Montana WIC Application for Local Agency Programs

I. Instructions:

A. Contact the State WIC Director to discuss intent to apply for a new local agency program or clinic within an existing program.
B. Please answer all questions completely (may attach additional pages or references if needed).
C. Use the most current available applicable.

II. Applicant Information:

A. Applying Agency Name: _____

B. Address: _____

C. Telephone: _____

D. Name, title and address of responsible official: _____

E. Applying for (check one):
☐ New Local Agency (Region) ☐ New clinic within existing region

If this application is for a satellite/outlying clinic, provide a brief explanation of why an additional clinic is desired or needed:

_____

_____

F. Type of Agency:

☐ Public/Government Entity
☐ Private, Non-profit
☐ IRS Tax Exempt #: _____
☐ IRS application pending- Date submitted ___/___/____
☐ Tribal
☐ Other: _____

III. Please address the following questions related to administrative feasibility:

A. Are commissioners, Health Officer, and/or management staff at the local site supportive of starting an independent/new WIC clinic?

B. Is there adequate infrastructure to support the WIC clinic?

C. What equipment will need to be purchased to begin the operation of a new clinic (i.e., computer, scales, measure/stature boards, hemoglobin testing machine, office furniture, storage cabinets, etc.)?

What costs are associated with this and is there existing equipment that could be shared with adjoining entity?

D. If this application is for a new satellite/outlying clinic, are there enough funds to operate an additional clinic within the existing grant?

E. When do you anticipate being ready to open a WIC clinic?

F. How many days per month and hours per day do you anticipate offering WIC services?

IV. Health Services:

A. Is there currently pediatric and/or perinatal care available in your agency or community? If yes, describe:

If no, describe your plans to ensure WIC participants have access to these services:

B. Describe your plans to refer Program participants to a public agency or private provider for follow-up on identified health problems, including the procedure for feedback from the public or private provider.

V. Nutrition Services:

A. Provide the name of the individual who will act as Competent Professional Authority (CPA). A CPA is an individual on the staff of the local agency authorized to determine an applicant eligible for participation, determine nutritional risk and prescribe supplemental foods (see current State Plan for criteria)

If no one is currently on staff who meets the criteria as a CPA, what are your plans for recruitment?

B. What do you anticipate necessary FTE(s) to be? List position title and anticipated FTE(s):

C. Is there a Registered Dietitian (RD) available to work with high-risk participants? Y N
Note: if an RD is not available in your agency, the State may deduct some funds from your contract to provide coverage by another local agency (remote RD).

VI. Socio-Economic/Vital Statistics:

A. What will be your service area (geographic boundaries)?

B. What is the service area population?

C. What is the service area racial/ethnic composition?

1. White _____%

2. Black _____%

3. Hispanic _____%

4. American Indian _____%

5. Asian or Pacific Islander _____%

D. What is the median family income in your service area? _____

E. Provide information on how you plan to coordinate services with the following programs if available in your location:

1. Office of Public Assistance:

2. Immunizations:

3. Head Start:

4. Home Visiting Program (MIECHV):

5. Substance Abuse Treatment Facilities:

6. Mental/Behavioral Health:

7. Primary Care (pediatric and/or perinatal):

VII. Financial Management:

A. Request from the State Office and attach a completed budget request and staffing contact form.
B. Attach a copy of the most recent financial audit of your agency.
C. Attach a completed Financial Questionnaire (State Plan attachment)

VIII. WIC Caseload:

A. Provide data (if available) on the current and/or projected caseload for the clinic you would like to open_____

B. Describe your plans for outreach to meet annual requirements for a public announcement of services locally, and effective collaboration/coordination in your community to enroll and retain eligible participants.

IX. Physical Location:

A. Describe the location where participants will be served. Be specific (i.e. Health Department, City-County Building, Hospital, etc.). Describe office space, size of space, available waiting area, etc.

B. Is the space compliant with the Americans with Disabilities Act (ADA) criteria? Y N

C. Is the space clean, safe and well-maintained? Y N

D. Describe what secure storage is available for eWIC cards, computer equipment, breast pumps, etc.

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The applicant agrees to comply with all non-discrimination and American with Disabilities Act (ADA) regulations as described in Part 7 CFR 246.8.

The applicant further agrees and assures that if selected, it will comply with the WIC Program Federal Regulations and State Policies and Procedures. The current State Plan may be located at www.wic.mt.gov.

The information contained in this application for a WIC Program is true and accurate to the best of my knowledge.

_____
Signature of Local Official with Authority to Implement WIC Program

_____
Date

State Agency Review:

Received Date: _____

Reviewed (name and date): _____

Decision: Approved Denied On-hold until funds are available

Notification to Applicant (date): _____

Comments:

State Director (or designee) signature:

_____