Breastfeeding/Postpartum Women Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date ____________

1. Name (First, Middle, Last)

2. Birth Date — 331 332 333

3. **If receiving Medicaid, please provide Medicaid number:**

4. Is this person Hispanic or Latino? ☐ Yes ☐ No

5. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

6. How are you doing after having your baby? Please tell us if you have any concerns?

7. What was the actual date your baby was born?

8. What was your baby's weight at birth? What was the baby's length at birth?

9. At what Birthing Facility was the child born?

10. How many weeks did your pregnancy last?

11. When did your Prenatal care begin? (Month, Year)

12. How far apart were your last two pregnancies? 332

13. How many babies did you have during your last pregnancy? 335

14. How many times have you been pregnant? (Do not count this pregnancy)

15. How old are your children? 333

16. How much did you weigh before pregnancy?

17. Check it you had any of the problems during your recent pregnancy?

☐ Miscarried - How many? ________	321	☐ Baby born 3 or more weeks early	311	☐ Genetic or birth defects	339
☐ Stillbirth - How many? ________	321	☐ Baby, less than 5 pounds 9 oz at birth	312	☐ C-section	359
☐ More than one baby How many? ________	335	☐ Baby, 9 pounds or more at birth	337	☐ History of Gestational Diabetes	303
		☐ Baby died before 1 month old	321	☐ History of Preeclampsia	304

18. List any medication, vitamin, prenatal vitamins, mineral or herbal supplement you are taking. If not daily, how often? 357 427.01 427.04

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s) ex: hypertension, pre-hypertension, pre-diabetes, diabetes, anemia or gastrointestinal disorders. 201 302-304 341-349 351-363

Describe:

20. If you were in the hospital in the last 3 months, please tell us why. 359

Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars? ☐ Yes ☐ No If yes, How much a day? 371

22. Did you smoke in the last 3 months of your pregnancy? ☐ Yes ☐ No If yes, How many a day?

23. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? ☐ Yes ☐ No 904

24. Do you use smokeless, chewing tobacco or iqmik? ☐ Yes ☐ No If yes, How much a day?

25. Did you drink alcohol in the last 3 months of your pregnancy? ☐ Yes ☐ No If yes, How many a week? 371

26. Do you drink, wine, beer, or other alcoholic beverages? ☐ Yes ☐ No If yes, How many a day? If yes, How many a week? 372

To Be Completed by Health Care Provider (HCP)

Medical date________Ht________Pre-Pregnancy Wt________(101,111) Weight Before Delivery________Current Wt________(133) Hgb/Hct________(201)

Name of HCP verifying applicant lives in Alaska________________ID Verified by: Visual Recognition________/Other________WIC

Name of CPA reviewing WIC application________________Certification Date________________

27. Check any drugs you are using during this pregnancy:

☐ Cocaine ☐ Crack Methamphetamine ☐ Marijuana ☐ Speed ☐ Other ____________

☐ Crank ☐ Heroin ☐ Methadone ☐ None ☐ Stopped Using When? ____________

Eating & Feeding

28. What concerns, if any, do you have about having enough food to feed your family?

29. How are you feeding your baby? ☐ Breastmilk ☐ Breastmilk+Formula ☐ Formula Only

30. **If breastfeeding**, what date did it begin? When did breastfeeding end?

31. What was the reason that breastfeeding was stopped?

32. On a scale of 0 to 10,
How confident are you about breastfeeding your baby? Not Confident ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Confident

a. How long do you plan to breastfeed?____________ 601

b. I breastfeed__________times in 24 hours and each feeding lasts__________minutes. 601,602 602

33. **If formula only**, did you ever breastfeed? ☐ Yes ☐ No If yes, how long? (i.e. days or weeks)

34. When did you introduce formula?

35. On a scale of 0 to 10,
How well do you think you are eating? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. I usually eat __________meals/day and __________snacks/day.

b. I usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

c. I usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

36. Check if you crave or eat 427.03

☐ Ashes ☐ Carpet Fibers ☐ Clay ☐ Soil

☐ Baking Soda ☐ Chalk ☐ Dust ☐ Starch (laundry or corn starch

☐ Burnt Matches ☐ Cigarettes ☐ Paint Chips ☐ Large quantities of ice and/or freezer frost

37. Do you fast, binge, vomit to control your weight or follow a specific diet? ☐ Yes ☐ No 358 427.02

Describe:

38. Do you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others? 353-355 381

Additional

39. Have you been screened or referred for lead poisoning? ☐ Yes ☐ No 211

40. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping? ☐ Yes ☐ No 801

41. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? ☐ Yes ☐ No 801

42. Did a family member have a seasonal farming job with a temporary home in the last 24 months? ☐ Yes ☐ No 802

43. Are you in a relationship with anyone who pushes, hits or threatens you in any way? ☐ Yes ☐ No 901

44. How often do you feel down, depressed or hopeless? ☐ Never ☐ Sometimes ☐ Often ☐ Always 361

45. What type of milk you would like on your WIC check?

☐ Fresh/Refrigerated ☐ Boxed (UHT) ☐ Soy ☐ Dry ☐ Evaporated ☐ Lactose Reduced 355

46. What problems, if any do you have caring for yourself or your baby/children? 902

47. Write the date of you last dental check-up: (Month, Year) 381

48. What does your family do for fun?

49. How can WIC help your family today?

Thank You!

Family Information Form

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date ____________

1. Are you currently on WIC? ☐ Yes ☐ No **If yes, where?**

2. Have you been on WIC before? ☐ Yes ☐ No **If yes, where?**

3. How did you hear about WIC?

Applicant or Parent / Guardian for applicants under age 5 (Please print and use legal names)

4. Name (First, Middle, Last)	5. Maiden Name	6. Birth Date

7. Home address	8. Apartment or suite number

9. City	10. State	11. ZIP Code

12. Mailing Address (If different from Home address)	13. Apartment or suite number

14. City	15. State	16. ZIP Code

17. Cell phone number	18. Home phone number	19. Other phone number

20. May we call or leave a message? ☐ Yes ☐ No
21. May we send texts to your cell phone? ☐ Yes ☐ No
22. May we send mail for appointment reminders? ☐ Yes ☐ No

23. Email address:

24. Are you Hispanic or Latino? ☐ Yes ☐ No

25. Race (Check all that apply)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Household Information (Please provide proof of income and identification)

26. Are you applying for your own WIC benefits today? ☐ Yes ☐ No

27. Are you currently working? ☐ Yes ☐ No Pay per hour? Hours worked per week?

28. Is anyone else in the household working? ☐ Yes ☐ No Pay per hour? Hours worked per week?

29. Are you pregnant? ☐ Yes ☐ No

30. How many people are living in your household?

31. How many members of your household received last year's Permanent Fund Dividend? (Include even if garnished)

32. Check any of the following programs you or any family member is currently receiving:
☐ Food Stamps/SNAP ☐ Applied for Denali Kid Care, Medicaid, ATAP - "Application Pending" ☐ Medicaid
☐ Denali Kid Care ☐ Alaska Temporary Assistance Program - Amount: ____________ ☐ Head Start/School Lunch

33. Check any other money received by you or anyone in your household. (Include monthly amount)
☐ Supplemental Security Income/Disability ____________ ☐ Self Employment ____________ ☐ Unemployment ____________
☐ Native Corporation Dividends ____________ ☐ Commissions ____________ ☐ Other ____________

34. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Living with a partner / significant other

35. What is the highest grade in school you completed?

36. If you are a U.S. Citizen, do you want to register to vote here at the WIC office? ☐ Yes ☐ Already registered ☐ Not interested

37. Would you like someone else's name on your checks, who can pick up and use your checks for you? ☐ Yes ☐ No

If yes, please print name: ____________ Relationship: ____________ **Please sign on the back.** ⟶

Alaska WIC Rights and Responsibilities

You have rights and responsibilities as a WIC participant. The names and addresses of you and your child may be given to agencies such as Medicaid, Denali Kid Care, Supplemental Nutrition Assistance Program (SNAP), Heating Assistance, Temporary Assistance, Child Care, Infant Learning, Head Start and Public Health Nursing Programs for referral and outreach. Programs listed above may give the WIC program name(s), address, income, identification and residency for you and your child to help check if you qualify for WIC.

Other WIC information may also be shared with health programs to see if you qualify for their program's services, to share needed health information with programs you are already participating in, and to help assess the overall health of Alaskan families through reports and studies. These same programs listed below may also share their information with WIC for the same purposes. You may ask WIC staff for more information about these programs. These programs include: Medicaid, Denali Kid Care, Pro Care, Head Start, Supplemental Nutrition Assistance Program (Formally known as the Food Stamp Program), Immunizations Program, Public Health Nursing, State Epidemiology and Infant Learning Program.

I understand my Rights and Responsibilities

Responsibilities:

- I will treat WIC and store staff with courtesy and respect.
- All the information I give WIC is true and accurate. WIC staff can check this information.
- I will immediately report any changes in my income, family size, address, phone number or eligibility for Medicaid/Denali Kid Care, or the SNAP Program. I will also notify the WIC office if my card is lost or stolen, or if I am no longer breastfeeding.
- I will get WIC benefits from only one clinic at a time. If I move out of Alaska, I will ask for a transfer.
- I will not sell, or try to sell my eWIC card, trade or give away formula or other WIC food benefits and breast pumps. This includes sell of such items in person, in print, or online.
- I will be removed from the WIC program if my benefits are not issued or I do not use my benefits, for two months in a row.
- I will allow WIC staff to take my or my child's height and weight and take a small amount of blood to check my or my child's iron level. I understand this information is needed to check nutrition needs and determine eligibility for WIC.
- I will come to my appointments or call ahead when I need to reschedule.
- I will reapply for benefits as needed. I understand that WIC benefits are for participant use only.
- I will follow the WIC program and shopping rules that are on my WIC food list.
- WIC is a Federal program. If I break the rules, make false statements, intentionally misrepresent, conceal, or withhold facts about my eligibility for the WIC Program, I understand that:
  - I or my child can be taken off WIC.
  - I will have to pay money back to WIC for foods, formula or breast pumps I should not have received. If I do not pay back the WIC program for foods and/or formula that I accepted or return loaned breast pumps that I was not eligible to receive, the state may use other types of legal options to collect payment, including small claims court, which could result in **Permanent Fund Dividend (PFD) garnishment.**
  - I can face civil or criminal prosecution under State and Federal law.

Rights:

- If I qualify for WIC, I will get benefits to buy healthy foods. **I understand that WIC does not give all the food or formula needed in a month.** WIC foods help promote and support the nutrition and well-being and help meet the needed intake of important nutrients or foods for myself and / or my child(ren).
- WIC will give me information for healthy eating and active living. WIC will provide me with breastfeeding support.
- WIC will give me information to find a doctor and get immunizations for my child. I will be referred to other services.
- WIC staff will treat me with courtesy and respect.
- WIC will keep information about me and / or my child(ren) confidential and share only needed information to determine eligibility and for referral to other services.
- The rules for getting on WIC are the same for everyone. I can ask for a Fair Hearing if I do not agree with a decision about my WIC eligibility. WIC will tell me why my child or I qualify for the WIC Program.

By signing this form I agree that:

- **I have read the Rights and Responsibilities form or a WIC staff has read it to me.**
- **I agree to the above.**

____ ____________________

Client/Guardian Signature Required for WIC Enrollment **Date**

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.

Completed applications can be submitted by:

- fax to 907-842-2039 or
- email to WIC@bbahc.org or
- mail to WIC Office PO Box 130 Dillingham, AK 99576

Please check to make sure you have the following items completed before turning in your application.

☐ All pages of application completed

☐ Height, weight and hemoglobin taken
(this can be done at your local clinic or at the WIC Office, Public Health Center or Kanakanak Hospital)

☐ Read and sign your "Rights and Responsibilities"
(the last page of the application)

☐ Provide income information
(most recent pay stubs of everyone in household or copy of Denali Kid Care card or Food Stamp acceptance letter)

☐ Provide identification information
(DKC card/ Medicaid stickers, Drivers license, Birth certificate, or tribal enrollment card)

If you have any questions, please feel free to call us at 842-2036 or toll free 1-888-842-2037.

Alaska Income Eligibility Guidelines

If you are pregnant, add one to household size.

Household Size	Annual	Monthly	Weekly
1	$36,168	$3,014	$696
2	$48,896	$4,075	$941
3	$61,624	$5,136	$1,186
4	$74,352	$6,196	$1,430
5	$87,080	$7,257	$1,675
6	$99,808	$8,318	$1,920
7	$112,536	$9,378	$2,165
8	$125,264	$10,439	$2,409
For each additional family member add	$12,728	+$1,061	+$245

WIC clients are encouraged to work on one thing that you would like to accomplish with you and your child. Think of this as a goal for you and your family. Your goal can be as simple has weaning off the bottle, eating more fruits and vegetable, or being more physically active.

My family's goal is: ______________________________

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