# Kids Campus
# 468 Browns Lane
# Coshocton, OH 43812
# 740.622.3542

Maria Hay Forbes Centre

## Kids Campus Preschool and Child Care
## Enrollment Forms and Procedures
## For Child Care and Preschool Classroom

*Complete entire Enrollment package and return to Child Care Administrative Assistant with $25 enrollment fee.*

*Things to bring on your child's first day:*

*Preschool: A full change of clothes, a small pillow and/or blanket, and a box of tissues.*

*Infant: A full change of clothes, blanket, diapers, baby wipes and bottles, (a clean bottle for each feeding).*

*Toddlers: A full change of clothes, blanket, diapers, and baby wipes.*

*Please label all items.*

**Kids Campus**

**Preschool and Child Care**

# Congratulations!!

Your child is enrolled, or you may be considering enrolling your child, in a learning and development program whose level of quality exceeds Ohio's child care licensing standards.

High quality learning and development program settings are important because early experiences last a lifetime. Your child has 1,892 days from the day they are born until they enter kindergarten. What happens on this journey lays the foundation for success in school and life.

A Step Up To Quality **Three-Star** rated program means that your child is in a program where:

- **The administrator and teachers have higher education qualifications.**
  The administrator and 50% of lead teachers have an associate degree or equivalent. These qualifications benefit your child's development and learning.

- **The administrator and teachers complete 20 hours of specialized training every two years.**
  The administrator and teaching staff are committed to expanding their knowledge and skills to better support your child's development and learning.

- **Each year the lead teacher uses results from a classroom self-assessment to develop a plan to improve their classroom.**
  The program evaluates the classrooms and teacher/child interactions to make sure the environment supports children where they are in their development. Programs can then make the changes to better support your child's growth and learning.

- **The program builds relationships with families.**
  Teachers and families work together to create goals for your child and share information about your child's progress. The program offers at least one event to involve families in their child's learning and development.

**For more information on your program or other star rated programs visit http://childcaresearch.ohio.gov/**

To stay current with information regarding learning and development programs in your area and statewide, visit https://boldbeginning.org/

Ohio Department of Job and Family Services

# CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

| Child's Name | Date of Birth | First Day at Program/Home |
|---|---|---|

| Home Address | City |
|---|---|

| State | Zip Code | Home Telephone Number |
|---|---|---|

| Parent/Guardian Name #1 | Relationship to Child |
|---|---|
| Home Address ☐ Same as Child's | Home Telephone Number ☐ Same as Child's |

| City | State | Zip |
|---|---|---|

| Email Address *(if applicable)* | Cell Phone *(if applicable)* |
|---|---|
| Parent's Work/School Name | Parent's Work/School Telephone Number |
| Parent's Work/School Address | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

| Parent/Guardian Name #2 | Relationship to Child |
|---|---|
| Home Address ☐ Same as Child's | Home Telephone Number ☐ Same as Child's |

| City | State | Zip |
|---|---|---|

| Email Address *(if applicable)* | Cell Phone |
|---|---|
| Parent's Work/School Name | Parent's Work/School Telephone Number |
| Parent's Work/School Address | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

**Emergency Contacts:** Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

| Name | | Name | |
|---|---|---|---|
| City | State | City | State |
| Telephone Number | Relationship to Child | Telephone Number | Relationship to Child |
| Other numbers where emergency contact can be reached *(if applicable)* | | Other numbers where emergency contact can be reached *(if applicable)* | |

| Name of Physician or Clinic/Hospital | | |
|---|---|---|
| Street Address | | |
| City | State | Telephone Number |

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

*Kids Campus*

*Child Care and Preschool*

*Pick Up List*

The following persons have permission to pick up my child: ___________________.

| NAME | RELATIONSHIP TO CHILD | PHONE NUMBER |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Parent Signature:____________________________________Date:________________

Ohio Department of Job and Family Services

# FAMILY INFORMATION
# FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

| Child's Name *(Last)* | *(First)* | Nickname *(If any)* |
|---|---|---|
| | | |

*By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.*

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

| Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain. |
| --- |
| What might you and/or your child be anxious about as he/she starts in this program? |
| What are you and/or your child excited about as he/she starts in this program? |
| What are your expectations of this program? |
| What other information would be helpful for the staff caring for your child to know? |

| Parent/Guardian's Signature | Date |
| --- | --- |
| | |

# KIDS CAMPUS PHOTO RELEASE FORM

I, ________________________, the parent of a child/children at Kids Campus Preschool and Child Care Center, agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed at Kids Campus during normal daycare hours, field trips, or activities. I understand that these photographs will be posted on our Private Kids Campus Facebook page and may be used in promoting child care services, either in print or on the Internet.

The child(ren) name(s): ________________________________________________.

With my signature below I grant permission for my child(ren) to be photographed. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

**Parent/Guardian Signature** __________________________ Date ______________________

Relationship To Child __________________________

Ohio Department of Job and Family Services

# CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)* | Date of Birth

**Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):**

**Section A- EXAMINATION**

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below)*:

*Check below, if applicable:*

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Height ______ | Vision ______ | ☐ Yes | ☐ No | Lead ______ | ☐ Yes | ☐ No |
| Weight ______ | Hearing ______ | ☐ Yes | ☐ No | Hemoglobin ______ | ☐ Yes | ☐ No |
| BMI ______ | Dental ______ | ☐ Yes | ☐ No | Other: ______ | | |

Notes:

**Signature of Examining Health Care Practitioner** | Date of Examination

Name of Examining Health Care Practitioner | Telephone Number

Street Address | City, State and Zip Code

***ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.***

**IMMUNIZATION (*Complete ONLY ONE SECTION below*)**

***Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:***
Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

**Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:**

☐ The above named child has been immunized against the diseases listed above.

*If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*

**Initials of Examining Health Care Practitioner**

Date

**Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):**

☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):

**Signature of Parent**

Date

# We are seeking parents who are interested in being a part of our Parent Advisory Committee

Parent Advisory Committee (PAC) members will:

- Have an advisory role regarding, but not limited to, the following areas:
  - programming & policy,
  - fundraising,
  - parent involvement and
  - marketing.
- Include parents of children who are enrolled at Kids Campus Preschool and Child Care, Administration, and the Director.
- Will always maintain confidentiality. Issues relating to individual families will not be discussed.
- Attend meetings scheduled quarterly on the first Thursdays of the months of February, May, August, and November. (Communication between as needed via emails.)

If interested, please complete the form below and return to the office.

---

Parent's Name ______________________________

Child(ren)'s Name(s) ______________________________

Email ______________________________

Phone Number ______________________________

Best time of day to meet ______________________________

## CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
## INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS *Fiscal Year 2022-2023*

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an* adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

**CENTER NAME:** MHFC KIDS CAMPUS

**PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER**

| * NAME OF ENROLLED CHILD(REN) | AGE | BIRTH DATE | CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation) |
|---|---|---|---|
| 1. | | | ☐ |
| 2. | | | ☐ |
| 3. | | | ☐ |
| 4. | | | ☐ |

**PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.**

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

| | |
|---|---|
| CASE NO. | _ _ _ _ _ _ _ |
| CASE NO. | _ _ _ _ _ _ _ |
| CASE NO. | _ _ _ _ _ _ _ |
| CASE NO. | _ _ _ _ _ _ _ |

**PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.**

| a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1 | b. CHECK IF NO/ZERO INCOME | c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually | | | |
|---|---|---|---|---|---|
| | | 1. Earnings from work before deductions | 2. Welfare payments, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA | 4. All Other Income |
| EXAMPLE: JANE SMITH | ☐ | $ amount / how often | $ amount / how often | $ amount / how often | $ amount / how often |
| 1. | ☐ | $____/____ | $____/____ | $____/____ | $____/____ |
| 2. | ☐ | $____/____ | $____/____ | $____/____ | $____/____ |
| 3. | ☐ | $____/____ | $____/____ | $____/____ | $____/____ |
| 4. | ☐ | $____/____ | $____/____ | $____/____ | $____/____ |
| 5. | ☐ | $____/____ | $____/____ | $____/____ | $____/____ |
| 6. | ☐ | $____/____ | $____/____ | $____/____ | $____/____ |

**PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.**

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

| * ______________________ SIGNATURE OF ADULT HOUSEHOLD MEMBER | * __________ DATE | * If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐<br>☐ (Check if applicable) I do not have a Social Security Number |
|---|---|---|
| Print Name: | Daytime Phone Number: | Work Phone Number: |
| Street / Apt: | City / State / Zip: | County: |

**PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).**

| | | |
|---|---|---|
| American Indian or Alaska Native | Asian | Black or African American |
| Native Hawaiian or Other Pacific Islander | White | Other |

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

**State Distribution: June 2022**

**THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.**

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion :
Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

- ☐ **FREE**, based on ☐ Food Assistance/OWF Case No. ☐ Household size and income ☐ Foster Child
- ☐ **REDUCED**, based on Household size and income
- ☐ **PAID**, based on ☐ Income too high ☐ Incomplete ☐ Invalid case number or information

Total Household Size: ______

**Total Household Income: $**______________________
Per: ☐ week ☐ every two weeks ☐ twice per month ☐ month ☐ year

| ______________________ | ______________________ | ______________ | ______________ |
|---|---|---|---|
| Signature of Sponsor / Center Representative | Date Sponsor Certified/Categorized Form | Effective Date (From the first of month of date signed) | Expiration Date (Valid until last day of month in which form was signed one year earlier) |

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

Ohio Department of Education - Office for Child Nutrition

# CHILD AND ADULT CARE FOOD PROGRAM

# ENROLLMENT FORM

**Required Form for use by Child Care Centers and Head Start Programs**

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

**Instructions for Completion**

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

**CENTER NAME**

MHFC KIDS CAMPUS

| CHILD'S NAME (please print) | AGE | BIRTHDATE month / day / year |
|---|---|---|
| | | |

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE**

| Check (✓) Days Child Normally in Care | | List Hours Child Normally in Care | | | | Check (✓) Meals Child Normally Receives while in Care | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Arrive | Depart | Arrive | Depart | Breakfast | AM Snack | Lunch | PM Snack | Supper | Evening Snack |
| Monday | | | | | | | | | | | |
| Tuesday | | | | | | | | | | | |
| Wednesday | | | | | | | | | | | |
| Thursday | | | | | | | | | | | |
| Friday | | | | | | | | | | | |
| Saturday | | | | | | | | | | | |
| Sunday | | | | | | | | | | | |

☐ Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule

| SIGNATURE OF PARENT/GUARDIAN | DATE | DAY PHONE NUMBER |
|---|---|---|
| MAILING ADDRESS: STREET /APT. | CITY | ZIP CODE |

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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, 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.

This institution is an equal opportunity provider.

(rev. 12/3/2015)

Gross income (before taxes) cannot exceed the following amounts:

| Family Size | Annual | Monthly | Weekly |
|---|---|---|---|
| 1 | $23,828 | $1,986 | $459 |
| 2 | 32,227 | 2,686 | 620 |
| 3 | 40,626 | 3,386 | 782 |
| 4 | 49,025 | 4,086 | 943 |
| 5 | 57,424 | 4,786 | 1,105 |
| 6 | 65,823 | 5,486 | 1,266 |
| 7 | 74,222 | 6,186 | 1,428 |
| 8 | 82,621 | 6,886 | 1,589 |

*If you have more than 8 people in your family, please contact your local WIC clinic for guidelines.*

*Note: A pregnant woman counts as more than one family member. A person who currently receives Medicaid, Food Assistance, or Ohio Works First (OWF) automatically meets the income eligibility criteria for WIC.*

**Guidelines effective July 1, 2021. If you are unsure of income eligibility, contact your local WIC office.*

*This institution is an equal opportunity provider.*

## NOT ELIGIBLE FOR WIC?

Find more community resources here: Coshocton County Hunger Resource

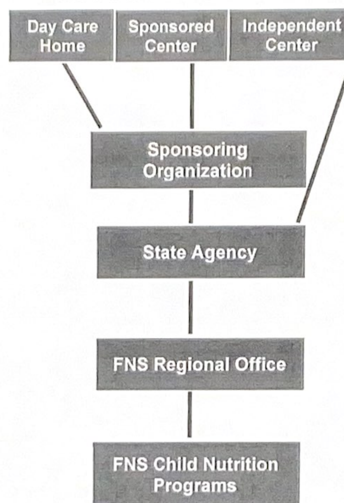
### How does CACFP work?

Day care homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.

States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right.

Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.

## CACFP Partners




**Contacts**

*MHFC KIDS CAMPUS*
*468 Browns Lane*
*Coshocton, OH 43812*
*740.622.3542*

FNS-319
October 2019
USDA is an equal opportunity provider, employer and lender.

# Building for The Future

# In the Child and Adult Care Food Program (CACFP)

United States Department of Agriculture

# The Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program)

Since 1974
The Foundation of Healthy Families

**What is WIC?** WIC was established as a permanent program in 1974 to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk. This mission is carried out by providing nutritious foods to supplement diets, nutrition education (including breastfeeding promotion and support), and referrals to health and other social services. Find out more: http://www.fns.usda.gov/wic/about-wic-wic-glance

## Where is WIC available?

The program is available in all 50 States, 34 Indian Tribal Organizations, American Samoa, District of Columbia, Guam, Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands. While funded through grants from the Federal Government, WIC is administered by 90 State agencies, with services provided at a variety of clinic locations including, but not limited to, county health departments, hospitals, schools, and Indian Health Service facilities. To find the WIC offices serving your area go to: http://www.fns.usda.gov/wic/contacts

## What food benefits do WIC participants receive?

The foods provided through the WIC Program are designed to supplement participants' diets with specific nutrients. WIC authorized foods include infant cereal, baby foods, iron-fortified adult cereal, fruits and vegetables, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, yogurt, soy-based beverages, tofu, peanut butter, dried and canned beans/peas, canned fish, whole wheat bread and other whole-grain options. For infants of women who do not fully breastfeed, WIC provides iron-fortified infant formula. Special infant formulas and medical foods may also be provided if medically indicated. Learn more about food benefits here: http://www.fns.usda.gov/wic/wic-food-packages

## Program benefits include more than food.

WIC benefits are not limited only to food. Participants have access to a number of resources, including health screening, nutrition and breastfeeding counseling, immunization screening and referral, substance abuse referral, and more. Find out more:
http://www.fns.usda.gov/wic/wic-benefits-and-services

## Am I eligible?

Pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who meet certain requirements are eligible. These requirements include income eligibility and State residency. Additionally, the applicant must be individually determined to be at "nutrition risk" by a health professional or a trained health official. To find out if you might be income eligible for WIC benefits go to:
http://wic.fns.usda.gov/wps/pages/start.jsf