

Ohio Department of Health WIC Program Application

A. Parent, guardian or applicant's name		Telephone		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> 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.

1. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> White	If pregnant: number of unborn babies / /
2. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> White	If pregnant: number of unborn babies / /
3. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> White	If pregnant: number of unborn babies / /
4. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> White	If pregnant: number of unborn babies / /
5. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> White	If pregnant: number of unborn babies / /
6. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> White	If pregnant: number of unborn babies / /

C. If anyone in your home is pregnant, is she under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, who?
E. Is anyone in your home breastfeeding a baby less than 12 months old? <input type="checkbox"/> Yes <input type="checkbox"/> 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 If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Assistance If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.

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 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 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)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> 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 <input type="checkbox"/> OWF <input type="checkbox"/> Disability Assistance <input type="checkbox"/> Food Assistance <input type="checkbox"/> Medicaid <input type="checkbox"/> Refugee		Economic unit size
Card number <input type="checkbox"/> Medicaid <input type="checkbox"/> Food Assistance		Effective date
Verification statement used (document/check stub/letter) <input type="checkbox"/> Yes <input type="checkbox"/> No	Statement date	Income amount \$ <input type="checkbox"/> Weekly x 4.3 <input type="checkbox"/> Biweekly x 2.15 <input type="checkbox"/> Semimonthly x 2 <input type="checkbox"/> Monthly
Telephoned (name)	Agency/Business	Call date
Confirmed or other information		
<p>Proof of Residence</p> <input type="checkbox"/> Ohio License/ID <input type="checkbox"/> Utility/credit bill <input type="checkbox"/> WIC Reminder Card <input type="checkbox"/> Medical card /FS document <input type="checkbox"/> Other _____		
WIC personnel signature		Date

This Institution is an equal opportunity provider.