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, relocate an existing WIC clinic, or renew an existing WIC Local Agency agreement.
When To Use	When an agency wants approval to establish a new WIC clinic, relocate a WIC clinic, or renew an existing agreement. 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. 3. Mail to the enclosed address
Disposition	Submit the application to WIC State Agency via postal mail.
Retention	Retain a copy for local files.

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I. CLINIC INFORMATION

1. Select **ONE** option that applies:
   - ☐ New agency applying to operate a WIC clinic
   - ☐ Current local agency applying to renew existing agreement
   - ☐ Current local agency applying to add a WIC clinic location
   - ☐ Current local agency applying to move a WIC clinic location
2. Enter information for the Applicant Organization.

   This is the parent organization and must be a public or private nonprofit health agency that provides ongoing, routine pediatric or obstetric care, and administrative services.

   - Name
   - Address:
   - City:
   - State:
   - Zip Code:
   - County:
   - Phone Number

Complete this section to RELOCATE a WIC clinic location:

3. Enter the information for the existing WIC clinic location you plan to move:

   Name, Address, City, State, Zip Code

4. Enter information for site you plan to place the WIC Clinic you want to move.

   Name, Address, City, State, Zip Code

Complete this section if you are a CURRENT WIC Local Agency applying to renew an existing agreement:

5. Enter the information below for **ALL** the existing WIC clinic location(s) you plan to renew. *Please attach a list with the requested information if additional space is needed.*
   Name, Address, City, State, Zip Code

6. Enter the information below for **ANY** the existing WIC clinic location(s) you do **not** plan to renew. *Please attach a list with the requested information if additional space is needed.*
   Name, Address, City, State, Zip Code

7. Enter the information below for **ANY** new WIC clinic location(s) you plan to operate. *Please attach a list with the requested information if additional space is needed.*
   Name, Address, City, State, Zip Code

All applicants must complete the remaining sections:

8. Clinic Director Name:

9. Clinic Director Title:

10. Contact Person for WIC:

11. Contact Person for WIC's Title:

12. Agency / Organization Sponsoring Clinic:

    - Name
    - Address:
    - City:
    - State:
    - Zip Code:
    - County:

13. Source(s) of Clinic Funding:

14. Is the facility a for-profit or non-profit clinic?
    ☐ For- profit
    ☐ Non- profit

15. IRS Tax Exemption Certification Number (if applicable):

16. Does the agency anticipate overall WIC Program growth with this site or re-distribution of current WIC participant caseload?
    ☐ Overall growth
    ☐ Re-distribution of current caseload

17. Has your organization/ agency been suspended or federally disbarred?
    ☐ Yes
    ☐ No

II. STAFF

18. Complete the table below. Enter the number by the type of competent professional authorities who will assess applicants for determination of eligibility. This includes physicians, nutritionists, dietitians, registered nurses, or physician assistants.
A competent professional 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's assistant certified by the State medical certifying authority.

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

19. Complete the table below. Enter the number of full-time equivalents (FTEs) by type of competent professional authorities who will provide applicants with nutrition education. Please note that all WIC certifiers must successfully complete a competency-based training program on performing the duties of a competent professional authority; 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)

20. Complete the table below. Enter the number of full-time equivalents (FTEs) and type of other clinic employees (not mentioned in #13 and #14) who will interact with eligibility determination for WIC participants. Some examples include clerical, lab, aide, etc.

Number of FTEs	Type

III. CLINIC SERVICES

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

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

23. List ongoing nutrition services presently available.

24. Specify lab tests that are currently available at the clinic. Select all that apply.
    - Hemoglobin by _____ Method
    - Hematocrit by _____ Method
    - Other. If other, please specify the lab test and method below:

25. The site must have internet access. Please indicate availability of internet and/ or any potential challenges for accessing the WIC management information system online.

26. 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.

27. Specify the information currently recorded in patient records. Select all that apply.

Pregnant and lactating women

- Height
- Weight
- Medical history
- Hemoglobin
- Hematocrit
- Diet records
- Other routinely recorded lab tests:
- Other recorded medical data:

Infants and children up to age 5

- Height
- Weight
- Head circumference (infants only)
- Hemoglobin
- Hematocrit
- Diet records
- Immunizations
- Other routinely recorded lab tests:
- Other recorded medical data:

IV. CRITERIA FOR RECEIVING SERVICES

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

29. Enter the estimated number of migrant workers served annually.

V. PROPOSED WIC OPERATIONS

30. 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 open time and close time. 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		

31. Estimated (or actual) number of WIC participants to be served monthly:

32. Complete the table below. Specify estimated (or actual) 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)

33. Outline proposed timeframe for adding WIC to ongoing services. Please be sure to include proposed opening date.

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

35. Is the proposed population underserved?

☐ Yes
☐ No

VI. COMPLIANCE

36. Describe all Civil Rights complaints received during the past 2 years.

37. Were all substantiated Civil Rights problems or noncompliance situations corrected/ resolved?
    - ☐ Yes
    - ☐ No

38. Are any persons denied access to clinic sites because of race, color, national origin, age, sex, gender identity, or disability?
    - ☐ Yes
    - ☐ No

39. Is there a significant proportion of non-English or limited English proficiency persons residing in the service area?
    - ☐ Yes
    - ☐ No

40. The site must have resources available to serve non-English speaking individuals and individuals with limited English proficiency (LEP). Indicate the available resources. Select all that apply.
    - ☐ Language access line
    - ☐ Qualified bilingual staff
    - ☐ Qualified contracted interpretation service
    - ☐ Translated materials
    - ☐ Other. Please specify:

41. The site must be able to offer auxiliary aids and services and provide reasonable modifications in the program or activity whenever a person with a disability requests such aids and services or modifications. Indicate the available resources. Select all that apply.
    - ☐ Wheelchair accessible
    - ☐ Video interpretation services for deaf or hard of hearing
    - ☐ Access for service animals
    - ☐ Large print
    - ☐ Use of relay line
    - ☐ Other. Please specify:
42. Is the space used for the WIC clinic accessible by participants or applicants with strollers?
    - ☐ Yes
    - ☐ No
43. Is the site tobacco- free?
    - ☐ Yes
    - ☐ No
44. Will the site provide a space for breastfeeding staff or participants to pump and feed?
    - ☐ Yes
    - ☐ No
45. Describe the racial/ ethnic makeup of the service area.

VII. ATTACHMENT A. DESCRIPTION OF COSTS TO WIC BUDGET

For a new site, please provide a detailed budget for **each** site. *Please note that submission of a budget does not guarantee funding.*

Site Name and Address: _____

Table 1. Estimated 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. Estimated 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 will be provided in adherence to Federal Regulations and Mississippi State Department of Health policies.

_____	_____
Name	Title
_____	_____
Signature	Date

Please complete this application, sign, and return to the address below:

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

IX. FOR MSDH AGENCY USE ONLY

Date received:

Select one: ☐ Complete ☐ Incomplete

Applicant notification date(s):