



Ohio Department of Health Welcome to WIC Letter

Dear _____,

WIC health professionals partner with you to develop nutrition goals that support a healthy pregnancy, breastfeeding, and postpartum experience, and growth for infants and children.

I have discussed my nutrition goal with the WIC health professional. I agree to try:

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Date	Height	Length	Weight	Blood Iron (Hemoglobin)
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Your next WIC clinic visit is scheduled for:

Nutrition Education and Benefit Pickup Date	Health Assessment/Recertification Date
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Keep all WIC appointments or your benefits may end.

Your benefits will end on _____ because

- ☐ Child turns age 5.
☐ Six month postpartum period has ended.
☐ Breastfeeding eligibility for WIC has ended.

Ohio WIC Consent to Receive Text/Phone Notification

WIC provides appointment reminders and notifications by text and/or phone calls. WIC uses prerecorded voice messages and automatic dialing technology. Notifications include local WIC agency announcements, community events, Ohio Department of Health or WIC program information, including notices from the Ohio Department of Health's Infant Hearing Program, emergency notifications, and nutrition and breastfeeding education. Messages may have protected health information and/or confidential information. Your consent is needed before WIC sends messages. You may have message charges, depending on your phone plan. You may opt out of these messages at any time. Refusing will not affect your eligibility for, or participation in, the WIC Program or the eligibility or participation for any children for whom you are legally responsible. This consent is valid while you are active in the Ohio WIC program or until you opt out through the texting service opt-out option or via notification to WIC clinic staff of the desire to opt out.

_____ I agree to texts and/or automated phone calls.

_____ I opt out. (TEXT STOP to 22300)

Information Sharing in the WIC Program

WIC works with many programs to meet your service needs. The *Information Sharing in the WIC Program* pamphlet explains programs that may receive your information for outreach; eligibility; and improving health, education, and well-being for your family.

Your consent is needed before information can be shared with programs or medical providers not listed in the *Information Sharing in the WIC Program* pamphlet. You are not required, but may check or add programs or medical providers below for sharing your information.

☐ Head Start/Early Head Start ☐ Medicaid provider for breast pump _____

☐ Other _____

_____ I received an Information Sharing in the WIC Program pamphlet.

I certify that the information I provided is correct to the best of my knowledge. My WIC program application information may be verified. I understand making a false or misleading statement, or misrepresenting, concealing or withholding facts may result in my paying back the cost of benefits issued to me and may result in prosecution under state and federal law.

I have had my nutrition risk explained to me. I have read this form or WIC staff have read this form to me. I understand and agree to the responsibilities.

Signature of Participant or Guardian	Signature of WIC Personnel	WIC Effective Date
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Participant Rights and Responsibilities

Participant Rights

I have the right to:

1. Ask for a fair hearing if denied participation, disqualified from the WIC program or required to pay back the value of the benefits. I must ask for a fair hearing within 60 days from the date notified of disqualification. At the time of the fair hearing, I may be represented and accompanied by a relative, friend, legal counsel, or other spokesperson.
2. Appeal any decision made by the local agency regarding eligibility for the program.
3. Receive breastfeeding and nutrition education services and to participate in these services.
4. Transfer my WIC records to any clinic, state, or U.S. territory, or countries where WIC-like services are provided by a U.S. entity.

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

Participant Responsibilities

I understand that failure to abide by my responsibilities may result in disqualification. I and my alternates must:

1. Not sell, trade, or give away WIC foods or formula, breast pumps, Farmers' Market benefits, or WIC Nutrition Cards. This includes using social media and other online outlets.
2. Not accept cash, credit, unauthorized foods, or other items of value for WIC Nutrition Cards.
3. Not redeem WIC or Farmers' Market food benefits that were previously reported as lost or stolen.
4. Not purchase or receive foods or formula more than those listed as my participant benefits.
5. Return loaned breast pumps upon request from the local WIC office.
6. Not physically abuse, threaten physical abuse, or verbally abuse anyone at the WIC clinic, store or farmers' markets.
7. Not receive WIC benefits from more than one WIC program at a time.
8. Use WIC foods for participants only and send WIC Nutrition Cards or foods benefits with participants if they leave the household.
9. Notify the clinic of a change in income, address, telephone number, family size, and pregnancy due date.
10. Keep WIC Nutrition Cards in a safe place. It can take up to four days to replace WIC Nutrition Cards.
11. Bring back excess, unopened formula and baby foods to the WIC clinic.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (833) 256-1665 or (202) 690-7442; or
- (3) email: program.intake@usda.gov

This institution is an equal opportunity provider.