



## Health and Human Services

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*Public Health  
Social Services  
Child Support  
Financial Assistance*

### **WIC APPLICATION**

WIC is a state & federally funded supplemental nutrition program for Women, Infants, and Children that has been shown to improve the health of its participants.

#### **HOW ARE YOU ELIGIBLE?**

Be a pregnant, postpartum, breastfeeding woman, or a child from birth to age five years.

- Live in Lake County
- Meet income guidelines
- Have a medical or nutritional need

#### **WHAT DOES WIC PROVIDE?**

- Quality food such as low fat milk, cheese & yogurt, whole grain cereals, bread, brown rice & tortillas, juice, eggs, peanut butter, fresh fruits & vegetables and baby foods
- Information on nutrition and health by professional staff
- Breastfeeding education and support
- Information and referrals to other health or social services

#### **HOW DO YOU APPLY**

- Fill out the application to determine if you are income eligible. Any household member that receives Food Support (SNAP), MFIP, Medical Assistance (MA), MinnesotaCare, fuel assistance, reduced or free school lunch, Head Start or TEFRA (child only) is automatically income eligible.
- After the application is received, WIC staff will contact applicant to schedule an appointment. A WIC appointment is required to determine eligibility.
- Proof of I.D., residence and income, or proof of MA, MinnesotaCare, Food Support (SNAP), or MFIP is required for each applicant. Children under the age of five must attend WIC appointment.

Mail this application to:                      Lake County WIC Program  
616 Third Avenue  
Two Harbors, MN 55616

#### **NOTE: WIC IS NOT AN EMERGENCY FOOD PROGRAM**

The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, sex, age and disability. Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) Should contact USDA's TARGET center at (202) 720-2600 (voice and TDD).

To file a complaint, write to:  
Administrator, Food and Nutrition Services, USDA, 3103 Park Center Drive, Alexandria Virginia 22302 USDA is an equal opportunity employer.

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# WIC APPLICATION

GENERAL INFORMATION			
Full Name	DOB	Day Phone #	
Mailing Address	City	County	State/Zip Code
Family / Household Size:	<ul style="list-style-type: none"> <li>People "in family" are related or non-related and share in consumption of the same goods and services.</li> <li>If pregnant include number of fetuses.</li> <li>Foster children are considered a family of one.</li> <li>Applicant may include children not living in household that household member pays child support for.</li> </ul> <p><b>If so, how may non-residing children are included in Family HH Size: _____</b></p>		
APPLICANT INFORMATION – <i>Provide information for everyone you are applying for.</i>			
Full Name	DOB	Due Date (If pregnant)	MA# (If applicable)
<b>Has anyone in your household participated in WIC before?</b>		YES	NO
		<b>Where/When?</b>	
FINANCIAL INFORMATION – <i>*Gross Income is the amount before taxes and other deductions are taken out.</i>			
<b>Does anyone in your household receive:</b>	<b>Circle One</b>		<b>*Gross Amount</b>
SNAP, Reduced or Free Lunch, Fuel Assistance, Head Start	YES	NO	
Medical Assistance (MA), MinnesotaCare, TEFRA	YES	NO	
General Assistance (GA), or MFIP	YES	NO	\$ _____ per month
Unemployment or Workers Comp	YES	NO	\$ _____ per month
Foster Care, Child Support, and/or Alimony	YES	NO	\$ _____ per month
Social Security and/or SSI	YES	NO	\$ _____ per month
Veteran's or Other Pensions	YES	NO	\$ _____ per month
VA or Other Grants or Other Income (not loans)	YES	NO	\$ _____ per month
Rental Income (received from tenants)	YES	NO	\$ _____ per month
Is anyone in your household employed?			
NAME OF EMPLOYED PERSON:			
PLACE OF EMPLOYMENT:			
*GROSS INCOME:	\$ _____ Per (Circle One):    Weekly    Biweekly    Monthly    Yearly		
NAME OF PERSON EMPLOYED:			
PLACE OF EMPLOYMENT:			
*GROSS INCOME:	\$ _____ Per (Circle One):    Weekly    Biweekly    Monthly    Yearly		

**I certify the information I provided for my eligibility is correct to the best of my knowledge. I understand that intentionally giving false or misleading information will result in my not receiving WIC benefits.**

**Signature:** \_\_\_\_\_

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