

**SOUTH DAKOTA DEPARTMENT OF HEALTH
WIC PROGRAM
PARTICIPANT AGREEMENT PARTICIPANT RIGHTS AND RESPONSIBILITIES**

Participant Name: _____

The Total Income Amount I Declared Is: Cert 1: _____ Cert 2: _____

AS A PARTICIPANT OF THE WIC PROGRAM I HAVE THE RIGHT TO:

- Appeal any decision made by the Program regarding my eligibility for the WIC Program.
- The same standards for eligibility and participation regardless of race, color, national origin, sex, age or disability.
- Be notified not less than 15 days before my certification period expires.
- Be assured that my race/origin data collection is used for statistical data collection purposes only and will not affect my ability to receive WIC benefits.
- Know that information that I provide to WIC is kept confidential.

MY RESPONSIBILITIES AS A PARTICIPANT OF THE WIC PROGRAM ARE TO:

- Assure that I am not participating in the WIC program at more than one WIC office or program.
- Assure that I am not participating on the Commodity Supplemental Food Program.
- Keep all appointments including certification, follow-up nutrition education counseling and picking up my WIC checks.
- Notify the WIC office to reschedule a new appointment, if I am unable to keep an appointment.
- Notify the WIC office if I am running late and will not make the scheduled time.
- Take good care of my WIC checks as WIC checks will not be replaced.
- Notify the WIC office if my WIC checks are lost or stolen and notify the police if stolen.
- Assure that the family member eligible for the WIC program is the person using the WIC foods received.
- Notify the WIC office if: my income changes, my address changes, or the number of family members changes.
- Assure that I or my alternate will bring the WIC ID pouch when picking up WIC checks and cashing them at grocery store.
- Teach the person I chose as my alternate how to pick up and use my WIC checks.
- Assure that I or my alternate will :
 - Cash the WIC checks before they outdate.
 - Buy only WIC approved foods.
 - Not change, sell or trade WIC checks.
 - Sign the WIC check when cashing at the store.
- Treat all WIC staff, store employees and other WIC participants kindly and with respect.

AT THE TIME OF MY WIC CERTIFICATION:

- WIC will tell me why I or my family member is eligible for WIC.
- WIC may share information that is provided to them with:
 - The Office of Disease Prevention staff for program eligibility and outreach.
 - Other WIC Programs and The Commodity Supplemental Food Program to prevent a person from being on two programs at the same time.
 - South Dakota Department of Health and Education Programs called Baby Care, Bright Start, Children's Special Health Services, Newborn Metabolic Program, Family Planning and HeadStart/Early HeadStart for program eligibility and outreach.
- I will receive access to other health care services.
- I will receive Nutrition Education Counseling and educational information.
- I will allow the WIC staff to obtain height or length and weight.
- I will allow the WIC staff to complete a blood test as needed.
- WIC staff will notify me that should I miss my appointment for certification my previous certification will expire and I will not be able to receive WIC checks until a new certification has been completed.

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 if I do not sign this agreement I cannot be on WIC.

Cert. 1 _____ Signatures of Participant or Parent/Guardian _____ Date Cert. 2 _____ _____ Date

Cert. 1 _____ Administrative Signature _____ Date Cert. 2 _____ _____ Date

"This institution is an equal opportunity provider"