

# Women, Infants, and Children (WIC) Program Application

5303 S. Cedar St, Lansing, MI 48911 • Phone: (517) 887-4326 • Fax: (517) 676-7278

Note to Applicant: Please ask a healthcare provider to help you complete this form. If you do not have a healthcare provider to assist you, please provide as much information as you are able. Please return the completed form to the WIC office, located in the Ingham County Health Department, or mail it to: 5303 S. Cedar St., PO Box 30161, Lansing MI 48909-7661

Please note that if your infant needs a special infant formula, WIC can only provide this after your healthcare provider completes the *Special Formula Request Form* which can be located at [michigan.gov/wic](http://michigan.gov/wic) under the *Medical Providers* link. Your healthcare provider will need to fax the *Special Formula Request Form* to (517) 676-7278.

GENERAL INFORMATION	MOTHER (BREASTFEEDING, PREGNANT, OR POSTPARTUM)
<p>Applicant's name: _____</p> <p>Date of birth: _____</p> <p>Phone: (     )     -  <input type="checkbox"/> Home   <input type="checkbox"/> Cell   <input type="checkbox"/> Work</p> <p>Address: _____</p> <p>City and Zip: _____</p> <p>Medicaid #: _____</p> <p>Number in household: _____</p> <p>Household gross income: \$ _____  <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly   <input type="checkbox"/> Annually</p> <p>Assistance received:   <input type="checkbox"/> SSI   <input type="checkbox"/> Food Stamps  <input type="checkbox"/> FIP   <input type="checkbox"/> Medicaid</p> <p>Race:   <input type="checkbox"/> White   <input type="checkbox"/> Black or African American  <input type="checkbox"/> Asian  <input type="checkbox"/> Native Hawaiian or Pacific Islander  <input type="checkbox"/> American Indian or Alaskan Native</p> <p>Ethnicity:   <input type="checkbox"/> Hispanic/Latino   <input type="checkbox"/> Arabic</p> <p>If interpreter desired: Language: _____</p>	<p>Date of exam: _____</p> <p>Mother's name: _____</p> <p>Date of birth: _____</p> <p>Current weight: _____ Circle: lbs / kg</p> <p>Pregnancy weight gain: _____ Circle: lbs / kg</p> <p>Weeks gestation: _____</p> <p>Expected due date: _____</p> <p># of pregnancies: _____</p> <p># of live births: _____</p> <p>*Medical concerns or special dietary needs: _____</p>

INFANTS AND CHILDREN UNDER 5 YEARS OF AGE (USE A SECOND FORM IF MORE THAN 3 CHILDREN)			
	INFANT/CHILD 1	INFANT/CHILD 2	INFANT/CHILD 3
Name:	_____	_____	_____
Date of birth:	_____	_____	_____
*Medical concerns or special dietary needs:	_____	_____	_____

*\*If a special formula or supplemental beverage is medically indicated, the Special Formula Request Form must be completed by a healthcare provider. This request will be subject to approval by a WIC staffed Registered Dietitian.*

(Optional) Signature of Physician or Health Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

## WHAT WIC PROVIDES

Healthy Foods	Nutrition Education	High Risk Nutrition Counseling	Breastfeeding Support
Supplemental nutritious foods are provided for infants, children under 5, and women who are breastfeeding, pregnant, or postpartum.	<ul style="list-style-type: none"> <li>• Infant and toddler feeding</li> <li>• Breastfeeding</li> <li>• Prenatal weight gain</li> <li>• Anemia or iron deficiency</li> <li>• Child growth and development</li> <li>• Many other nutrition topics that parents deal with today</li> </ul>	Individualized, nutrition counseling is provided by registered dietitians at no cost to you.	The American Academy of Pediatrics recommends breastfeeding for the first year of life. Peer Counselors and Certified Lactation Consultants provide support and counseling to help you achieve this goal.

## INCOME GUIDELINES

Family Size**	Hourly	Weekly	Bi-Weekly	Monthly	Annually
1	\$11.10	\$445	\$889	\$1,926	\$23,107
2	\$15.04	\$602	\$1,204	\$2,607	\$31,284
3	\$18.97	\$759	\$1,518	\$3,289	\$39,461
4	\$22.90	\$917	\$1,833	\$3,970	\$47,638
5	\$26.83	\$1,074	\$2,147	\$4,652	\$55,815
6	\$30.76	\$1,231	\$2,462	\$5,333	\$63,992
7	\$34.69	\$1,388	\$2,776	\$6,015	\$72,169
8	\$38.62	\$1,546	\$3,091	\$6,696	\$80,346
9	\$42.55	\$1,703	\$3,405	\$7,377	\$88,523
10	\$46.49	\$1,860	\$3,720	\$8,059	\$96,700

*\*\*Pregnant women are counted as 1+ the number of expected infants*

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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