FORM 104 (1/2021)

WIC PARTICIPANT RIGHTS, RESPONSIBILITIES AND CONSENT

What does WIC ask from you?

- You will buy only the foods allowed on the current Idaho Food List from an Idaho grocery store that takes eWIC cards.
- You will use the foods only for the person(s) on the program. If you share custody of your child(ren), you will make sure that the WIC food benefits are shared for your child(ren).
- At any time, you can ask WIC staff to add or remove a second cardholder who can shop for WIC food benefits. You will make sure the second cardholder knows how to use their eWIC card and how to shop for foods.
- You will get food benefits from only one clinic at a time. If you move or expect to move soon, you will ask for a transfer paper.
- You will attend appointments or call ahead when you need to reschedule.
- You will attend all appointments to apply at least each year (certification). You can have another person or second cardholder attend follow-up appointments with your permission. If another person attends an appointment, they will share handouts or appointment details with you.
- You and a second cardholder (if applicable) will treat WIC and store staff with courtesy and respect.

What can you ask from WIC?

- *Standards for eligibility and participation in the WIC program are the same for everyone, regardless of race, color, national origin, age, handicap, or sex.*
- *You may appeal any decision made by the local agency regarding your eligibility for the program.*
- *The local agency will make health services, nutrition education and breastfeeding support available to you, and you are encouraged to participate in these services.*
- WIC staff will treat you with courtesy and respect.
- If you qualify for WIC, you will get WIC benefits to buy healthy foods. You understand that WIC does not give all the food or formula needed in a month.

Caregiver or Participant Rights and Responsibilities:

- I will notify WIC of <u>any</u> changes to the information I have given.
- I will not return WIC foods to the grocery store for money, credit, or other items. I will not sell or attempt to sell, trade, or give away WIC food benefits, formula or breast pumps paid for by WIC. If I do, I understand that I may be taken off WIC.
- If I break the rules, make false statements, or withhold facts about my eligibility for the WIC program, I understand that I can be taken off WIC.
- If I fail to receive WIC benefits for three months in a row, my WIC account will automatically be suspended and I can contact the clinic to reactivate it. Remembering to receive benefits is an important part of WIC participation.
- If I move out of state I will turn in my transfer paper from my old WIC clinic to my new WIC clinic.
- I will be told in writing when and why my WIC program benefits will end.
- Your rights and responsibilities are also written inside the Idaho WIC Food List.

(over)

Caregiver or Participant Consents:

Please **choose** if you **do or do not give permission** for the items below. Refusal of any or all consent has no effect on eligibility for or participation in WIC. You may review your record and have the right to cancel consent in writing at any time.

Yes	No	
❒	❒	The taking of height and weight measurements and a finger stick blood test to check iron status for myself and/or my child(ren). These are used to establish nutritional need for the WIC program.
❒	❒	The WIC program to share eligibility information (such as name, address, income level and birth date) for myself and my child(ren) with the Idaho Medicaid and SNAP programs for the purpose of referral.
❒	❒	The WIC program to share immunization status with the Immunizations program for referral purposes.
❒	❒	The WIC program to schedule remote or virtual appointments when possible, such as video or phone options offered by the clinic. I understand that I can opt out and come to the clinic for these appointments at any time.
❒	❒	The WIC program to contact me and leave messages at the phone number provided. I understand messages left on my phone may contain information such as the WIC program name, applicant, participant and/or family name(s) and information related to appointments. I understand I can notify the clinic and change my choice about WIC contacting me at any time.

By signing, you agree with the following:

- I have been advised of my rights and obligations under the program.
- I understand my rights and responsibilities and I agree to follow them.
- I understand that I am responsible for the use and behavior of my second cardholder, if applicable.
- I understand the WIC program uses health data and eligibility information for receiving WIC services and may share this information with local, State and Federal WIC programs. This information is also used for evaluating the success of the program, monitoring, and auditing the program. I release the Idaho Department of Health and Welfare from any and all responsibility and liability concerning the release of information I have consented to be released.
- I understand the Chief State Health Officer may allow sharing information about my participation in WIC with other Department of Health and Welfare programs that serve WIC-eligible persons. Sharing this information is for the collection of public health data to review outcomes.
- 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.

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.

WIC PARTICIPANT RIGHTS, RESPONSIBILITIES AND CONSENT

Please **choose** if you **do or do not give permission** for the following:

Yes	No	
❒	❒	The taking of height and weight measurements and a finger stick blood test to check iron status for myself and/or my child(ren). These are used to establish nutritional need for the WIC Program.
❒	❒	The WIC Program to share eligibility information (such as name, address, income level and birth date) for myself and my child(ren) with local, state, and federal WIC programs. This information may also be shared with the Idaho Department of Health and Welfare's Medicaid and SNAP programs for the purpose of referral.
❒	❒	The WIC Program to share immunization status with the Immunizations Program for referral purposes.
❒	❒	The WIC Program to schedule remote or virtual appointments when possible, such as video or phone options offered by the clinic. I understand that I can opt out and come to the clinic for these appointments at any time.
❒	❒	The WIC Program to contact me and leave messages at the phone number provided. I understand messages left on my phone may contain information such as the WIC program name, applicant, participant and/or family name(s) and information related to appointments. I understand I can notify the clinic and change my choice about WIC contacting me at any time.

You may review your record and have the right to cancel consent in writing at any time.

Please read the statements and check the box below to approve your understanding of the following:

- I have been advised of my rights and obligations under the program.
- I understand my rights and responsibilities and I agree to follow them.
- I understand that I am responsible for the use and behavior of my second cardholder, if applicable.
- I understand the WIC program uses health data and eligibility information for receiving WIC services and for evaluating the success of the program, monitoring, and auditing the program. I release the Idaho Department of Health and Welfare from any and all responsibility and liability concerning the release of information I have consented to be released.
- I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.
- All application information submitted is connected to the receipt of federal assistance. Program officials may verify application information.
- 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, _____, have read, understand and agree with the statements above.**
Name

_____
Date

FID#:_____
(For WIC staff use only)

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