

# Ohio Department of Health WIC Program Application

Please answer all questions on this page.

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, including yourself.

1.	Full name—first, middle, last	Relationship to you <b>SELF</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /
2.	Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /
3.	Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /
4.	Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /
5.	Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /
6.	Full name—first, middle, last	Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 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? <span style="float: right;">If yes, what is the doctor's name?</span>			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
D.	Has anyone in your home had a pregnancy that ended within the last six months? <span style="float: right;">If so, who?</span>			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
E.	Is anyone in your home breastfeeding a baby less than 12 months old? <span style="float: right;">If so, who?</span>			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

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

Ohio Works First Cash <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?	Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?	Food Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?
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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
		\$	
		\$	
		\$	

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)	<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		Economic unit size	
<input type="checkbox"/> OWF	<input type="checkbox"/> Disability Financial Assistance	<input type="checkbox"/> Food Assistance	<input type="checkbox"/> Medicaid
Card number		<input type="checkbox"/> Benefits Notice/Printout <input type="checkbox"/> Provider Information Line <input type="checkbox"/> MITS or EBT Portal	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 <input type="checkbox"/> Bi Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> 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
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