

NEW JERSEY WIC PROGRAM

PARTICIPANT RIGHTS AND OBLIGATIONS – CERTIFICATION AND RECERTIFICATION SIGNATURE FORM

Use this form to collect required signatures and documentation submitted for proof of income, identity and residency, and to document Economic Unit Size. This document must be kept in the participant's file.

Current Certification Date _____ Authorized Representative _____ Household ID # _____

The following **must** be read by or to the participant/authorized representative:

PARTICIPANT RIGHTS AND OBLIGATIONS

- Standards for eligibility and participation in the WIC Program are the same for everyone, regardless of race, color, national origin, age, disability, or sex.
- You may appeal any decision made by the local agency regarding your eligibility for the Program within 60 days of the decision.
- The local agency will make health services and nutrition available to you, and you are encouraged to participate in these services.

WIC shares certification and immunization screening information with health and welfare programs that service WIC participants to determine if they qualify for these programs and for outreach and educational purposes.

I have been advised of my rights and obligations under the Program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying the State Agency, in cash, the value of the food benefits improperly issued to me and may subject me to Civil or Criminal prosecution under State and Federal law. I understand that it is illegal to be enrolled in more than one WIC clinic at the same time, either in New Jersey or in another state.

- I certify that this participant is not enrolled in another WIC program/clinic and will not enroll in another WIC program/clinic while enrolled here.
- I understand that this participant can be disqualified from WIC for not picking up checks for two (2) consecutive months.

Buying, selling or otherwise misusing WIC benefits is a crime. To report suspected abuse, call 800-424-9121 or visit www.usda.gov/oig/hotline.htm. Failure to comply with WIC obligations and regulations may result in penalties or in disqualification from WIC for up to one year.

IMMUNIZATION REGISTRY (not required for application/participation in the WIC program)

I consent to let WIC collect the immunization data for this participant and share it with the New Jersey Immunization Information System

LAB CONSENT: I consent to let WIC collect the height, weight, and blood work for this participant.

ALTERNATIVE AUTHORIZED REPRESENTATIVE/PROXY: Completed Deferred (not interested at this time) On file

Participant or Authorized Representative (sign here) _____ Date _____

ELIGIBILITY DOCUMENTATION: Check if participant is receiving TANF SNAP MC (verified by MC Application or REVS); otherwise, complete the Household & Income Information Form (Att. 8.06H) and list income proof below.

Income Proof _____ Residency Proof _____ Economic Unit Size _____

Income Amount _____

Staff Who Documented Eligibility (print name here) _____ Staff Signature _____

| | |
|---|--|
| STATUS: <input type="checkbox"/> P <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> New <input type="checkbox"/> Recertification | Immunization Record <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
|---|--|

| | |
|--------------------------|-----------|
| Participant's Name _____ | DOB _____ |
|--------------------------|-----------|

| | |
|----------------|----------------|
| WIC ID # _____ | WIC ID # _____ |
|----------------|----------------|

| | |
|----------------------|----------------------|
| Identity Proof _____ | Identity Proof _____ |
|----------------------|----------------------|

| | |
|--|--|
| HEIGHT _____ Inches <input type="checkbox"/> Standing <input type="checkbox"/> Recumbent | HEIGHT _____ Inches <input type="checkbox"/> Standing <input type="checkbox"/> Recumbent |
|--|--|

| | |
|-----------------------------|-----------------------------|
| WEIGHT _____ lbs _____ ozs. | WEIGHT _____ lbs _____ ozs. |
|-----------------------------|-----------------------------|

| | |
|-----------------------------|-----------------------------|
| HGB _____ mg/dl HCT _____ % | HGB _____ mg/dl HCT _____ % |
|-----------------------------|-----------------------------|

| | |
|--|--|
| <input type="checkbox"/> Referral Form is Attached _____ | <input type="checkbox"/> Referral Form is Attached _____ |
|--|--|

| | |
|--|--|
| This applicant is eligible <input type="checkbox"/> Yes <input type="checkbox"/> No | Participant was present? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

| | |
|--|--|
| CPA Who Determines Nutritional/Medical Risk: | CPA Who Determines Nutritional/Medical Risk: |
|--|--|

| | |
|------------------|------------------|
| PRINT Name _____ | PRINT Name _____ |
|------------------|------------------|

| | |
|--------------------------------|--------------------------------|
| CPA Signature _____ Date _____ | CPA Signature _____ Date _____ |
|--------------------------------|--------------------------------|

CPA: If participant is found ineligible or is placed on Waiting List, complete Notice of Ineligibility Form. Maintain copy in participant file.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider

Rev. 01/2016

Additional WIC Participants →

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DERECHOS Y DEBERES DE LOS PARTICIPANTES:

- Las normas de elegibilidad y de participación en el programa de WIC son las mismas para todas las personas, independientemente de su raza, color, origen étnico, edad, incapacidad o sexo.
- Dispone de 60 días a partir de que la agencia local emita una decisión relacionada con su elegibilidad para apelar la decisión que la agencia haya tomado.
- La agencia local se asegura que los servicios médicos y de nutrición estén a su disposición y le recomendamos a que participe en estos servicios.

El Programa de WIC provee información sobre la evaluación de inmunización y certificación con el departamento de salud de New Jersey, y programa de Welfare que sirven a elegibles de WIC.

He sido informado(a) de mis derechos y obligaciones en el Programa. Yo certifico que la información que he dado para determinar mi elegibilidad es correcta en la medida de mi conocimiento. Este formulario de certificación es entregado en conexión con el recibo de asistencia Federal. Oficiales del Programa pueden verificar la información en este formulario. Comprendo que hacer declaraciones falsas o engañosas intencionalmente o falsificar encubrir o retener información intencionalmente puede resultar en que yo pague a la agencia estatal, en efectivo, el valor de los beneficios de comida que me han entregado pueda someterme a prosecución civil o criminal bajo las leyes Federales y Estatales. Comprendo que es ilegal estar inscrito en más de una clínica de WIC al mismo tiempo, en Nueva Jersey, o en otro estado.

- Certifico que este/a participante no está inscrito/en ningún otro programa o clínica de WIC y que no se tratará de inscribir en ningún otro programa/ clínica de WIC mientras esté inscrito/a aquí.
- Comprendo que si este/a participante no recoge sus cheques durante dos meses consecutivos, se la puede descalificar del programa de WIC y que de no cumplir con los reglamentos y deberes para con WIC podría traer como consecuencia que se le impongan multas o que se le descalifique del programa de WIC hasta por un periodo de un año.

Comprando, vendiendo o abusando los beneficios de WIC es un crimen. Para reportar sospechas de abusos, llama 800-424-9121 o visite www.usda.gov/oig/hotline.htm. WIC es un proveedor y empleador que ofrece igualdad de oportunidades.

REGISTRO DE VACUNAS (No es obligatorio para hacer una solicitud o participar en el programa de WIC.)

Autorizo a que WIC obtenga la información relacionada con las vacunas de este/a participante y que comparta esta información con el Registro Integral de Vacunas de New Jersey.

LAB CONSENT: Autorizo a que WIC obtenga la talla, el peso y le haga análisis de sangre a este/a participante.

REPRESENTANTE AUTORIZADO OTRA/O PERSONA/PROXY: Completo Pospuesto En Record

El/la Participante o Representante Autorizado/a firme aquí _____ Fecha _____

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Income Amount _____

Staff Who Documented Eligibility (print name here) _____ Staff Signature _____

STATUS: P B N I C **Immunization Record**
 New Recertification Yes No N/A

STATUS: P B N I C **Immunization Record**
 New Recertification Yes No N/A

Participant's Name _____ DOB _____

Participant's Name _____ DOB _____

WIC ID # _____

WIC ID # _____

Identity Proof _____

Identity Proof _____

HEIGHT _____ Inches Standing Recumbent

HEIGHT _____ Inches Standing Recumbent

WEIGHT _____ lbs _____ ozs.

WEIGHT _____ lbs _____ ozs.

HGB _____ mg/dl HCT _____ %

HGB _____ mg/dl HCT _____ %

Referral Form is Attached _____ Staff Initials _____

Referral Form is Attached _____ Staff Initials _____

This applicant is eligible Yes No **Participant was present?** Yes No

This applicant is eligible Yes No **Participant was present?** Yes No

CPA Who Determines Nutritional/Medical Risk:

CPA Who Determines Nutritional/Medical Risk:

PRINT Name _____

PRINT Name _____

CPA Signature _____ **Date** _____

CPA Signature _____ **Date** _____

CPA: If participant is found ineligible or is placed on Waiting List, complete Notice of Ineligibility Form. Maintain copy in participant file.

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en inglés), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, discapacidad, edad, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA. Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas. Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA, (AD-3027) que está disponible en línea en: http://www.ascr.usda.gov/complaint_filing_cust.html y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por: (1) correo: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; o (3) correo electrónico: program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.