



MEMORANDUM

Date: April 17, 2024

To: Subrecipient agencies

From: Dyane Gogan Turner, Chief *DGT/AS*
Bureau of Child and Family Health
Ohio Department of Health

Subject: Subrecipient Continuation Solicitation for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Federal Fiscal Year 2025 (10/1/2024 – 9/30/2025), WIC Administration (WA25)

The Ohio Department of Health (ODH), Bureau of Child and Family Health, announces the availability of grant funds.

All electronic applications and attachments are due by 4 p.m., on Monday, June 3, 2024. Applications received after the due date will not be considered for funding. Faxed, hand-delivered or mailed applications will not be accepted.

Electronic application components must be submitted via the on-line Grants Management Information System (GMIS). For new staff requiring GMIS access, you must successfully complete GMIS training offered by ODH.

Any award made through this program is contingent upon the availability of funds for this purpose. The subrecipient agency must be prepared to support the costs of operating the program until receipt of grant payments.

Submission of the **continuation application** constitutes acknowledgment and acceptance of ODH Grants Administration Policies and Procedures (OGAPP) manual rules, policy and procedure updates posted on the GMIS bulletin board, the Ohio WIC Policy and Procedure manual, and any other program-specific requirements as outlined in the competitive solicitation. Reference the competitive solicitation for more information. The competitive solicitation for this grant program can be found on the ODH website at [(https://odh.ohio.gov/about-us/funding_opportunities/sfy-23/wa-23-wic-administration)].

If you have questions, please contact Amy Alwood at Amy.Alwood@odh.ohio.gov.

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I. CONTINUATION FUNDING APPLICATION GUIDANCE

X Base Only Funding Base and Deliverable Funding

A. Policy and Procedures: The Continuation Funding Application consists of three parts: Program Updates (if applicable), Program Budget and Budget Narrative, and Other Required Attachments.

Submission of the continuation application constitutes acknowledgment and acceptance of ODH GAPP (OGAPP) manual rules, the Ohio WIC Policy and Procedure manual, and any other program-specific requirements as outlined in the competitive Solicitation. This Solicitation pertains to budget period: October 1, 2024 – September 30, 2025, of the total project period, October 1, 2024 – September 30, 2025. Reference the competitive solicitation for more information.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or, 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of the agency's policy in regard to subawards and are prepared to establish the necessary inter- institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. Number of Grants and Funds Available: Up to 74 grants may be awarded for a total amount of \$50,354,220. The maximum funding that will be awarded to each designated service area is listed in the FY2025 Local Project Funding and Caseload Plan, Appendix C, in the FY25 Total NOA column.

*No grant award will be issued for less than **\$30,000**. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.*

C. Formatting Requirements for Attachments [Suggested language provided, but can be updated to reflect program-specific requirements]:

- Properly label each item of the application packet (ex. budget narrative, program narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and budget narratives must be submitted in portrait orientation and fit on 8 ½ x 11 paper when printed.
- Number all pages (print on one side only). Place agency name and GMIS number on each page.
- Use a 12-point Calibri font.
- Forms must be completed and submitted in the format provided by ODH.

D. Qualified Applicants:

The following criteria must be met for grant applications to be eligible for review:

1. The Applicant does not owe funds to ODH and has repaid any funds due with 45 days of the invoice date.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted an application and all required attachments by **4 p.m. on Monday, June 3, 2024**.

II. PROGRAM UPDATES:

Program should review the Evidence of Health Equity Strategies Checklist in Appendix C when drafting the program narrative, objectives, and workplan.

A. Program Progress Report: 1) Attach the program progress report for the current grant period. If the program progress report is not scheduled to be submitted before the application due date, then it must be submitted with the application. WIC Programs should submit the second quarter of FY24 electronic Quarterly Activity Report (eQAR) in GMIS, per eQAR instructions, by April 10, 2024.

B. Program Narrative: Complete and submit a narrative statement (do not exceed five pages) which explains any changes to program scope, personnel, partnerships with agencies or organizations, or other information the subrecipient wishes to share for continuation funding. Additional topics to address include, but are not limited to, the following:

- Confirmation of annual licensure requirements of applicable positions (Section 113.3 of the Ohio WIC Policy and Procedure Manual).
- Newly created or substantially revised positions.
- Changes to total number of hours used to calculate your project's full-time equivalency (i.e., 35, 37, or 40).
- Personnel or equipment deficiencies need to be addressed in order to carry out this grant.
- Progress to successfully resolve cited corrective actions or any revision(s) made to your action plan identified in last Management Evaluation (not applicable to projects with a scheduled Management Evaluation in the second or third quarter of FY24).
- Plans for breastfeeding promotion and support for all families:
 - Re-state your project's breastfeeding goals for FY2024. Discuss progress and challenges toward achieving these goals and any adjustments made to improve their impact. Describe lessons learned and how you will carry those forward into your project's breastfeeding promotion and support endeavors.
 - Describe how your local Breastfeeding Peer Program supports moms in achieving their breastfeeding goals.
 - Share how your project addresses breastfeeding issues that are beyond the skill level of WIC Health Professionals. Provide the name for at least one person that will serve as a local IBCLC referral source and the name of your local Designated Breastfeeding Expert (DBE).

- Explain your project's process for determining eligibility for a breast pump and helping to ensure participants have a successful pumping experience.
- Describe how your project will provide ongoing breastfeeding training for all staff.
- List any changes to breastfeeding specific staff and describe their role in providing breastfeeding support.

C. Objectives and Work Plan: Complete and submit a short summary of any changes in the Specific, Measurable, Achievable, Results-Oriented, and Time-Based (SMART-IE) objectives and submit an updated work plan. Reference the competitive Solicitation for information. This should be based on a review of the Progress Plans submitted to date. Provide a brief report addressing elements of each objective and activity, including current status (met, ongoing or unmet); major findings; and barriers and how barriers were addressed.

Please complete the following:

1. The project's completion of eQARs is considered a response to this question.
2. Submit an updated Nutrition Education Plan, Attachment 8. Reference the Ohio WIC Policy and Procedure Manual, Section 411, for instructions to complete.

D. Documentation and Progress on Health Equity and Disparity Reduction Activities:

Please provide detailed updates on the goals, objectives and deliverables specified in the Competitive Solicitation relating to health equity. This information must be supported by data. Continuation Solicitations should prepare a summary of activities completed, during the previous funding period, to outreach to the priority populations and / or neighborhoods specified in their plan. *The project response to the SMARTIE Objective/eQAR submission is considered a response to this question.*

E. Program Budget: Prior to completion of the budget section, reference the competitive Solicitation for unallowable costs and review criteria.

- 1. Budget Narrative:** Provide a detailed budget justification in a narrative that describes how categorical costs are derived. Discuss the necessity, reasonableness, and allocation of the proposed costs. Describe the specific functions of the personnel, consultants, and collaborators. Explain and justify equipment, travel, (including plans for out-of-state travel), supplies and training costs. If you have shared costs, refer to OGAPP Chapter 2 Section C2.4 Cost Allocation Plan for additional information. Please refer to the GMIS 2.0 bulletin board for attachment instructions.

Match or Applicant Share is not required by this program. Do not include match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative may be used to identify additional funding information from other resources.

- 2. FY2025 Budget via GMIS:** Complete requested budget information as follows:

- Personnel, Other Direct Costs, Equipment and Contracts Sections:** Submit a new budget to support costs for the period Date to Date. Funds may be used to support personnel, staff training, travel (see OBM website <https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/agency-overview/obm-travel-rule/obm-travel-rule>, and supplies directly related to planning, organizing, and conducting the program activity. Itemize, in the Equipment Section, all equipment (minimum \$1,000 unit cost value) to be purchased with grant funds.

Any personnel listed in the budget must complete daily timesheets. Time and Effort reporting must be completed if staff are charged to multiple funding sources.

The applicant shall retain all original fully executed contracts on file. A completed "Confirmation of Contractual Agreement" (CCA) must be submitted via GMIS for each contract once it has been signed by both parties. All contracts must be signed and dated by all parties prior to any services being rendered and must be attached to the CCA section in GMIS. The submitted CCA and attached contract must be approved by ODH before contractual expenditures are authorized. CCAs and attached contracts cannot be submitted until the first quarter grant payment has been issued.

- **Compliance:** Answer each question on this form. Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.

3. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying.
2. To disseminate factually incorrect or deceitful information.
3. Consulting fees for salaried program personnel to perform activities related to grant objectives.
4. Bad debts of any kind.
5. Contributions to a contingency fund.
6. Entertainment.
7. Fines and penalties.
8. Membership fees — unless related to the program and approved by ODH.
9. Interest or other financial payments (including but not limited to bank fees).
10. Contributions made by program personnel.
11. Costs to rent equipment or space owned by the funded agency.
12. Inpatient services.
13. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building (unless allowable by the grant).
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
15. Travel and meals over the current state rates (see OBM website: <http://obm.ohio.gov/TravelRule/default.aspx> for the most recent Mileage Reimbursement memo.)
16. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative.
17. Training longer than one week in duration, unless otherwise approved by ODH.
18. Contracts for compensation with advisory board members.
19. Grant-related equipment costs greater than \$1,000, unless justified in the budget narrative and approved by ODH.
20. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants.
21. Promotional Items.
22. Office Furniture (including but not limited to desks, chairs, file cabinets) unless otherwise stated.

The following are unallowable program-specific costs, unless approved by the ODH WIC Program:

23. Refreshments unless related to nutrition education, outreach, or combined nutrition education and outreach efforts;
24. Certification—ODH will not reimburse any local agency staff member for performing heights, weights, bloodwork, and evaluations on a cost per certification basis;
25. The expenses of the Chief or Assistant to the Executive Officer of the local agency or of a political subdivision except when that officer functions as a WIC Health Professional;
26. Advertising (i.e., print, radio, television) unless directed at the appropriate target audience;
27. Staff overtime expenses exceeding 10% of a position's budgeted salary or any salary increase that Form # OFA-013 | 7 exceeds 10% of a position's budgeted salary;
28. Staff bonuses, regardless of amount;

- 29. New staff positions;
- 30. Outreach, nutrition education materials, and conference registration or materials costs exceeding \$300;
- 31. Any rent increase or move to a new clinic site;
- 32. All out of state travel;
- 33. In-state travel costing \$300 or more when not sponsored by State WIC;
- 34. All IT equipment regardless of cost, except mouse, keyboard, speakers, microphone, webcam, and monitor.
- 35. Outreach items such as breast pumps, breastfeeding aids, and written materials purchased with Breastfeeding Peer funds.

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to subrecipients for purposes later discovered to be prohibited. Please refer to the OGAPP manual for additional information.

4. Indirect (Facilities and Administration):

Use the indirect cost rate included in the agency's Indirect Cost Rate Agreement as negotiated with and approved by the cognizant federal funder. If the applicant chooses this option, then the agreement must be submitted in GMIS as an attachment to the application.

If the subrecipient has not executed a federally approved Indirect Cost Rate Agreement, the subrecipient may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely.

Base the budget solely upon direct costs.

For further information please see Chapter 2 Section B2.11 of OGAPP.

F. Other Application Requirements:

Program Specific Attachments: Complete and submit the following attachments. Attachments will be sent separately to your project in a Microsoft Office Program format to be completed and submitted via GMIS. All attachments submitted to GMIS must be attached in the format originally provided. Attachments 1, 2, 3, 4, 5, 6, 8, and 9 must be completed and submitted. Attachment 7 is to be completed and submitted only if changes have occurred since FY2024. Attachment 10 does *not* need to be submitted.

- Attachment 1- FY25 Clinic and Staff Data Sheet
- Attachment 2 - Breastfeeding Peer Program Budget and Expenditure Form
- Attachment 3 - Budget Tool
- Attachment 4 - Voter Registration Assistance Plan
- Attachment 5a - WIC Employee Daily Time Study
- Attachment 5b - WIC Employee Monthly Time Study
- Attachment 6 - WIC Farmers' Market Nutrition Program Responsibilities
- Attachment 7 - Private Physician/Hospital/Clinic Medical Services Memorandum of Agreement (MOA)
- Attachment 8 - Nutrition Education Plan
- Attachment 9 - Assurance of Civil Rights Compliance
- Attachment 10 - Program Attachment Checklist

a. Other Required Documentation:

- Subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information is maintained on the following website: <http://supplier.ohio.gov/>.

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

- **Audit:** Subrecipient agencies are responsible for submitting an audit report. Once an audit is completed, a copy must be sent to ODH via audits@odh.ohio.gov. Reference the GMIS Bulletin Board for more information.

- **Civil Rights Review Questionnaire — EEO Survey:** The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS. Subrecipients must complete the questionnaire as part of the application process. This questionnaire is submitted online automatically with each application.
- **Assurances Certification:** Each subrecipient must acknowledge the Assurances (Federal and State Assurances for Sub-grantees) form in GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive, and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the “Complete” button. By submission of an application, the subrecipient agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.
- **Federal Funding Accountability and Transparency Act (FFATA):** All new applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS. Applicants must ensure that the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant’s information does not successfully upload into the federal system.

All applicants for ODH grants are required to register in SAM.gov and submit the information in the grant application. For information about System for Award Management (SAM) go to <https://beta.sam.gov/>.

Information on Federal Spending Transparency can be located at www.usaspending.gov or the Office of Management and Budget’s website for Federal Spending Transparency at <https://www.whitehouse.gov/>.

(Required by all applicants, the FFATA form is located on the GMIS Application page and must be completed in order to submit the application.)

- **For Non-Profit Organizations Only:**
 1. **Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations must submit documentation validating current liability coverage. Attach the current Certificate of Insurance Liability in GMIS.
 2. **Non-Profit Organization Status:** Non-profit organizations must submit documentation validating current status. If changed, attach in GMIS the Internal Revenue Services (IRS) letter approving non-tax-exempt status.

G. Human Trafficking: Human trafficking is defined by the use of force, fraud, or coercion to compel victims into performing labor or commercial sex acts. Populations at increased risk include but are not limited to lesbian-gay-bisexual-transgender-questioning individuals, individuals with disabilities, undocumented immigrants, runaway and homeless youth, temporary guest-workers, and low-income individuals.

ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

- a. Victims of human trafficking are included in your agency's target population.
 - 1. At-risk population.
 - 2. Mental health population.
 - 3. Homeless population.

Agencies that promote the expansion of services to identify and serve those affected by human trafficking.

☒ Not Applicable to Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC)

H. Post Submission Requirements: Continuation applicants are required to submit subrecipient program and expenditure reports.

Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

- a. **Program Reports: Subrecipient program reports must be completed and submitted via GMIS** by the following dates. **Program reports that do not include required attachments (non-Internet submitted) will not be approved.** All program report attachments must clearly identify the authorized program name and grant number.

☒ Program Reports Required ☐ No Program Reports Required

Period	Report Due Date
October 1 – December 31, 2024	January 10, 2025
January 1 - March 31, 2025	April 10, 2025
April 1- June 30, 2025	July 10, 2025
July 1- September 30, 2025	October 10, 2025

- b. **Subrecipient Reimbursement Expenditure Reports:** Subrecipient monthly expenditure reports **must** be completed and submitted **via GMIS** by the following dates:

[Period	Report Due Date
October 1 – 31, 2024	November 10, 2024
November 1 – 30, 2024	December 10, 2024
December 1 – 31, 2024	January 10, 2025
January 1 – 31, 2025	February 10, 2025
February 1 – 29, 2025	March 10, 2025
March 1 – 31, 2025	April 10, 2025
April 1 – 30, 2025	May 10, 2025
May 1 – 31, 2025	June 10, 2025
June 1 – 30, 2025	July 10, 2025
July 1 – 31, 2025	August 10, 2025
August 1 – 31, 2025	September 10, 2025
September 1 – 30, 2025	October 10, 2025

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	Report Due Date
October 1 – December 31, 2024	January 10, 2025
January 1 – March 31, 2025	April 10, 2025
April 1 – June 30, 2025	July 10, 2025
July 1 – September 30, 2025	October 10, 2025

Note: Obligations not reported on the final monthly or fourth quarter expenditure report will not be considered for payment with the final expenditure report.

- c. **Final Expenditure Reports:** A Subrecipient final expenditure report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4 p.m. on or before November 5, 2025. The information contained in this report must reflect the program’s accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient final expense report, which serves as an invoice to return unused funds.

Submission of ALL Subrecipient program and expenditure reports via the ODH’s GMIS system indicates acceptance of OGAPP. Clicking the “Submit” or “Approve” button constitutes your authorization of the submission as an agency official and serves as your electronic acknowledgment and acceptance of OGAPP rules and regulations.

III APPENDICES

- A. Continuation Solicitation Reimbursement Type Form
- B. Evidence of Health Equity Strategies Checklist
- C. FY25 Local Project Funding and Caseload Plan

Appendix A

CONTINUATION SOLICITATION REIMBURSEMENT TYPE FORM

Ohio Department of Health
Office of the Medical Director
Bureau of Child and Family Health

ODH Program Title:
Special Supplemental Nutrition
Program for Women, Infants, and
Children (WIC), WA25

Reimbursement Type (check one) Monthly ☐ **OR** Quarterly ☐

(Please note that no changes to the reimbursement type can be made after the project number is created in GMIS. No waivers/appeals will be accepted.)

Please print:

Current Project Number _____

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Contact Person Name and Title _____

Telephone Number _____

E-mail Address _____

Agency Head (Print Name)

Agency Head (Signature)

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS.

Due to ODH by April 24, 2024.

Please email completed form to Maria Kapenda at maria.kapenda@odh.ohio.gov

Appendix B

ODH Evidence of Health Equity Strategies Checklist

This checklist should be used to support planning, implementation, and evaluation of equitable strategies to reduce disparities and overcome social determinants of health. This checklist is a guide to establish a baseline criterion that all projects funded by ODH to support alignment with established priorities to achieve optimal health for all Ohioans.

Health Disparities, Health Inequities, Social Determinants of Health & Health Equity

Racial and ethnic minorities, those living in rural communities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. Health disparities occur when these groups experience more disease, death, or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, learn, work, play, and age. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods and freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH)**. SDOH are a root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

The ODH is committed to the elimination of health disparities and achieving health equity for all Ohioans. The items below are requirements for all applicants to ensure health equity is embedded within all components of the application (e.g., Goals, Program Narrative, and Objectives.)

- 1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation. See Ohio's State Health Assessment Ohio's health data. <https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-online-state-health-assessment>
- 2) Identify geographic reference points (i.e., census tracts, census block groups or zip codes) to specify where program activities are focused.
- 3) Use direct or indirect feedback from the prioritized population, community, group, or community agency to identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities.
- 4) Identify measurable health equity targets that demonstrate reducing disparities and improving health equity are critical goals to be achieved through program activities. This information must also be supported by data. For guidance on methodology to establish equity targets, review [2030 Target Setting Methodologies for Objectives in Healthy People 2030](#).

- 5) Outline specific evaluation strategies to measure the impact of program activities on decreasing and/or eliminating health disparities and health inequities.

The following are best practices aimed at eliminating disparities and achieving health equity. They are not required, but highly encouraged to use.

- 1) Link proposed activities to health equity strategies identified in local, state, or national planning documents. These documents include, but are not limited to strategies, goals and objectives outlined in [Healthy People 2030](#), the [State Health Improvement Plan \(SHIP\)](#) and local Community Health Assessments .
 - State Health Improvement Plan - <https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship>.
 - Healthy People 2030 - <https://health.gov/healthypeople>.
- 2) Develop staffing plans where board members, leadership and program staff reflect the race, ethnicity, background, and/or culture of the population being served.
- 3) Identify up- and downstream approaches to address social determinants of health and reduce disparities. Upstream factors like food, housing and income insecurity that focus on addressing social determinants of health decrease barriers and improve supports that provide opportunity for people to achieve their full health potential. Downstream approaches focus on providing equitable access to care and services to reduce the negative impact of social determinants on health outcomes.
- 4) Establish non-traditional partnerships among different sectors of the community (e.g., faith-based organizations, community organizations, businesses, universities, healthcare) that can provide valuable insight, new perspective, and more effective ways to achieve program goals. Non-traditional partners create opportunity to collaborate across sectors and may serve as a new source of support for the program.

[Note to Program: These requirements and best practices should be tied to deliverables and review criteria when possible and appropriate.]

Appendix C FY2025

FY2025 Local WIC Project Funding and Caseload Plan

Local WIC Project	FY25 TOTAL NOA	FY25 NSA Portion of NOA	FY25 Peer Portion of NOA*	NSA BF Requirement**	1/6 NSA Requirement for Nutrition and BF**	FY25 Caseload
ADAMS/BROWN COUNTY WIC PROGRAM	\$ 476,902	\$ 452,900	\$ 24,002	\$ 11,575	\$ 75,483	1,473
ALLEN COUNTY WIC PROGRAM	649,165	620,900	28,265	16,085	103,483	2,047
ASHTABULA COUNTY WIC PROGRAM	593,697	565,997	27,700	13,626	94,333	1,734
ATHENS/PERRY CNTY WIC PROGRAM	554,119	527,600	26,519	13,838	87,933	1,761
AUGLAIZE COUNTY WIC PROGRAM	235,471	217,935	17,536	4,644	36,323	591
BELMONT COUNTY WIC PROGRAM	309,490	289,986	19,504	6,554	48,331	834
BUTLER COUNTY WIC PROGRAM	1,918,736	1,848,755	69,981	58,110	308,126	7,395
CARROLL COUNTY WIC PROGRAM	165,065	149,250	15,815	3,143	24,875	400
CHAMPAIGN CNTY WIC PGM	159,343	143,099	16,244	3,167	23,850	403
CLARK COUNTY WIC PROGRAM	921,841	884,378	37,463	27,912	147,396	3,552
CLERMONT COUNTY WIC PROGRAM	724,819	693,832	30,987	18,702	115,639	2,380
CLINTON COUNTY WIC PROGRAM	241,108	222,870	18,238	5,116	37,145	651
COSHOCTON COUNTY WIC PROGRAM	228,037	210,177	17,860	5,108	35,030	650
CRAWFORD COUNTY WIC PROGRAM	358,189	338,349	19,840	8,054	56,392	1,025
CUYAHOGA COUNTY WIC PROGRAM	3,732,492	3,618,233	114,259	112,872	603,039	14,364
DARKE/MERCER COS. WIC PROGRAM	422,256	400,400	21,856	10,483	66,733	1,334
DEFIANCE COUNTY WIC PROGRAM	207,084	190,142	16,942	4,243	31,690	540
DEL/UNION/MORROW CNTY WIC PGM	633,222	604,700	28,522	15,787	100,783	2,009
ERIE/HURON COUNTY WIC PROGRAM	637,482	611,594	25,888	14,852	101,932	1,890
FAIRFIELD COUNTY WIC PROGRAM	487,478	462,500	24,978	12,070	77,083	1,536
FAYETTE COUNTY WIC PROGRAM	208,195	190,875	17,320	4,275	31,813	544
FRANKLIN COUNTY WIC PROGRAM	6,225,120	5,999,976	225,144	210,036	999,996	26,729
FULTON/HENRY CO. WIC PROGRAM	367,379	344,866	22,513	8,612	57,478	1,096
GALLIA COUNTY WIC PROGRAM	273,526	254,454	19,072	6,444	42,409	820
GREENE COUNTY WIC PROGRAM	482,736	458,000	24,736	12,604	76,333	1,604
GUERNSEY COUNTY WIC PROGRAM	308,018	287,354	20,664	7,206	47,892	917
HAMILTON COUNTY WIC PROGRAM	3,578,811	3,462,060	116,751	118,703	577,010	15,106
HARRISON COUNTY WIC PROGRAM	110,004	95,229	14,775	1,517	15,872	193
HHP: HANCOCK/HARDIN/PUTNAM WIC PROGRAM	583,957	557,900	26,057	13,917	92,983	1,771
HIGHLAND COUNTY WIC PROGRAM	349,231	328,479	20,752	7,520	54,747	957
HOCKING COUNTY WIC PROGRAM	202,305	184,877	17,428	4,251	30,813	541
HOLMES COUNTY WIC PROGRAM	144,934	129,425	15,509	2,397	21,571	305
JACKSON COUNTY WIC PROGRAM	237,278	219,580	17,698	5,155	36,597	656
JEFFERSON COUNTY WIC PROGRAM	309,110	290,332	18,778	6,931	48,389	882
KNOX COUNTY WIC PROGRAM	276,362	255,441	20,921	6,114	42,574	778
LAKE - GEAUGA COUNTY WIC PROGRAM	868,072	835,272	32,800	23,118	139,212	2,942
LAWRENCE COUNTY WIC PROGRAM	343,950	321,899	22,051	7,889	53,650	1,004
LICKING COUNTY WIC PROGRAM	624,746	596,635	28,111	15,119	99,439	1,924
LOGAN COUNTY WIC PROGRAM	220,447	201,375	19,072	4,974	33,563	633
LORAIN COUNTY WIC PROGRAM	1,227,383	1,185,064	42,319	35,125	197,511	4,470
LUCAS COUNTY WIC PROGRAM	2,410,011	2,336,983	73,028	73,519	389,497	9,356
MADISON COUNTY WIC PROGRAM	268,388	248,931	19,457	6,404	41,489	815
MAHONING COUNTY WIC PROGRAM	1,079,051	1,041,992	37,059	29,900	173,665	3,805
MARION COUNTY WIC PROGRAM	492,270	467,600	24,670	11,732	77,933	1,493
MEDINA COUNTY WIC PROGRAM	393,486	370,100	23,386	9,681	61,683	1,232
MEIGS COUNTY WIC PROGRAM	169,024	151,381	17,643	3,049	25,230	388
MIAMI COUNTY WIC PROGRAM	320,820	301,172	19,648	6,836	50,195	870
MONROE COUNTY WIC PROGRAM	137,690	121,875	15,815	2,790	20,313	355
MONTGOMERY CNTY. WIC PROGRAM	2,088,971	2,010,658	78,313	68,443	335,110	8,710
MUSKINGUM COUNTY WIC PROGRAM	524,754	498,800	25,954	12,376	83,133	1,575
NOBLE COUNTY WIC PROGRAM	104,493	89,596	14,897	1,886	14,933	240
OTTAWA COUNTY WIC PROGRAM	121,950	106,257	15,693	2,782	17,710	354

FY2025 Local WIC Project Funding and Caseload Plan (continued)

Local WIC Project	FY25 TOTAL NOA	FY25 NSA Portion of NOA	FY25 Peer Portion of NOA*	NSA BF Requirement**	1/6 NSA Requirement for Nutrition and BF**	FY25 Caseload
PAULDING COUNTY WIC PROGRAM	\$ 138,839	\$ 122,534	\$ 16,305	\$ 2,813	\$ 20,422	358
PIKE COUNTY WIC PROGRAM	214,837	197,625	17,212	5,084	32,938	647
PORTAGE/COLUMBIANA WIC PROGRAM	1,049,208	1,010,984	38,224	26,552	168,497	3,379
PREBLE COUNTY WIC PROGRAM	237,084	219,332	17,752	5,202	36,555	662
RICHLAND/ASHLAND CNTY WIC PRG	796,433	764,008	32,425	20,965	127,335	2,668
ROSS/PICKAWAY COUNTY WIC PROG.	651,008	623,000	28,008	17,963	103,833	2,286
SANDUSKY COUNTY WIC PROGRAM	324,118	303,146	20,972	7,622	50,524	970
SCIOTO COUNTY WIC PROGRAM	515,429	490,400	25,029	12,392	81,733	1,577
SENECA COUNTY WIC PROGRAM	342,452	322,228	20,224	8,149	53,705	1,037
SHELBY CNTY WIC PGM	178,513	161,625	16,888	3,678	26,938	468
STARK COUNTY WIC PROGRAM	1,459,904	1,410,824	49,080	42,708	235,137	5,435
SUMMIT COUNTY WIC PROGRAM	2,141,052	2,068,595	72,457	60,727	344,766	7,728
TRUMBULL COUNTY WIC PROGRAM	1,026,809	988,680	38,129	26,969	164,780	3,432
TUSCARAWAS COUNTY WIC PROGRAM	433,644	411,500	22,144	10,192	68,583	1,297
VAN WERT COUNTY WIC PROGRAM	174,547	157,875	16,672	3,827	26,313	487
VINTON COUNTY WIC PROGRAM	125,533	110,269	15,264	2,609	18,378	332
WARREN COUNTY WIC PROGRAM	381,951	359,900	22,051	8,974	59,983	1,142
WASHINGTON/MORGAN CNTY WIC PGM	327,423	307,067	20,356	7,009	51,178	892
WAYNE COUNTY WIC PROGRAM	407,140	383,600	23,540	9,210	63,933	1,172
WILLIAMS COUNTY WIC PROGRAM	244,722	226,160	18,562	5,493	37,693	699
WOOD COUNTY WIC PROGRAM	365,900	343,130	22,770	9,037	57,188	1,150
WYANDOT COUNTY WIC PROGRAM	109,206	93,942	15,264	2,310	15,657	294
STATEWIDE	<u>\$ 50,354,220</u>	<u>\$ 48,074,459</u>	<u>\$ 2,279,761</u>	<u>\$ 1,396,728</u>	<u>\$ 8,012,411</u>	<u>177,746</u>

* These are special USDA peer grant funds that can only be used to support the peer helper program. Local agencies may supplement the peer program with NSA funds.

** The amount listed for each project under 1/6 Requirement for Nutrition & BF, and BF\$* is the portion of NSA Grant that must be used for support activities. These dollars are part of the NSA NOA total, not additional dollars.

Project Name: Attachment 1 - Clinic and Staff Data Sheet – FY 2025

WIC CLINIC NAME:		GMIS PROJECT NUMBER:	
CLINIC NUMBER:		ASSIGNED CASELOAD CEILING:	
ADDRESS:		CITY:	ZIP:
PHONE: ()		FAX #: ()	
SITE SUPERVISOR/CONTACT NAME:		IDENTIFY CHANGES:	

Type of WIC System: ☐ Network (includes 1 Server) _____ Number of Workstations on LAN

☐ Standalone

☐ Portable (Laptop)

☐ Paper

Please list your office and clinic hours with any special activities noted (including group nutrition education, migrant clinics, staff meetings, etc.). In the Special Activities column, please note if clinic hours vary from week to week (for example, clinic open until 7:00 pm every other week).

DAY	WIC OFFICE HOURS	CLINIC HOURS	SPECIAL ACTIVITIES
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

List all WIC funded staff at this clinic location (all WIC funded staff must appear on one of these forms).

Last Name, First Name

Position

Copy and paste additional pages for each clinic.

FY25 Attachment 2
Breastfeeding Peer Program Budget and Expenditure Form

PROGRAM NAME:		GMS PROJECT NUMBER:					
GRANT YEAR: FY 2025		____ Original Revision # ____					
PERSONNEL				PEER PROGRAM			
POSITION	NAME	PEER PROGRAM HOURS	PEER PROGRAM SALARY	FRINGE BENEFITS	PEER PROGRAM TOTAL		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
					\$0.00		
TOTAL PERSONNEL					\$0.00		
OTHER DIRECT COSTS (Items listed must match line items in GMS.)							
TOTAL OTHER DIRECT COSTS					\$0.00		
EQUIPMENT (Items listed must match line items in GMS.)							
TOTAL EQUIPMENT					\$0.00		
TOTAL PEER BUDGET					\$0.00		
Peer Dollars of NOA Awarded (See Funding table)					\$0.00		
Additional NSA Funds Used to Supplement Peer Dollars of NOA					\$0.00		

Employee	Function/Title	HP / BF Credentials	Program Time (%)	Yearly Salary (\$)	Program Salary Cost (\$)	Program Salary per NCBA Hr.	Fringe Rate (%)	Program Fringe Cost (\$)	Program Total Cost (\$)	NCBA Cost	Hrs/Wk	NCBA \$/y	Other Funding Sources	Time (%)	Non-WIC Salary
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
					\$ -			\$ -	\$ -	Admin		n.a.			n.a.
Program Salary and Salary from Other Funding Sources do not equal 100% Missing NCBA Data Missing Program Salary										Breastfeeding		n.a.			n.a.
										Clinic		n.a.			n.a.
										Nutrition		n.a.			n.a.
				\$ -	\$ -			\$ -	\$ -						

	NCBA Hrs.	NCBA Costs	CBA Hours	BA Cost
Admin	0	\$ -	#DIV/0!	#DIV/0!
Breastfeeding	0	\$ -	#DIV/0!	#DIV/0!
Clinic	0	\$ -	#DIV/0!	#DIV/0!
Nutrition	0	\$ -	#DIV/0!	#DIV/0!
Total	0	\$ -	#DIV/0!	#DIV/0!

Attachment 4

**VOTER REGISTRATION ASSISTANCE PLAN
Fiscal Year 2025**

WIC PROGRAM

(Project Name)

(GMIS Project Number)

Review and check off assurances for the following five items pertaining to the implementation of agency-based voter registration in the local WIC project area.

1. ____ The name of the voter registration coordinator and the locations of all the local clinic sites where voter registration is being conducted were reviewed and submitted in response to the FY2025 grant application.
2. ____ This local WIC project will be conducting voter registration at each application and recertification visit according to section 207 of the Ohio WIC Policy and Procedure Manual.
3. ____ Each WIC applicant will be provided a link and/or copy of the *Designated Voter Registration Notice of Rights* form at the time of application and recertification.
4. ____ Each local WIC project staff person who will be giving out and accepting voter registration forms will be trained according to section 207 of the Ohio WIC Policy and Procedure Manual.
5. ____ The local WIC voter coordinator is: _____.
The coordinator has met with a representative of the County Board of Elections and discussed and agreed that the *Agency Based Voter Registration Transmission Form* and the completed *Voter Registration Forms* will be transmitted to the Board of Elections within five days through:

(Check All That Apply)

____ U.S. mail, ____ courier service, ____ pickup by Elections Board staff, ____ delivered by WIC staff, or ____ other (explain below)

Employee Time Study Report						
Employee Name: <u>0</u>		Position: <u>0</u>				
Type in Total Regular WIC hrs/wk: <u>0</u>		Clinic(s): _____				
Date Time Study was Conducted:		From: <u>1/0/00</u>		To: <u>1/0/00</u>		

Date	Nutrition Education (N)	Clinic Services (C)	Breast-feeding (B)	Admin-istration (A)	Breast-feeding Peer (BFP)	Hours Per Day (HPD)
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
1/0/00	0.00	0.00	0.00	0.00	0.00	0.00
Total Hours	0.00	0.00	0.00	0.00	0.00	0.00

Percent Nutrition Education: #DIV/0!

Percent Clinic Services: #DIV/0!

Percent Breastfeeding: #DIV/0!

Percent Administration: #DIV/0!

Percent Breastfeeding Peer: #DIV/0!

For Director's use only

If employee's regular work hours change after the Time Study has been completed causing an alteration in the NCBA and BFP hours, enter employee's new hours and give justification to the change in NCBA and BFP; e.g., change in FT to PT status. Use the new hours on the Personnel Budget for NCBA.

Enter employee's new hours *self calculates

N Hours #DIV/0!

C Hours #DIV/0!

B Hours #DIV/0!

A Hours #DIV/0!

BFP Hours #DIV/0!

Justification:

Date:

Type comments below (Please explain if there was any activity out of the ordinary)

*if an employee's NCBA and BFP hours are not reflective of the **percent of time spent** as calculated by the current time study, enter in actual NCBA and BFP and provide justification, e.g., HP no longer issues WNC benefits, decreasing clinic time. Use the new hours on the Personal Budget for NCBA.

N Hours

C Hours

B Hours

A Hours

BFP Hours

Justification:

Date:

The Hours listed below are the hours to be used in the Personnel Budget for NCBA

N Hours #DIV/0!

C Hours #DIV/0!

B Hours #DIV/0!

A Hours #DIV/0!

BFP Hours #DIV/0!

*If the decimal is 0.5 or greater round up

*If the decimal is 0.4 or less round down

* Add BFP+B hours together for B hours on the Personnel Budget

When you have completed the form please type in your name below, date, and click on the 'Authenticate Signature' box verifying you have reviewed the information and it is correct to the best of your knowledge.

Employee Name: _____

Supervisors Name: _____

Date: _____ ☐ Check to Authenticate Signature

Date: _____ ☐ Check to Authenticate Signature

Employee Monthly Time Study Report						
Employee Name: _____			Position: _____			
Type in Total Regular WIC hrs/wk: _____			Clinics: _____			
Date Time Study was Conducted (e.g., February 2011) _____			From: _____		To: _____	
Type in Employee's Total Hours for NCBA Below: e.g., 2.25 (*cell will automatically format)						
Date e.g., October-08 (*cell will automatically format)	Nutrition Education (N) *whole #'s only no text	Clinic Services (C) *whole #'s only no text	Breast-feeding (B) *whole #'s only no text	Admin-istration (A) *whole #'s only no text	Breast-feeding Peer (BFP) *whole #'s only no text	Hours Per Month (HPM)
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
Total Hours	0.00	0.00	0.00	0.00	0.00	0.00

Percent Nutrition Education: #DIV/0!

Percent Clinic Services: #DIV/0!

Percent Breastfeeding: #DIV/0!

Percent Administration: #DIV/0!

Percent Breastfeeding Peer: #DIV/0!

Type comments below (Please explain if there was any activity out of the ordinary)

The Hours listed below are the hours to be used in the Personnel Budget for NCBA

N Hours: #DIV/0!

C Hours: #DIV/0!

B Hours: #DIV/0!

A Hours: #DIV/0!

BFP Hours: #DIV/0!

*If the decimal is 0.5 or greater round up
*If it is 0.4 or less round down.

*Add BFP + B hrs together for B hrs on the Personnel Budget

When you have completed the form please type in your name below, date, and click on the 'Authenticate Signature' box verifying you have reviewed the information and it is correct to the best of your knowledge.

Employee Name: _____

Supervisor's Name: _____

Date: _____

Date: _____

☐ Check to Authenticate Signature

☐ Check to Authenticate Signature

For Director's use only

If employee's regular work hours change after the Time Study has been completed causing an alteration in the NCBA, enter employee's new hours and give justification to the change in NCBA; e.g., change in FT to PT status. Use the new hours on the Personnel Budget for NCBA.

Enter employee's new hours:

*self calculates

N Hours: #DIV/0!

C Hours: #DIV/0!

B Hours: #DIV/0!

A Hours: #DIV/0!

BFP Hours: #DIV/0!

Justification:

Date:

If the employee's NCBA hours are not reflective of the percent of time spent as calculated by the current time study; enter in actual NCBA and provide justification; e.g., HP no longer issues WIC benefits decreasing clinic time. Use the new hours on the Personnel Budget for NCBA.

N Hours:

C Hours:

B Hours:

A Hours:

BFP Hours:

Justification:

Date:

Attachment 6

WIC FARMERS' MARKET NUTRITION PROGRAM RESPONSIBILITIES – FY 2025

WIC PROGRAM

(Project Name)

(GMIS Project Number)

The responsibilities of the parties are set forth below:

A. State WIC Agency Responsibilities. The State WIC Agency Shall:

1. Assist Local WIC Agency in developing and implementing participation in the WIC Farmers' Market Nutrition Program (FMNP), as authorized by Section 17(m) of the Child Nutrition Act of 1966, as amended, (42 USC 1786(m)).
2. Provide consultation and guidance in the interpretation of all FMNP regulations, guidelines and instructions from the United States Department of Agriculture, Food and Nutrition Services (USDA, FNS) and the State WIC Agency.
3. Provide consultation and technical guidance to Local WIC Agency relevant to the provision of WIC FMNP services.
4. Provide Local WIC Agency with guidance regarding FMNP coupon issuance procedures.
5. Provide guidance in the development and coordination of the nutrition education portion of WIC FMNP operations including identification of procedures to ensure that nutrition education is provided to all FMNP participants.
6. Provide Local WIC Agency with a list of authorized FMNP farmers in counties served by the WIC FMNP.
7. Assist the Local WIC Agency in training farmers authorized to accept FMNP coupons.
8. Monitor the activities of Local WIC Agency using methods including, but not limited to, on-site evaluations as it pertains to the FMNP.

B. Local WIC Agency Responsibilities. The Local WIC Agency Shall:

1. Assist the State WIC Agency in implementing and operating the WIC Farmers' Market Nutrition Program (FMNP), as authorized by Section 17(m) of the Child Nutrition Act of 1966, as amended, (42 USC 1786(m)), to provide locally grown fresh fruits, herbs, and vegetables to eligible participants.
2. Cooperate with FMNP farmers, State WIC Agency, or federal officials to resolve questions or issues as they arise.
3. Issue FMNP coupons in accordance with and as designated by State WIC Agency criteria through specified clinics, and to specific categories and numbers of participants.

4. Verify receipt of FMNP coupons from State WIC Agency and record coupons issued to eligible participants based upon the eligibility criteria established by State WIC Agency. Coupon issuances shall be properly recorded in the WIC Certification System.
5. Provide nutrition education on selecting, using and storing fresh fruits, herbs, and vegetables to all FMNP participants.
6. Provide education how to properly use and redeem FMNP coupons at authorized FMNP farmers including providing a list of all authorized FMNP foods to all FMNP participants.
7. Develop and distribute a pamphlet listing the dates, times and locations of the authorized FMNP farmers' markets and farm stands located in the county to all FMNP participants.
8. Conduct an FMNP participant survey as directed by State WIC Agency.
9. Assist the State WIC agency in training and contracting farmers to be authorized to accept FMNP coupons.
10. Assist the State WIC agency in conducting on-site monitoring visits to authorized FMNP farmers, authorized FMNP farmers' markets and authorized FMNP farm stands in the county.
11. Direct employees involved in the FMNP, when requested, to attend training sessions conducted by State WIC Agency.
12. Surrender to State WIC Agency, upon expiration or termination of this Agreement, all equipment and work product pertaining to the administration of the FMNP.

C. Mutual Understanding:

State WIC Agency reserves the right to redistribute Local WIC Agency's FMNP coupons for reasons including, but not limited to, funding shortages and/or failure to meet and maintain FMNP coupon issuance and redemption rates.

*(All projects must answer one of the three questions below
this table and return as an attachment.)*

Allen	Hamilton	Muskingum
Ashland	Hancock	Paulding
Ashtabula	Hardin	Perry
Athens	Henry	Pickaway
Belmont	Highland	Pike
Butler	Holmes	Portage
Champaign	Huron	Putnam
Clark	Jefferson	Richland
Clermont	Knox	Ross
Clinton	Lake	Sandusky
Columbiana	Lawrence	Scioto
Coshocton	Licking	Seneca
Crawford	Logan	Stark
Cuyahoga	Lorain	Summit
Darke	Lucas	Trumbull
Defiance	Madison	Tuscarawas
Delaware	Mahoning	Union
Erie	Marion	Van Wert
Fairfield	Medina	Wayne
Franklin	Meigs	Williams
Fulton	Mercer	Wood
Geauga	Miami	Wyandot
Greene	Monroe	
Guernsey	Montgomery	

☐ Yes, the project wishes to operate the FMNP.

☐ No, the project no longer wishes to participate in the FMNP.

☐ The project does not currently participate in FMNP and does not wish to participate.

Attachment 7

PRIVATE PHYSICIAN/HOSPITAL/CLINIC MEDICAL SERVICES MEMORANDUM OF AGREEMENT

Fiscal Years 2023 - 2027

(Project Name)

(GMIS Project Number)

Physician's Name:

Specialty:

Office Address:

Office Telephone Number:

Office Hours:

Please check the categories of people to whom you provide health services:

Pregnant Women ☐ Breastfeeding Women ☐ Postpartum Women ☐

Infants 0 -1 ☐ Children 1-5 ☐

Do you accept Medicaid payment? ☐ Yes ☐ No

If yes, what is your provider number?

Do you accept reduced fees for services? ☐ Yes ☐ No

List hospital affiliations (optional):

This institution is an equal opportunity provider.

MEMORANDUM OF AGREEMENT FY 2023 - 2027

By and between the _____ and _____
(local agency) (Physician)

whereas, the _____, as a designated local agency for the Special Supplemental
(local agency)
Nutrition Program for Women, Infants and Children (WIC Program), wishes to provide WIC Program services to eligible women, (pregnant, postpartum, and breastfeeding), infants, and children, but does not provide the health services which the WIC Program requires; and whereas, _____, is a physician licensed by
(Physician)
the State Medical Board of Ohio, pursuant to Chapter 4731 of the Ohio Revised Code or the State Medical Board of _____ to practice medicine or surgery or osteopathic medicine and surgery;
now therefore, it is mutually agreed by and between the _____ (hereinafter
(local agency)
referred to as the "Local Agency") and _____ (hereinafter referred to as the
(Physician)
"Physician") that the covenants enumerated in this agreement will be kept and performed.

1. The Physician shall provide such pediatric, obstetrical, lactation, and other services as the Physician deems appropriate in the exercise of his or her professional medical judgment to persons who seek such services upon referral from the Local Agency.
2. With the written consent of the patient, the Physician shall provide the Local Agency with such information pertaining to the patient as the Local Agency may require in order to determine the patient's eligibility for participation in the WIC Program.
3. The Physician understands that the Local Agency shall not reimburse the Physician for providing health services to patients who the Local Agency refers to the Physician.
4. The Physician or clinic shall, in providing its services and in its terms and conditions of employment, comply with all requirements under federal and state law pertaining to nondiscrimination and equal employment opportunity, including Title VI of the 1964 Civil Rights Act and pertinent federal regulations.
5. This agreement shall take effect on October 1, 2022, and shall remain in effect through September 30, 2027 unless terminated by either party upon written notice of termination being served by the party terminating on the other party. A 30 day notification of termination by the terminating party is required.

BY: _____
Signature of the WIC Program Director

Date

Signature of Physician or Clinic Administrator

Date

Attachment 8

Nutrition Education Plan for Low Nutrition Risk Participants

FY _____ Project _____

Nutrition Education Coordinator _____ Approved by: _____

SAMPLE October Event: Halloween (I,C,B,N) and Dental (All) Class: Infant Feeding (P) Outside: Head Start Parent's Night Newsletter: Immunizations and Flu Season (All) Youtube Video: (B)	SAMPLE November Newsletter: Holiday Foods (All) State Modules: (All) WICHealth.org: (C, N) Class: Breastfeeding Support Group: (B ,I) Class: Infant Feeding (P) Bulletin Board: Holiday Foods (All)	SAMPLE December Newsletter: Holiday Foods (All) Event: Santa & Mrs. Claus visit (all) Event: Librarian visit and story time (C) Class: Older Infant Feeding (I) Class: OSU Extension Budget Class (P,B,N) Bulletin Board: Holiday Foods (All)
October	November	December
January	February	March
April	May	June
July	August	September

Attachment 9

Assurance of Civil Rights Compliance

The Local Agency hereby agrees that it will comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.); Title II and Title III of the Americans with Disabilities Act (ADA) of 1990 as amended by the ADA Amendment Act of 2008 (42 U.S.C. 12131-12189) as implemented by Department of Justice regulations at (28 CFR Parts 35 and 36); Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." (August 11, 2000), all provisions required by the implementing regulations of the U.S. Department of Agriculture (7 CFR Part 15 et seq); and FNS directives and guidelines to the effect that no person shall, on the ground of race, color, national origin, age, sex, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity for which the Agency receives Federal financial assistance from FNS; and hereby gives assurance that it will immediately take measures necessary to effectuate this agreement. By providing this assurance, the Local Agency agrees to compile data, maintain records and submit records and reports as required to permit effective enforcement of the nondiscrimination laws, and to permit Department personnel during normal working hours to review and copy such records, books and accounts, access such facilities, and interview such personnel as needed to ascertain compliance with the non-discrimination laws. If there are any violations of this assurance, the State Agency shall have the right to seek judicial enforcement of this assurance.

This assurance is given in consideration of and for the purpose of obtaining any and all Federal financial assistance, grants, and loans of Federal funds, reimbursable expenditures, grant, or donation of Federal property and interest in property, the detail of Federal personnel, the sale and lease of, and the permission to use Federal property or interest in such property or the furnishing of services without consideration or at a nominal consideration, or at a consideration that is reduced for the purpose of assisting the recipient, or in recognition of the public interest to be served by such sale, lease, or furnishing of services to the recipient, or any improvements made with Federal financial assistance extended to the Program applicant by USDA. This includes any Federal agreement, arrangement, or other contract that has as one of its purposes the provision of cash assistance for the purchase of food, and cash assistance for purchase or rental of food service equipment or any other financial assistance extended in reliance on the representations and agreements made in this assurance.

This assurance is binding on the Local Agency, its successors, transferees, and assignees as long as it receives assistance or retains possession of any assistance from the Department. The person or persons whose signatures appear below are authorized to sign this assurance on the behalf of the Local Agency.

Signature: _____

Date: _____

Title: _____

Attachment 10

PROGRAM ATTACHMENT CHECKLIST

FY 2025

Project Name:

GMIS Project Number:

Please use this checklist to ensure you've completed all required attachments and submitted in GMIS along with your continuation application. Attachments 1 and 7 are to be completed and submitted only if changes have occurred since FY2024. This checklist does *not* need to be submitted.

1. ☐ Clinic and Staff Data Sheet/s
2. ☐ Breastfeeding Peer Program Budget and Expenditure Report
3. ☐ Budget Tool
4. ☐ Voter Registration Assistance Plan
5. ☐ WIC Employee Time Study
6. ☐ WIC Farmers' Market Nutrition Program Responsibilities
7. ☐ Private Physician/Hospital/Clinic Medical Services Memorandum of Agreement (MOA)
8. ☐ Nutrition Education Plan
9. ☐ Assurance of Civil Rights Compliance