

WIC Program Income Screening		D.O.B.	Social Security No.	Employer's Name and Address (physical or city) and/or WIC Form Number (if applicable)	Different pay frequency/Annual:		Same pay frequency: weekly, every 2 weeks, twice monthly, monthly	SEU
Household Members					Paid weekly X by 52	Paid every 2 weeks X 26		
A/P/G #1								
P/G #2								
Participant #1								
Participant #2								
Participant/Other								
Participant/Other								
Participant/Other								
Participant/Other								
Participant/Other								
Participant/Other								
Participant/Other								
Participant/Other								
Gateway Verification Client ID or Case #: _____				1) Compare Total to Income Guidelines	1 Annual Total	or	1 Total	
<input type="checkbox"/> By Phone — Contact Name: _____ <input type="checkbox"/> Automated — Phone No.: _____ <input type="checkbox"/> Online				1a) Meets Income Guidelines Yes <input type="checkbox"/> No <input type="checkbox"/>				
				2) Monthly income to be entered in TWIN and other side of WIC-35	2 Annual total divided by 12	or	2 Determine annual total and divide by 12	

FOR WIC STAFF USE ONLY

SEU — must meet the requirements in WIC Policy CS:10.0.

(a) The unit usually purchases or intends to purchase, and prepare food separately.

(b) The unit meets the minimum income requirements for an SEU as listed in WIC Policy CS:10.0.

Income Checked by _____ **Staff Signature** _____ **Title** _____ **Date** _____

Disclosure of your Social Security number and that of your dependents is voluntary and WIC services will not be denied if you fail to do so. Social Security numbers are collected in accordance with 42 U.S.C. 405(c)(2)(C)(i), 7CFR246.7(d)(2)(v) and WIC Policy CS: 13.0 to verify information you have provided and to guard against dual participation as required by 7CFR246.7(l).

I hereby state that neither my dependents nor I currently receive benefits from another clinic. I also agree that I (we) will not receive WIC benefits from more than one clinic or State WIC Program during the same period. I understand that receiving dual benefits is considered fraud.

Receiving dual benefits may subject me to:

- repaying in cash the value of food benefits improperly issued to me and/or my dependent(s)
- prosecution under state and federal laws, and
- being disqualified from participating in WIC.

By signing this form, I certify that all 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. WIC

program officials may verify information including income and date of birth. I understand that intentionally making a false or misleading statement or intentionally omitting or withholding facts may result in my paying the state, in cash, the value of food benefits improperly issued and that I and/or my household members can be removed from WIC or criminally prosecuted or both.

Divulgar su Número de Seguro Social o el de sus dependientes es voluntario de manera que los servicios de WIC no se le pueden negar por no proporcionarlos. Los Números de Seguro Social se piden de acuerdo con 42 U.S.C. 405 (c)(2)(C)(i), la regla 7CFR246.7(d)(2)(v) y la norma de WIC CS: 13.0 para verificar la información que usted ha proporcionado y para evitar la participación doble de acuerdo con los requisitos de la regla 7CFR246.7(l).

Declaro que en este momento ni mis dependientes ni yo estamos recibiendo beneficios de ninguna otra clínica. Además, estoy de acuerdo en que yo (nosotros) no recibiré (no recibiremos) beneficios de más de una clínica o programa estatal de WIC a la vez. Entiendo que esto se considera un fraude. Al recibir beneficios dobles, es posible que:

- tenga que pagar en efectivo el valor de los beneficios de alimentos que recibimos indebidamente mis dependientes y yo,
- sea juzgado bajo las leyes estatales y federales, y
- sea descalificado para participar en WIC.

Con mi firma certifico, hasta donde tengo conocimiento, que es verdadera toda la información que proporcioné para determinar mi elegibilidad para el programa. Esta forma de certificación se entregará al recibir la asistencia federal. El personal de WIC puede verificar la información incluyendo ingresos y fecha de nacimiento. Entiendo que el hecho de falsificar o usar información engañosa, así como omitir intencionalmente datos, puede resultar en un reembolso con dinero al contado para el estado por el valor de los alimentos distribuidos indebidamente. Además, yo u otros miembros de la unidad familiar podemos ser removidos del programa WIC, enfrentar un proceso penal o ambos.



Applicant's or Parent's/Guardian's or Authorized Adult's Signature (Firma de solicitante o padre/tutor o del adulto autorizado) _____ **Date (Fecha)** _____