DELAWARE WIC

Program Rights & Responsibilities

Participant Name:_____ WIC ID #:_____ Date:_____

ELIGIBILITY

☐ Participates in Medicaid, TANF or SNAP

☐ Presumptive Eligibility (Medicaid, TANF or SNAP)

☐ Valid VOC Card

☐ Household Gross Income within WIC Income Limits

Documents used for proof of Income:_____ Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Amount:_____ ☐ Semi-Monthly ☐ Other

Document used for Personal Identification:_____

Document used for Proof of Residency:_____

I CERTIFY THAT I RECEIVED AN eWIC CARD (IF APPLICABLE).

I WILL:

1. Tell the WIC staff if I cannot keep my appointment, before I miss it.
2. Tell the WIC staff if there are changes in my eligibility status.
3. Bring my Proof of Identification to every WIC clinic visit.
4. Use the eWIC card properly. I will:
   - Keep it clean, away from magnets and electronics, and not leave it in direct sunlight.
   - Safeguard my eWIC card and PIN.
     - Be careful about sharing my eWIC card and PIN. Food benefits will not be replaced if my eWIC card was misused by any person to whom I give my eWIC card and/or PIN.
   - Tell WIC staff if my eWIC card is lost or stolen.
5. Purchase only the foods on my shopping list. Substitutions, rain checks or IOUs are not allowed.
6. Teach the Second Parent or Designee to use the eWIC card correctly. I am responsible for their actions.
7. Tell WIC staff about any complaints or problems about the store.

WIC RULES

I may have to pay back the cost of WIC foods I received or I may be taken off WIC and/or have legal action taken against me if:

1. I do not tell the truth.
2. I try to or actually participate in more than one WIC program at the same time.
3. I try to or actually obtain WIC benefits under another name.
4. I enroll a child not in my legal care.
5. I do not keep my certification appointments.
6. I try to or actually return or exchange any of my authorized WIC foods and/or formula.
7. I try to, actually sell or give away my eWIC card or any of my WIC benefits (food, formula, breast pumps). This includes verbally offering or posting an offer in print or online.
8. I use abusive language, threaten, or being physically violent with people at the WIC office or WIC stores.

REMEMBER

1. Measurements including height, weight and a blood test for hemoglobin will be done as part of determining WIC eligibility.
2. I am responsible for the actions of the Second Parent or Designee.
3. eWIC benefits are like cash. Used benefits will not be replaced.
4. eWIC benefits are only redeemable at WIC authorized stores.

RELEASE OF INFORMATION

I understand that information provided to the WIC program that identifies an individual can be released to WIC staff, Division of Public Health or USDA Officials. It may also be released to representatives designated by the Director of Public Health to other health and welfare programs serving WIC participants including the Delaware Immunization Registry. This information is used only to evaluate the eligibility of WIC participants for these programs and for outreach purposes.

DELAWARE PREGNANCY RISK ASSESSMENT RELEASE OF INFORMATION

_____ _____
(Initial) *(Date)*

I authorize the WIC Program to release my personal contact information to the Delaware Pregnancy Risk Assessment Team.

_____ _____
(Initial) *(Date)*

I do not authorize the WIC Program to release my personal contact information to the Delaware Pregnancy Risk Assessment Team.

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 made 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 or Federal law. I may appeal any decision made by the local agency regarding my eligibility for the program. I will call the clinic site or State Agency Office at 1-800-222-2189 if I disagree or have any questions about any decision made in the clinic.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) email: Program.Intake@usda.gov

This institution is an equal opportunity provider.

My Signature shows that I understand the WIC Program Rules

Participant/Parent or Guardian of Participant *(printed)*	Participant/Parent or Guardian of Participant *(signature)*	Date
Designee *(printed)*	Designee *(signature)*	Date
WIC Staff Name *(printed)*	WIC Staff Name *(signature)*	Date