

Iowa WIC Program Request for Clinic Approval

October 1, 2013

As outlined in policy 300.45, before implementing a long-term program change the agency must complete and submit this form and supporting documents to the State WIC Program for approval. Local agencies must obtain written approval from the State Office prior to making any changes. The completed request must be submitted no later than 90 days prior to the anticipated action.

Agency Name	Date
Agency Contact Person	Telephone Number

<input type="checkbox"/> <b>Opening New Clinic</b> Name for new clinic:	<input type="checkbox"/> <b>Relocating Current Clinic</b> Clinic Name & Number:	Date of opening/relocation:
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**New or Relocating Site Information**

Clinic Location	Clinic Address	Phone number (clinic & cell)
Amount of advance notice to participants and plan for notification	If relocating, distance from old clinic to new clinic	Closest WIC clinics (list with distance)
Number of days per month site will be open	Days and hours clinic will be open each month	Anticipated or current caseload
Is the clinic located in or affiliated with a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will or does the clinic serve a special group? <input type="checkbox"/> Yes* <input type="checkbox"/> No *Specify group(s):	Clinic services
Is a breastfeeding room or other designated space available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this site handicap accessible*? <input type="checkbox"/> Yes <input type="checkbox"/> No *Attach completed WIC clinic access survey (policy 300.55)	Describe available transportation and parking:
Language(s) spoken at clinic:	Staff planned & model of service (# of each staff planned): ___ clerks ___ nurse ___ RD  ___ nutrition educator ___ BFPC  ___ interpreters	Does space accommodate confidentiality? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Space cost/month:
Internet access availability <input type="checkbox"/> Yes <input type="checkbox"/> No* *If no, indicate if building has internet for potential use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is new equipment needed? <input type="checkbox"/> Yes* <input type="checkbox"/> No *Review policy 340.10 & submit completed equipment acquisition form if applicable.	Are there authorized WIC grocery & special purpose vendors within 1 – 10 miles of the clinic? Indicate name and distance of vendors:
Reasons for opening/relocating clinic and how the change will impact current or potential WIC participants (use extra pages if needed)		

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<input type="checkbox"/> Closing Current Clinic	Clinic Name & Number:	Date of closing:
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**Closing Clinic Site Information**

Caseload served:	Estimated cost savings from closing clinic:	List closest clinics & distance:
Where will current participants go for WIC services?	How will participants be notified of closing?	Does the clinic serve a special group? <input type="checkbox"/> Yes* <input type="checkbox"/> No *Specify group(s):
Reasons for closing clinic and how the change will impact current or potential WIC participants (use extra pages as necessary):		

**Demographics**

**Complete this section for all requests to relocate or close a clinic**

White/Non-Hispanic	Black/Non-Hispanic	Hispanic/White	American Indian or Alaskan Native	Asian	Native Hawaiian or Other Pacific Islander	Multiple Races or Unknown

**STATE USE ONLY**

<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved <input type="checkbox"/> Conditional Approval* *Date conditional approval met:					
Date request received:			If new equipment needed, acquisition form completed <input type="checkbox"/> Yes <input type="checkbox"/> No		
Consideration of Affirmative Action Plan Information:					
Reason not approved:					
Conditions for approval:					
Date local agency notified:	Site number assigned:	Date IWIN updated:	Date website updated:	Date clinic policies updated if necessary:	Date posted to SharePoint:

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**Instructions for Completing Request for Clinic Approval**

Please save the form to your computer and submit electronically to the state office. Do not mail or fax this form as the request will only be accepted electronically.

1. **Agency name:** name of local agency
2. **Date:** date you are completing the form
3. **Agency contact person:** name and title of person to contact for questions related to this clinic
4. **Telephone number:** number where the contact person may be reached
5. **Opening new clinic:** check here if you are opening a new WIC clinic; include the name that you wish to use for the new clinic
6. **Relocating current clinic:** check here if you are relocating a site and are still serving the same population/county; include the name and number of the relocating clinic
7. **Date of opening/relocation:** anticipated date of opening new or relocated site for WIC services
8. **Clinic location:** county in which services will be provided and the name of the building where the clinic will be located
9. **Clinic address:** street, city and zip code of clinic
10. **Phone number:** telephone number of actual clinic site and cell phone number for the clinic
11. **Amount of advance notice to participants and plan for notification:** provide the timing for advance notice to participants and how participants will be notified
12. **If relocating, distance from old clinic to new clinic:** provide distance in miles between the old and new clinic location
13. **Closest WIC clinics:** list the closest WIC clinics to the proposed/relocated site; indicate the distance in miles from the proposed site to the listed clinic
14. **Number of days per month site will be open:** list the number of days this clinic will be open each month
15. **Days and hours clinic will be open each month:** list the days this clinic will be open each month to provide services and the corresponding hours the site will be open
16. **Anticipated or current caseload:** for new clinics – anticipated number of participants that will be served at clinic; for relocating clinics – current caseload
17. **Is the clinic located in or affiliated with a hospital:** indicate if the clinic is/will be operated in a hospital or is/will be affiliated with a hospital
18. **Will or does the clinic serve a special group:** indicate if this clinic location will/does serve a specific group of participants; examples include: military, migrants, Native American, homeless, etc.
19. **Clinic services:** indicate program services that are provided in the clinic location regardless if provided by the WIC agency or not
20. **Breastfeeding room or other designated space available:** this should be a place other than a bathroom that is shielded from view and free from intrusion from others which may be used by participants and employees to express breastmilk
21. **Is this site handicap accessible:** indicate if the site is handicap accessible and include with the submission the completed WIC clinic access survey from policy 300.55
22. **Describe available transportation and parking:** examples include public buses, parking adjacent to clinic building, taxi service, adequate parking for caseload, etc.
23. **Language(s) spoken at clinic:** list the languages spoken by current participants at clinics which are relocating OR languages it is anticipated participants who will attend a new clinic will speak

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24. **Staff planned & model of service:** list the number of each type of staff who will be staffing clinic and the model of service to be provided – single provider or traditional
25. **Confidentiality:** does space allow for staff to arrange clinic for optimal confidentiality of the participants
26. **Space cost/month:** at the new or relocated site cost to rent the clinic space each month; if the location is agency owned then include the monthly amount charged to WIC for use of the space
27. **Internet access availability:** indicate if there is internet access at this site that WIC will use; if mark no that WIC will not use then indicate if there is internet available for potential use
28. **Is new equipment needed:** review policy 340.10 and submit the completed equipment acquisition form if applicable; if new laptops are requested contact the WIC Helpdesk with proposal
29. **Are there authorized WIC grocers and special purpose vendors within 1 to 10 miles of the clinic:** Indicate the name of the authorized vendor(s) and distance in miles from the clinic
30. **Reasons for opening/relocating clinic and how the change will impact current or potential WIC participants:** explain why you want to open/move to a new site; reasons may include serving increased caseload, coordination efforts with other health services, convenience for participants, loss of current site, etc. and the impact to participants
31. **Closing current site:** mark here if you are requesting to permanently close a clinic site
32. **Clinic name & number:** list the name and number of the clinic you would like to close
33. **Date of closing:** anticipated date WIC services will no longer be provided at this site
34. **Caseload served:** number of participants affected by the closure of the clinic
35. **Estimated cost saving from closing clinic:** provided a dollar amount for the anticipated cost savings
36. **List closest clinics & distance:** provide a list of the closest clinics and the distance from each to the new/relocated site
37. **Where will current participants go for WIC services:** explain where current participants will need to travel to for WIC services at other sites
38. **How will participants be notified of closing:** explain how clients will be notified of the closing and the timeline for notification
39. **Does the clinic serve a special group:** indicate if this clinic location serves a specific group of participants; examples: military, migrants, Native American, homeless, etc.
40. **Reasons for closing clinic and how the change will impact current or potential WIC participants:** explain reasons for closing clinic and include impact on participants
41. **Demographics:** complete this section for all requests to close or relocate clinics and include both information for old and new locations; list the number of clients who attend this clinic by ethnic/racial group

#### **Required Attachments**

1. New & relocating clinics:
  - a. Floor plan of clinic space: include a floor plan that shows where the clinic is located in the building along with entrances and exits; a diagram/floor plan of the WIC space that identifies work areas
  - b. Digital images of the site: digital pictures of the exterior entrance to the building where the WIC clinic will be held and pictures of the space planned for WIC use
2. The WIC clinic access survey from policy 300.55
3. Equipment acquisition form if applicable