Attachment 8.14A

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 or 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.

1. 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.

2. 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: ☐ **P** ☐ **B** ☐ **N** ☐ **I** ☐ **C** ☐ **New** ☐ **Recertification**	**Immunization Record** ☐ Yes ☐ No ☐ N/A
Participant's Name _____	**DOB** _____
WIC ID # _____	
Identity Proof _____	
HEIGHT _____ Inches ☐ Standing ☐ Recumbent	
WEIGHT _____ lbs _____ ozs.	
HGB _____ mg/dl HCT _____ %	
☐ Referral Form is Attached _____ Staff Initials	
This applicant is eligible ☐ **Yes** ☐ **No**	**Participant was present?** ☐ **Yes** ☐ **No**
CPA Who Determines Nutritional/Medical Risk:	
PRINT Name _____	
CPA Signature _____ **Date** _____	

STATUS: ☐ **P** ☐ **B** ☐ **N** ☐ **I** ☐ **C** ☐ **New** ☐ **Recertification**	**Immunization Record** ☐ Yes ☐ No ☐ N/A
Participant's Name _____	**DOB** _____
WIC ID # _____	
Identity Proof _____	
HEIGHT _____ Inches ☐ Standing ☐ Recumbent	
WEIGHT _____ lbs _____ ozs.	
HGB _____ mg/dl HCT _____ %	
☐ Referral Form is Attached _____ Staff Initials	
This applicant is eligible ☐ **Yes** ☐ **No**	**Participant was present?** ☐ **Yes** ☐ **No**
CPA Who Determines Nutritional/Medical Risk:	
PRINT Name _____	
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.

Rev. 01/2016

☐ **Additional WIC Participants** →

Attachment 8.14B

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 #** _____

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 dias a partir de que la agencia local emita una decisión relacionada con su eligibilidad 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 immunización 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 entragado pueda someterme a prosecución civil o criminal bajo las leyes Federales y Estatales. Comprendo que es ilegal estar inscrito en más de una clinica de WIC al mismo tiempo, en Nueva Jersey, o en otro estado.

1. Certifico que este/a participante no está inscrito/en ningún otro programa o clinica de WIC y que no se tratará de inscribir en ningún otro programa/clinica de WIC mientras esté inscrito/a aqui.
2. 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 período de un año.

Comprando, vendiendo o abusando los beneficios de WIC es un crimen. Para reportár 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** _____

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

Rev. 01/2016

☐ **Additional WIC Participants** →