate if the clinic is/will be operated in a hospital or is/will be affiliated with a hospital.
- **Will or Does this Clinic Serve a Special Group:** Indicate if this clinic location will/does serve a specific group of participants. Examples – military, migrants, Native American. If YES, specify which group is/will be served at the clinic
- **Days and Hours Clinic is/will be Open Each Month:** List the days this site will provide services and the corresponding hours the site will be open.
- **Will the Clinic be Co-located with Other Health Services:** Indicate if other health services will be held and available to participants at this location during WIC clinic hours.
- **Breastfeeding Room/Designated Space:** This should be a place, other than a bathroom, that is shielded from view and free from intrusion from others, which may be used by clients and employees to express breast milk.
- **Describe Available Transportation and Parking:** For example, public buses, parking adjacent to clinic building, taxi service
- **Are Restrooms Available:** Are restrooms available for WIC participant use during clinic.
- **Language(s) Spoken at Clinic:** List the languages spoken by current participants at clinics which are relocating OR languages it is anticipated participants who will attend a new clinic will speak.
- **Staffing Planned at Clinic:** List the number of each type of staff who will be staffing the clinic.
- **Is this Clinic Handicap Accessible:** For example, are there wheelchair ramps, handicap accessible bathrooms, etc.
- **Space Cost/Month:** The cost to rent the clinic space each month. If agency owned the monthly amount charged to WIC for use of space.
- **Square Footage of Clinic Space:** Square footage used for WIC services at the new or relocated site.
- **Will the Clinic be Ready to Use on First Day of Occupancy:** Repairs and renovations should be scheduled prior to move in, or negotiated within lease or space agreement with at date of completion.

- **Will New Equipment Need to be Purchased:** A Equipment Purchase Request should be submitted with this form when any one item will cost more than $250. This includes computer equipment.
- **Internet Access Available at this Site:** Indicate if there is Internet Access at this site that WIC can use. Also list the type of internet available at this site and the company which provides internet service.
- **Reasons for Opening/Relocating Clinic:** Please explain why you want to open/move to a new site. Reasons might include serve additional caseload; coordination efforts with other health services/agencies/providers; convenience for participants; physical building; loss of current site, etc.
- **Closing Current Site:** Mark here if you are requesting to permanently close a clinic site.
- **Clinic Name:** The name of the clinic you would like to close
- **Clinic Number:** The clinic number for the clinic you would like to close
- **Anticipated Date of Closing:** Anticipated date WIC services will no longer be provided at this site.
- **Caseload Served:** Number of participants affected by the closure of the clinic
- **Estimated Cost Savings from Closing Clinic:** Provide a dollar amount for the anticipated cost savings
- **List Closest Clinics and Distance:** Provide a list of the closest clinics and the distance from each to the new/relocated site
- **Where will Current Participants Go:** Explain where current participants will need to travel to get WIC services at other sites
- **How will Current Participants be Notified of the Closing:** Explain how clients will be notified of the closing and the timeline for notification
- **Reasons for Closing:** Explain reasons for closing this clinic; include impact on participants.
- **Ethnic/Racial Participation:** Complete for all requests to close or relocate clinics. List the number of clients who attend this clinic by ethnic/racial group.

REQUIRED ATTACHMENTS:

FOR ALL NEW & RELOCATING CLINICS:

1. **Floor Plan of Clinic Space:** Include a floor plan that shows where the clinic is located in the building, along with entrances and exits. A diagram/floor plan of the WIC space that identifies work areas. These may be hand drawn.
2. **Digital Images of the Site:** Digital pictures of the exterior entrance to the building where the WIC clinic will be held and pictures of the space planned for WIC use.

FOR EQUIPMENT PURCHASES OVER $250:

3. **Equipment Purchase Request:** Form must be completed for all new equipment needed for the clinic which exceeds $250.

FOR ALL NEW & RELOCATING CLINICS WHERE ANOTHER AGENCY SERVES THE SAME AREA:

4. **Notification Letter of Proposed New/Relocating Clinic:** Must be sent to all WIC agencies which serve the same geographic area, explaining your proposed clinic changes and offering them an opportunity to comment within 30 days. You obtain written responses from each local agency and include their responses with the Request for WIC Clinic Approval.

FOR ALL NEW & RELOCATING CLINICS THAT ARE NOT HANDICAP ACCESSIBLE:

5. **Services for Disabled Clients:** When a site is not accessible to disabled clients explain why this site was chosen for WIC services. Also include a plan detailing how WIC services will be provided to disabled clients at this clinic. EX. a room on the ground floor will be available for WIC use to serve clients.