



Child Application

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

Today's Date _____

1. Child's Name (First, Middle, Last)	2. Child's Birth Date <input type="checkbox"/> Boy <input type="checkbox"/> Girl
3. Your Name (First, Middle, Last)	4. Relationship to Child

5. If receiving Medicaid, please provide Medicaid number:

6. Is this child Hispanic or Latino? Yes No

7. Race (Check all that apply)

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

Current History

8. What concerns, if any, do you have about your child's eating behaviors or growth?

9. What was the child's Birth Weight? _____ Birth Length? _____

10. At what Birthing Facility was the child born?

11. How many weeks did your pregnancy last?

12. Please Answer if your child is under 2:

Child's birth weight was less than 5 lbs. 9 oz Yes No ¹⁴¹ My child's immunizations are up to date Yes No
My child was born at 37 weeks or less Yes No ¹⁴²

13. Check the box if you have any of the following concerns about your child:

Chewing/Swallowing Choking/Gagging Constipation Diarrhea Vomiting Other 342

14. List any medication, vitamin, mineral or herbal supplement your child takes.

357
425.07
425.08

15. Please, tell us if your child sees a doctor, dietitian or health care provider for medical or emotional reason(s)
ex: hypertension, pre-hypertension, diabetes, fetal alcohol syndrome, gastrointestinal disorders or anemia.

151
201
341-357
359
360,362
382

Describe:

16. If your child was in the hospital in the last 3 months, please tell us why.

359

Eating & Feeding

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

18. I am breastfeeding my child. Yes No

19. If breastfed, what date did it begin? _____ When did breastfeeding end? _____

20. What was the reason that breastfeeding was stopped?

21. If your child used(s) formula, at what age (weeks or months) did you first offer?

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

a. He/she usually eats _____ meals/day and _____ snacks/day.

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

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

23. My child eats: Liquid Foods Finger Foods Table Foods Mashed, Pureed / Baby Foods

425.04
428

To Be Completed by Health Care Provider (HCP)

Medical date _____ Current Wt _____ (103,113,134,135) Ht _____ (121) 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 _____

24. Check the box if your child eats any these foods. 425.05

<input type="checkbox"/> Raw sprouts: alfalfa, clover and radish <input type="checkbox"/> Raw or undercooked: meat, chicken, turkey, fish, eggs <input type="checkbox"/> Uncooked refrigerated smoked seafood <input type="checkbox"/> Unheated meats: lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs	<input type="checkbox"/> Food with raw or undercooked eggs: salad dressing, cookie and cake batter, sauces <input type="checkbox"/> Soft cheese made with unpasteurized milk: feta, mexican-style (queso blanco fresco), brie, blue <input type="checkbox"/> Unpasteurized milk or foods made with unpasteurized milk <input type="checkbox"/> Unpasteurized fruit or vegetable juice
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25. My child drinks from (Check all that apply): Sippy Cup Cup Baby Bottle 425.03

a. If your child drinks from a baby bottle, how many in 24 hours? _____

b. What's in the baby bottle? _____

26. When does your child get a baby bottle? Bedtime/Naptime Mealtime All day Other: _____ 425.03

27. When do you want your child to only use a cup?

28. Check if your child drinks regularly 425.01
425.02

<input type="checkbox"/> Water	<input type="checkbox"/> Dry milk	<input type="checkbox"/> Whole milk	<input type="checkbox"/> Sweet tea	<input type="checkbox"/> 100% Pasteurized juice	<input type="checkbox"/> Cereal/Solid foods in a baby bottle
<input type="checkbox"/> Pedialyte	<input type="checkbox"/> Raw milk	<input type="checkbox"/> 1% or 2% milk	<input type="checkbox"/> Coffee/tea	<input type="checkbox"/> Fruit drink (not 100% juice)	
<input type="checkbox"/> Soy milk	<input type="checkbox"/> Breastmilk	<input type="checkbox"/> Evaporated milk	<input type="checkbox"/> Tang/Kool-aid	<input type="checkbox"/> Raw juice	<input type="checkbox"/> Other _____
<input type="checkbox"/> Skim milk	<input type="checkbox"/> Rice milk	<input type="checkbox"/> Formula	<input type="checkbox"/> Pop/Soda	<input type="checkbox"/> Sports Drinks	

29. Check if your child craves or eats: 425.09

<input type="checkbox"/> Ashes	<input type="checkbox"/> Carpet Fibers	<input type="checkbox"/> Clay	<input type="checkbox"/> Soil
<input type="checkbox"/> Baking Soda	<input type="checkbox"/> Chalk	<input type="checkbox"/> Dust	<input type="checkbox"/> Starch (laundry or corn starch)
<input type="checkbox"/> Burnt Matches	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Paint Chips	<input type="checkbox"/> Large quantities of ice and/or freezer frost

30. Does your child eat meals with the family?

31. Is your child on a special diet? 425.06

32. Does your child have any problems eating any type of food for any reason such as dental problems, food intolerances, or others? 354
355
381

33. List any food allergies your child may have. 353

Additional

34. Has your child been screened or referred for lead poisoning? Yes No 211

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

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

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

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

39. Do you have any concerns about anyone hurting your child? Yes No 901

40. Has your child been in foster care or moved to a new foster home within the last 6 months? Yes No

41. What type of milk you would like with your WIC benefits? 355

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

42. In a typical day, how much time does your child watch TV, play video games and or play computer games?

Less than 1 hour 1-2 hours More than 2 hours

43. Do you have problems taking care of your child? 902

44. Write the date of you last child's last dental check-up: (Month, Year) 381

45. For dads, please tell us your weight: _____ height: _____

46. What does your family do for fun? _____

47. How can WIC help your family today? _____



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, audiotope, 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.

Revised: 6/14/19

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 as weaning off the bottle, eating more fruits and vegetable, or being more physically active.

My family's goal is: _____