Ohio Department of Health

# WIC Program Application

Please answer all questions on this page.

A.

| Parent, guardian or applicant's name | | Telephone ☐ Home ☐ Work ☐ Cell ☐ Leave message | | |
|---|---|---|---|---|
| Street address | City | State | ZIP | County |
| Mailing address (if not the same as street address) | City | | State | ZIP |

B. In the section below please list everyone who is living in your home, including yourself.

| | | | | | |
|---|---|---|---|---|---|
| 1. | Full name—first, middle, last | | Relationship to you **SELF** | ☐ Female ☐ Male | Date of birth / / |
| | Hispanic/Latino ☐ Yes ☐ No | ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American | | If pregnant: number of unborn babies | Due date / / |
| 2. | Full name—first, middle, last | | Relationship to you | ☐ Female ☐ Male | Date of birth / / |
| | Hispanic/Latino ☐ Yes ☐ No | ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American | | If pregnant: number of unborn babies | Due date / / |
| 3. | Full name—first, middle, last | | Relationship to you | ☐ Female ☐ Male | Date of birth / / |
| | Hispanic/Latino ☐ Yes ☐ No | ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American | | If pregnant: number of unborn babies | Due date / / |
| 4. | Full name—first, middle, last | | Relationship to you | ☐ Female ☐ Male | Date of birth / / |
| | Hispanic/Latino ☐ Yes ☐ No | ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American | | If pregnant: number of unborn babies | Due date / / |
| 5. | Full name—first, middle, last | | Relationship to you | ☐ Female ☐ Male | Date of birth / / |
| | Hispanic/Latino ☐ Yes ☐ No | ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American | | If pregnant: number of unborn babies | Due date / / |
| 6. | Full name—first, middle, last | | Relationship to you | ☐ Female ☐ Male | Date of birth / / |
| | Hispanic/Latino ☐ Yes ☐ No | ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American | | If pregnant: number of unborn babies | Due date / / |

C. If anyone in your home is pregnant, is she under a doctor's care? ☐ Yes ☐ No — If yes, what is the doctor's name?

D. Has anyone in your home had a pregnancy that ended within the last six months? ☐ Yes ☐ No — If so, who?

E. Is anyone in your home breastfeeding a baby less than 12 months old? ☐ Yes ☐ No — If so, who?

F. Please check Yes or No if anyone in your home is receiving any of the following:

| | | |
|---|---|---|
| Ohio Works First Cash ☐ Yes ☐ No<br>If so, who? | Medicaid ☐ Yes ☐ No<br>If so, who? | Food Assistance ☐ Yes ☐ No<br>If so, who? |

For each person in your home who has any income such as wages, self-employment, unemployment, SSI, Social Security, VA pension, workers compensation, alimony, child support, lump-sum payments, please complete the lines below.

| Name | Name of income source | Gross amount | How often received |
|---|---|---|---|
| | | $ | |
| | | $ | |
| | | $ | |

Important! You must sign the back of this application form.

HEA 4460 (Rev. 12/15)

By signing this WIC application, I agree to give proof of eligibility for information entered on this form and any other information asked to meet program rules.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided to me under the Medicaid, WIC, and other medical assistance programs.

I also authorize the Ohio Department of Health, the Ohio Department of Medicaid, and the Ohio Department of Job and Family Services to exchange any information I have provided on this form to enable the departments to determine my eligibility.

I understand that this application is considered without regard to race, color, national origin, sex, age, or disability.

By my signature below, I affirm under penalty of perjury that to the best of my knowledge and belief all the answers on this application are true and complete. I understand that the law provides penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive.

| Signature of applicant who completed this form | Date of signature |
|---|---|
| Signature of person who helped complete this form | Date of signature |

**AGENCY USE ONLY**

**Pregnancy Verification** ☐ Medical statement attached

| Medical chart location (office name) | Patient name and number | |
|---|---|---|
| Telephoned (name) | Agency/Business | Call date |
| Verification statement | | |

**Identification Verification**

| | | |
|---|---|---|
| Name (Circle one— I C P N B) | ☐ Present ☐ Exempt | Document type or number |
| Name (Circle one— I C P N B) | ☐ Present ☐ Exempt | Document type or number |
| Name (Circle one— I C P N B) | ☐ Present ☐ Exempt | Document type or number |
| Name (Circle one— I C P N B) | ☐ Present ☐ Exempt | Document type or number |
| Medical chart location (office name) | | |

**Income Verification** ☐ Verification attached (county department of job and family services, employer, other agencies)

| Check those that apply<br>☐ OWF ☐ Disability Financial Assistance ☐ Food Assistance ☐ Medicaid ☐ Refugee | | | Economic unit size |
|---|---|---|---|
| Card number | | ☐ Benefits Notice/Printout<br>☐ Provider Information Line<br>☐ MITS or EBT Portal | Effective date |
| Verification statement used (document/check stub/letter)<br>☐ Yes ☐ No | Statement date | Income amount<br>$ | ☐ Weekly ☐ Bi Weekly<br>☐ Semimonthly ☐ Monthly |
| Telephoned (name) | Agency/Business | | Call date |
| Confirmed or other information | | | |

**Proof of Residence**

☐ Ohio License/ID ☐ Utility/credit bill ☐ WIC Reminder Card ☐ Medical card/JFS document ☐ Other_____

| WIC personnel signature | Date |
|---|---|

This institution is an equal opportunity provider.