Mississippi State Department of Health (MSDH)
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Local Agency Application

Purpose	To apply for approval to establish a new WIC clinic or relocate an existing WIC clinic.
When To Use	When an agency wants approval to establish a new WIC clinic or relocate a WIC clinic. Applicants must be a public or private nonprofit health agency that will provide ongoing, routine pediatric or obstetric care and administrative services.
Instructions	1. Complete all fields on the form. 2. Attach additional information if necessary.
Disposition	Submit the application to WIC State Agency.
Retention	Retain a copy for local files.

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I. CLINIC INFORMATION

1. Select the option that applies:
   a. ☐ New agency applying to operate a WIC clinic.
   b. ☐ Current local agency applying to add a WIC clinic location.
   c. ☐ Current local agency applying to move to a WIC clinic location.
2. Applicant Health Clinic:
   a. Name: _____
   b. Address: _____
   c. City: _____
   d. State: _____
   e. Zip Code: _____
   f. County: _____
3. Clinic Director Name:_____
4. Clinic Director Title: _____
5. Contact Person for WIC: _____
6. Contact Person for WIC's Title: _____
7. Agency / Organization Sponsoring Clinic:
   a. Name_____
   b. Address: _____
   c. City: _____
   d. State: _____
   e. Zip Code: _____
   f. County: _____

8. Source(s) of Clinic

   Funding:_____

   _____

9. Is the facility a for-profit or non-profit clinic? (check the answer)
   - ☐ For-profit
   - ☐ Non-profit

10. IRS Tax Exemption Certification Number (if applicable): _____

11. Does the agency anticipate overall WIC Program growth with this site or re-distribution of the current caseload? (Please check all that apply)
    a. ☐ Overall growth
    b. ☐ Re-distribution of current caseload

12. Has your organization/ agency been suspended or federally disbarred?
    (Please check answer).
    a. ☐ Yes
    b. ☐ No

II. STAFF

13. Complete the table below. Enter a number by the type of clinic staff who will assess applicants for determination of eligibility. This includes physicians, nutritionists, dietitians, registered nurses, or physician assistants.
A clinic staff authority must be a physician, nutritionist (Master's or Bachelor's degree in Nutritional Sciences, Community Nutrition, Clinical Nutrition, Dietetics, Public Health Nutrition, or Home Economics with emphasis in Nutrition), dietitian, registered nurse, physician assistant certified by the State medical certifying authority.

Number of FTEs	Type
	Physician(s)
	Nutritionist(s)
	Dietitian(s)
	Registered Nurse(s)

14. Complete the table below. Enter the number of clinic staff by type who will provide applicants with nutrition education. Please note that all WIC certifiers must successfully complete a competency-based training program on performing WIC certification duties and have literacy and language skills appropriate to address the needs of diverse participants.

Number of FTEs	Type
	Physician(s)
	Nutritionist(s)
	Dietitian(s)
	Registered Nurse(s)

15. Complete the table below. Enter the number of FTEs and type of other clinic staff (not referenced in #13 and #14) who will interact with determining eligibility for WIC participants. Some examples include clerical, lab, aide, etc.

Number of FTEs	Type

III. CLINIC SERVICES

16. List ongoing services presently available to pregnant, post-partum, and breastfeeding women._____

17. List ongoing services presently available to infants and children up to 5 years of age._____

18. List current nutrition services provided.

19. Specify the current lab test method used for the following: Select all that apply.
    a. ☐ Hemoglobin by _____ Method
    b. ☐ Hematocrit by _____ Method
    c. ☐ Other. If other, please specify the lab test and method below:

20. The clinic must have internet access during business hours. Please indicate availability of internet and/ or any potential challenges for accessing the WIC management information system online.

21. Access to computer(s), scanner(s), and printer(s) is required. Please indicate availability of these devices and/ or any potential challenges for gaining access to these devices.

22. Provide the following information currently recorded in patient records.

Pregnant and postpartum women

a. ☐ Height

b. ☐ Weight

c. ☐ Medical History

d. ☐ Hemoglobin

e. ☐ Hematocrit

f. ☐ Diet records

g. ☐ Other routinely recorded lab tests:

_____

_____

h. ☐ Other recorded medical data:

_____

_____

Infants and children up to age 5

a. ☐ Height

b. ☐ Weight

c. ☐ Head circumference (infants only)

d. ☐ Hemoglobin

e. ☐ Hematocrit

f. ☐ Diet records

g. ☐ Immunizations

h. ☐ Other routinely recorded lab tests:

_____

_____

_____

i. ☐ Other recorded medical data:

_____

_____

IV. CRITERIA FOR RECEIVING SERVICES

23. Specify any financial, residential, or socioeconomic restrictions on clinic populations.

_____

_____

_____

24. Enter the estimated number of migrant workers served annually. _____

V. PROPOSED WIC OPERATIONS

25. What hours and days of the week would the location be open for WIC clients? For the days of the week listed below, please enter the hours of operation. Enter ***closed*** as the open time if you are closed for that day.

Day of the Week	Open Time	Close Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

26. Estimated number of WIC participants to be served monthly: _____

27. Complete the table below. Specify the estimated monthly number of potential WIC participants in each of the categories listed below:

Number	WIC Category
	Pregnant women
	Postpartum women (up to 1 year)
	Breastfeeding women (up to 1 year)
	Infants (under 1 year of age)
	Children (1 to 4 years of age)

28. Outline a proposed timeframe for adding WIC services to current services already being offered by the clinic. Please be sure to include proposed opening date.

_____
_____
_____
_____
_____
_____

29. Specify reasons for applying for WIC Local Agency Status.

_____
_____
_____
_____

30. Is the proposed population underserved? (Please check answer)
    a. ☐ Yes
    b. ☐ No

VI. COMPLIANCE

31. Provide the following for any Civil Rights complaints received by your clinic during the past two (2) years.
    - Date complaint received_____
    - Explanation of complaint

      _____
      _____
      _____
      _____

    - Status of complaint

      _____
      _____
      _____
      _____

32. Have all substantiated Civil Rights issues been resolved? (please check answer)
    a. ☐ Yes
    b. ☐ No
33. Does the clinic have non-discrimination policies based on race, color, national origin, age, sex, gender identity, or disability? (please check answer)
    a. ☐ Yes
    b. ☐ No
34. Is there a significant proportion of non-English or limited English proficiency persons residing in the service area? (please check answer)
    a. ☐ Yes
    b. ☐ No
35. The clinic must have resources available to serve non-English speaking individuals and individuals with limited English proficiency (LEP). Please indicate what resources are currently available. (Check all that apply).
    a. ☐ Language access line
    b. ☐ Qualified bilingual staff

c. ☐ Qualified contracted interpretation service

d. ☐ Translated materials

e. ☐ Other. Please specify:

_____

_____

36. The clinic must be able to offer auxiliary aids and services and provide reasonable accommodations in the program or activity whenever a person with a disability request such aids and services or accommodations. Please indicate what resources are currently available. (Check all that apply).

a. ☐ Wheelchair accessible

b. ☐ Video interpretation services for deaf or hard of hearing

c. ☐ Access for service animals

d. ☐ Large print

e. ☐ Use of relay line

f. ☐ Other. Please specify: _____

37. Is the space used for the WIC clinic accessible by participants or applicants with strollers? (please check answer)

a. ☐ Yes

b. ☐ No

38. Is the clinic tobacco-free? (please check answer)

a. ☐ Yes

b. ☐ No

39. Will the clinic provide a space for breastfeeding staff or participants to pump and feed? (please check answer)

a. ☐ Yes

b. ☐ No

40. Describe the racial/ ethnic makeup of the service area.

_____

_____

VII. ATTACHMENT A. DESCRIPTION OF COSTS TO WIC BUDGET

For a new clinic, please provide a detailed budget for each site.

Clinic Name:

_____

Table 1. One Time Costs

Type of Cost	Cost	If no cost, indicate how this is supplied.
Moving	$	
New furnishings – TOTAL of all items listed below	$	
Office desk(s)	$	
Office chair(s)	$	
Waiting room chair(s)	$	
Bulletin board(s)	$	
Mobile WIC cart(s)	$	
Locking storage cabinet(s) for eWIC cards, returned formula, FMNP FI's, etc	$	

Infant changing table for bathroom	$	
Trash can(s)	$	
Other (Please specify):	$	
New equipment – TOTAL of all items listed below	$	
Desktop computer(s)	$	
Laptop computer(s)	$	
Scanner(s)	$	
Printer(s)	$	
Standing scale	$	
Infant scale	$	
Infant measuring board	$	
Height measuring device	$	
Hematological device(s) and supplies	$	
Breastfeeding room supplies	$	
Office supplies	$	
Wiring/ site preparation	$	
Other (please specify)	$	
TOTAL:	$	

Table 2. Recurring costs (per month)

Type of Cost	Cost	If no cost, indicate how this is supplied.
Rent	$	
Square footage		
Difference in rent from current to new location, if relocating	$	
Utilities	$	
Maintenance / Janitorial	$	
Internet	$	
Phone	$	
Other (please specify):	$	
TOTAL:	$	

Please use this space to add any additional information the WIC State Office should consider, if applicable:

VIII. SIGNATURES

WIC Services provided must adhere to Federal Regulations and the Mississippi State Department of Health policies.

PLEASE READ CAREFULLY AND SIGN BELOW:

Submission of this application does not constitute authorization to participate in the MSDH WIC Program. This application is NOT an Agreement. Participation in the MSDH WIC Program will not be authorized until all completed application materials have been received, evaluated, and approved. The MSDH WIC Program or its designee may verify the information contained in this application.

1. I certify that all information submitted on this application is accurate and complete.

2. I understand that if the application is approved and an Agreement is executed, I will be bound by all rules and requirements of the MSDH WIC Program, in addition to the terms and conditions of the Mississippi State Department of Health WIC Subgrant Agreement.

3. I understand that if any information contained in this application is found to be false, the application will be denied, or if authorized, can result in being suspended or disqualified from participating in the MSDH WIC Program.

4. The undersigned declares that he/she has the legal authority to sign this application.

Signature: _____ Date: _____

Title: _____

E-Mail: _____

Telephone: _____

IX. FOR MSDH AGENCY USE ONLY

Date received: _____

Select one: ☐ Complete: ☐ Incomplete:

Applicant notification date(s): _____

Mississippi State Department of Health
WIC Program
State WIC Director
P.O. Box 1700
Jackson, MS 39215-1700

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