**WIC Local Agency Application FY 2016-2020**

**FY 2017 Update**

**Please submit all documents electronically to the ITCA WIC Director at** [**mindy.jossefides@itcaonline.com**](mailto:mindy.jossefides@itcaonline.com)**.**

**Required:** All documents marked with an asterisk must be submitted in Word or Excel formats.

**Optional:** Items that are marked as optional only need to be submitted if desired by the Tribe/agency.

**Conditional:** Items marked as conditional must be submitted if applicable to the Tribe/agency.

Place a check in the “Yes” column if the document is being submitted with your application. If the document does not pertain to your agency, place a check in the “N/A” column.

|  |  |  |  |
| --- | --- | --- | --- |
| **Checklist** | | | |
|  | **Document** | **Yes** | **N/A** |
| **Required** | **Signed Cover Sheet** |  |  |
| **Sections VII and VIII are required.**  **Only submit changes since FY 2016 submission for other sections.** | **WIC Application \* (Sections I-VIII)** |  |  |
| **Required** | **FY 2017 Nutrition and Breastfeeding Plan \*** |  |  |
| **Required** | **FY 2017 WIC Funding Formula & Budget \*** |  |  |
| **Conditional** | **Indirect Cost Agreement covering FY 2017**  **(required if charging indirect costs)** |  |  |
| **Conditional** | **Certification Regarding Lobbying**  **(required for entities that are not tribal governments)** |  |  |
| **Optional** | **Breastfeeding Peer Counseling Application**  **FY 2017-2020** |  |  |
| **Optional** | **Breastfeeding Peer Counseling Budget** |  |  |

I hereby affirm that the statements contained in the funding application and all supporting documents are true and complete, to the best of my knowledge. I further affirm that the WIC Local Agency will comply with applicable ITCA and federal requirements, policies, standards, instructions, and regulations; and I certify that I have the authority to apply for WIC funds for this organization. I affirm that there are no changes in the application submitted in FY 2016 applicable to FY 2017 except as submitted in the attached documents.

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Signature Date

Click here to enter text. Click here to enter a date.

Printed Name

**Section I: WIC Local Agency Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **WIC Local Agency’s Legal Name** |  | | Federal Employers ID# |
| **Type of Organization** | Tribe  Private Non-profit | DUNS # | CFDA #  10.557-WIC  10.578-BFPC |
| **Tribe/Agency Administrative Mailing Address** | Number and Street or PO Box | | |
| City, State, Zip | | |
| **WIC Main Clinic Street Address**  **(provide description if no street address is available)** | Number and Street or intersection/description | | |
| City, State, Zip | | |
| **WIC Clinic Mailing Address**  **(if different)** | Number and Street or PO Box | | |
| City, State, Zip | | |
| **WIC Clinic UPS/Fed Ex Shipping Address**  **(if different)** | Number and Street or intersection/description | | |
| City, State, Zip | | |
| **Primary Contact**  **(person responsible for day-to-day functions)** | Name | | |
| Email | | |
| Phone | | |
| Cell Phone | | |
| Fax | | |

**Section II: WIC Staffing Plan**

**Part 1: Complete the table below and attach an organizational chart for WIC including how WIC fits in with the overall organization of the Tribe/Agency. Note: If staff will be performing the duties of a Competent Professional Authority\* (CPA), including, but not limited to nutrition assessment, risk assignment and nutrition education, the staff person must have completed the required ITCA training and must have been deemed competent using the Competency Tool for tasks they are performing.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Name and Title** | **Languages Spoken** | **% WIC Time** | **If staff is CPA\*, date determined competent.** |
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**Part 2: Select one of the following options to specify how nutrition services oversight and high risk counseling will be provided.**

The local agency will utilize an ITCA designated Registered Dietitian (RD) to oversee nutrition services and provide high-risk counseling. The agency understands that if it serves more than 250 clients, an adjustment in funding will be made to support the cost of providing these services (see funding formula).

**OR**

The local agency will utilize the following RD to oversee nutrition services and provide high-risk counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identify which of the following the RD will be responsible for. For those not checked, describe who will be responsible and the person’s qualifications.

Provides high-risk counseling

Provides staff in-services and education

Evaluates staff and provides coaching and mentoring

Approves special formulas and coordinates care with medical providers

Participates in the development and implementation of goals and objectives

**Section II: WIC Staffing Plan (Continued)**

**Part 3: Complete parts 3a-3g below if your agency has a single WIC staff person or mark the box below.**

The agency has more than one WIC staff person so this section is not applicable.

**Part 3a: Describe how oversight of the Program will be provided to ensure that ITCA policies and procedures will be followed and that staff is deemed competent to provide services as a Competent Professional Authority.**

Click here to enter text.

**Part 3b: Agencies with only one staff person must provide a back-up plan in the event that the primary staff person is unable to provide services or has a conflict of interest in serving a relative or friend. Complete the table below to describe the back-up person for the WIC Program.**

|  |  |  |
| --- | --- | --- |
| **Name of Back-up Staff Person** | **Title of Back-up Staff Person** | **Staff Person Contact Information** |
|  |  |  |

**Part 3c: Describe how the back-up staff person will be trained to provide WIC services and how competency will be ensured.**

**Part 3d: Describe how the person will access needed equipment and materials for providing WIC services. For example, describe how the staff person will gain access to the WIC office, computer, and other equipment.**

**Part 3e: Describe how clients will be notified of any changes to the clinic schedule that may be made due to the staffing change.**

**Part 3f: Describe how ITCA will be notified of staffing or clinic schedule changes.**

**Part 3g: Describe how the agency will ensure program integrity and separation of duties with the single staff person.**

**Section III: Potentially Eligible and Client Services (Attachment A to MOA)**

**Part 1: Describe the geographic service area and population that you will be serving below. Geographic boundaries for the service area must be clearly defined such as reservations, counties, cities and/or villages. For example, a service area may be defined as “Pinal County and XYZ reservation”. Vague service areas cannot be accepted such as “near the reservation” since residency is a federal requirement for eligibility. Include any special target populations.**

**Part 2: How many clients do you anticipate serving per month on average?**

**Part 3: List the primary languages other than English spoken by clients, the total number of clients speaking each language, the percentage of the total caseload speaking each language and the number of WIC staff fluent in each language.**

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| --- | --- | --- | --- |
| **Primary Language** | **Number of Clients** | **Percent of Total Caseload** | **Number of WIC Staff Fluent in Language** |
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**Part 4: Fill in the clinic locations and schedule for all sites providing services. Add additional rows if needed.**

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| --- | --- | --- | --- |
| **Clinic Locations and Hours** | | | |
| **Clinic Name** | **Clinic Location Description** | **Clinic Days** | **Clinic Hours** |
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**Section IV: Outreach and Coordination of Services**

**Part 1: Describe how the agency will notify the public of the WIC services provided at least one time per year. This is usually achieved through radio, television or newspaper advertisements.**

**Part 2: Describe how you will target benefits to pregnant women, migrants, homeless persons and persons residing in group homes or other institutions in your area.**

**Part 3: Complete the Outreach Plan below for the coming year describing how your agency will outreach to clients and coordinate with referral agencies and grassroots organizations. It is expected that the program will, at a minimum, provide presentations to and meet at least annually with Indian Health Service providers, Head Start, Social Services, Tribal day care centers and other maternal and child health programs. All outreach completed must be documented in the Outreach Log.**

|  |  |  |
| --- | --- | --- |
| **Name of Entity/Program/Event** | **Frequency/Timeframe for Outreach** | **Description/Goal of Outreach** |
| *Example: Indian Health Service Health Care Providers* | *2x/year* | *Presentation on WIC services available and coordination on referrals to WIC especially for pregnant women.* |
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**Section V: Fit WIC Classes**

**Part 1: Describe the Fit WIC classes to be provided by the local agency using the table below.**

Not Applicable. The local agency does not choose to provide Fit WIC Classes.

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| --- | --- | --- | --- |
| When are classes provided? (i.e. every Thursday AM) |  | | |
| Number of classes to be offered per month |  | Estimated number of clients per class |  |
| Which classes will be provided? Specify the names of the Fit WIC classes that will be provided during the first fiscal year. |  | | |
| Who will facilitate the classes? |  | | |
| Where are classes held? |  | | |

**Part 2: Select one of the following options if the agency is offering Fit WIC classes.**

The local agency confirms that it will follow the guidelines for the Fit WIC classes as outlined in the Fit WIC Manual.

**OR**

The local agency will follow the guidelines for the Fit WIC classes as outlined in the Fit WIC Manual or the RD will create classes following the general structure of the Fit WIC classes on topics relevant to the population. Note: Course outlines must be available for review during monitoring visits.

**Section VI: WIC Nutrition and Breastfeeding Services**

**Part 1: Describe the agency’s system for referring breastfeeding clients to breastfeeding resources including within the local agency and the community.**

**Part 2: Identify the breastfeeding lead and describe his/her qualifications.**

**Part 3: Complete the table below to describe who the agency refers clients to that have problems that are outside the scope of the WIC staff.**

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| --- | --- | --- | --- |
| **Program/Agency** | **Name of Staff Person** | **Staff Credentials** | **Phone Number** |
|  |  |  |  |

**Part 4: Describe the process for making the referrals as outlined above.**

**Part 5: Complete the attached Nutrition and Breastfeeding Plan for your agency.**

**Section VII: WIC Staff Training and In-Services**

**Part 1: This section has been deleted.**

**Part 2: List the in-services that the agency plans to provide to staff this year. We understand that there may be changes to the proposed list based on need identified during the year. Add additional rows as needed.**

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| --- | --- | --- |
| **Proposed Month** | **Topic** | **Brief description** |
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**Section VIII: WIC Funding Level and Budget**

**Part 1: Use the enclosed spreadsheet to calculate the funding level for the program.**

**Part 2: Used the enclosed spreadsheet to complete the budget.**

**Part 3: Describe and justify the expenses requested in your budget. Be as specific as possible.**

**Personnel:**

**ERE:**

**Supplies:**

**Travel:**

**(This line item includes travel to conferences. Conference registration fees should be included under training)**

**Postage:**

**Communications:**

**Utilities:**

**Contractual:**

**Occupancy:**

**Training:**

**(This line item is for registration fees. Travel to training should be included in the travel line item)**

**Fuel/Vehicle Maintenance:**

**Insurance:**

**Other:**