Ohio Department of Health

WIC Program Application

Please answer all questions on the top portion of this page.

Parent, guardian or applicant's name	Other parent/guardian	Telephone ☐ Home ☐ Work ☐ Cell ☐ Leave Message Phone Number

Street Address	City	State	ZIP	County
Mailing address (if not the same as street address)	City		State	ZIP

Is anyone else in your household pregnant, recently had a baby, or is an infant or child under the age of 5? ☐ Yes ☐ No I,C,P,N,B

By signing this WIC application, I agree to give proof of eligibility for information entered on this form and any other information asked to meet program rules.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided to me under the Medicaid, WIC, and other medical assistance programs.

I also authorize the Ohio Department of Health, the Ohio Department of Medicaid, and the Ohio Department of Job and Family Services to exchange any information I have provided through the application process to enable the departments to determine my eligibility.

I understand that this application is considered without regard to race, color, national origin, sex, age, or disability.

By my signature below, I affirm under penalty of perjury that to the best of my knowledge and belief all answers on this application are true and complete. I understand that the law provides penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive.

Signature of applicant who completed this form	Date of signature
Signature of person who helped complete this form	Date of signature

STOP HERE

AGENCY USE ONLY

Pregnancy Verification ☐ Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephone (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Name (I C P N B) ☐ Present ☐ Exempt	Document type or number	Name (I C P N B) ☐ Present ☐ Exempt	Document type or number
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Medicaid/OWF/SNAP verification			
WIC personnel signature			Date

Ohio Department of Health

WIC Program Addendum

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I am requesting that my WIC services be continued.

I have reviewed and updated information since my last application ☐ **Yes** ☐ **No**

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Signature of person who helped complete this form	Date of signature

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WIC personnel signature			Date

HEA 4460 (Revised 4/19)

This institution is an equal opportunity provider.

Ohio Department of Health

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