# CERTIFICATION POLICIES AND PROCEDURES

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2.29  This policy has been removed  

2.30  This policy has been removed  

2.31  Assessment of Nutritional Risk  

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2.32  Weight and Height Measurement Requirement  

   2.32A  Procedures to Collect Weight and Height/Length Measurements  

2.33  Blood Test Requirement  

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2.34  Nutrition and Health Information Requirement  

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2.35  This policy has been removed  

2.36  Certification of Participants in Hospitals  

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   2.38A  has been removed  

   2.38B  has been removed  

   2.38C  has been removed  

   2.38D  has been removed  

8/2018
A. Policy

Pregnant, breastfeeding, or postpartum women, infants, and children who apply to receive WIC benefits, including those who currently participate but are re-applying because their certification period is about to expire, are known as applicants. Certification is the implementation of criteria and procedures to assess and document each applicant’s eligibility for the Program. Local agency staff shall follow the same basic procedure when certifying applicants.

B. Procedure

In determining the eligibility of an applicant and certifying qualified applicants, local agencies shall assure that:

1. The applicant is informed that:
   a. The purpose of the WIC Program is to promote desirable health outcomes through nutrition education, breastfeeding support, special supplemental foods, and referrals during critical times of growth and development.
   b. The relationship between the participant (or participant’s caregiver) and WIC staff is a partnership with open dialogue and two-way communication and encourage them to ask questions throughout the process.
   c. They will be notified of the determination of eligibility or ineligibility during this visit.
   d. Each participant must reapply at the end of the certification period and be reassessed for eligibility.
   e. They will need to read (or have read to them) the participant rights and responsibilities and sign that they have received a copy.

2. The certifier will ensure that:
   a. A participant focused approach to communication and good customer service practices are followed.
   b. Applicant confidentiality is protected.
   c. Demographic information is correct.
   d. The applicant meets current income eligibility requirements.
e. The applicant meets current residency requirements.
f. The applicant meets current identity requirements.
g. The applicant is categorically eligible as a pregnant, postpartum, or breastfeeding woman, an infant, or a child under the age of five.
h. The applicant is asked about voter registration status and offered the opportunity to register to vote, as appropriate.
i. The applicant is evaluated for nutritional risk by collecting and evaluating relevant information that includes:
   i. Height or length and weight measurements;
   ii. Hemoglobin or hematocrit test results, as applicable; and
   iii. Health and nutrition information.

j. If an infant or child, the applicant receives a review of his/her immunization history up to age two and is referred to their health care provider if needed.

k. If a child, the applicant is referred for a blood lead test and given information about the dangers of lead poisoning, if it cannot be determined that the test has been performed.

l. All pregnant, postpartum and breastfeeding women and parents or caretakers of infants and children are provided a list of local resources for drug and other harmful substance abuse counseling and treatment.

m. All adult applicants are provided written information about the Medicaid Program and if not currently participating, are given a referral to the Medicaid Program when income levels appear to be below the maximum allowable limits for Medicaid.

n. All adult applicants and caretakers are provided information on, and when appropriate, given referrals to other health related and public assistance programs, such as:
   i. Breastfeeding Support
   ii. Dental Services
   iii. Food Supplement Program
   iv. Expanded Food and Nutrition Education Program
   v. Food banks and pantries
   vi. Homeless facilities
   vii. Family Planning Services
   viii. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
   ix. Head Start
   x. Immunization Services
   xi. Pre- and Post-natal care
   xii. Well Child Care
   xiii. Mental Health Services
   xiv. Smoking Cessation Programs
   xv. Substance abuse counseling and treatment programs
   xvi. Temporary Cash Assistance (TCA)
   xvii. Other local services that may be applicable to the applicant’s needs.
o. Any family member(s) deemed eligible for the Program receive at the initial certification, and thereafter, as needed:
   i. A prescription for the most appropriate food package using information obtained during the certification, including any food preferences.
   ii. An explanation of what the WIC foods are and why they were selected, that the foods are supplemental and intended for the participant(s), and what to do if a change in the food package is needed.
   iii. Participant focused nutrition education that is appropriate for categorical status, and targeted to reducing nutritional risk(s) identified during the certification.
   iv. If pregnant, information verbally and in writing, about the benefits of and contraindications to breastfeeding.
   v. Food instruments and an explanation on how to use them and the importance of preventing loss or theft.
   vi. A list of WIC authorized foods and vendors.
   vii. An explanation of the need to return to the clinic for future appointments, as appropriate.
   viii. A written appointment date and time to obtain the next allotment of food benefits and secondary nutrition education contact.
   ix. Information about how to contact the clinic.
   x. Encouragement to participate in the local agency’s nutrition education activities.
   xi. Encouragement to keep and be on time for all appointments
   xii. Instruction to explain Program information including the use of food instruments and procedures for WIC appointments to all persons identified in the management information system as proxies or designees.

p. The applicant reads (or has read to her) and receives a copy of the Participant’s Rights and Responsibilities form before electronically signing to acknowledge understanding and receipt of such.

q. A verification of certification (VOC) is issued to every migrant family as well as military families or others who are likely to be relocating within the certification period.

References:
   ▪ 7CFR 246.7
   ▪ 7CFR 246.11
   ▪ COMAR 10.54.01.08
   ▪ SFP 01-032, WIC Final Policy Memorandum, Clarification of WIC’s FY 2001 Appropriations Act Provision Regarding Blood Lead Screening
   ▪ SFP 06-056 Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy (HQ Policy Memo 2006-5)
A 17. added wording that the ID folder is required to pick up and redeem food instruments

10/08 Changed Food Stamps to read Supplemental Nutrition Assistance Program SNAP

01/09 Changed Supplemental Nutrition Assistance Program SNAP to read Food Supplement Program

10/10 Added B2 and B5. Reordered B 1-6

10/11 Specified in A.2. that an applicant may live or work in the service area of the local agency. Added participant focused in A.12 Added clarification to B.6.

10/12 Minor language changes/clarifications

10/13 Changed WOW to management information system and Applicant’s Rights and Responsibilities to Participant’s Rights and Responsibilities; added electronic signature. Consolidated A.10 and A.24.

10/15 Reorganized information; added information from and deleted Policy and Procedure 2.35.

06/07/2017 Updated with eWIC terminology, removed reference to ID folders
Policy and Procedure 2.01 has been renamed as Policy and Procedure 7.60.
A. Policy

To be certified as eligible for the WIC Program, applicants shall meet the following criteria for eligibility in accordance with policies established by the State agency.

a. Establishment of Applicant Identity (Policy and Procedure 2.23);

b. Residency requirements (Policy and Procedure 2.04);

c. Income eligibility requirements (Policy and Procedure 2.05); and

d. Assessment of nutritional risk (Policy and Procedure 2.31).

B. Procedure

The local agency shall:

1. Use the management information system or the manual certification form provided by the State agency (Attachment 2.02A) to certify all applicants in accordance with the policies and procedures listed in section A and other related policies and procedures.

2. Advise the participant or the parent/legal guardian or designee of the participant’s rights and responsibilities as outlined in Policy and Procedure 2.12 Participant’s Rights and Responsibilities.

3. Ensure that the staff who determines income and nutrition risk documents their review and approval of information provided by and/or obtained from the applicant to be certified as eligible for the WIC Program by entering their secure user login in the management information system or signing the Participant Rights and Responsibilities form in the appropriate spaces. Refer to the procedures in Policy and Procedure 2.12 Participant Rights and Responsibilities.
Attachments: 2.02A Manual Certification/Mid-Certification Form

References: 7 CFR 246.7

Revisions 10/99
July 2002 - Added Establishment of Identity in A. Policy
October 1, 2007 – updated Nutrition Risk Policy Name and Number
10/11- clarified the policy in B.2d
10/12- Changed B.1 to indicate that WOW or Attachment 2.02A should be used to complete the mid-certification appointment as well as the certification. Changed name of Attachment 2.02A to Manual Certification/Mid-Certification Form.
10/13 – changed name of policy to Certification of Applicant, deleted B.2.a-e, moved a portion of B.2.d to Policy and Procedure 7.66, B.2.e is already reflected in Policy and Procedure 2.33 and 2.32, added new language for B.2 and B.3., removed attachment 2.02B.
10/15 Added Maryland WIC Program Nutrition Care Referral Form to Attachment 2.02A.

06/07/2017  Updated Attachment A to include eWIC language and to reflect new high risk categories, updated B.3 to reflect needed staff signatures based on new separation of duties guidelines.

11/08/2017  Update Attachment A to include new nutrition risk questions and new high-risk categories.
## Maryland WIC Program Manual

### Certification / Mid-Certification Form

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### Family Information

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**Head of Household**

**Proxy #1**

**Proxy #2**

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**Primary**

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<th>Call</th>
<th>Text</th>
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<th>No</th>
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**E-mail Address**

**Family Size**

### Income Information

**Income Provider Name**

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<th>Source</th>
<th>Documentation</th>
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**Additional Family Information**

**Primary Language if not English**

**Proof of Residence**

**Voter Registration**

**Pickup Interval**

**Internet Usage**

**Referred From**

**Disability**

**Other Information**

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### Participant Information (Woman)

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<th>Last Name</th>
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<th>MI</th>
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<th>Proof of Identity</th>
<th>Proof of Pregnancy</th>
<th>Source of Health Care</th>
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**Adjunct Eligibility**
- □ MA
- □ Food Stamps
- □ TCA

**Adjunct Eligibility Card Number**
- [ ]

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<th>Enrollment in other Federal Programs</th>
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<td>American Indian or Alaska Native</td>
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<td>TCA</td>
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<td>Black or African American</td>
<td>Food Stamps</td>
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<td>Native Hawaiian or Other Pacific Islander</td>
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**Certification**

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**Pregnancy Information**

1. When did you see a doctor for this pregnancy?
   - □ Haven’t
   - □ Date of 1st visit: [ ]

1a. What has your doctor told you about getting flu and Tdap shots while you’re pregnant.

2. What special concerns does your care provider have?
   - □ Twins, triplets or more
   - □ Weight loss while pregnant
   - □ Hyperemesis gravidarum
   - □ Gestational diabetes
   - □ Fetal growth restriction (IUGR)
   - □ None or unknown

3. Is this your first pregnancy?
   - ☐ Yes ☐ No

3a. Tell me about any medical issues with your past pregnancies.
   - □ Baby born 5 pounds, 8 ounces or less
   - □ Baby born 9 pounds or more
   - □ Baby born 37 weeks or earlier
   - □ Baby born with a birth defect
   - □ Two or more miscarriages less than 20 weeks
   - □ Pregnancy loss (20 weeks or more)
   - □ Stillbirth or death before 1 month of age
   - □ Gestational diabetes
   - □ History of Preeclampsia
   - □ None of these

WPP/BE/BP:

1. Tell me about this last pregnancy.
   - □ Baby born 5 pounds, 8 ounces or less
   - □ Baby born 9 pounds or more
   - □ Baby born 37 weeks or earlier
   - □ Twins, triplets or more
   - □ Baby born with a birth defect
   - □ Miscarriage (less than 20 weeks)
   - □ Pregnancy loss (20 weeks or more)
   - □ Stillbirth or death before 1 month of age
   - □ Caesarean “C” section
   - □ Gestational diabetes
   - □ History of Preeclampsia
   - □ None of these

2. Were you ever pregnant before this last time? □ No ☐ Yes

Date of last live birth: [ ]

<table>
<thead>
<tr>
<th>Category</th>
<th>Cert Start</th>
<th>Cert End</th>
<th>Cert Reason</th>
<th>Actual Delivery Date</th>
<th>Term Date</th>
<th>Term Reason</th>
<th>Comment</th>
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| Date of last live birth: | [ ]
|-------------------------|---|

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**Physician Name**
- [ ]

**Telephone Number**
- [ ]

---

**Source of Health Care**
- [ ]

---

**Adjunct Eligibility Card Number**
- [ ]

---

**Proof of Identity**
- ☐ N/A MCV

---

**Proof of Pregnancy**
- [ ]

---

**Enrollment in other Federal Programs**
- Medical Assistance: ☐ Yes ☐ No
- TCA: ☐ Yes ☐ No
- Food Stamps: ☐ Yes ☐ No

---

**Certification**

| Date of last live birth: | [ ]
|-------------------------|---|

---

**Pregnancy Information**

1. When did you see a doctor for this pregnancy?
   - □ Haven’t
   - □ Date of 1st visit: [ ]

1a. What has your doctor told you about getting flu and Tdap shots while you’re pregnant.

2. What special concerns does your care provider have?
   - □ Twins, triplets or more
   - □ Weight loss while pregnant
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   - □ History of Preeclampsia
   - □ None of these

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   - □ Baby born 5 pounds, 8 ounces or less
   - □ Baby born 9 pounds or more
   - □ Baby born 37 weeks or earlier
   - □ Twins, triplets or more
   - □ Baby born with a birth defect
   - □ Miscarriage (less than 20 weeks)
   - □ Pregnancy loss (20 weeks or more)
   - □ Stillbirth or death before 1 month of age
   - □ Caesarean “C” section
   - □ Gestational diabetes
   - □ History of Preeclampsia
   - □ None of these

2. Were you ever pregnant before this last time? □ No ☐ Yes

Date of last live birth: [ ]

---

**Physician Name**
- [ ]

**Telephone Number**
- [ ]

---

**Source of Health Care**
- [ ]

---

**Adjunct Eligibility Card Number**
- [ ]

---

**Proof of Identity**
- ☐ N/A MCV

---

**Proof of Pregnancy**
- [ ]

---

**Enrollment in other Federal Programs**
- Medical Assistance: ☐ Yes ☐ No
- TCA: ☐ Yes ☐ No
- Food Stamps: ☐ Yes ☐ No

---

**Certification**

| Date of last live birth: | [ ]
|-------------------------|---|
# Medical Information (Women)

1. Do you have any health problems or recent illnesses that concern your doctor?  
   □ None □ Some  Specify__________________________________________________________

2. What medicine do you take regularly? □ None □ Takes  Specify__________________________

3. What vitamins do you take regularly?  
   □ None □ Prenatal vitamin w/Iodine □ Prenatal vitamin □ Iron Pill
   □ Multivitamin □ Folic acid pill □ Herbal supplement □ Other: ______________________

4. What dental problems are you having?  
   □ None □ Missing or extracted teeth □ Untreated Caries □ Gum Disease
   □ Other __________________________ Have a dental provider? □ No □ Yes

5. Do you have any food allergies diagnosed by a health care provider?  
   □ None □ Peanuts □ Nuts □ Milk □ Soy □ Eggs □ Fish □ Shellfish □ Wheat
   □ Corn □ Other: __________________________

6. Do you eat or want to eat things that are not food? □ No □ Yes  Specify________________________

7. Do you smoke any kind of tobacco products? □ No □ Yes  Number per day____________

8. Do you use recreational (street) drugs? □ No □ Yes

9. During the past month, - have you often been bothered by feeling down, depressed or hopeless?  □ No □ Yes
   - had little interest or pleasure in doing things? □ No □ Yes

10. What concerns do you have about the safety of you or your children? □ Some concerns □ None

   Physician’s Name:  Phone: (______ )

## Wt/Ht/Bloodwork

<table>
<thead>
<tr>
<th>Date</th>
<th>LBS</th>
<th>OZ</th>
<th>IN</th>
<th>1/8 IN</th>
<th>Weeks</th>
<th>Hgb</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Pre Pregnancy Weight  

Have you had a blood lead test? □ No □ Yes □ Don’t Know

Weight at Delivery
### Participant Information (Infant – Child)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>DOB</th>
<th>Gender</th>
<th>Proof of Identity</th>
<th>Adjunct Eligibility</th>
<th>Adjunct Eligibility Card Number</th>
<th>Source of Health Care</th>
<th>Mom’s ID Number</th>
<th>Physician Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Male</td>
<td>□ Female</td>
<td>□ MA □ Food Stamps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Proof of Identity**: □ N/A MCV

### Hispanic or Latino?

- □ Yes □ No

### Enrollment in other Federal Programs

- **American Indian or Alaska Native**: Medical Assistance □ Yes □ No
- **Asian**: TCA □ Yes □ No
- **Black or African American**: Food Stamps □ Yes □ No
- **Native Hawaiian or Other Pacific Islander**: 
- **White**: 

### Cert Action (Infant – Child)

**Immunization Status:**

- □ Yes □ No

<table>
<thead>
<tr>
<th>Immunization Document</th>
<th>DTaP #1</th>
<th>DTaP #2</th>
<th>DTaP #3</th>
<th>DTaP #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Breastfeeding Now:**

- □ Yes □ No

<table>
<thead>
<tr>
<th>Amount of BF</th>
<th>□ Exclusive □ Mostly (&lt;14oz formula) □ Some (&gt;14oz formula)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

**Ever Breastfed:**

- □ Yes □ No □ Unknown

<table>
<thead>
<tr>
<th>Age when routinely fed something other than breast milk?</th>
<th>Food Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ □ □ months □ weeks □ days</td>
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</tbody>
</table>

**Date/Age BF Ended**

<table>
<thead>
<tr>
<th>Date/Age BF Ended</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ □ months □ weeks □ days</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Cert Start</th>
<th>Cert End</th>
<th>Cert Reason</th>
<th>Term Date</th>
<th>Term Reason</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
# Medical Information (Infant – Child)

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell me about any health concerns for your child in the past 6 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. What medicines does your child take on a regular basis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. What vitamins or supplements do you give your child?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What dental problems does your child have?</td>
<td>□ White or dark spots on teeth □ Dental caries □ Extracted teeth □ Other: ____________</td>
<td></td>
</tr>
<tr>
<td>Has he/she seen dentist?</td>
<td>Name:</td>
<td>Phone:</td>
</tr>
<tr>
<td>5. Where does the drinking water you use for your child/infant come from?</td>
<td>□ City (fluoride) □ Well □ City (no fluoride) □ Outdoor Spring/Cistern □ Store-bought (w/fluoride) □ Don’t Know □ Store-bought (no fluoride) □ None</td>
<td></td>
</tr>
<tr>
<td>6. Does your child eat or want to eat things that are not food?</td>
<td>If yes, what?</td>
<td></td>
</tr>
<tr>
<td>7. Does your child have any food allergies that have been diagnosed by a health care provider?</td>
<td>□ Milk □ Soy □ Eggs □ Nut □ Peanuts □ Shellfish □ Fish □ Wheat □ Corn □ Other ____________</td>
<td></td>
</tr>
<tr>
<td>8. Does anyone living in the household smoke inside the home?</td>
<td>□ No □ Yes □ Don’t Know</td>
<td></td>
</tr>
<tr>
<td>9. Mother (only if present)</td>
<td>Height (inches)</td>
<td>Weight (lbs)</td>
</tr>
<tr>
<td>10. Father (only if present)</td>
<td>Height (inches)</td>
<td>Weight (lbs)</td>
</tr>
<tr>
<td>11. How do you feel about your child’s growth?</td>
<td>□ Too slow □ Just right □ Too fast</td>
<td></td>
</tr>
</tbody>
</table>

**Physician’s Name:**

**Phone:**

---

## Wt/Ht/Bloodwork

<table>
<thead>
<tr>
<th>Date</th>
<th>LBS</th>
<th>OZ</th>
<th>IN</th>
<th>1/8</th>
<th>R/S</th>
<th>Hgb</th>
<th>Comment</th>
</tr>
</thead>
</table>

**Infant Preterm or Early Term**

**Weeks of Gestation**

**Birth Weight** __________ lbs __________ oz

**Lead Test**

□ Yes □ No □ Don’t Know
### Participant Information (Infant – Child)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>DOB</th>
<th>Gender</th>
<th>Proof of Identity</th>
<th>Adjunct Eligibility</th>
<th>Adjunct Eligibility Card Number</th>
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<th>Physician Name</th>
<th>Telephone Number</th>
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</table>

<table>
<thead>
<tr>
<th>Hispanic or Latino?</th>
<th>Yes</th>
<th>No</th>
<th>Enrollment in other Federal Programs</th>
<th>American Indian or Alaska Native</th>
<th>MA</th>
<th>Food Stamps</th>
<th>TCA</th>
<th>Food Stamps</th>
<th>White</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>Medical Assistance</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>TCA</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>Food Stamps</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>Native Hawaiian or Other Pacific Islander</td>
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<tr>
<td>No</td>
<td></td>
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<td>White</td>
<td></td>
<td></td>
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### Cert Action (Infant – Child)

<table>
<thead>
<tr>
<th>Immunization Status:</th>
<th>Record Date Given:</th>
<th>Immunization Document:</th>
<th>DTaP #1</th>
<th>DTaP #2</th>
<th>DTaP #3</th>
<th>DTaP #4</th>
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**Notes:**
- Proof of Identity: N/A MCV
- Adjunct Eligibility: MA, Food Stamps, TCA
- Source of Health Care
- Mom’s ID Number
- Physician Name
- Telephone Number
- Hispanic or Latino? Yes, No
- American Indian or Alaska Native: Yes, No
- Asian: Yes, No
- Black or African American: Yes, No
- Native Hawaiian or Other Pacific Islander: Yes, No
- White: Yes, No
- Breastfeeding Now: Yes, No
- Amount of BF: Exclusive, Mostly (<14oz formula), Some (>14oz formula)
- Age when routinely fed something other than breast milk?
- Date/Age BF Ended
- Category
- Cert Start
- Cert End
- Cert Reason
- Term Date
- Term Reason
- Comment
# Medical Information
## (Infant – Child)

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
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<th>Specify</th>
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<td>1. Tell me about any health concerns for your child in the past 6 months.</td>
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Physician’s Name:                                                                                   Phone:

## Wt/Ht/Bloodwork

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<td></td>
<td></td>
</tr>
</tbody>
</table>

Infant Preterm or Early Term | | Weeks of Gestation | Birth Weight |     |     |     |          |

Leads Test

• Yes □ No □ Don’t Know

Attachment 2.02A 11/2017 Page 8
### Risk Factors
<table>
<thead>
<tr>
<th>Participant #1</th>
<th>Participant #2</th>
<th>Participant #3</th>
</tr>
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### Nutrition Education Topics
<table>
<thead>
<tr>
<th>Participant #1</th>
<th>Participant #2</th>
<th>Participant #3</th>
</tr>
</thead>
</table>

#### Goal:

### Referrals

<table>
<thead>
<tr>
<th>Nutrition Care</th>
<th>Immunizations</th>
<th>Dental</th>
<th>Food Stamps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>Health Care</td>
<td>MA</td>
<td>Additional Food Resources</td>
</tr>
</tbody>
</table>

**Local Provider:**

### Food Package Requested

<table>
<thead>
<tr>
<th>Participant #1</th>
<th>Milk Type: Cheese/Tofu</th>
<th>Dry Beans/Can Beans/P.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant #2</td>
<td>Milk Type: Cheese/Tofu</td>
<td>Dry Beans/Can Beans/P.B.</td>
</tr>
<tr>
<td>Participant #3</td>
<td>Milk Type: Cheese/Tofu</td>
<td>Dry Beans/Can Beans/P.B.</td>
</tr>
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</table>

### Next Appointment

<table>
<thead>
<tr>
<th>CPU</th>
<th>PSV</th>
<th>IND</th>
<th>MCV</th>
<th>NC</th>
<th>BFF</th>
<th>Note:</th>
</tr>
</thead>
</table>

### Comments / Notes

**Initials of staff member who entered information into WOW verifying completion**

**Recert:** Family called to notify them their benefits are loaded:
- [ ] Left message
- [ ] Person answered
- **Date of contact:**

**Certification:** PSV scheduled for family to pick-up eWIC card
- [ ] Family has transportation concerns and requested staff mail eWIC card
- [ ] Address verified
- [ ] Next appointment made and is entered in WOW
- [ ] Shopping List mailed with eWIC card
## Codes

<table>
<thead>
<tr>
<th>Proof of Residency</th>
<th>Proof of Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation of Residency Form</td>
<td>Birth Certificate/Registration</td>
</tr>
<tr>
<td>Drivers License</td>
<td>Drivers License</td>
</tr>
<tr>
<td>Homeless Shelter</td>
<td>Hospital Birth Record</td>
</tr>
<tr>
<td>Lease</td>
<td>Immunization Record</td>
</tr>
<tr>
<td>MVA Identification</td>
<td>Other (system note required)</td>
</tr>
<tr>
<td>Migrant Camp Resident</td>
<td>Proof of Age/Majority</td>
</tr>
<tr>
<td>No Proof</td>
<td>Proof of Identity Affidavit</td>
</tr>
<tr>
<td>Official Mail</td>
<td>Proof of Identity Card</td>
</tr>
<tr>
<td>Other (system note required)</td>
<td>Social Security Card</td>
</tr>
<tr>
<td>Utility Bill</td>
<td>Immigration/Naturalization Record</td>
</tr>
<tr>
<td></td>
<td>Military Records, ID Card or Discharge Papers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proof of Pregnancy</th>
<th>Source of Income</th>
<th>Income Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider’s Note</td>
<td>Alimony or Child Support</td>
<td>Collateral Verification</td>
</tr>
<tr>
<td>No Proof</td>
<td>Collateral Verification Form</td>
<td>Contributions from Other Persons</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>Contributions from Other Persons</td>
<td>Dividends or Interest on Savings or Bonds</td>
</tr>
<tr>
<td>Other (system note required)</td>
<td>Dividends or Interest on Savings or Bonds, Income</td>
<td>Foster Child Status Verification</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>From Estate</td>
<td>Income Tax Returns</td>
</tr>
<tr>
<td>Pregnancy Test Results/Sonogram</td>
<td>Foster Care</td>
<td>Letter from Employer</td>
</tr>
<tr>
<td>VOC</td>
<td>Military LES</td>
<td>Military LES</td>
</tr>
<tr>
<td>WIC Referral Form</td>
<td>Net Income From Farm and Non-Farm Self-Employment</td>
<td>No Proof</td>
</tr>
<tr>
<td></td>
<td>Pending</td>
<td>Other Cash Income Received or Withdrawn from Any</td>
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<td></td>
<td></td>
<td>Source</td>
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<td>Private Pensions or Annuities</td>
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<td>Retirement Pensions or Veteran Payment</td>
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<td>VOC card</td>
</tr>
<tr>
<td></td>
<td></td>
<td>W-2 Form (copy)</td>
</tr>
</tbody>
</table>
**Name________________________________________**

**Women**

**Please answer all questions below.**

1. **Tell me about any problems you have with eating.**
   - [ ] Nausea
   - [ ] Heartburn
   - [ ] Vomiting
   - [ ] Constipation
   - [ ] Mouth pain
   - [ ] Don’t feel like eating
   - [ ] No time to eat
   - [ ] Can’t find the foods I like
   - [ ] None of these

2. **What times do you eat in a typical day?**
   - [ ] Morning
   - [ ] Noon
   - [ ] Evening
   - [ ] Snacks ____________(number)

3. **Tell me what kinds of foods you eat most days:**
   - [ ] Bread, tortillas, or crackers
   - [ ] Orange or red vegetables
   - [ ] Cold or hot cereal
   - [ ] Green vegetables
   - [ ] Noodles, macaroni, or rice
   - [ ] Dry beans /canned beans
   - [ ] Fish or shellfish
   - [ ] Tofu
   - [ ] Fruit
   - [ ] Peanut butter or nuts
   - [ ] Green leafy salads
   - [ ] Meat, chicken, or turkey
   - [ ] Noodles, macaroni, or rice
   - [ ] Dry bean/canned beans
   - [ ] Fish or shellfish
   - [ ] Tofu
   - [ ] Fruit
   - [ ] Peanut butter or nuts
   - [ ] Green leafy salads
   - [ ] Meat, chicken, or turkey

4. **What do you drink in a typical day?**
   - [ ] Milk
   - [ ] Water
   - [ ] Fruit juice
   - [ ] Soda or fruit-flavored drinks
   - [ ] Diet soda
   - [ ] Coffee or tea (hot or cold)
   - [ ] Herbal tea
   - [ ] Beer, wine, or drinks with alcohol
   - [ ] Other: ____________________________

   **Milk Type**
   - [ ] Whole
   - [ ] 2%
   - [ ] 1% or fat free
   - [ ] Lactose reduced
   - [ ] Evaporated
   - [ ] Powdered
   - [ ] Soy milk

5. **What, if any, foods do you avoid for health reasons?**
   - [ ] No
   - [ ] Yes: ____________________________(foods)

6. **Do you follow any personal eating plan or diet?**
   - [ ] None
   - [ ] Fasting
   - [ ] Vegan
   - [ ] Low Carbohydrate/High Protein
   - [ ] Metabolic
   - [ ] Raw Foods
   - [ ] Other: ____________________________

7. **Describe how you include physical activity in your day.**
   - **How much time?**
     - [ ] None
     - [ ] 15 minutes
     - [ ] 30 minutes
     - [ ] 1 hour
     - [ ] More than 1 hour

8. **Would you like information on other food resources beyond WIC?**
   - [ ] No
   - [ ] Yes

9. **What do you wish were different about what and how you eat?**
   ____________________________
(Infant) Birth – 5 months

Baby's Name: ______________________

1. Baby is: □ Breastfed  □ Bottle-fed

   **How breastfeeding is going?**
   - Does baby have:
     □ Difficulty with latch-on
     □ Weak suck
     □ Jaundice
     □ Other: __________
     □ None of these
   - Does mom have:
     □ No milk at 4 days postpartum
     □ Cracked, bleeding, or severely-sore nipples
     □ Mastitis
     □ Flat or inverted nipples
     □ Other: __________
     □ None of these


3. How do you know when you baby is hungry?
   □ Sucks on hand  □ Fusses  □ Gets restless  □ Cries  □ Don't Know  □ Other: __________

4. How do you know when your baby is full?
   □ Pushes nipple out  □ Turns away  □ Gets sleepy  □ Don't Know  □ Other: __________

5. How does your baby act after eating?
   □ Is happy and satisfied  □ Want to sleep, not eat  □ Stays hungry  □ Other: __________
   □ Acts fussy or cries a lot  □ Spits up a lot  □ Takes too long to eat

6. How many wet and dry diapers does your baby have in 24 hours?
   - Wet diapers: □ Less than 6  □ 6 to 8  □ 9 or more
   - Dirty diapers: □ 0 to 1  □ 2 to 5  □ 6 or more

   **Skip to question 13 if you do not bottle-feed your baby.**

7. What does your baby drink from a bottle?
   □ Breast milk  □ Plain water  □ Other: __________
   □ Breast milk not from mother  □ Formula with iron  □ Fruit juice
   - How many ounces of formula do you put in a bottle?
     □ Less than 2  □ 2 to 3  □ 4 to 5  □ 8 or more
   - How many ounces of breast milk do you put in a bottle?
     □ Less than 2  □ 2 to 3  □ 4 to 5  □ 8 or more
   - How much of that does your baby drink?
     □ All or most  □ Half  □ Less than half
   - What do you do if he/she doesn’t finish the bottle?
     □ Try to get baby to finish  □ Save it for later  □ None of these
   - Do you put cereal or other food in the bottle? □ No  □ Yes  Food: __________

**Tell me how you make and store the bottles:**

8. How do you sterilize the bottles and water?
   □ Sterilize incorrectly  □ Sterilize correctly  □ N/A

9. How do you mix formula?
   □ Mixed incorrectly  □ Mixed correctly  □ N/A

10. How do you store the formula or breast milk?
    □ Stored incorrectly  □ Stored correctly  □ N/A

11. How do you warm the bottle?
    □ Warmed incorrectly  □ Warmed correctly  □ N/A

12. Is baby put to bed with bottle or is bottle propped?
    □ No  □ Yes
13. Do you feed your baby anything from a spoon?
   - None
   - Fruit
   - Meats
   - Cereal
   - Vegetables
   - Other: __________________________

14. Does anyone give the baby honey, Karo syrup or sugar?  □ No  □ Yes

15. What do you wish were different about feeding your baby?

16. Was mom on WIC during this pregnancy?  □ No  □ Yes

17. Are you interested in other food resources beyond WIC?  □ No  □ Yes
(Infant) 6 – 12 months

Baby’s name__________

Please tell us how feeding is going.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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</thead>
<tbody>
<tr>
<td>1. What does your baby drink?</td>
<td>□ Breast milk from: □ Breast □ Bottle □ Cup with lid □ Cup</td>
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<tr>
<td></td>
<td>□ Breast milk not from mother</td>
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<td></td>
<td>□ Formula ___oz./day from: □ Bottle □ Cup with lid □ Cup</td>
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<td></td>
<td>□ Plain water from: □ Bottle □ Cup with lid □ Cup</td>
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<td></td>
<td>□ 100% fruit juice from: □ Bottle □ Cup with lid □ Cup</td>
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<td></td>
<td>□ Sugar-sweetened drinks from: □ Bottle □ Cup with lid □ Cup</td>
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<tr>
<td></td>
<td>□ Cow or other milk from: □ Bottle □ Cup with lid □ Cup</td>
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<tr>
<td></td>
<td>□ Other_________________</td>
</tr>
</tbody>
</table>

2. How often do you feed your baby breast milk or formula:
   Breast milk _____ times in 24 hours.
   Formula ______ times in 24 hours.

3. How many ounces do you put in a bottle or cup?
   Breast milk □ Less than 2 □ 2 to 3 □ 4 to 5 □ 6 to 7 □ 8 or more
   Formula □ Less than 2 □ 2 to 3 □ 4 to 5 □ 6 to 7 □ 8 or more
   • Do you add cereal or other food to the bottle or cup? □ No □ Yes

Tell me how you make and store formula:

4. How do you mix formula? □ Mixed incorrectly □ Mixed correctly □ N/A

5. How do you store breastmilk or formula?
   Breast milk □ Stored incorrectly □ Stored correctly □ N/A
   Formula □ Stored incorrectly □ Stored correctly □ N/A

6. How do you warm the bottle? □ Warmed incorrectly □ Warmed correctly □ N/A

7. Is baby put to bed with bottle or is bottle propped? □ No □ Yes □ N/A
8. What foods have you offered your baby?

- Baby cereal
- Green vegetables
- Dry beans or tofu
- Baby dinners
- None of these
- Regular cereal
- Orange vegetables
- Meat/Meat sticks
- Baby desserts
- Noodles or rice
- Other vegetables
- Chicken or turkey
- Cookies/Sweets
- Bread or tortillas
- Fruit
- Eggs
- Chips/Puffs

9. What feeding skills does your baby have?  
- Eats from a spoon
- Eats with fingers
- None of these

10. How do you know when your baby is hungry?

- Facial expression
- Makes sounds
- Body Movement
- Don’t know
- Other: ______________

11. How do you know when your baby is full?:

- Facial expression
- Won’t sit still
- Fusses
- Turns away, closes mouth
- Pushes or slaps at food
- Don’t know
- Other ______________

12. What do you do if your baby doesn’t finish the food you give him?

- Try to get baby to finish
- Saves food for later
- None of these

13. How do you feel about the amount of food your baby eats:

- Too little
- Just enough
- Too much

14. How often does your baby eat with the family?

- Most of the time
- Sometimes
- Rarely

15. What would you like to change about feeding your baby?

16. Are you interested in other food resources beyond WIC?

- No
- Yes
**Child**

*Child's name ________________________________*

1. Describe how your family is physically active together ________________________________

2. How much time does your child spend in active play?
   - [ ] None
   - [ ] 15 minutes
   - [ ] 30 minutes
   - [ ] 1 hour
   - [ ] More than 1 hour

3. How many hours did your child sit and watch TV or videos yesterday?
   - [ ] None
   - [ ] 1 hour
   - [ ] 2 hours
   - [ ] 3 hours
   - [ ] More than 3 hours

4. Tell me how you feel about mealtimes:  
   - [ ] Mostly pleasant
   - [ ] Sometimes pleasant
   - [ ] Rarely pleasant

5. How do you feel about how much your child eats?  
   - [ ] Eats too little
   - [ ] Eats just enough
   - [ ] Eats too much

6. What are the usual times your child eats during the day?  
   - [ ] Morning
   - [ ] Noon
   - [ ] Evening
   - [ ] Snacks___

7. Which of these foods do you offer during the day?
   - [ ] Bread or tortillas
   - [ ] Crackers
   - [ ] Cereal
   - [ ] Noodles or macaroni
   - [ ] Rice
   - [ ] Fruit
   - [ ] Potatoes or corn
   - [ ] Green vegetables
   - [ ] Orange or red vegetables
   - [ ] Fish or shellfish
   - [ ] Meat or chicken
   - [ ] Dry bean/canned beans
   - [ ] Tofu
   - [ ] Peanut butter
   - [ ] Eggs
   - [ ] Cheese or yogurt
   - [ ] Hot dogs, sausage or coldcuts
   - [ ] Ice cream or pudding
   - [ ] Cookies, cake, pie, or donuts
   - [ ] Hard or chewy candy or fruit snacks
   - [ ] Chips, popcorn, or nuts

8. Child drinks from:  
   - [ ] Cup
   - [ ] Cup with lid
   - [ ] Baby Bottle

9. What does your child drink?  
   - [ ] Breast milk
   - [ ] Breast milk not from mother
   - [ ] Formula ________________________________ (name)
   - [ ] Milk _______ (oz per day)
   - [ ] Water _________ (oz per day)
   - [ ] Fruit Juice __________ (oz per day)
   - [ ] Soda, fruit-flavored drinks or sweetened tea
   - [ ] Other: ________________________________  
   - [ ] Milk Type
     - [ ] Whole
     - [ ] 2%
     - [ ] 1% or fat free
     - [ ] Lactose reduced
     - [ ] Evaporated
     - [ ] Powdered
     - [ ] Soy milk
10. How often do you or another adult sit and eat with this child?
   - Most of the time
   - Sometimes
   - Rarely

11. Does your child refuse to eat foods or meals?  
    - Most of the time
    - Sometimes
    - Rarely
    - If your child won’t eat, what do you do?
      - Tries to get child to eat
      - Gives different food
      - Offers reward
      - Saves food for later
      - Other __________________________
      - N/A

12. Would you like information on other food resources beyond WIC?  
    - No
    - Yes

13. What do you wish could be different about feeding this child?  ________________________________
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<tr>
<th>Condition</th>
<th>PG</th>
<th>BE</th>
<th>BP</th>
<th>WPP</th>
<th>IBE</th>
<th>IBP</th>
<th>IFF</th>
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<td>Breastfeeding Infant of Mother at Nutritional Risk</td>
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<td>Hyperemesis Gravidarum Diagnosis</td>
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<td>Lead Poisoning ( \geq 5.0 \text{ ug/dl} ) in last 12 months</td>
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<td>Low Birth Weight ( \leq 5 \text{ lb, 8 oz} )</td>
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<td>Low Hemoglobin/Hematocrit ( &lt; 10.0 \text{ g} ) or ( &lt; 30% )</td>
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<td>Multi-Fetal Gestation</td>
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<td>Pica (Eating or wanting to eat non-food items)</td>
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<td>PreTerm ( \leq 36 \text{ 6/7 weeks gestation} )</td>
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<td>Or Early Term ( \geq 37 \text{ 0/7 and} \leq 38 \text{ 6/7 weeks gestation} )</td>
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<td>Slowed/Faltering Growth weight loss ( \geq 7% ) before 2 weeks of age; any weight loss between 2 weeks-6 months</td>
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<td>Small for Gestational Age Diagnosis</td>
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<td>Special Diet: Vegan, Fasting, Metabolic</td>
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<td>Underweight ( \text{ Weight/length} \leq 2.3^{rd} \text{ percentile} )</td>
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<td>Underweight ( \text{ Weight/length} \leq 5^{th} \text{ percentile} )</td>
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A. Policy

1. When the local agency is serving its maximum assigned caseload, it shall maintain a priority waiting list of applicants from which the highest priority applicants can be selected to participate in the Program when caseload slots become available. Priority is determined by the nutritional risk status and length of time an applicant has remained on the waiting list.

2. Applicants for Program benefits shall be placed on the priority waiting list in accordance with the following criteria:

   a. Priority I. Pregnant women, breastfeeding women, and infants at nutritional risk as demonstrated by hematological or anthropometric measurements, or other documented nutritionally related medical conditions which demonstrate the need for supplemental foods.

   b. Priority II. Except those infants who qualify for Priority I, infants up to 6 months old born to Program participants who participated during pregnancy, or to women who were not Program participants but whose medical records document that they were at nutritional risk during the pregnancy due to nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions which demonstrated the person's need for supplemental foods.

   c. Priority III. Children at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions which demonstrate the child's need for supplemental foods and postpartum women at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions.

   d. Priority IV. Pregnant women, breastfeeding women, and infants at nutritional risk because of an inadequate dietary pattern and
homeless or migrant pregnant women, breastfeeding women, and infants.

e. Priority V. Children at nutritional risk because of an inadequate dietary pattern and homeless or migrant children.

f. Priority VI. Postpartum women at nutritional risk because of an inadequate dietary pattern and homeless or migrant postpartum women.

B. Procedure

1. State Agency Responsibility

   The State agency continuously monitors program operations and expenditures to ensure maximum use of grant funds. Upon determination that there are insufficient funds to continue to provide program benefits to all eligible applicants, the State shall initiate procedures to establish a waiting list of eligible applicants. The State shall notify the local agencies of the nutritional risk priority levels that will be on the waiting list and the effective date for starting the waiting list.

   The State agency shall advise the local agencies of the procedures for placing persons on the benefit waiting list. The procedures for updating client information while on the benefit waiting list, and procedures for transferring a client from benefit waiting list status to active participant status from the benefit wait list or to terminate.

2. Local Agency Responsibility

   The local agency shall maintain a list of the names, addresses, and telephone numbers, by date and by priority of all applicants who are waitlisted after they are certified.

   When applicants are assigned to the waiting list, the certifier shall explain why the applicant is being placed on the waiting list, the priority system, the operation of the waiting list and their right to a fair hearing. The person shall also be advised to contact the local agency should there be changes to the information collected to determine eligibility.

3. Procedures for transferring a wait list person to active participant status:

   a. When funds are available to increase caseloads, the State agency shall provide the local agency the priority nutritional risk in which all persons shall be activated and the effective date to be activated.
b. When additional caseload slots become available either through increased funds from the State agency or from individual participants being terminated, the local agency shall contact the individuals on the waiting list by priority (highest to lowest) and date order (oldest to newest) and schedule appointments for those applicants who telephoned and mail food instruments to those who were certified and placed on the waiting list. If the medical data which was used to determine eligibility was taken more than sixty days from the date the applicant is to be activated, the medical data cannot be used. Medical data must be collected or documentation received from the applicant’s health care provider within sixty days of the certification date.

Attachments:

References: 7 CFR 246.7 e(4)
7 CFR 246.7 f (1)

Revisions April 1999
10/10 Changed reference from 7CFR 246.7 e (1) to 7 CFR 246.7f(1)
10/12 Deleted references to WOW
A. Policy

To be certified as eligible for the WIC Program, the applicant must reside in Maryland and live, work, or receive other services within the local agency’s service area as defined by the State agency. Length of residency within the service area may not be used as an eligibility requirement. This policy is intended to:

1. Prevent simultaneous participation in more than one local agency;
2. Yield more accurate data on the extent to which each local agency is meeting the program needs of its citizens; and
3. Prevent residents of a local agency from being denied WIC benefits because benefits are being provided to participants who live outside the local agency’s service area.

B. Procedure

The local agency shall:
1. Require and document in the management information system that all applicants provide documentation of residency at each certification. Accepted documentation shall include but not be limited to:
   a. Official mail, less than 30 days old, sent to the applicant's home address;
   b. Copy of a lease or mortgage for the current address; or
   c. Valid State of Maryland driver's license or identification card with the current address or a change of address card;
   d. A selection of “Other” requires a note in the applicant’s record.
2. Local agencies shall allow the applicant up to 30 days after the certification to provide documentation of residency. If documentation is not provided by the end of the 30 day certification, then the participant shall be terminated by the management information system. Participants may have their cert end date restored to the full certification period if documentation is provided before the 30 days has expired. Under no circumstances may a second, subsequent 30 day certification period be used if the applicant fails to provide the required documentation of residence before the temporary certification period expires.

3. Use the Confirmation of Residency form (Attachment 2.21A) for homeless applicants only.

Attachments:

References: 7 CFR 246.7 (c)(2)(i)
COMAR 10.54.01.06

Revisions:

10/01/08 - deleted Attachment 2.04A

01/21/09 - deleted Attachment 2.04A in B. 12.

10/01/10 - changed reference from 7 CFR 246.7 (b) (1) to 7 CFR (c) (2) (i)

10/2013 - minor wording and format changes, changed WOW to management information system, referenced the participant’s rights and responsibilities form will be signed electronically, clarified B.1.a-d

10/2014 – added language on short certs

1/2017 – clarified can “live, work, or receive other services” in local agency service area; updated references from COMAR 10.54.01.04A to 10.54.01.06 and removed FNS Instruction 803-1 Rev which was incorporated into 7 CFR 246

11/08/2017 – Removed reference to electronically signing the R&R as this is in policy 2.12 and no longer applies here.
MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.05
Effective Date: July 24, 1995
Revised Date: May 10, 2019

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Income Eligibility Requirements

A. Policy

To be eligible to participate in the Maryland WIC Program, applicants must have a gross household income of less than or equal to 185% of the Federal Poverty Level Income Guidelines. Applicants shall provide documentation of all income in the household for the past 30 days or the past 12 months, whichever shows a more accurate reflection of household income. Family size shall be determined following Policy and Procedure 2.06. Income guidelines shall be adjusted annually each spring and be implemented concurrently with the Medicaid income guidelines.

An applicant may be considered adjunctively income eligible if:

1. The applicant is participating in one of the following programs:
   a. Temporary Cash Assistance (TCA);
   b. Food Supplement Program (SNAP);
   c. Medical Assistance (MA or MCHP);
   d. Certain other means tested programs as approved by the state WIC office and that:
      i. Routinely require documentation of income
      ii. Have income guidelines at or below those of WIC
      iii. Show the applicant’s period of eligibility in the program

2. Or a member of the applicant's household is:
   a. Receiving TCA, or SNAP; or is
   b. A pregnant woman or an infant:
      i. currently participating in the Medical Assistance Program; or
      ii. certified eligible for the Maryland Children’s Health Insurance Program.

The head of household or designee must present documentation showing eligibility/participation in one of these programs and must also self-declare household income.
Applicants who are determined to be income ineligible must be informed of the decision in writing and are entitled to a fair hearing; refer to Policy and Procedure 2.11. Notice of Ineligibility or Termination and Right to a Fair Hearing.

B. Procedure

Income Determination:
Local agencies shall require that all applicants provide proof of adjunct eligibility or proof of all family or household gross income.

1. Determination of Adjunctive Eligibility
   Local agency staff shall verify, if applicable as described in A.1 or A.2, an applicant’s, or a member of an applicant’s household, current participation in MA/MCHP, TCA or SNAP in the following manner:

   a. MA/MCHP: if the local agency has an established provider number confirm eligibility online at [www.emdhealthchoice.org](http://www.emdhealthchoice.org) otherwise confirm eligibility via telephoning the Medical Assistance Program Eligibility Verification System (EVS) at:

      1-866-710-1447

   b. Independence Card (TCA and SNAP): require the applicant to provide an ATM or store receipt dated within 30 days. Verify the account number on the receipt is the same account number embossed on the Independence card; or telephone the Eligibility Verification System (EVS) at:

      1-800-997-2222

Verification of MA/MCHP, TCA, SNAP or an approved means tested program, may also include a notification letter that identifies the respective program and the person’s period of eligibility.

Applicants who are determined to be adjunctively eligible shall still be probed for a verbal report of gross household income.

2. Determination of Family/Household Gross Income

   a. Refer to Attachment 2.05B for the acceptable types of income. Income may consist of but is not limited to:
      i. Wages;
      ii. Social security benefits;
      iii. Child support;
      iv. Unemployment benefits
      v. Cash from other persons

   b. Local agencies shall consider the income of the family during the past 12 months (average income) and the family's current rate of income within the last 30 days (most recent income) to determine
which indicator more accurately reflects the family status.

3. Income Exclusions

a. Income determination for military personnel is the total entitlements found on the Leave and Earnings Statement (LES) less any funds received for:

- Basic Allowance for Housing (BAH),
- Family Supplemental Subsistence Allowance (FSSA),
- Cost of Living Outside of the Continental United States (OCONUS COLA)
- Prepayments into the Veteran’s Educational Assistance Program (GI BILL).
- Hostile Fire/Imminent Danger Pay (HFIDP)
- Hardship Duty Pay (HDP)
- Overseas Housing Allowance (OHA)
- Family Separation Housing (FSH)

To determine income eligibility, subtract the deductions from the total entitlements and compare the amount to the income guidelines.

Refer to Attachment 2.05D for a description of possible acronyms used on the LES. Refer to Attachment 2.05E for a summary of allowances to include or exclude from the LES.

b. The value of in-kind housing and other in-kind benefits;

c. Loans, not including amounts to which the head of household has constant or unlimited access.

d. Payments or benefits provided under certain federal programs or acts listed in federal regulations 7CFR 246.7(d)(2)(iv)(D) are excluded from consideration as income by federal legislative prohibition;

4. Income Clarifications

a. **Self-employed persons** are assessed for WIC income eligibility using net income rather than gross income. Net income is determined by using the applicant’s most recently completed Internal Revenue Service (IRS) tax returns. The adjusted net income figure indicated on the completed federal tax return should be used. Local agencies may choose to establish limitations on the length of time a federal tax form is accepted unless the restrictions cause undue hardship to the applicant.
b. **Foster Children**: A foster child is considered a family of one. Payments made by the welfare agency or from any other source for the care of the foster child shall be the income of the foster child. Foster children are enrolled in Medical Assistance and by their participation are adjunctively eligible. Follow the procedures to verify current participation in Medical Assistance.

c. **Child support payments** are counted as income for both the parent receiving the child support payment and the parent making the child support payment. An infant or child is to be counted in the family size of the parent or caretaker with whom the infant or child resides.

d. **Employees on Strike or Furlough**: Persons from families with adult members placed on temporary strike or furlough shall be assessed based on income during the period of the strike or furlough. Participants certified in this situation shall be issued benefits in monthly increments. Participants shall be instructed to call the WIC office each month to ascertain if additional benefits are necessary or if the work situation has been resolved. Once the participant returns to work their income shall be reassessed to determine if they remain eligible.

e. **Withdrawals from Savings**: Persons using withdrawals from savings as income shall be asked to provide a bank statement showing the amount of funds that have been withdrawn in the last 30 days.

f. **Lump Sum Payments as Income**: Lump sum payments may be classified in two ways: 1) as reimbursements for lost assets; or 2) as money that is intended for income. Lump sum payments for reimbursement of lost assets (such as insurance money for damage to a vehicle) shall not be counted as income. Lump sum payments that are intended as income shall be counted as income. Examples of this include but are not limited to: bonuses, lottery winnings, workman’s compensation, severance pay, etc. Lump sum payments shall be considered in the way that most accurately reflects the economic situation of the household. If income is determined annually then the entire lump sum shall be included; if income is determined based on the current month then the lump sum shall be divided by 12 to reflect a monthly amount.

**Income Documentation**

5. **Documentation of Adjunctive Eligibility**

   a. Staff shall document which program the applicant/participant is adjunctively participating in under the applicant’s participant screen.
in the management information system.

b. MA or Independence Card identification numbers shall be entered into the management information system under the adjunct eligibility section without any symbols or letters preceding the number –
   correct entry: 1234567890 evs OK
   incorrect entry: #ma1234567890

c. A verbal gross household income shall still be reported and documented in the family screen of the management information system.

6. Documentation of Family/Household Income

a. Applicants not adjunctively eligible shall provide documentation substantiating reported income for all members of the economic unit. Such documentation may include but is not limited to: pay stubs, social security statements, earnings or bank statements, child support documentation, unemployment benefit statements, income tax forms, etc. Documentation provided electronically may be accepted at the discretion of the local agency.

b. Exceptions to income documentation:

i. Valid Verification of Certification (VOC) cards may serve as documentation of income eligibility for in-stream migrant farmworkers and their family members, and participants transferring into Maryland from another state. If a VOC card reflects that an in-stream migrant farmworker’s certification period has expired, the VOC card may still serve as income documentation if the VOC card reflects that an income determination was made within the past 12 months.

   Transferring families that are non-migrant shall be probed for income changes if the move required a change in employment unless less than 90 days remain in the certification period. Refer to Policy and Procedure 2.13 Transferring Participants and the Use of VOC Cards.

ii. Self-Declaration of Income Statement

   1. If an applicant claims to have no income, probe carefully asking the applicant who pays the rent and buys the food. After verifying that the applicant has zero income, a statement that they truly have zero income is required. Request that the applicant have the Self-Declaration of Income form (Attachment
2.05C) completed by a non-relative; attesting to the accuracy of the applicant’s level of income.

2. Consideration shall be given to a homeless individual who cannot provide proof of income. If a homeless applicant does not have documentation of income, the local agency shall accept a Self-Declaration of Income form (Attachment 2.05C) from the applicant, completed by a non-relative, attesting to the accuracy of the applicant’s level of income. Refer to Policy and Procedure 2.21 Homeless Individuals.

3. If an applicant works for cash and cannot provide documentation for income verification, the local agency shall request that the applicant have the Self-Declaration of Income form (Attachment 2.05C) completed by a non-relative attesting to the accuracy of the applicant’s level of income.

c. Staff shall document all reported income in the family screen of the management information system.

No Proof and Changes to Income

7. No Proof of Income

Applicants who do not have adequate documentation of household income shall receive up to 30 days after the certification start date to provide income documentation. Participants may have their certification end date restored to the full certification period if documentation is provided before the 30 days has expired. If documentation is not provided by the end of the 30 days, the participant shall be terminated by the management information system. Under no circumstances may a second, subsequent 30 day certification period be used if the applicant fails to provide the required documentation of income.

8. Income Changes during a Certification Period

a. If a participant, parent or caregiver reports income changes during a certification period which exceed Program income eligibility guidelines, the participants are subject to termination. In such cases, if less than 90 days remain in the certification period, income determination may be postponed until the time of recertification. If greater than 90 days remain in the certification period, income shall be re-evaluated.

b. Participants and family members who were determined income eligible on the basis of adjunctive eligibility, may not be disqualified from the WIC Program during their certification period solely
because they no longer participate in the adjunctive programs. Participants shall be asked to provide income documentation and local agency staff shall re-evaluate the family income to determine if they are income eligible.

c. If a participant is found to be income ineligible during an active certification period, all members of the family participating in the WIC Program based on that participant’s income eligibility shall be disqualified at that time in accordance with Policy and Procedure 2.11 Notice of Ineligibility or Termination and the Right to a Fair Hearing.

Attachment(s)
2.05A Maryland Income Guidelines
2.05B Types of Income
2.05C Self-Declaration of Income Statement
2.05D Common Military Pay/Allowances Acronyms
2.05E Chart of Common Military Allowances

References:
1. CFR Part 246.7 (d)
2. COMAR 10.54.01.07
3. WIC Policy Memorandum #2013-3, 4/26/2013 Income Eligibility Guidance
4. WIC Policy Memorandum #2011-7, June 8, 2011 Conversion Factors for WIC Income Eligibility Guidelines
5. WIC Policy Memorandum #2010-02, November 2, 2009 Exclusion of Combat Pay from WIC Income Eligibility Determination
7. WIC Policy Memorandum #99-06, March 30, 1999 Impact of the Children’s Health Insurance Program (CHIP) on WIC Adjunct Income Eligibility
8. SFP 93-012, November 4, 1992 WIC Income Eligibility and Natural Disasters
9. Policy Memorandum 92-14, July 9, 1992 Lump Sum Payments as Income
10. FNS Instruction 803-14 April 1, 1988 Eligibility of Special Populations

Revisions:
1. 4/99 Changed AFDC to TCA
2. 8/02 Revised B.9 to include on-base and off-base housing.
3. 4/05 Deleted School Lunch as adjunct eligibility
4. 12/05 B.1.e Added National Flood Insurance Program (NFIP) to list.
   B.1.g. Added FSSA to the deductions for military LES.
5. 10/06 Revised B. 2. c. New EVS name and telephone number
6. 10/07 Revised B. 1. e. to include loans
7. 11/07 Revised B. 1. g. to include Attachment 2.05D
8. 03/08 Revised B. 1. G Deleted FSSA from reductions in military income and added OCONUS COLA and GI BILL to reductions
9. 04/08 Revised B. 1. g to add FSSA to reductions in military income; added
10. 10/08 Changed Food Stamps to read Supplemental Nutrition Assistance Program (SNAP)
11. 01/09 Changed Supplemental Nutrition Assistance Program (SNAP) to read Food Supplement Program
12. 07/10 Combat pay can be deducted in determining income eligibility B.1.g. and 2.05E, Reduced short cert from 60 days to 30 days in B.1.h.
13. 10/10 Changed reference from 7 CFR 246.7 (c) to 246.7 (d)
14. 10/11 Included DEIP and DESP as income exclusions in B.1.g. Changed examples of income in B.1.a
15. 10/12 Added B.4. Income Changes during a Certification Period
16. 10/13 Added language to clarify B.1.h, and B.1.f, Changed WOW to management information system, removed pharmacy assistance program and weatherization program as adjunct options, included “other means tested” programs as possible adjunct choices, added VOC cards as a means to prove income. Deleted attachment 2.05F. Moved footnote on the medical assistance family planning program to page 5.
17. 04/14 Updated Attachment 2.05A with the new 2014 Income Guidelines
18. 04/15 Updated Attachment 2.05A with the new 2015 Income Guidelines
19. 04/16 Updated Attachment 2.05A with the new 2016 Income Guidelines; corrected format and outline numbering.
20. 04/17 Updated Attachment 2.05A with the new 2017 Income Guidelines
21. 11/17 Clarified that a family member participating in the SNAP program income qualifies the whole family.
22. 05/18 Updated Attachment 2.05A with the new 2018 Income Guidelines
23. 03/19 Reorganized to more closely match federal regulations; added income clarification section including applicants on strike/furlough and lump sum payments; updated military deductions; added procedure for applicants paid in cash; updated references; changed attachment C to a self-declaration of income form; updated attachments D and E.
24. 05/19 Updated Attachment 2.05A with the new 2019 Income Guidelines.
# INCOME GUIDELINES

Income Eligibility Guidelines for
Maryland WIC Program Benefits

**Effective May 10, 2019**
185 Percent of 2019 Federal Poverty Income Guidelines

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<th>Monthly</th>
<th>Twice-Monthly</th>
<th>Bi-Weekly</th>
<th>Weekly</th>
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<td>$31,284</td>
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<td>$1,204</td>
<td>$602</td>
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<tr>
<td>3</td>
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<td>$3,289</td>
<td>$1,645</td>
<td>$1,518</td>
<td>$759</td>
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<tr>
<td>4</td>
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<td>$3,970</td>
<td>$1,985</td>
<td>$1,833</td>
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<tr>
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<tr>
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<td>$6,696</td>
<td>$3,348</td>
<td>$3,091</td>
<td>$1,546</td>
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</table>

For each additional family member add:

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<th>Additional Member</th>
<th>Extra Monthly</th>
<th>Extra Twice-Monthly</th>
<th>Extra Bi-Weekly</th>
<th>Extra Weekly</th>
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<td>+$682</td>
<td>+$315</td>
<td>+$158</td>
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Guía Para Evaluar Ingresos

Tabla de Ingresos para Determinar Elegibilidad en los Beneficios del Programa WIC

**Efectivo el 10 de mayo de 2019**

El Porcentaje de acuerdo a la Guía Federal de Ingresos de Pobreza 2017 es 185

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<th>Ingreso Mensual</th>
<th>Dos veces al mes</th>
<th>Ingreso Quincenal</th>
<th>Ingreso Semanal</th>
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<td>$963</td>
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<td>$6,696</td>
<td>$3,348</td>
<td>$3,091</td>
<td>$1,546</td>
</tr>
</tbody>
</table>

Para cada miembro de la familia adicione

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<thead>
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<td>$8,177</td>
<td>$682</td>
<td>$341</td>
<td>$315</td>
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</tbody>
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TYPES OF INCOME

For the purpose of the WIC Program, "income" means gross cash income before deductions. Other sources of income include:

a) Monetary compensation for services, including wages, salary, commissions, or fees;
b) Net income from farm and non-farm self-employment;
c) Social Security benefits;
d) Dividends or interest on savings and bonds, income from estates or trust or net rental income;
e) Public assistance or welfare payments;
f) Unemployment compensation;
g) Government civilian employee or military retirement pensions or veteran's payments;
h) Private pensions or annuities;
i) Alimony or child support payments;
j) Regular contributions from persons not living in the household;
k) Net royalties;
l) Other cash income which is defined as, but not limited to, cash amounts received or withdrawn from any source including savings, investments, trust accounts, grants and scholarships except Pell Grants, State Student Incentive Grants and National Direct Student Loans and others listed in 7CFR 246.7(d)(2)(iv)(12) and other resources which are readily available to the applicant or family
Maryland WIC Program
Self-Declaration of Income Statement

Head of Household Name: ____________________________________________
                          Last  First  Middle Initial

Address: ____________________________________________________________

City/Zip Code: _______________________________________________________

Telephone: ____________________  Family Size: _______________________

I, ________________________________________________________________,
am unable to provide documentation of my income because I:

  □ Work for Cash
  □ Have No Income/am Homeless
  □ Other (system note required) _______________________________________

I certify that my hourly, daily, weekly, monthly, annual income is: _____________.
   (circle one)

_____________________________________________________________________

Head of Household Signature                      Date

_____________________________________________________________________

This is to confirm that the above information is true to the best of my knowledge.

Attest:

_____________________________________________________________________

Signature*

_____________________________________________________________________

Address

City/Zip Code

Telephone Number: ____________________________________________

*To be signed by a non-family member who is familiar with the economic situation of the applicant.
COMMON MILITARY PAYS/ALLOWANCES
SEEN WHEN DETERMINING WIC INCOME ELIGIBILITY

This list has been developed to provide WIC staff with a better understanding of the common acronyms used on military Leave and Earning Statements (LES) which are used when determining income eligibility for WIC clients. More information regarding military pay can be found at www.military.com\benefits

BASIC ALLOWANCES (BAS)
BAS is intended to provide meals for the service member; its level is linked to the price of food.

BASIC ALLOWANCE FOR HOUSING (BAH)
BAH is a housing allowance intended to provide improved, quality housing for military families living off-base. **BAH is not counted as income in determining eligibility.**

CAREER ENLISTED FLYER INCENTIVE PAY (CEFIP)
A Navy or Air Force service member may be eligible to receive CEFIP if he/she is considered “Career Enlisted Flyer” by the military. If this is the case, the service member may be eligible for continuous, monthly incentive pay.

CAREER SEA PAY
Active Duty Enlisted Service Members or Commissioned Officers on sea duty are entitled to Career Sea Pay up to $750 a month.

CLOTHING ALLOWANCE
A clothing allowance may be issued to help a member pay for his/her uniforms. This is an annual pay given primarily to enlisted members. While it is counted as income it may be divided out to a monthly amount.

COMBAT PAY - HARDSHIP DUTY PAY (HDP)
Hardship Duty Pay is a special pay used as additional compensation for service members who are either serving in locations where living conditions create undue hardship or are performing designated hardship missions. **HDP is not counted as income in determining eligibility.**

COMBAT PAY - HOSTILE FIRE/IMMINENT DANGER PAY (HFIDP)
A service member may be paid special pay at the rate of $225 for any month in which he/she was entitled to basic pay. **HFIDP is not counted as income in determining eligibility.**

COST OF LIVING ALLOWANCE (CONUS COLA) & (OCONUS COLA)
COLA is a cash allowance intended to enable an equitable standard of living in areas where the cost of living is unusually high in the continental U.S. If the cost of living in the area where the member is assigned is the same or lower than the average in the U.S.,
COLA is not authorized. COLA provided to military personnel residing in the continental U.S. (CONUS) is different from Overseas Continental United States (OCONUS) COLA which is provided to military personnel residing in designated overseas high-cost living areas. **CONUS COLA is counted as income in determining WIC eligibility. OCONUS COLA is not counted as income and should be deducted when determining WIC eligibility.**

**FAMILY SEPARATION ALLOWANCE (FSA)**
This pay is for service members with dependents that meet the eligibility criteria to receive an additional $250 per month. Service members will receive FSA pay from the day of departure from the home station and will end the day prior to their return arrival at the home station.

**FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE (FSSA)**
This allowance, based on household size and income, may not exceed $500 per month. It is provided to low-income members of the Armed Forces to bring a household’s income up to 130% of the Federal Poverty Standard. **FSSA is not counted as income in determining eligibility.**

**FOREIGN LANGUAGE PROFICIENCY PAY or Bonus (FLPP or FLPB)**
An officer or enlisted member of the Armed Forces who has been certified as proficient in a foreign language or dialect may be paid Foreign Language Proficiency Pay or Bonus (FLPP or FLPB).

**HAZARDOUS DUTY INCENTIVE PAY (HDIP)**
Service members who perform hazardous duties such as flying duty as non-crew members, parachute jumping, demolition of explosives, handle toxic fuels, flight deck duty, etc. may be eligible for HDIP on a monthly basis.

**MILITARY SURVIVOR BENEFITS PLAN (SBP)**
The Uniformed Services Survivor Benefit Plan (SBP) was created by Congress in 1972. SBP is the sole means by which survivors can receive a portion of military retired pay. Without it –retired pay stops on the date of death of the retiree. The dollar amount of the survivor’s benefits pay depends on the coverage elected by the service member upon retirement.

**OVERSEAS EXTENSION PAY**
Select service members who extend an overseas tour of duty may be eligible for this entitlement. It may be paid monthly or in one annual lump sum. While it is counted as income, if paid in one annual sum it may be divided out to a monthly amount for income determination.
OVERSEAS HOUSING ALLOWANCE (OHA)
OHA is a monthly allowance paid to services members stationed overseas and authorized to live in private housing to defray the cost of rent and utilities. **OHA is not counted as income in determining eligibility.**

SELECTIVE RETENTION BONUS (SRB)
SRB may be paid to an enlisted member who meets certain conditions. Retention bonus amounts may vary depending on the member’s prior years of service. The member receives 50% of the bonus up front and the remaining balance is paid in annual installments over the life of the reenlistment contract. SRB is counted as income but may be divided out to a monthly amount for income determination.

SPECIAL DUTY ASSIGNMENT PAY (SDAP)
All enlisted active service members who perform duties designated as extremely difficult or requiring a high level of responsibility in a military skill may be paid SDAP. Amounts paid monthly based on duties range from $75 to $450.

VETERAN’S EDUCATIONAL ASSISTANCE PROGRAM OR THE GI BILL
Service members pay into an education program, the Veteran’s Educational Assistance Program or the GI Bill, and the military matches the amount. When these individuals subsequently attend school/college, they receive a monthly check for school expenses.

**Payments taken out upfront from a military person’s salary that are placed into the education assistance program are not counted as income.** However, there is no Federal law which permits the amount of the monthly checks that are subsequently received by the individual for school expenses from being excluded from income in determining financial eligibility.
# Chart of Common Military Pays/Allowances Seen When Determining WIC Income Eligibility

<table>
<thead>
<tr>
<th>Cannot be Deducted from Total Entitlements</th>
<th>Can be Deducted from Total Entitlements</th>
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</thead>
<tbody>
<tr>
<td>Basic Allowances (BAS)</td>
<td>Basic Allowance for Housing (BAH)</td>
</tr>
<tr>
<td>Overseas Extension Pay</td>
<td>Overseas Housing Allowance (OHA)</td>
</tr>
<tr>
<td>Hazardous Duty Incentive Pay (HDIP)</td>
<td>Family Separation Housing (FSH)</td>
</tr>
<tr>
<td>Career Enlisted Flyer Incentive Pay (CEFIP)</td>
<td>Combat Pay:</td>
</tr>
<tr>
<td></td>
<td>• Hostile Fire/Imminent Danger Pay (HFP)</td>
</tr>
<tr>
<td></td>
<td>• Hardship Duty Pay (HDP)</td>
</tr>
<tr>
<td>Career Sea Pay</td>
<td></td>
</tr>
<tr>
<td>Clothing Allowance</td>
<td></td>
</tr>
<tr>
<td>Cost of Living Allowance (COLA or CONUS COLA)</td>
<td>Overseas Continental United States Cost of Living Allowance (OCONUS COLA)</td>
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<tr>
<td>Family Separation Allowance (FSA)</td>
<td>Family Subsistence Supplemental Allowance (FSSA)</td>
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<tr>
<td>Foreign Language Proficiency Pay or Bonus (FLPP or FLPB)</td>
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<tr>
<td>Military Survivor Benefits Plan (SBP)</td>
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<tr>
<td>Payments received from the Veteran’s Educational Assistance Program (GI BILL)</td>
<td>Payments into the Veteran’s Educational Assistance Program (GI BILL)</td>
</tr>
<tr>
<td>Selective Retention Bonus (SRB)</td>
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</tr>
<tr>
<td>Special Duty Assignment Pay (SDAP)</td>
<td></td>
</tr>
</tbody>
</table>
Policy and Procedure 2.05F has been removed.
SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Family Size Determination

A. Policy

To be certified as eligible for the WIC Program, a family shall have a gross income which is less than or equal to 185% of Poverty Income Guidelines. Since the income guidelines are established by family size, it is required that applicants/caregivers or designees report the number of persons living in their household or the household of the child being recertified.

B. Procedure

At each certification, local agencies shall ask the applicant/caregiver or designee the number of persons residing in the household and document the number in the management information system. A family is defined as "a group of related or nonrelated individuals, who are not residents of an institution, but who are living together as one economic unit."

In determining family size, the following criteria shall apply:

1. If the pregnant woman’s family income exceeds the Maryland Income Guidelines for the size of her family, her eligibility should be reviewed using a family size increased by one or by the number of expected multiple births. In the case of multiple births, the pregnant woman must provide documentation of the number of multiple births from her doctor if her income eligibility is assessed using a family size increased by the number of expected multiple births.

   Local agencies shall not be required to implement this policy in those individual cases where increasing a pregnant woman’s family size by the number of the unborn child or children conflicts with cultural, personal, or religious beliefs of the woman.

2. In situations where the family size has been increased for a pregnant woman, the same increased family size shall also be used for any of her categorically eligible family members.
3. An infant or child is to be counted in the family size of the parent or caretaker with whom the infant or child resides. Child support payments are counted as income for the parent receiving the child support payment. The parent making the child support payment may not have the amount deducted from their income and may not have the child included in their family size.

4. If an infant, child, or other family member resides in a school or institution and the parent or caretaker continues to provide the economic support, that person is counted in the family size of that parent or caretaker. Otherwise the person is not to be counted.

5. If an infant or child is a foster child living with a family but remains the legal responsibility of a welfare or other agency, the foster child shall be a family of one. Payments made by the agency or from any other source for the care of that foster child shall be the income of the foster child only.

6. If a family has an adopted child or any other person for whom a family member has accepted legal responsibility, that person is counted in the family size for that family if the person lives with the family or is in a school or institution paid by the family.

7. If a family is providing shelter to a WIC applicant who is homeless, that family would not be considered in determining family size for the applicant (See P & P Number 2.21 B.1.c.).

Attachment(s)

References:
1. CFR Part 246.7 (d)
2. COMAR 10.54.01.07B3. FNS Instruction 803-3

Revisions:
01/2009 Renamed 2.05a to 2.06
10/2012 minor language changes/clarification in A. Policy
10/2013 Changed WOW to management information system, clarified B.1.
Policy and Procedure 2.07 has been renamed as Policy and Procedure 2.33
Policy and Procedure 2.08 has been renamed as Policy and Procedure 2.31
A. Policy

The local agency shall process applications and notify applicants of their eligibility or ineligibility within the following time frames:

a. Pregnant women, infants, migrant farm workers and their family members shall be notified of their status in the program within 10 calendar days of their first request in person, at a WIC site, to participate. The State agency may provide an extension of the notification period to a maximum of 15 calendar days for those local agencies submitting a written request, including a justification, of the need for an extension.

b. All other applicants shall be notified within 20 calendar days of their first request in person to participate.

c. Local agencies shall issue food instruments to the applicant at the time of notification that they are eligible for the program.

d. If the applicant is eligible for the program but must be placed on a waiting list, the applicant should be advised as above (a or b as appropriate). The Local Agency should advise the applicant of how they will be notified when space is available on the program. (Refer to Policy & Procedure 2.03)

e. If applicant is ineligible, he should be advised in writing within 10 or the 20 calendar days (as described in a. or b. above) of his status, the reason for the ineligibility, and his right to a fair hearing. (Refer to Policy & Procedure 2.11) Provide the applicant with the name, address and telephone number of emergency food assistance programs in the area.

B. Procedure

Local Agencies shall abide by the above policy.
1. 7CFR 246.7 (f)(2)
2. COMAR 10.54.01.06 D (4)

Revisions:

1. 10/01/10  Changed reference from 7CFR 246.7 (e)(2)(iii) to 246.7 (f) (2).
2. 10/2011  Added reference to Policy and Procedure 2.11
3. 10/2012  Format corrections in A.e
A. Policy

1. Program benefits shall be based on certification periods established in the management information system in accordance with the following time frames:

   a. Pregnant women shall be certified for the duration of their pregnancy and up to the last day of the month in which the infant turns six weeks old or the pregnancy ends (miscarriage, stillbirth, etc.).

   b. Postpartum women shall be certified up to the last day of the sixth month after the baby is born or the pregnancy ends (miscarriage, stillbirth, etc.).

   c. Breastfeeding women shall be certified up to the last day of the month of the infant's first birthday as long as they are breastfeeding.

   d. Infants certified before six months of age will be certified until the last day of the month in which the infant turns one year old.

   e. Infants certified from age six months to age one will be certified up to the last day of the sixth month from the date of the certification.

   f. Children certified at age one year or older will be certified up to the last day of the month one year from the date of the certification or the month in which the child turns five years of age.

2. A participant's certification period may be extended by not more than 30 days on a case-by-case basis if categorically eligible. Reasons for extending a certification period may include but are not limited to: insufficient appointment times to conduct a certification or to sync family members' certification periods.
3. A participant’s certification period may be shortened for reasons that may include but are not limited to termination or voluntary withdrawal from the program. For applicants that have at least one qualifying nutrition risk and are able to present at least two out of the three required eligibility documents during a certification appointment (identity, residency, and income), the following timeframes apply:

   a. Failure to provide documentation of identity shall result in a shortened certification of 30 days with no subsequent certification allowed until documentation of identity is presented. Refer to P&P 2.23.

   b. Failure to provide documentation of residency shall result in a shortened certification of 30 days with no subsequent certification allowed until documentation of residency is presented. Refer to P&P 2.04.

   c. Failure to provide documentation of income shall result in a shortened certification of 30 days with no subsequent certification allowed until documentation of income is presented. Refer to P&P 2.05.

   d. Failure to provide documentation of proof of pregnancy for a pregnant woman shall result in a shortened certification of 60 days with subsequent certifications allowed until the participant is visibly pregnant. Refer to P&P 2.24.

4. Certification periods for eligible infants, children, and breastfeeding women that last longer than six months shall have the required nutrition and health assessment approximately mid-way through the certification, also known as a mid-certification visit.

B. Procedure

1. Certification periods are established in the management information system with the start date based on the date of eligibility determination. The length of the certification is based on applicant category and age as noted in A.1.

   A pregnant woman’s length of certification shall be determined by her expected due date (EDD) as self-reported or calculated by her last menstrual date (LMP). Both the EDD and LMP shall be documented in the management information system.

   If a pregnant woman has a loss of pregnancy during an active certification period, her certification period shall terminate on the last day of the month in which the loss occurred. She should be encouraged to recertify as a postpartum woman.
2. Certification periods that are extended by not more than 30 days shall be documented in the management information system. Only one 30-day extension is allowed per certification period. Circumstances that this may apply to include but are not limited to; insufficient appointment times to conduct a certification or to synchronize family members’ certification periods.

3. Certification periods that are shortened shall be documented in the management information system. In cases of a shortened certification due to lack of necessary documentation, the participant shall be given an opportunity to provide the necessary documentation prior to the end of the shortened certification period.

If the missing documentation is provided prior to the expiration of the shortened certification and the participant remains eligible, then the length of the certification is based on applicant category and age as noted in A.1.

If the missing documentation is not provided before the shortened certification expires then a new certification process shall be initiated.

4. For certification periods longer than six months, the required mid-certification health and nutrition assessment (MCV) shall occur according to the following timeframes:

- Infants certified between 0-5 months of age
  - MCV ideally between 4-7 months of age
- Infants certified between 6-11 months of age
  - MCV not required
- Children certified between 1-4 years of age
  - MCV approximately halfway through the certification
- Pregnant Women
  - MCV not required
- Breastfeeding Women
  - MCV approximately halfway through the certification ideally in conjunction with the infant MCV between 4-7 months.
- Postpartum Women
  - MCV not required
Reference(s):
1. 7CFR 246.7 (g)(1)(i-v)
2. 7CFR 246.11 (a)(2)
3. 7CFR 246.11 (e)(3)
4. USDA Guidance for Providing Quality WIC Nutrition Services during extended Certification periods (August 29, 2011)
5. COMAR 10.54.01.13

Revisions:
12/2006  Extended cert periods to the end of the month
10/2010  Changed reference from 7CFR 246.7 (f) to 246.7(g)
10/2012  Changed reference from 7CFR 246.7 (g) to 7 CFR 246.7 (g)(1)(iii-v), and changed certification periods 1. d, e, and f to correspond
10/2013  Updated references to 7CFR 246.7 (g)(1)(i-v) and COMAR 10.54.01.13
8/22/2018 Merged previous P&P2.38 on extended certs into this policy, defined when MCV appointments should occur, added statements on short certs
A. Policy

The WIC Program regulations have established time frames to inform applicants and participants of their ineligibility or eligibility as written in P&P 2.09 Processing Standards for Applications.

A person found ineligible for the Program shall be advised in writing at the time of determination using the Ineligibility Notice Attachment 2.11A. The written notice shall include:

a. The reason(s) for the ineligibility;

b. The name and telephone number of the person to contact about their ineligibility; and

c. The due date to request a fair hearing.

Applicants have the right to request a fair hearing within sixty (60) days of the determination of ineligibility. Requests for fair hearings may be either in writing or verbal, stating the desire to present their case to a higher authority. Completed requests for fair hearings shall be faxed to the Office of Administrative Hearings using the MDH Transmittal Form 2.11C.

B. Procedures

New Applicants

1. When a new applicant is found ineligible for the Program, Local Agency staff shall print and complete the Ineligibility Notice from the print documents section of the management information system.
2. Local Agency staff shall give a completed copy of the Ineligibility Notice to the applicant/caregiver and inform them of:

   a. the reason for the ineligibility;
   b. the right to request a fair hearing;
   c. the due date to request a fair hearing; and
   d. the name and telephone number of the person to contact regarding the determination.

   If an applicant/caregiver refuses to take the Ineligibility Notice, the notice shall be mailed to the head of household name and address on file.

3. When an Ineligibility Notice is printed from the management information system it will automatically be documented under Communications. Local Agency staff shall also document in the comments section of communications the reason for the ineligibility.

4. Local agencies shall maintain a file containing copies of the completed Ineligibility Notice as well as the income and/or residency documentation provided by the applicant/caregiver that was used to determine that the applicant was ineligible.

Existing Participants

1. A participant found ineligible for the Program at any time during the certification period shall be advised in writing of the reason(s) for ineligibility, the termination date, and of the right to a fair hearing.

   Reasons for ineligibility during a certification period and the termination notice timeframes are:

   15-day Notification of Termination:
   a. No longer categorically eligible;
   b. Changes to income or family size making them income ineligible per P&P 2.05;
   c. No longer have a required nutritional need; or
   d. Sanctions for Program Abuse per P&P 4.23.

2. Local Agency staff shall print and complete the Ineligibility Notice from the print documents section of the management information system.

3. When an Ineligibility Notice is printed from the management information system it will automatically be documented under Communications. Local Agency staff shall also document in the comments section of communications the reason for the ineligibility.
4. A copy of the completed Ineligibility Notice shall be handed to or mailed to the head of household name and address on file.

5. Local agencies shall maintain a file containing copies of the completed Ineligibility Notice as well as the income and/or residency documentation provided by the applicant/caregiver that was used to determine that the applicant was ineligible.

6. A written notice of termination is not required when terminating for failure to pick up food benefits for two consecutive issue months. The participant is advised of this policy at certification and signs the Rights and Responsibilities (Attachment 2.12A) acknowledging the policy.

Request for a Fair Hearing:

1. When a fair hearing is requested either verbally or in writing, Local Agency staff or the participant shall complete attachment 2.11B Request for a Fair Hearing, which advises the applicant/caregiver that notification of a hearing date will be provided by the Office of Administrative Hearings.

2. Upon receipt of the Request for a Fair Hearing, Local Agency staff shall transmit the request to the Office of Administrative Hearings using the MDH Transmittal Form Attachment 2.11C. The transmittal form can also be found in the Forms section of the management information system.

3. Participants who request a fair hearing to appeal the termination of benefits before the date entered on the Ineligibility Notice shall continue to receive WIC benefits until the Hearing officer reaches a decision or the certification period expires, whichever occurs first. This does not apply to applicants denied benefits at initial certification, participants whose certification period has expired or participants who become categorically ineligible for benefits.

Attachments:
2.11A Ineligibility Notice
2.11B Request for a Fair Hearing
2.11C Transmittal for MDH Appeals

References:
1. CFR 246.7 (h)
2. CFR 246.7 (j)
3. COMAR 10.54.01.06 D

Revisions:
04/1999 Changed AFDC to TCA
06/1999  New address on Attachment 2.11B
10/2003  WICWINS references
04/2008  Used the name “Ineligibility Notice” when referring to Attachment 2.11A
10/2008  Revised A.3.c. to indicate the Local Agency’s role in transmitting the appeal on behalf of the Applicant/Participant. Added new Transmittal for DHMH Appeals form, Attachment 2.11C
01/2009  Changed Food Stamp to read Food Supplement Program in A.6.
10/2010  Changed “in communication notes” to “Alerts.” Changed reference from 7CFR246.7 (l) to 246.7 (j).
10/2011  Deleted obsolete reference to WOW in A.7 Changed reference from 7CFR 246.7(j) to 7CFR 246.7(h)
10/2013  Revised wording to reflect changes due to revised/electronic format of the Participant Rights and Responsibilities.
06/17/2017 Changed reference from food instruments to food benefits in B.1. Updated 2.11A to remove reference to checks.
10/01/2018 Rewrote policy section to remove duplicative parts that are already in 2.09 and moved lines that were really procedure to further down in the document. In procedure section separated out new applicants, existing applicants, and procedure for fair hearing requests; specified that ineligibility notices must be given in writing even if it must be mailed; updated references. Removed paragraphs regarding income determination mid-cert and adj. elig and moved them to 2.05. Updated attachments: A is now both the ineligibility notice and a termination notice; B removed participant from the name; C corrected name for MDH.
Ineligibility/Termination Notice

<Date>

<HoH Name>
<Address>
<City, State Zip>
WIC Applicant/Participant <Participant Name> (<Participant ID>):

Based on the information we have, it has been determined that:

☐ your certification with the WIC Program will be terminated on <insert date>. If you ask for a Fair Hearing before <insert date>, you will still receive food benefits until the court reaches a decision or your certification period expires, whichever occurs first. This does not apply if your certification period has already expired or you have been determined to be categorically ineligible for the program.

☐ you are not eligible to participate in the WIC Program at this time.

This determination has been made based on the following reason(s):

☐ You are not categorically eligible.
☐ Your family income is too high for the receipt of WIC benefits.
☐ You do not live in the Agency’s service area.
☐ You are not considered by the Agency’s certifying staff to have a required nutritional need.
☐ All current WIC funding is being used, so you are being placed on the waiting list for participation.
☐ Other: ________________________________________________________________

If you think this is not correct, please call <insert phone number> to talk about it.

You have the right to a fair hearing on this denial of WIC benefits. If you think you should receive WIC benefits and you want to appeal this denial of WIC eligibility, you may request a hearing on the denial by filling in the Request for Fair Hearing, which has been included with this letter, and giving it to a WIC staff person or mailing it to the address below by <Date>.

<Local Agency Name>
<Address>
<City, State Zip>

Attn: <Local Agency Point of Contact>

You may also telephone your request for a Fair Hearing by calling the <Local Agency Name> WIC Program by <Date>. The WIC Office will transmit your Fair Hearing request to the Maryland State Office of Administrative Hearings, which will schedule and conduct the Fair Hearing. At the hearing, you and anyone else you want, such as a relative, friend, or lawyer will be able to tell the Administrative Law Judge why you think you should receive benefits.

If you are found ineligible for WIC when you first apply or at a recertification, you can ask for a hearing, but you will not receive any food benefits while you wait for the hearing.

Local WIC Representative
In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.
REQUEST FOR A FAIR HEARING

I am requesting a fair hearing pursuant to WIC Program regulations. My reason(s) for requesting a hearing is (are): (Give any information which you this is important to your appeal.)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Date: ______________________  Signature: __________________________

WIC Applicant/Participant: Please make any corrections here (print clearly):

Applicant/Participant Name> ________________________________
<Address> ____________________________________________
<City, State Zip> _______________________________________
WIC Participant ID: <Part ID> _________________________________
WIC Family ID: <Family ID> _________________________________
Date of Birth: <DoB> _______________________________________

Specific information concerning Fair Hearing procedures and scheduling will be provided to you by the Office of Administrative Hearings with the hearing scheduling notice the Office of Administrative Hearings will send to you. Complete this form and mail it to:

<Local Agency Name>
<Address>
<City, State Zip>
Attn: <Local Agency Point of Contact>

You may also telephone your request to the WIC Office by calling: <Local Agency Phone>.

Attachment 2.11B
TRANSMITTAL FOR MARYLAND DEPARTMENT OF HEALTH APPEALS
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

Specify County of Applicant/Participant

Transmitting Official: __________________________ Date Appeal Received: __________________

Telephone Number: __________________________ Name of Case: __________________________

Agency File No.: (if any) __________________________

Appellant (#1) and/or Appellant’s Counsel (#2)

(#1) Name: __________________________ (#2) Name: __________________________

LAST FIRST MI LAST FIRST MI

Address: __________________________ Address: __________________________

__________________________ __________________________

ZIP ZIP

Telephone No.: ______________ Telephone No.: ______________

Department’s Representative(s)

(#1) Name: __________________________ (#2) Name: __________________________

LAST FIRST MI LAST FIRST MI

Address: __________________________ Address: __________________________

__________________________ __________________________

ZIP ZIP

Telephone No.: ______________ Telephone No.: ______________

Appeal Category: Women, Infants and Children’s Program

PLEASE ATTACH APPEAL LETTER AND ANY CORRESPONDENCE RELATING TO CASE
Transmittal Form Instructions

Specify County of Applicant/Participant

Indicate the County of Applicant or Participant for whom you are submitting a hearing request. (If Baltimore City, indicate Baltimore City)

Transmitting Official:

Indicate name of Local Agency official submitting the Appeal.

Name of Case:

Enter Applicant’s or Participant’s name vs. Local WIC Agency Name (e.g. Jane Doe vs. Garrett County WIC Program)

Agency File No.:

Complete only if your Local Agency has developed an internal tracking procedure or log for appeals. Otherwise, leave blank.

Appellant (#1) and/or Appellant’s Counsel (#2)

Enter the name of the Applicant or Participant in #1. If the Applicant or Participant is being represented, provide the name of this individual in #2

Department’s Representative(s)

Enter the name of the Local Agency Coordinator in #1. If necessary, use #2 to indicate additional staff such as the Certifier or Clinic Supervisor whose attendance at the hearing may be necessary.

Attach a copy of the Ineligibility Notice and the Fair Hearing Request Notice and any other correspondence, if applicable, and transmit via Fax or mail to the Office of Administrative Hearings at:

Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031
410-229-4262
Fax 410-229-4268
A. Policy

1. Applicants or their caregiver or designee must be advised of the Program rights and responsibilities. These Program rights and responsibilities are listed on the *Maryland WIC Program Rights and Responsibilities* (Attachment 2.12A) and include the following information:

   a. A statement of nondiscrimination and information on how to file a discrimination complaint.

   b. A statement explaining the right to appeal any decision made by the WIC agency regarding eligibility, and information on the method for requesting a fair hearing.

   c. A statement regarding health services and nutrition education that will be made available by the agency.

   d. A statement that the Program has been explained to and is understood by the applicant, caregiver or designee.

   e. A statement that the applicant has provided correct information for this application, because intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued and subject the participant to civil and criminal prosecution under State and Federal law.

   f. A statement that any information provided to the Program can be released to persons directly involved with the administration, enforcement, or audit of the program or to public organizations designated by the Secretary of the Maryland Department of Health.

   g. A statement that unused or expired benefits cannot be rolled over to another month or replaced.
2. The caregiver may designate an individual to sign the *Maryland WIC Program Rights and Responsibilities*.

B. Procedure:

1. Certification using the management information system:
   Local agencies shall ensure that all applicants or their caregiver or designee:
   
   a. Prior to signing, read, or have read to them, the *Maryland WIC Program Rights and Responsibilities*;
   
   b. Prior to signing, are informed that they are receiving a copy of the *Maryland WIC Program Rights and Responsibilities*; and
   
   c. Electronically sign their full name acknowledging that they have read or have had someone read to them the *Maryland WIC Program Rights and Responsibilities* and that they have received a copy of the *Maryland WIC Program Rights and Responsibilities*.

2. Manual Certification:
   Local agencies shall ensure that all applicants or their caregiver or designee:
   
   a. Prior to signing, read, or have read to them, the *Maryland WIC Program Rights and Responsibilities*;
   
   b. Prior to signing, are informed that they are receiving a copy of the *Maryland WIC Program Rights and Responsibilities*;
   
   c. Sign their full name, where indicated, acknowledging that they have read or have had someone read to them the *Maryland WIC Program Rights and Responsibilities* and that they have received a copy of the *Maryland WIC Program Rights and Responsibilities*.

Local agency staff shall complete the Income and Nutritional Risk Determination areas of the form. A signature is required of the staff who has completed each portion of the certification.

Attachments:

2.12A Maryland WIC Program Rights and Responsibilities

References: 7 CFR 246.7 (j)
COMAR 10.54.01.16
Revisions:
10/99
5/03
5/09 deleted sentence in B7 regarding initials
2/2010 Changed designee to proxy and included participant in the name of the form Changed reference from 7 CFR 246.7 (i) to 7 CFR 246.7(i)(j)
10/2013 Added distinction between automated and manual certifications, reference to electronic signatures, removed authorization for release of immunization information.
10/2015 Emphasized that the R & R must be read by or read to the participant and the participant is notified that they are receiving a copy prior to obtaining a signature.
1/2017 Added A.1.g and updated 2.12A to incorporate eWIC.
11/2017 Replaced DHMH with Maryland Department of Health and removed check references from 2.12A
8/22/2018 Reworded to include applicant or remove reference to either participant/applicant where possible.
MARYLAND WIC PROGRAM
Rights and Responsibilities

My Rights

• **WIC foods:** I will get a food instrument (eWIC card) to buy healthy foods.
• **Nutrition information:** I will get information about healthy eating and active living.
• **Breastfeeding support:** WIC will help and support me with breastfeeding.
• **Health care information:** I will get information about immunizations and other services I might need.
• **Fair treatment:** The rules for applying for WIC are the same for everyone. I can ask a WIC employee for a Fair Hearing if someone tells me I cannot be on WIC and I do not agree.
• **Common courtesy:** WIC and store staff will treat me with courtesy and respect. I can tell WIC staff that I would like to file a complaint if I am not treated with respect. I can also file a complaint with USDA at the address below.
• **Transfer information:** If I am moving, I can transfer my WIC to another state. I can ask for transfer paperwork to take with me.

My Responsibilities

I understand that:

• WIC does not give all the food or formula needed for a month and that unused benefits do not carry over to the next month.
• If I lose my eWIC card it can be replaced. If my food benefits expire before I receive a new eWIC card, the benefits will not be replaced.
• Information that I provide to the WIC Program is being submitted in connection with the receipt of Federal assistance. Program officials may verify information provided to them.
• Information that identifies a WIC participant shall be released to those persons directly connected with the administration, enforcement, or audits of the Program.
• The Secretary of the Maryland Department of Health may authorize the release of information to representatives of public organizations that serve persons who are eligible for the WIC Program. A list of these organizations is available upon request from the WIC Program.
• Information released to organizations will only be used for the purpose of determining the eligibility of WIC participants for programs that it administers, conducting outreach to WIC participants for such programs, evaluating the State’s responsiveness to the health care needs and outcomes of WIC participants, or to simplify the procedures for participating in those programs.

I agree to follow the rules below. I will:

• Always bring my proof of identification (ID) to every clinic visit.
• Provide all documents requested by the WIC Program in a timely manner.
• Use WIC foods and formula only for the person on WIC.
• Report lost, stolen, or damaged eWIC cards as instructed.
• Make sure any person I name to use my benefits knows the WIC Rights and Responsibilities. I will teach him or her how to use my benefits properly.
• Keep my WIC appointments or call the clinic to reschedule. If I fail to pick-up benefits two times in a row I may be removed from the Program.
• Not sell, give away or trade my, eWIC card, foods, or formula for money, credit, rain checks or other items. If I have WIC items I can’t use, I will return them to the clinic.
• Not post WIC items for sale or trade on the internet.
• Not swear, yell, harass, threaten, or physically harm WIC or store staff; or damage WIC or store property.
• Not enroll a child who is not in my legal or designated care.
• Not enroll in WIC in more than one State or get benefits from more than one WIC clinic each month.
I agree to give true and complete information about:

- My identity, pregnancy status and address.
- The number of all people living in my household.
- The total income of all people living in my household.
- Being on Medicaid, the Maryland Food Supplement Program (FSP), also referred to as Food Stamps or SNAP, or Temporary Cash Assistance (TCA).
- All changes in life circumstances (for example, I will notify WIC if I have changes in my income or family size or if I move).

My signature in the WIC system means that:

- The information I have provided for eligibility determination is correct to the best of my knowledge.
- I understand and agree that intentionally making a false or misleading statement or misrepresenting, hiding, or withholding facts may result in my having to pay the WIC Program, in cash, the value of food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law and disqualification from the WIC Program.
- I have been, or will be, issued a food instrument (eWIC card) for my household.
- I have asked any questions I have about WIC and they have been answered.
- I understand what my rights and responsibilities are.
- I understand that if I fail to comply with my responsibilities that I may be disqualified from the WIC Program.

The following participants were certified on ________________________:

#1: ________________________________  #4: ________________________________
#2: ________________________________  #5: ________________________________
#3: ________________________________  #6: ________________________________

Signature of Applicant/Caregiver/Designee    Signature of WIC Staff

For Manual Certifications Only:

☐ Income Determination    ☐ Nutrition Risk Determination

Staff Signature            Staff Signature

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.
Derechos y responsabilidades del PROGRAMA WIC DE MARYLAND

**Mis derechos**

- **Alimentos de WIC**: Obtendré un instrumento alimenticio (tarjeta electrónica de WIC) para comprar comida saludable.
- **Información nutritiva**: Recibiré información sobre la alimentación saludable y un estilo de vida activa.
- **Apoyo para amamantar**: WIC me ayudará y me apoyará con la lactancia materna.
- **Información sobre cuidados de salud**: Recibiré información sobre las inmunizaciones y otros servicios que pueda necesitar.
- **Tratamiento justo**: Las reglas para solicitar WIC son las mismas para todos. Puedo solicitar una audiencia justa a un empleado de WIC si alguien me dice que no puedo estar en el programa WIC y no estoy de acuerdo.
- **Cortesía común**: El personal de WIC y de la tienda me tratarán con cortesía y respeto. Puedo decirle al personal de WIC que me gustaría presentar una queja si no me tratan con respeto. También puedo presentar una queja al Departamento de Agricultura de los Estados Unidos (United States Department of Agriculture, USDA) en la dirección escrita abajo.
- **Información de transferencia**: Si me mudo, puedo cambiarme al programa WIC de otro estado. Puedo pedir que me den los documentos de transferencia.

**Mis responsabilidades**

**Entiendo que:**

- WIC no proporciona todo los alimentos o la fórmula infantil necesaria para un mes y los beneficios que no se usaron no se acumulan para el mes siguiente.
- Si pierdo mi tarjeta electrónica de WIC, puede ser reemplazada. Si mis beneficios de comida se vencen antes de recibir una nueva tarjeta electrónica, los beneficios no serán reemplazados.
- La información que proporcione al programa WIC está siendo presentada en conexión con el recibimiento de la asistencia federal. Los funcionarios del programa pueden verificar la información que se les presente.
- La información que identifica al participante de WIC se suministrará a las personas que están directamente relacionadas con la administración, la ley o las auditorías del programa.
- La Secretaría del Departamento de Salud de Maryland puede autorizar la publicación de información a los representantes de las organizaciones públicas que atienden a personas que califican para el programa WIC. Una lista de estas organizaciones está disponible al solicitarla al programa WIC.
- La información proporcionada a las organizaciones solo se usará con el propósito de determinar la elegibilidad de los participantes de WIC para programas que estén bajo su administración, realizar campañas de promoción de tales programas para los participantes de WIC, de evaluar el grado de reacción del Estado ante las necesidades de cuidado de salud y a los resultados de los participantes en WIC, o simplemente para simplificar los procedimientos por participar en estos programas.

**Acepto seguir las reglas que están a continuación: Yo:**

- Siempre llevaré la prueba de identificación (ID) a todas las citas.
- Proporcionare de manera oportuna todos los documentos solicitados por el programa WIC.
- Usaré la comida y la fórmula infantil proporcionadas por WIC solo para la persona registrada en WIC.
- Declararé las tarjetas electrónicas de WIC como perdidas, robadas o dañadas según las instrucciones.
- Me aseguraré de que todos los que nombre para que reciban mis beneficios conozcan las responsabilidades y derechos de WIC. Le enseñaré como usar los beneficios de forma adecuada.
- Asistiré a las citas de WIC o llamaré a la clínica para reprogramarlas. Si no busco los beneficios dos veces seguidas, pueden retirarme el Programa.
- No venderé, regalare ni intercambiaré la tarjeta electrónica de WIC, ni la comida ni la fórmula infantil a cambio de dinero, crédito, cupones o por ningún otro artículo. Si no puedo usar alguno de los beneficios, los regresaré a la clínica.
- No pondré en venta o intercambio ningún beneficio de WIC en el Internet.
- No insultaré, gritaré, acosaré ni amenazaré físicamente al personal de WIC ni de la tienda ni destruiré ninguna instalación de WIC ni de la tienda.
- No inscribiré a ningún niño que no esté bajo mi cuidado legal.
- No me inscribiré en el programa WIC en más de un estado ni recibiré beneficios mensualmente de más de una clínica de WIC.
Acepto dar información completa y verdadera sobre:

- Mi identidad, estado de embarazo y dirección.
- El número de personas que viven en mi casa.
- El ingreso total de las personas que viven en mi casa.
- Mi participación en Medicaid, el Programa de Suplemento Alimenticio de Maryland (Maryland Food Supplement Program, FSP), también conocido como el programa de cupones para alimentos o el Programa Asistencial de Nutrición Suplementaria (Supplemental Nutrition Assistance Program, SNAP) o Asistencia Temporal en Efectivo (Temporary Cash Assistance, TCA).
- Todos los cambios relacionados con las circunstancias de la vida, (por ejemplo: notificaré a WIC en caso de que tenga algún cambio en mi ingreso, en el número de personas en mi familia o si cambio de dirección).

Mi firma en el sistema WIC significa que:

- La información que he proporcionado para la determinación de la elegibilidad es correcta, a lo mejor de mi conocimiento.
- Entiendo y acepto que dar información falsa, o engañosa o tergiversar, ocultar o retener datos puede resultar en que tenga que pagar, en efectivo, al programa WIC, el valor de los beneficios alimenticios que he recibido de forma inapropiada y puedo enfrentarme a una acusación criminal o civil, ante la ley federal y estatal y a la descalificación del programa WIC.
- He sido o seré beneficiario de un instrumento alimenticio (tarjeta electrónica de WIC) para mi familia.
- Me han hecho preguntas sobre WIC y han sido respondidas.
- Entiendo cuáles son mis derechos y responsabilidades.
- Entiendo que, si no cumplo con mis responsabilidades, puedo ser descalificado del programa WIC.

Los siguientes participantes fueron certificados en__________________:

#1: ______________________________ #4: ______________________________
#2: ______________________________ #5: ______________________________
#3: ______________________________ #6: _____________________________

____________________________________  __________________________________
Firma del solicitante/cuidador/designado Firma del personal de WIC

Solo para certificaciones manuales:

☐ Determinación del ingreso  ☐ Determinación del riesgo de nutrición

Firma del personal  Firma del personal

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en inglés), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, discapacidad, edad, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA.

Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA (AD-3027) que está disponible en línea en: http://www.ascr.usda.gov/complaint_filing_cust.html y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por:

(1) correo: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; o

(3) correo electrónico: program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.  C19/0818
A. Policy

A Verification of Certification (VOC) document will be used to:

1. Ensure that every participant who is a member of a family in which there is a migrant farm worker or who is likely to relocate has written proof of his/her certification and eligibility. This policy also applies to WIC participants affiliated with the military who may be transferred overseas (Refer to Policy & Procedure 2.17 - WIC Overseas Program).

2. Ensure that participants transferring from a WIC agency in another state are provided continuous benefits. Refer to Policy and Procedure 2.17 for WIC participants affiliated with the military who are returning from overseas.

B. Procedure

1. IN-STATE TRANSFERS

   Outgoing Transfers

   Participants shall only be transferred into a local agency at the request of the participant. Any participant advising the local agency that he/she will be moving to another local agency within the State must be given information on how to transfer.

   Incoming Transfers

   a. If a participant from another local agency within the State telephones or walks into a WIC clinic at the new local agency, the new local agency shall initiate In State transfer procedures in the management information system.

   b. When accepting a transfer from another local agency within the State, the receiving local agency shall:
i. Follow the in-state family transfer procedure in the management information system.

ii. Obtain proof of identity (Refer to P&P 2.23) and proof of residency (Refer to P&P 2.04).

iii. Update the address, phone number, family size and head of household, as necessary. Add any new family members and respond to any Alerts.

iv. If the local agency receives information indicating that the participant’s household income has changed and greater than 90 days remain in the certification period; the local agency shall redetermine income eligibility following Policy and Procedure 2.05 Income Requirements.

v. If applicable, retrieve and destroy any participant ID folder issued from the sending local agency and issue a new ID folder with the receiving local agency stamp.

vi. Determine what benefits have been issued to the participant and follow the local agency guidelines for issuing future benefits, if appropriate.

vii. Make the appropriate appointment.

2. OUT-OF-STATE-TRANSFERS

Outgoing Transfers

a. Any participant advising the local agency that he will be moving out-of-state must be given a Verification of Certification (VOC), and if possible, the address of the WIC Program in the area where the participant is moving. In stream migrant farm workers and their family members, homeless persons, and other transient WIC participants will be issued Maryland VOC upon transferring into the local agency. VOC from the previous WIC enrollment will become part of the WIC certification records. Refer to Policy and Procedure 2.17 for instructions on issuing a VOC for WIC participants affiliated with the military who will be transferred overseas.

b. The VOC must be filled out completely and signed by the participant/caregiver or designee and a local agency staff person authorizing certification. VOC may be sent in a secure manner if the
participant faces a hardship in coming to the WIC office.

c. If a VOC is reported lost or stolen by a participant, it must be noted in the Notes screen of the management information system with the date reported and initials of the person accepting the report. The VOC can then be reissued.

d. States requesting VOCs may be directed to the WIC helpdesk at 410.767.5166. If the local agency chooses to assist the requesting agency they may not require a client release of information in order to provide VOC information. Local agencies may require a request on letterhead be faxed to assure confidentiality.

Incoming Transfers

A participant presenting a VOC has already been certified for WIC and has been guaranteed the right to complete his/her certification period. If the receiving local agency has a waiting list but is enrolling some new participants, then such persons must be enrolled and allowed to finish out their certification periods even if the local agency is not serving the priority level. If the receiving local agency is not serving any new persons, the person must be placed on the wait list ahead of all waiting applicants, regardless of the priority level under which he/she was certified. In the event a local agency reserves caseload slots for a short period of time for Priority I participants and a person presents a valid VOC to the local agency, that individual must be enrolled before a Priority I applicant.

The local agency shall:

a. Accept the data on the VOC for the duration of that certification period. Program regulations require that VOC contain the following information:

i. Name of the participant
ii. Date the certification was performed
iii. Date income eligibility was determined: this may be different than the certification date
iv. The nutritional risk of the participant in clear language
v. Date the certification expires
vi. The signature and printed name of the certifying local agency official (does not have to be the person who performed the certification)

vii. The name, address, and phone number of the certifying agency
viii. An identification number (which may be the WIC participant ID number) or other form of VOC accountability
The transferring participant should not be penalized if the original agency does not complete the VOC properly. Local agencies shall accept an incomplete VOC as long as the person’s name and date of certification are present and the certification period has not expired. If possible, it is recommended that the local agency telephone the original agency if information is missing or appears to be altered. State contact information can be found at www.fns.usda.gov/wic/wic-contacts.

b. Verify participant identity according to Policy and Procedure 2.23 - Establishment of Applicant Identity.

c. Verify residency according to Policy and Procedure 2.04 – Residency Requirements.

d. If the local agency receives information indicating that the participant’s household income has changed and greater than 90 days remain in the certification period; the local agency shall redetermine income eligibility following Policy and Procedure 2.05 Income Requirements. The income determination shall be waived for migrant farm workers and their family members if the income eligibility has been determined within 12 months.

e. Ask the person presenting the VOC to read or read to them the Participant Rights and Responsibilities and electronically sign their full name acknowledging acceptance of the Participant Rights and Responsibilities.

f. Honor all nutritional risk conditions from other WIC programs for the duration of the certification period stated on the VOC.

g. Retrieve and destroy any WIC issued identification folder from the sending agency.

h. Retrieve and destroy any food instruments from the sending agency. In the event the participant does not present their food instruments from the original agency, the original agency shall be contacted to determine last benefits received. Duplicate benefits shall not be issued.

i. Issue a replacement food instrument in accordance with P&P4.30 Food Instrument Issuance and Replacement.

j. If the client is receiving a WIC medical nutritional formula, the sending agency shall be contacted for confirmation of special formula issuance. In the event the sending agency cannot be
contacted, the WIC medical nutritional can be approved for 30 days and the caregiver provided a copy of the WIC Medical Documentation Form to have completed by a local health care provider.

If the certification period stated on the VOC presented by the applicant has expired, the applicant shall reapply for WIC benefits according to Maryland certification procedures and processing standards.

3. **Migrants** - When accepting a VOC from a migrant, follow the appropriate procedures for either the In-State Transfer or Out-of-State Transfer.

4. **Military** – Refer to Policy and Procedure 2.17 for WIC participants affiliated with the military who will be transferred overseas or are returning from overseas.

Attachments: 2.13A VOC

References: 7 CFR 246.7 (k)
7 CFR 246.7 (h)(1)(i)
COMAR 10.54.01.17
FNS Instruction 803-11, Rev 1
Policy Memo 2016-4 Verification of Certification
WIC Policy Memorandum 2001-4 WIC Overseas Program and VOC Cards

Revisions
10/01/2003 WICWINS References
10/01/2010 Deleted from Incoming Transfers c. enter a risk code. Changed reference from 7 CFR 246.7(j) to 7 CFR 246.7(k)
10/01/2011 Clarified the steps for in state family transfers in B.1.b.(i-v); Added to Procedure: Participants shall only be transferred into a local agency at the request of the participant.
10/01/2012 Deleted references to WOW and minor language and format changes
10/01/2013 Revised wording to include the new Participant Rights and Responsibilities form procedures.
10/01/2014 Added proof of identity in B. 2. Incoming Transfers section b. per WIC Policy Memorandum 2001-4
6/7/2017 New guidance Policy Memo 2016-4 Verification of Certification and updated language to be compatible with eWIC
11/08/2017 Clarified transfer process for out of state requests and when to redetermine income.
Maryland WIC Program
Verification Of Certification

Participant Name: Sample Voc
Date of Birth: 05/25/2015
Eligibility Begins: 05/27/2016
Bloodwork Date: 05/27/2016
Comment:
Termination Date:

Nutritional Risks:
Prematurity
Low Birth Weight (LBW)

Priority: 3
Height: 2 ft 4 in.
Weight: 19 lbs. 2 oz.
Ends: 05/31/2017
HGB = 12.5

Participant Number: 201117070
Income Determ Date: 05/27/2016
Last Benefit Issued:
First Date To Spend: 07/22/2016
Last Date To Spend: 08/21/2016

Signature and Title
Towson Health Center
1046 Taylor Ave.
Towson, MD 21286
(410) 887-5955

No Signature Obtained

Head of Household/Designee Signature
A. Policy

The WIC Program regulations do not require citizenship so aliens, including students, are in no way categorically ineligible for the WIC Program.

Participation in the WIC Program does not give rise to a public charge determination and that no reimbursement of WIC benefits is required when the individual applies for immigration or citizenship.

B. Procedure

If a WIC Program participant experiences any action by Immigration and Naturalization Service (INS) field agents because of their participation in the WIC Program, please notify the State WIC Office immediately with specific details and copies of the INS documents or forms.

Attachments:

References:

SFP 98-140, SFP 98-079, SFP 97-036

Revisions October 2012 – minor formatting change
A. Policy

1. The WIC Program regulations state that WIC Supplemental food "shall not be issued for use in institutions which serve meals". However, it is not the intent of program regulations to unconditionally exclude otherwise eligible persons affiliated with institutions from the WIC Program. Local agencies are encouraged to extend benefits to institutionalized persons who may be at high risk and consequently in need of the WIC Program, provided the applicants who reside in institutions (e.g. shelter) are eligible for WIC under the following conditions.

   a. The institution does not accrue financial or in-kind benefit from a person's participation in WIC.

   b. Food items purchased with WIC food instruments are used only by those for whom they are prescribed.

   c. No institutional constraints are placed on the ability of the WIC participant to partake of supplemental foods and all associated WIC services made available by the WIC local agency.

2. The Maryland WIC Program is not at this time extending benefits to those women who are incarcerated.

B. Procedure

1. Local Agency staff should evaluate the situation for each person residing in a shelter on an individual basis. If any of the above conditions would be violated, the applicant would not be considered eligible to receive WIC benefits.

2. If the individual situation allows the participant to have access to foods provided by the WIC Program, food instruments tailored to the participant's needs should be issued. Such tailoring should include the prescription of non-perishable foods and/or smaller quantities of
perishable foods. All circumstances should be documented in the WIC record and reevaluated regularly for changes in circumstances.

Attachments:

References:  
CFR Part 246.7 (m)  
FNS Instruction 803-13

Revisions:  
10/1/2011  Changed reference from CFR 246.7 (o) to 246.7 (m)
MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number:  2.16
Effective Date: October 1, 1992
Revised Date: August 22, 2018

SECTION:  ELIGIBILITY AND CERTIFICATION

SUBJECT:  Applicant/Participant Present for Certification/Mid-Certification

A.  Policy

Local agencies shall require that all applicants/participants be present for certifications/mid-certifications unless extenuating circumstances exist.

Eligibility determination cannot be conducted solely through the use of referral data. Referral data for children have occasionally shown inaccurate patterns of weight loss or poor linear growth. Staff must physically assess the applicant to determine whether the referral data are depicting real problems with growth or are reflective of poor measurements. The presence of other medical conditions, which would render the child eligible for certification, can also be discerned and social conditions that require intervention can be identified when the applicant is present at the time of certification.

Exceptions to this policy may be granted to individuals who have a disability or condition that would prevent them from being physically present. Examples of such circumstances include medical conditions that:

- necessitate the use of medical equipment that is not easily transportable; or
- require confinement to bed rest; or
- may be exacerbated by coming into the clinic.

B.  Procedure

1. All applicants for program services must be physically seen by WIC program staff at the time of certification unless extenuating circumstances exist. In those cases where being present for certification will be detrimental to the physical well being of the applicant, the applicant may request an exception to the policy from the Local Agency.

   a. Upon receipt of a request for an exception to the policy, the Local Agency will first attempt to arrange for an alternate method of certifying the applicant. Alternate methods may include scheduling the applicant to come to an alternate location; or an appointment at the clinic or WIC office outside of normal clinic hours.
b. If the Local Agency cannot arrange an alternate method of certification, the certification may be completed without the applicant present if all necessary certification information is provided. Growth and biochemical referral data must be in adherence to policies 2.32 and 2.33.

c. The applicant or their caregiver must present to the Local Agency documentation from a health care professional which specifically states the reason that the applicant cannot come to the clinic and the duration of time that this condition may last. A form letter stating in general terms that the applicant is "medically fragile" is not acceptable.

2. All participants must be present at mid-certification visits unless extenuating circumstances exist. A participant who fails to be present for a mid-certification visit shall not be denied food benefits. The certifier may attempt to schedule a follow up appointment in the following 30 days to complete the MCV anthropometric and biochemical measurements. Local agencies shall stress the positive long-term benefits of WIC nutrition services and encourage the participant to attend and participate in scheduled mid-certification appointments for nutrition assessment and education.

3. Any approved requests for exceptions must be fully documented by the Local Agency in the participant's file.

4. The number of exceptions granted and the circumstances involved will be reviewed by the State Agency as part of the Local Agency Review process.

References:
CFR 246.7 (o)
USDA Policy Memorandum #2006-5 VENA

Revisions:
10/2010        Added reference CFR 246.7 (o)
10/2012        Added mid-certification language. Added B.2.a-c. Improved formatting
10/2013        Deleted the 2nd paragraph in Policy section which allowed as an exception to this policy “infants certified as priority II based solely on the mother’s WIC enrollment or documented priority I status during pregnancy.” References: Deleted SFP 89-143; added USDA Policy Memorandum #2006-5. Clarified timeframes for height, weights and bloodwork obtained from private providers in B.1.c
10/2015        In B.1.b., deleted reference to arranging for a home visit
08/22/2018     Removed P&P2.38 reference and reworded for consistency between policies; clarified extenuating circumstances and removed requirement that documentation be from a HCP.
A. POLICY

1. Background

   The Department of Defense (DoD) is authorized by law to establish and operate a program like WIC, using DoD funds, for United States (U.S.) active duty military personnel and other support staff stationed overseas and their dependents. DoD has delegated the responsibility to administer the WIC Overseas Program to its Assistant Secretary of Defense (Health Affairs)/TRICARE Management Activity (TMA).

   Information about DoD's WIC Overseas Program can be accessed on the Web Site at:


2. Impact on USDA's WIC Program

   Legislation limits eligibility in the WIC Overseas Program to:

   a. Active duty service members and their family members;

   b. DoD civilian employees and their family members; and

   c. DoD contractors and their family members.

   All other eligibility requirements for the WIC Overseas Program mirror USDA’s WIC Program requirements. Further legislation and DoD guidelines provide that WIC Program participants who are transferred overseas and meet the eligibility requirements noted above are eligible to participate in the WIC Overseas Program until the end of their certification period.

   Because the WIC Overseas Program has been designed to mirror USDA’s WIC Program, WIC Overseas Program participants who return to the U. S. with a valid WIC Overseas Program Verification of Certification (VOC) card must be provided continued participation in the USDA’s WIC
Program until the end of his/her certification period. The WIC Overseas Program VOC card is a full-page document titled, WIC Overseas Participant Profile Report (Attachment 2.17A). In accordance with WIC policy, if the local agency has a waiting list for participation, transferring participants must be placed in the waiting list ahead of all waiting applicants regardless of the priority of their nutrition risk criteria.

B. PROCEDURE

1. Issuance of WIC VOC Cards

Local agencies shall issue WIC VOC cards to WIC participants affiliated with the military who will be transferred overseas. Local agencies should also emphasize the importance of WIC clinic staff completing all information on the VOC card because WIC Overseas Program personnel cannot readily contact a WIC Program to obtain further information. Refer to Policy and Procedure 2.13. WIC clinics are not responsible for screening and determining eligibility for WIC Overseas Program eligibility. WIC participants issued VOC cards when they transfer overseas must be instructed that:

a. There is no guarantee that the WIC Overseas Program will be operational at the overseas site where they will be transferred; and

b. Issuance of a WIC VOC card does not guarantee continued eligibility and participation in the WIC Overseas Program. Eligibility for the overseas program will be determined at an overseas WIC service site.

2. Acceptance of WIC Overseas Program VOC Cards

Local agencies shall accept a valid WIC Overseas Program VOC card presented at a WIC clinic by WIC Overseas Program participants returning to the U. S. from an overseas assignment. In accepting a VOC card, local agencies are reminded that at a minimum, the following elements on the cards are essential:

a. The participant’s name;
b. The date the participant was certified; and
c. The date that the current certification period expires.

WIC Overseas Program participants arriving in a WIC clinic and showing a VOC card with only these three pieces of information should be treated as if the VOC card contains all of the required information. However, if questions arise, contact information for WIC Overseas Offices can be found at:

http://www.tricare.mil/wic/
and on Attachment 2.17B.

Local agencies are also reminded that individuals presenting a valid VOC
card must provide proof of residency and identity, with limited exceptions, in accordance with the WIC Program policies.

In accordance with WIC policy, if the local agency is at caseload and has a waiting list for participation, transferring participants must be placed in the waiting list ahead of all waiting applicants regardless of the priority of their nutrition risk criteria.

Attachments:

2.17A DoD WIC Overseas Program Participant Profile Report/Verification of certification card (VOC)
2.17B WIC Overseas Program Contacts

References:

SFP 01-076 Impact of Implementation of the DoD’s WIC Overseas Program on the USDA’s WIC Program

Revisions

10/01/07 Revised 2.17B
01/21/09 Changed revised date on page 1 to October 1, 2007
10/2011 Updated link to website. Updated information in 2.17B
10/2012 Minor language changes; updated information in Attachment 2.17B
10/2015 Updated web address for WIC Overseas
**WIC Overseas Participant Profile Report**

**Visit Date:** Thursday, July 29, 2010  
**WIC Overseas Site ID:** 3005 Camp Foster, Japan  
**Encounter Type:** New Certification  
**Participant Category:** Infant  
**Gender:** Female  
**DOB:** 07/22/2010  
**Age:** 7 Days  
**Participant Type:** Dependent of a member of the armed forces stationed overseas

**Certification Dates:** 07/29/2010 - 07/31/2011

**Economic Unit:** 3  
**Address:** 123 ALA  
**APO, AE, 96386**

**Sponsor Name:** TEST T TEST  
**Non-Sponsor Name:**  
**Grade:** E-1  
**DEROS:** 12/22/2010  
**Home Phone:**  
**Work Phone:**  
**Home Email:**  
**Source of Health Care:** MTF: AKAMINE LC  
**PCM:** DR. ELIZABETH LEONARD

**Measurements**

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<tr>
<th>Measurement</th>
<th>Value</th>
<th>Date</th>
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<tbody>
<tr>
<td>Hematocrit</td>
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</tr>
<tr>
<td>Weight</td>
<td>17.00</td>
<td>07/29/2010</td>
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**Nutritional Risks**

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<tr>
<th>Risk Code</th>
<th>Risk Description</th>
<th>Priority</th>
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<tbody>
<tr>
<td>103</td>
<td>Underweight or at risk of becoming underweight</td>
<td>1</td>
</tr>
<tr>
<td>411</td>
<td>Inappropriate Nutrition Practices for Infants</td>
<td>4</td>
</tr>
</tbody>
</table>

**Draft Use Dates:** 07/29/2010 - 08/27/2010  
**Food Package:** IBP1-3PBF

**Food Instrument 1**

- 2 - 12/12.3/12.4/12.5/12.6/12.9 oz. cans powder Enfamil
- Gentle/GS Gentle Plus/
- GS Protect Plus/Similac Sensitive/
- Similac Advance/Enfamil Premium Lipil/
- Enfamil Lipil

**Food Instrument 2**

- 2 - 12/12.3/12.4/12.5/12.6 oz. cans powder Enfamil
- Gentle/GS Gentle Plus/
- GS Protect Plus/Similac Sensitive/
- Similac Advance/Enfamil Premium Lipil;
- OR 1 - 12.9 oz. can powder Enfamil Lipil

**Food Instrument 3**

- 1 - 12/12.3/12.4/12.5/12.6/12.9 oz. can powder Enfamil
- Gentle/GS Gentle Plus/
- GS Protect Plus/Similac Sensitive/
- Similac Advance/Enfamil Premium Lipil/
- Enfamil Lipil

**Participant Rights and Obligations:** I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. I understand I have a right to appeal any decision which I am aggrieved. This certification form is being submitted in connection with the receipt of Federal Funds. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the Federal agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under Federal Law. I hereby certify that I am not currently enrolled in any other WIC or WIC Overseas program. I understand that to do so would be deliberate misuse of program benefits and could result in the loss of these benefits.

**Participant or Parent/Guardian Signature:**

```
Signature: TEST TEST
Date: 08/12/10
```

**Competent Professional Authority:**

```
Signature: MARY JAFIT SANCHEZ
```
# WIC OVERSEAS PROGRAM CONTACTS

<table>
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Information obtained: August 2, 2012
A. Policy

The management information system maintains historical participant data which includes information used to make the eligibility determination.

If not scanned into the management information system, local agency clinics shall maintain paper files, according to the time schedule specified in Policy and Procedure 6.00, for the following documents:

1. Completed Ineligibility Notification forms and documentation for applicants determined to be ineligible for WIC Program benefits;
2. Incoming VOC from other states and the WIC Overseas Program;
3. Signed paper Participant Rights and Responsibilities form (when unable to obtain signature in the management information system);
4. Signed Release of Liability for breast pumps or aids.
5. Copies of documentation from a one person clinic as required in P&P 7.82 Separation of Duties

B. Procedure

Local agencies shall abide by the above policy and paper files shall be made available for review during Local Agency management evaluations (P&P 7.81).

References:
7 CFR 246.25
COMAR 10.54.01
Revisions:
10/01/2002    WICWINS References
10/01/2013    Deleted requirement to maintain copies of participant rights and responsibilities form except for manual certifications.
6/7/2017      Referenced policy 6.00, replaced reference CFR 246.7 with 7 CFR 246.25, removed check receipt due to eWIC and added A.4 and A.5
8/22/2018     Updated name of Policy 7.82; changed “fair hearing forms” to "completed ineligibility forms".
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.19
Effective Date: April 5, 1991
Revised Date: June 7, 2017

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Identification Folder

A. POLICY

1. A standard statewide Identification (ID) Folder may be issued and validated by local agencies for participants, proxies, or caregivers to use as identification at the WIC clinic. If there is more than one member of a family on the WIC Program only one folder shall be issued.

2. An ID Folder that will be used for identification at the clinic must be validated as described below.

B. PROCEDURE

1. The ID Folder shall be completed and validated by local agency staff in the following manner and as illustrated on Attachment 2.19A:

   A- Print the name of the participant(s) and ID number(s)

   B- Print the Head of Household name and obtain their signature.

   C- Either local agency staff or the Head of Household shall print the name(s) of the proxy(ies). Instruct the Head of Household to obtain the signature of their proxy(ies).

TO VALIDATE THE IDENTIFICATION FOLDER, TWO STAMPS MUST BE USED:

   D- Validate the ID Folder by using the stamp containing the local agency and/or county code.

   E- Validate the ID Folder by using the stamp with the local agency's name and telephone number.

   F- This section can be used to document the type and time of the next appointment.

Attachment(s)
1. Attachment 2.19A: Identification Folder
References:
1. 7 CFR 246.12 (r)
2. COMAR 10.54.01.08 B. (1) (a)

Revisions:
10/08  Section B.e. Deleted requirement of the local agency address on the ID Folder
01/09  Section B.2. Deleted requirement of the local agency address on the ID Folder
10/09  Updated to match the format on the new Identification Folder
01/10  Changed designees to proxies
02/10  Changed caretaker to caregiver. Clarified B.5 A-C
10/10  Changed reference from 7 CFR 246.7(o) to 7 CFR 246.7 (r)
10/12  Attachment 2.19A Changed information on what to bring for a mid-certification visit (MCV) to reflect all categories eligible for an extended certification period.
10/15  Removed requirement to have WIC symbol on the local agency stamp.
6/7/2017 Updated with eWIC terminology and made folder issuance optional. Attachment A update with branded colors and eWIC terminology.
A validated ID Folder may be used as identification for WIC participants, the caretaker of infant or child participants and their proxy(ies) at the WIC clinic. Inside the folder is information on what the participant can expect from WIC and what WIC expects from the participant, including when to contact the WIC Office. The Identification Folder also contains information on what to bring to a WIC appointment.
A. Policy

1. The local agency shall inform the head of household at the time of certification that:
   a. The head of household may designate a proxy or proxies, not to exceed two, to receive and/or redeem WIC benefits on their behalf.
   b. The head of household may authorize the proxy to also be a designee who can bring an infant or child participant to the clinic for subsequent certifications on their behalf. If so designated, local agency staff shall document in the participant’s record.
   c. It is the head of household’s responsibility to inform their proxy/designee how to pick up and redeem WIC benefits; and
   d. The proxy/designee is subject to program sanctions as specified in Policy and Procedure 4.23.

2. The head of household shall be permitted to change or add a proxy/designee at any time during the certification period by informing the local agency of the change.

3. The head of household may retain the same proxy/designee(s) for subsequent certifications.

4. A WIC employee may act as a proxy/designee for a participant with the approval of the local agency coordinator. The employee shall not participate in any way in executing a certification or the issuance of WIC benefits for a participant when they are acting as a proxy/designee for a participant as stated in Policy and Procedure 4.01 and 7.82.
B. Procedure

1. Choosing a proxy/designee

   a. The local agency shall ask the head of household at the initial certification if they would like to choose one or two persons designated as a proxy to pick up and/or redeem WIC benefits.

   b. If a proxy has been requested, the local agency shall enter the name(s) of the proxy(ies) in the appropriate field in the participant’s record.

   c. The local agency shall ask the head of household at the initial certification if they would like to authorize one or both of the proxies to serve as a designee who can bring an infant or child participant to the clinic for subsequent certifications on their behalf. If the head of household agrees, local agency staff shall document in the management information system.

   d. If the local agency is issuing a WIC ID Folder, the staff shall instruct the head of household to have their proxy(ies)/designee(s) sign the WIC ID Folder on the appropriate line(s) per Policy and Procedure 2.19.

2. The head of household shall be responsible to instruct their proxy(ies)/designee(s) how to pick up and redeem the WIC benefits.

3. The proxy/designee shall present valid identification (Refer to P&P2.23) when picking up WIC benefits at the local agency. The local agency shall ensure that the proxy(ies)/designee(s) name is listed in the management information system before issuing benefits.

4. The proxy/designee shall be subject to the sanctions listed in Policy and Procedure 4.23.

5. The head of household may request the local agency to change a proxy/designee by submitting the request in writing, in person, or by telephone if the local agency staff can verify the identity of the caller. The local agency may prohibit the changing of a proxy/designee if unable to verify the identity of the individual making the request.
Attachments:

References:
- 7 CFR 246.12(r)(1)
- COMAR 10.54.01.04

Revisions:
- 10/01 Changed proxy to designee
- 10/03 WICWINS References
- 01/10 Changed designee to proxy/designee; added description of designee
- 02/10 Corrected policy number in B.5
- 10/10 Changed reference from CFR 246.12(o) and (p) to 246.12(r)(1)
- 10/12 Corrected Policy reference in A.1.d. Deleted references to WOW and minor language changes/clarifications.
- 6/7/2017 Updated for eWIC terminology and optional WIC ID folder
- 8/22/2018 Removed 4.09 which no longer exists; added 4.01 and 7.82, minor word changes and added COMAR reference
A. POLICY

Identify homeless individuals, determine their eligibility and provide appropriate benefits expeditiously to maximize the benefits of the provision of authorized foods and nutrition education.

B. PROCEDURE

The local agency shall abide by the above policy by adhering to the following:

1. Identify a homeless individual by the following definition:

"Homeless individual" means a woman, infant or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

   a. A supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designated to provide temporary living accommodations;

   b. An institution that provides a temporary residence for individuals intended to be institutionalized;

   c. A temporary accommodation in the residence of another individual which cannot exceed 365 days; or

   d. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

2. To be certified as eligible for the WIC Program, homeless individuals shall meet the following criteria for eligibility in accordance with policies and procedures established by the State Agency:

   a. Residency requirements as outlined in Policy and Procedure 2.04. Consideration shall be given to a homeless individual who cannot provide proof of residency. Although a street and mailing address
is a required field in the WOW record, a permanent address is not required. The homeless applicant shall complete a Confirmation of Residency form (Attachment 2.21A). The local agency shall assist by asking the following:

(i) if the applicant frequently stays at one shelter, can that shelter's address be used;

(ii) if the applicant uses a "day shelter" (a shelter for the homeless which is open only during the day), can that shelter's address be used;

(iii) if the applicant can use the address of a relative or a friend; or

(iv) if no address is available, can the address of the local WIC clinic be used.

b. Homeless applicants who reside in homeless shelters which do not meet the conditions in B.5 are not eligible for WIC food benefits.

c. Income eligibility requirements as outlined in Policy & Procedure 2.05.

Consideration shall be given to a homeless individual who cannot provide proof of income. If a homeless applicant does not have the facilities to store written documentation for income verification, the local agency shall accept a self-declaration of income from the applicant. A homeless applicant who has no source of income or support is clearly income eligible.


3. To provide the benefit of supplemental foods necessary to accommodate the homeless individual, special food packages have been developed for the homeless individual who may not have the facilities to store or utilize the usual WIC supplemental foods.

4. To provide the benefit of nutrition education which is relevant to the homeless individual, specific education concerning the use and the storage of foods should be offered in addition to other topics.

5. Local agencies should ensure that homeless facilities meet certain conditions:

a. The homeless facility does not accrue financial or in-kind benefit
from a person's participation in the Program, e.g. by reducing its expenditures for food service because its residents are receiving WIC foods;

b. Foods provided by the WIC Program are not subsumed into a communal food service, but are available exclusively to the WIC participant for whom they were issued; and

c. The homeless facility places no constraints on the ability of the participant to partake of the supplemental foods and nutrition education available under the Program.

6. The local agency shall:

a. Contact the homeless facility at least once every six months to ensure continued compliance with conditions described in B.5; and

b. Request that the homeless facility notify the local agency if it ceases to meet any of these conditions.

7. In those cases where the local agency has not determined if a homeless facility meets the conditions of B.5, the local agency shall:

a. Contact the homeless facility to make this determination;

b. Inform applicants that the local agency will contact the homeless facility to determine if the facility meets certain conditions required by federal regulations for applicants to be eligible for WIC; and

c. Inform applicants that they will be notified by mail or telephone within the regulatory timeframe (refer to Policy and Procedure 2.09) of their eligibility status.

8. Homeless applicants and participants must be referred to appropriate health and human service agencies, such as:

a. Local welfare/TCA client assistance services

b. Homeless shelters

c. Food pantries/meal programs

d. Food Supplement Program

If necessary, a referral phone call should be made on behalf of the homeless applicant to food and shelter resources in the local area.
Attachment(s)
2.21 A Confirmation of Residency

References:
1. 7 CFR Part 246.2, 246.7(m), 246.10

Revisions:
1. 4/99 Revised definition to include “which cannot exceed 365 days” and changed AFDC to TCA.
2. 1/09 Changed Food Stamps to read Food Supplement Program in B. 8.d.
3. 10/11 Clarified B.2.b and citation 246.7(m)
MARYLAND STATE WIC PROGRAM
Confirmation of Residency

I, ___________________________, hereby certify that I am currently
(Applicant/Parent/Guardian)
living in __________________________________________
(Print County name or Baltimore City)
County and am asking the WIC Program to use the following address for their records:

_____________________________________________
_____________________________________________
__________________________________________

______________________________
Signature
A. Policy

Once a person's certification period is over, the participant must reapply for WIC benefits and compete for WIC appointments with other persons within their priority levels. It is generally easier for current participants to obtain WIC appointments because they are already in the system and more difficult for new applicants to obtain access to the system. Therefore, special efforts must be made to ensure that high-priority new applicants are able to gain access to WIC appointments in a timely manner.

An Appointment Waiting List shall be implemented and maintained if, due to staff or space limitations, the local agency cannot schedule and process the applicant who requests an appointment for certification or recertification by telephone within the regulatory timeframes. The names of applicants who request in person, at a WIC site, to participate in the Program cannot be placed on an appointment waiting list. These applicants must be interviewed and notified of their eligibility or ineligibility according to the processing standards described in Policy and Procedure 2.09. An appointment waiting list should be implemented as a short-term solution. When a local agency decides to implement an appointment waiting list, the local coordinator shall notify the State WIC Director in writing, regarding:

a. The date an appointment waiting list has been implemented;

b. The priorities that will be given appointments;

c. The anticipated length of time that the appointment waiting list will be maintained; and

d. The measures that will be pursued to resolve the problems of lack of resources and/or space.

B. Procedure

1. Establishing an appointment waiting list.
a. The local agency should determine the priorities that can be served in a timely fashion and should provide appointments to those applicants who will most likely fall into those priorities.

b. Recertification:

As a WIC participant's certification period draws to an end, local agency staff must determine whether a recertification appointment should be scheduled. This decision is based on the individual's potential new priority status when assessed. Persons likely to remain in Priority I must be given highest priority for appointments, followed by those who would be Priority II, III, IV, etc. Recertification appointments should be given consistent with procedures for giving new appointments.

c. New Certification:

Applicants who telephone the WIC Program to request an appointment should be scheduled according to priority. However, local agency staff may not have enough information to determine which priorities these applicants will be. The following guidelines shall apply:

i. Pregnant and breastfeeding women will be given highest priority;
ii. Infants will be given second priority; and
iii. Children and postpartum women who are believed to have a nutritionally significant medical condition or other risk factor which would place them in Priority III will be given third priority.

d. Local agencies should make every effort to schedule pregnant women within 10 days of the request, whether the request is made in person or by telephone.

e. Any infant who appears to have a condition qualifying as a Priority I risk must be given an appointment within 10 days of the request, whether in person or by telephone.

2. The local agency shall establish an appointment waiting list, which contains the following information:

a. Name, address and contact telephone number of the individual for whom the appointment is requested or if the individual is an infant or child, the parent or guardian of the infant or child.
b. Name of individual for whom the appointment is requested;

c. Date the appointment was requested; and

d. Category of the individual for whom the appointment is requested, i.e.:  
   i. Pregnant woman;  
   ii. Infant;  
   iii. Breastfeeding woman;  
   iv. Child; or  
   v. Postpartum women.

3. Implementing an appointment waiting list.

When an appointment becomes available, the local agency shall contact the individual, or the parent or guardian of an infant or child, from the appointment waiting list according to the:

a. Highest priority according to category, which is:
   i. Pregnant woman;  
   ii. Infant;  
   iii. Breastfeeding woman;  
   iv. Child; and  
   v. Postpartum woman; and

b. Earliest calendar date appointment was requested; and

c. The highest priority applicants (e.g. pregnant woman) must all be given appointments before the second highest priority can be given appointments

Attachments:

References:

Revisions:  
10/2012 Corrected spacing issues
A. **POLICY:**

To be certified as eligible for the WIC Program, applicants shall meet criteria for eligibility in accordance with policies established by the State Agency. In determining eligibility, all applicants must provide proof of identity.

B. **PROCEDURE:**

Local agencies shall require that all applicants provide proof of identity:

A. One of the following documents shall be an acceptable proof of an applicant's identity.

1. Birth registration or birth certificate: Official copy bearing State or Municipal seal; or seal of foreign government or province.

2. Hospital birth record. Usually bears child's footprints, date of birth and signature of physician or registered nurse.

3. Crib card bearing child's name and date of birth.

4. Immunization record (this is the preferred identification for children since it encourages parents to maintain their children's immunization records and is requested to be brought to all certification visits which occur through the second birthday).

5. Baptismal record: Official copy bearing the seal of the issuing church.


7. School identification card.

8. Military records. This may include a military identification card.

10. Driver's license.

11. Age of Majority identification card.

12. Passport, Visa and Health Passport.

13. Immigration or Naturalization record.


15. Medical Assistance Program (MAP) card.

16. Validated Maryland WIC Identification Folder.

17. Any other documentation that establishes the applicant’s identity.

Local agencies shall document the type of proof presented in the management information system.

B. The use of the Proof of Identity Affidavit Form (Attachment 2.23A) is acceptable in exceptional cases where efforts were made to obtain proof of identity but the applicant could not produce such proof. Examples would include the homeless, victims of fire or theft, illegal aliens, or teenagers who were put out of their homes.

C. If an applicant does not provide proof of identity, the local agency shall enter “No Proof” in the Proof of Identity field in the management information system. Local agencies shall allow the applicant up to 30 days after the certification to provide documentation of identity. If documentation is not provided by the end of the 30 day certification, then the participant shall be terminated by the management information system. Participants may have their cert end date restored to the full certification period if documentation is provided before the 30 days has expired. Under no circumstances may a second, subsequent 30 day certification period be used if the applicant fails to provide the required documentation of identity.

Attachments: 2.23A Proof of Identity Affidavit

References: 1. CFR 246.7 (c)(2)(i)
Revisions:
July 2002  Added check pick up appointments to C
April 2008  Added at authorized stores to C.
October 2010  Changed reference from 7 CFR 246.7(k)(2) to 7 CFR 246.7( c)(2)(i)
October 2014  added language about short certs
6/7/2017  Removed VOC as a valid form of ID and added Maryland WIC ID folder to the list rather than written in a paragraph.
MARYLAND WIC PROGRAM
PROOF OF IDENTITY

AFFIDAVIT

I hereby swear that:

__________________________
(print infant/child’s name) is the infant/child which is present for
certification/recertification.

__________________________
(print infant’s name) is the infant which is present for certification.
He/she is an infant of a WIC mother. The mother’s
WIC ID number is ____________________________

__________________________
(print individual's name) does not have any documentation to provide proof
of identity.

I, ________________________
(print name) have not misrepresented my identity to the Maryland
WIC Program.

Signature: ____________________________
A. Policy

To be certified as eligible for the WIC Program, applicants shall meet criteria for eligibility, in accordance with policies established by the State Agency. In determining nutritional risk, the local agency shall first establish the category of applicants according to the following definitions:

1. **Pregnant women** means women determined to have one or more embryos or fetuses in utero.

2. **Postpartum women** means women up to six months after termination of pregnancy.

3. **Breastfeeding women** means women up to one year postpartum who are breastfeeding their infants.

4. **Infants** means persons under one year of age.

5. **Children** means persons who had had their first birthday but have not yet attained their fifth birthday.

B. Procedure

WOW determines participant categories (i.e., woman, infant, child) by using the birth date entered. Local agency staff shall change a participant’s category according to the established WOW procedures.

Although it is desirable that the pregnant applicant presents documented proof of pregnancy, Program regulations do not require documentation as a condition of eligibility. In cases where an applicant’s categorical status as a pregnant woman may not be immediately apparent, the local agency shall ask the applicant to provide proof of pregnancy. However, the applicant should not incur cost to verify pregnancy. If available, local agencies shall refer the pregnant applicant to a clinic where a pregnancy test can be performed without cost to the applicant.
WIC benefits cannot be denied to a pregnant applicant who does not provide documented proof of pregnancy. Local agencies may allow pregnant participants up to 60 days after certification to provide documentation. If documentation is not provided, the participant should be asked to return to be reassessed for: (1) a second 60 day period if the pregnancy is not obvious (e.g. the woman does not look pregnant) with a request that proof of pregnancy be provided; or (2) for a regular certification period if pregnancy is obvious.

References:
1. CFR 246.2 Definitions
2. SFP 92-170
3. CFR 246.7 (c)(2)ii Eligibility Criteria and Basic Certification Procedures

Revisions:
October 2003 – WICWINS References

10/12- Changed 60 days to 30 days for short cert

10/2015 – Changed 30 days to 60 days and clarified referral for free pregnancy testing if available.
A. POLICY.

The intent of the National Voter Registration Act of 1993 is to increase the number of citizens registered to vote and to establish safeguards that ensure a citizen’s right to register to vote. The Act is designed to increase the number of Americans registered to vote by requiring many public agencies, including local agency WIC certification clinics, to provide registration opportunities to their clients or anyone else requesting to be registered to vote.

Local agencies shall provide all individuals applying for WIC Program benefits or the parent/caregiver/designee of individuals applying for WIC Program benefits an opportunity to register to vote at each certification and recertification visit.

Local agencies shall also provide assistance to other individuals who express an interest in registering to vote at any time.

B. PROCEDURE.

The local agency shall:

1. Inform each applicant or the applicant’s parent/caregiver at the initial certification:
   a. “As part of the services of the WIC Program we are offering you the opportunity to register to vote.”
   b. “Applying to register to vote, declining to register to vote, or refusing to complete the Voter Registration Agency Certification section of the Applicants Right and Responsibility form will not affect your participation in the WIC Program.”
   c. “If you are not registered to vote where you now live, would you like to apply to register to vote?”
2. Ask the applicant or the applicant’s parent/caregiver at the initial certification to:
   a. Read or have read to them the Voter Registration Certification form (Attachment 2.25B);
   b. Provide a response to question number 1 on the Voter Registration Agency Certification form and enter the response in the management information system; and
   c. Sign on the electronic signature device as instructed by the local agency staff.

3. For those WIC applicants or parents/caregivers/designees who want to register to vote and other individuals who express an interest:
   a. Give the individual the voter registration application (Attachment 2.25A);
   b. Ask the individual if he/she would like help in completing the voter registration application;
   c. Provide assistance to those individuals who would like help in completing the registration application; and
   d. Ask the individual if he/she would like the WIC Office to mail the completed voter registration application to the local election board.
   e. Individuals who accompany the applicant or the parent/caretaker of an infant or child applicant who express an interest in registering to vote do not need to complete the Voter Registration Agency Certification section of the Applicant’s Rights and Responsibilities form.

4. Local agency staff shall document in the management information system, the applicant or the applicant’s parent/caregiver/designee response to the voter registration questions.

5. Advise the applicant or the applicant’s parent/caregiver/designee that the voter registration applications can be transmitted to the local Board of Elections in one of two ways:
   a. Directly by the applicant; or
   b. By the local agency office.
   An applicant or the applicant’s parent/caregiver may, if he or she chooses, mail the voter registration application directly to the appropriate State
election official rather than returning it to the local agency office for transmittal. The local agency office providing voter registration services is prohibited from requiring registrant to mail the form.

If the local agency mails the completed voter registration application, the local agency shall date stamp each completed card in the two sections the applicant filled in and forward the card within 5 days to the appropriate registration official as listed on the form (Attachment 2.25A). The local agency must provide regular, visible means for collecting voter registration applications.

6. When a clinic serves a significant proportion of non-English speaking applicants or applicants with limited English and many applicants speak the same language, the local agency shall ensure:
   a. That required voter registration information is provided to such persons in the appropriate language orally and in writing; and
   b. That bilingual staff or interpreters are available to assist in completing the voter registration application.

C. ADMINISTRATION.

1. The local agency shall administer the voter registration program by:
   a. Appointing a person to be in charge of, and responsible for, voter registration activities;
   b. Training all employees involved with registration activities; and
   c. Ensuring the accountability of voter registration forms.

2. Local agency staff working on voter assistance activities shall not:
   a. Directly or indirectly seek to influence an applicant’s political preference or party or answer any question regarding party other than he must be enrolled in a party in order to vote in a primary election;
   b. Make any statement to an applicant or take any action the purpose or effect of which is to discourage the applicant from registering to vote; or
   c. Make any such statement to an applicant or take any action the purpose or effect of which is to lead the applicant to believe that a
decision to register or not to register has any bearing on the availability of WIC Program services or benefits.

Attachments:  
2.25A Voter Registration Application  
2.25B Voter Registration Certification form

References:  
National Voter Registration Act of 1993  
State of Maryland House Bill 650

Revisions  
October 1999  
October 2003 WICWINS References  
October 2008 Changed “clinic” to read “certification and recertification in B.1 and B.4 Changed the term “declination form” to “Applicant’s Rights and Responsibilities form” and entered table in B.5  
January 2009 Changed “clinic” to read “certification and recertification in B.1 that failed to be corrected in 10-08  
October 2012 Corrected typo in C.2.c  
October 2013 Revised wording to include the revised Participant Rights and Responsibilities form procedures.
MARYLAND WIC PROGRAM

VOTER REGISTRATION AGENCY CERTIFICATION

1. If you are not registered to vote where you live now, would you like to apply to register to vote here today?

YES _____ NO _____ ALREADY REGISTERED _____

2. IF YOU DO NOT CHECK ANY, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

3. Applying to register or declining to register to vote will not affect the assistance that you will be provided by this agency.

4. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private.

5. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether or register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

   Maryland State Board of Elections
   PO Box 6486
   Annapolis, MD 21401-0486
   800-222-8683

6. If you decline to register to vote, your decision will remain confidential and be used only for voter registration purposes.

7. If you decide to register to vote, information regarding the office to which the application was submitted will remain confidential, again to be used only for voter registration purposes.

Applicant’s Signature: Date:

Applicant Name:
PROGRAMA WIC DE MARYLAND

CERTIFICADO DE LA AGENCIA DE REGISTRO DE VOTANTES

1. ¿Si no está registrado en el lugar donde vive para votar, quisiera registrarse para votar aquí el día de hoy?
   SÍ _____  NO _____  ESTOY REGISTRADO _____

2. SI NO ELIGE NINGUNA OPCIÓN, SE CONSIDERARÁ QUE HA TOMADO LA DECISIÓN DE NO REGISTRARSE AHORA PARA VOTAR.

3. Registrarse o no registrarse para votar, no afectará la ayuda que le proporcionará esta agencia.

4. Si necesita ayuda para completar el formulario de solicitud de registro del votante, le brindaremos nuestra asistencia. La decisión acerca de buscar o aceptar ayuda es suya. Puede completar la solicitud en privado.

5. Si considera que alguien interfirió con su derecho de solicitar o declinar el registro para votar, su derecho a la privacidad para decidir si registrarse o solicitar el registro, o su derecho de elegir su propio partido político u otra preferencia política, puede enviar un reclamo a:

   Maryland State Board of Elections
   PO Box 6486
   Annapolis, MD 21401-0486
   800-222-8683

6. Si decide no registrarse para votar, su decisión será confidencial y se usará solo para fines de registro del votante.

7. Si decide registrarse para votar, la información de la oficina a la cual se envió la solicitud será confidencial, y una vez más se usará solo para fines de registro del votante.

Firma del interesado:      Fecha:

Nombre del interesado:
Policy and Procedure 2.26 was changed to Policy and Procedure 2.34.
A. Policy

1. Local agency staff shall, when scheduling WIC certification appointments, request that parents, legal guardians, or designees of children and infants under age 2 bring the child’s current documented immunization record to the appointment.

2. Local agency staff shall, at the certification appointment, screen the DTaP immunization status of the child using the documented immunization record provided by the parent, legal guardian or designee.

3. Local agency staff shall advise the parent, legal guardian or designee of the apparent immunization status of the child.

4. Local agency staff shall encourage the parent, legal guardian or designee to continue with the current schedule if the immunizations are current.

5. Local agency staff shall advise the parent, legal guardian or designee to contact their health care provider if the record indicates that the child has not had the necessary immunizations or if there is a problem with the timing of the receipt of the immunizations.

6. Local agencies that are housed or have clinic sites in a local health department shall provide aggregate or cumulative information to the local health department's immunization program on a monthly basis regarding the immunization status of all infants and children under age two certified by that agency during that month. In those counties where the local agency is not housed or have clinics in a local health department, this information will be provided to the local health department by the State Agency. Individual immunization information will be shared only if consent has been obtained from the parent or legal guardian.
B. Procedure:

Local agencies shall screen the documented immunization records of all infants and children under age two at each certification appointment in the following manner:

1. At the time that a certification appointment is made for an infant or child under age two, the local agency staff person making the appointment shall ask/remind the parent, legal guardian or designee to bring a documented record of the child’s immunizations with them to the visit. The staff person should tell the parent, legal guardian or designee that bringing the information is not required for application to the program but the information is important in doing the health assessment.

2. During the certification visit, the parent, legal guardian or designee shall be asked to provide the immunization record. The immunization information must be on a documented immunization record signed or stamped by the health care provider. Parental recollection or information written on a piece of paper is not acceptable. If the parent, legal guardian or designee does not present the immunization information, ask them to bring the information to the next certification visit and advise them that provision of the immunization information is not a requirement for application or participation in the program.

3. The local agency staff person assigned to review and screen the record shall enter whether or not a documented immunization record was brought to the clinic, and the dates DTαP immunization (s) were received.

4. The Immunization screen will provide a message that the immunizations are on schedule (Good or OK), or that the child needs to be referred to their health care provider (Due or Refer). If the child appears to be on schedule, congratulate the parent, legal guardian, or designee and encourage them to continue to follow through with timely immunizations. If the child is not on schedule or there are questions regarding the immunizations, make the appropriate referral.

5. If the documented immunization record is difficult to read, select “illegible” from the dropdown under the “Special” column on the Immunizations screen. Ask the parent, legal guardian, or designee to request that the infant or child’s health care provider clarify the dates.

6. All children under age two shall be provided with appropriate educational materials regarding immunizations. At a minimum, this information will contain a recommended immunization schedule such as provided by the CDC or the Maryland Immunization Program. Those infants and children whose status is “due” or “refer” or whose record was “illegible” should be
referred to their health care provider or local immunization program for immunization services. This referral shall be documented in the participant’s record.

7. The parent, legal guardian, or designee should be advised that the Participant Immunization Report, which can be printed from this screen at the local agency’s discretion, cannot be used as a documented immunization record for the child. Also advise the parent or legal guardian that appropriate immunization status and provision or release of immunization information is not a requirement for application or participation in the WIC Program.

References: SFP 01-111

Revisions:

10/01/08 Section B. 3. Changed WOW User’s Manual to read WOW clinic help screen
10/2010 Section B. 4. Clarified role of designee
10/2012 Deleted references to WOW
1/2017 Updates in procedure due to changes in the management information system. Clarified appropriate educational material resource of CDC or Maryland Immunization Program handouts.
A. Policy

When completing the medical assessment of an applicant, local agency staff shall ask the participant/parent or caregiver if the applicant has had a blood lead test to screen for lead poisoning. If it cannot be determined that the test has been performed, the local agency staff shall refer the participant/parent or caregiver to a program where the test can be obtained and offer information regarding the dangers of lead poisoning.

The Maryland Healthy Kids Program Schedule of Preventive Care requires that children receive a verbal lead assessment starting at 6 months of age and repeated at each visit through 5 years of age. A blood lead test is required at the ages of 12 and 24 months.

B. Procedure

1. Staff shall ask the participant/parent or caregiver if the applicant has had a blood lead test. If the response is “no” or “don’t know,” staff shall:

For women applicants:
- Offer the Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children and direct her to discuss any positive responses with her health care provider.

For infant and children applicants:
- Explain why children may need a blood test for lead;
- Offer the Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children and direct the parent or caregiver to discuss any positive responses with the child’s health care provider;
- Recommend that the caregiver inquire about the blood lead test at the child’s next scheduled health care appointment;
- Provide information about MCHP if the child has no source of health care;
- Provide supplemental information about childhood lead poisoning; and
• Document in the child’s record that the caregiver was encouraged to discuss the blood lead test with the health care provider and that information about childhood lead poisoning was provided.

2. Staff may provide information about the importance of the blood test and the dangers of lead poisoning by:

• Highlighting the message about the need for a blood lead test in the Help Me Be Healthy pamphlets for children aged 12 and 24 months to remind caregivers to discuss the issue with their child’s health care provider.

• Both the Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children and the Help Me Be Healthy pamphlets are available through the Maryland WIC Distribution Center.

3. If the woman or child has had a blood test for lead and the test result is known, staff shall enter the blood test result in the Medical Screen of the participant.

Attachments: 2.28 A Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children

Reference: WIC Final Policy Memo 2001-1
SFP 93-113 WIC’s Role in Screening for Childhood Lead Poisoning

Revisions:
10/2011  Updated MDE website
10/2012  Updated MDE website
01/2018  Removed MDE website; Updated procedure to include screening of women applicants and added attachment A
Maryland WIC Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children

**Lead Poisoning**

You and your children can get lead poisoning by breathing in or swallowing dust that contains lead.

### Sources of Lead

**Home**
- Lead can be in paint in old homes built before 1978.
- Chipped paint
- Old furniture and toys
- Dust
- Pewter/Crystal
- Play or costume jewelry

**Imported Goods**
- Items brought back from other countries may contain lead.
  - Glazed pottery
  - Mexican Candy (tamarindo and chile)

**Homo Remedies**
- Some home remedies may contain lead.
  - Traditional and folk remedies
  - Garlic, Azarcon, Foy, loo-sha

**Beauty Products**
- Imported beauty products from Asia, India, and Africa may contain lead.
  - (Ghawran, Khol, Kajal, Suma)

**Jobs**
- Jobs such as car repair, mining, construction, and plumbing may increase your exposure to lead. Lead dust can be brought into the home on your skin, clothes, shoes or other items you bring home from work.
  - Car Batteries
  - Scrap metal parts
  - Ammunition

**Hobbies**
- Certain hobbies increase your risk of coming in contact with lead.
  - Hunting (lead bullets)
  - Fishing (lead sinkers)
  - Artist paints
  - Refinished furniture

**Travel**
- Traveling outside the U.S. may increase your risk of coming in contact with lead-based items.
  - Souvenirs
  - Toys
  - Spices or food
  - Jewelry

### Cleaning

- Wash hands
- Keep shoes outside
- Mop & wet wipe
- Use a vacuum with a filter
- Wash toys

### Nutrition

- These foods can help lower your lead level.
  - Vitamin C
    - Tomatoes
    - Strawberries
    - Oranges
    - Potatoes
  - Calcium
  - Milk
  - Choose Yogurt
  - Iron
  - Chicken
  - Steak
  - Fish
  - Peas
  - Eggs

Adapted from a document produced by the Arizona Department of Human Services.
Maryland WIC Lead Risk Assessment Tool for Pregnant or Breastfeeding Women and Children

If you answer “Yes” or “Don’t Know” to ANY of the questions or have concerns about lead, please discuss them with your health care provider. A blood lead test may be needed.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you or your child/children eat any nonfood items, such as clay,</td>
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<tr>
<td>crushed pottery, soil, paint chips, paper, or baking soda?</td>
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<td>2. Does your child often put items such as jewelry or keys in his/her</td>
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<tr>
<td>mouth?</td>
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<td>3. Have you or your child/children ever lived in or often visited a</td>
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<tr>
<td>home or building built before 1978 with peeling or chipping paint or</td>
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<td>that has been repaired?</td>
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<td>4. Have you or your child/children ever spent a lot of time outside the</td>
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<td>United States?</td>
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<td>5. Do you use products from other countries such as health remedies,</td>
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<tr>
<td>spices, or food?</td>
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<tr>
<td>Do you use traditional “kohl” make up? (also known as “kajal” or “kuul”)</td>
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<td>6. Do you serve or store food in lead crystal, handmade or imported</td>
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<td>pottery, or pewter?</td>
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<td>7. Have any of your children, their playmates, or others in your home</td>
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<td>had lead poisoning?</td>
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<td>8. Do you have a child who was born before January 1, 2015, who has</td>
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<td>not had a blood lead test?</td>
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<td>9. Do you or others in your household have a job that involves exposure</td>
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<td>to lead, like auto repair, plumbing, painting, ship building, steel</td>
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<tr>
<td>welding, battery, glass, or lead manufacturing, or work with lead</td>
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<td>bullets?</td>
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<tr>
<td>Do your children have contact with an adult whose job or hobby involves</td>
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<tr>
<td>exposure to lead?</td>
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<td>10. Do you or others in your household have hobbies or activities likely</td>
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<td>to cause regular exposure to lead, like making stained glass,</td>
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<td>pottery, fishing lures or sinkers, gun and rifle activities, refinishing</td>
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<td>furniture, renovating or remodeling homes?</td>
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<td>11. Do you or your children live near an active lead smelter, battery</td>
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<td>recycling plant, other lead-related industry, or near a road where</td>
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<td>soil and dust may be contaminated with lead?</td>
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<tr>
<td>12. Do you eat deer meat or other animals shot with lead bullets?</td>
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<tr>
<td>13. Do you have any bullets in your body from past gunshot wounds?</td>
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</tbody>
</table>

Adapted from the 2016 Maryland Guidelines for the Assessment and Management of Childhood Lead Exposure. Maryland Department of Health and Mental Hygiene, and the Minnesota Department of Health.
Policy and Procedure 2.29 has been removed.
Policy and Procedure 2.30 has been removed.
A. **Policy**

To be certified as eligible for the WIC Program, an applicant who meets the categorical, residency and income eligibility requirements shall also be assessed for nutritional risk. Nutritional risk assessment shall include the collection and evaluation of relevant information to determine the presence of risk factors and to provide the most appropriate nutrition services.

B. **Procedure**

1. **To perform a nutritional risk assessment of applicants/participants, the local agency shall:**

   a. Obtain and evaluate relevant information that includes:

      - Height (or length) and weight measurements, as described in Policy and Procedure 2.32;
      - Hemoglobin or hematocrit test results, as described in Policy and Procedure 2.33; and
      - Nutrition and health information, as described in Policy and Procedure 2.34.

   b. Enter the data obtained from 1.a. into the applicant’s WOW record to document and generate nutrition risk factors.

   c. Review all WOW-generated risk factors to ensure that they are correct based on accurate data entry.

   d. Document each risk factor in the applicant’s WOW record.

   e. Use the results of the nutritional risk determination to provide the most appropriate nutrition education messages and to make referrals.
Attachments:

2.31A Nutritional Risk Criteria: Guidelines for Interpretation

References:
1. 7 CFR 246.7 (e)
2. COMAR 10.54.01.06 C (2)
3. WIC Policy Memorandum 98-09, Revision 9
4. WIC Nutrition Services Standards, Standard 7
5. SFP 06-056 Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy
6. SFP 09-057 WIC Policy Memorandum 98-9, Revision 10: Nutrition Risk Criteria

Revisions:

10/10 Renumbered Attachment 2.31 B as 2.31A
   Revised new Attachment 2.31A as follows:
   Women: Deleted Table WP. Changed Table WN to Table N. Revised definitions of Gestational Diabetes, Diabetes, and Fetal Growth Restriction. Added new risks: History of Preeclampsia, Hypertension/Prehypertension, Post Bariatric Surgery, and Pre-Diabetes.

   Renumbered attachment 2.31C as 2.31B
   Revised new Attachment 2.31B as follows:
   Women: Changes were made to Underweight, Overweight, Low Maternal Weight Gain, High Maternal Weight Gain, Hx Gestational Diabetes, Multi-fetal Gestation, Gestational Diabetes, Diabetes Mellitus, GI Disorders, and in Nutrition Practices, the amount of iron was reduced.

   Women: Risk codes were added for new conditions including History of Preeclampsia; Hypertension/Prehypertension; Pre-Diabetes; in GI Disorders, Post Bariatric Surgery, and in Nutrition Practices, requiring an iodine supplement.

   Infants and Children: changes were made to diabetes mellitus, GI disorders, and Hypertension/Prehypertension. In Nutrition Practices, the following risks were added: Eating unapproved local fish, not giving appropriate fluoride and/or vitamin D supplements.

   Deleted Table WP: Weight Status of Pregnant Women
   Changed Table WN: Weight Status of Breastfeeding and Postpartum Women to Table W: Weight Status of Pregnant, Breastfeeding and Postpartum Women.
   Revised Table H: High Maternal Weight Gain to meet new weight guidelines.
   Changed reference from 7 CRF 246.7(d) to 7 CFR 246.7(e)

01/12 Combined Attachments A and B
   Revised Attachment A as follows:
   Women: Added two thyroid conditions. Added contact information for metabolic dietitians to Inborn Errors of Metabolism.
Infants and Children: changed cut off values for Underweight/At Risk of Underweight, Obese, Overweight/At Risk of Overweight, Short Stature/At Risk of Short Stature, Low Head Circumference. Added new risk: High Weight for Length. Changed risk names to reflect cut off values. Added two thyroid risks. Added contact information for metabolic dietitians for Inborn Errors of Metabolism.

10/13 Attachment 2.31A: Provided more background information on the following risks: Lactose Intolerance, Food Allergies, Celiac Disease, and Failure to Meet Dietary Guidelines. Added Recipient of Abuse.

10/14 Attachment 2.31A, made the following Procedure changes. Risk condition Breastfeeding Mother of Infant at Nutritional Risk: Changed “If the infant is certified before the breastfeeding mother, this risk criterion may be assigned to the woman” to “This risk criterion shall be assigned to a breastfeeding mother of an infant at nutritional risk;”and “Refer participants whose infants have been identified with any risk criteria below to the breastfeeding specialist” to “Refer participants….to the breastfeeding specialist and to the CPA for Nutrition Care counseling.”

Risk condition Breastfeeding Infant of Mother at Nutritional Risk: Changed "If the breastfeeding mother is cert..." to “This risk criterion shall be assigned to the breastfeeding infant of a mother at nutritional risk.”

05/16 Attachment 2.31A updated Nutrition Risk Criteria related to clarify medical conditions and risk criteria definitions.

10/16 Changed the high risk blood lead level to 5 micrograms/dl for both women and children. Added Breastfeeding Complications or Potential Complications to pregnant woman high risk list and Breastfeeding Mother of Infant at Nutritional Risk to both pregnant woman and breastfeeding high risk lists. Removed Inadequate Growth risk from both infants and children.

11/17 Revised Attachment 2.31A Nutritional Risk Criteria to clarify medical conditions and risk criteria definitions and background information.
Nutritional Risk Criteria:
Guidelines for Interpretation
Nutritional Risk Criteria: Guidelines for Interpretation contains all of the allowed nutritional risk criteria that may be applied when determining nutritional risk eligibility of women, infants, or children who apply for WIC Program benefits. No additional risk criteria may be used.

Each risk criterion is listed with its definition or cut-off value, justification, WOW code number, and participant category or categories to which it applies. Risk criteria that require nutrition care counseling or referral to a breastfeeding specialist are identified. Guidance is included for the evaluation of each risk criterion and participant focused counseling goals are included. If additional guidance is needed regarding the applicability of a risk criterion, State Agency Nutrition or Breastfeeding Services staff should be consulted.

Tables include information and procedures used to evaluate specific risk criteria.

Frequently Asked Questions address common questions to assist certifiers in assigning specific risk criteria appropriately.

Nutritional risk documentation is required by Federal WIC regulations. Each participant record must document the specific nutritional risk condition(s) for which the applicant was found eligible to receive Program benefits. Appropriate documentation must be included in the record to substantiate the condition(s) and to validate conformance with the definition of the condition(s). Some nutritional risk criteria permit the applicant or caregiver to self report that the applicant has a condition diagnosed by a physician. A self-reported diagnosis should prompt the CPA or CPPA to validate the presence of the condition by asking more pointed questions related to the diagnosis.

Definitions
In order to ensure consistency in determining nutritional risk eligibility across the State, the following definitions should be applied during the applicant’s evaluation:

Date of Conception: Occurs on the 14th day following the onset of the last menstrual period (LMP).

Trimester:  
- First trimester = conception through completed week 13 of gestation.  
- Second trimester = week 14 through completed week 26 of gestation.  
- Third trimester = week 27 through completed week 40 of gestation.

Week of gestation: The last completed week of gestation as estimated by use of a State WIC issued gestation wheel.

Routine: A feeding, dietary, or lifestyle practice that currently occurs on more than one occasion.
Priority Levels

To be considered at nutritional risk, an applicant must exhibit at least one of the nutritional risk criteria listed in this attachment. Risk criteria fall into one of six priority levels:

**Priority I**  
A pregnant or breastfeeding woman or an infant with a condition identified by anthropometric measurements (1) or hematological (2) measurements; a nutrition-related medical condition; a current or recent pregnancy complication; substance abuse; a breastfeeding woman or breastfed infant with a breastfeeding complication; a breastfeeding woman whose infant has a Priority I risk or breastfed infant of a mother with a Priority I risk.

**Priority II**  
An infant less than 6 months of age whose mother was in WIC while pregnant or was eligible with a Priority I risk; a breastfeeding woman whose infant has a Priority II risk.

**Priority III**  
A child or postpartum, non-breastfeeding woman with a condition identified by anthropometric (1) or hematological (2) measurements; a nutrition-related medical condition; a recent pregnancy complication.

**Priority IV**  
A pregnant or breastfeeding woman or infant with a diet-related risk; homelessness or migrant farm worker status; a breastfeeding woman whose infant has a Priority IV risk or breastfed infant of a mother with a Priority IV risk.

**Priority V**  
A child with a diet-related risk; homelessness or migrant farm worker status.

**Priority VI**  
A postpartum non-breastfeeding woman with a diet-related risk; dental problem; homelessness or migrant farm worker status.

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1 Height or weight measurements. Examples include underweight, overweight, short stature, low maternal weight gain.
2 Hemoglobin or hematocrit test result.
Maryland WIC Program Scope of Practice – based on USDA WIC Nutrition Services Standards, August 2013.

Definitions

Scope of Practice - Encompasses a staff position’s range of unique roles and activities in the provision of information, counseling and support to WIC participants. Each staff position’s scope of practice is defined by the required qualifications and job-specific responsibilities for that position.

High Risk – A designation of a participant based on the nutrition risk condition(s). Criteria for a participant being designated “high risk” are based on State agency policy. The nutrition services associated with “high risk” includes an individual care plan, more frequent nutrition education contacts and the provision of nutrition services by a registered dietitian (or other professional).

Nutrition Services Staff

Standard 3 Staff Qualifications, Roles and Responsibilities

Section G. The local agency ensures that the Competent Professional Authority (CPA) has all of the following qualifications:

1. Is a physician or nutritionist (Master’s or Bachelor’s degree in Nutritional Sciences, Community Nutrition, Clinical Nutrition, Dietetics, Public Health Nutrition or Home Economics with emphasis in Nutrition), dietitian, registered nurse, physician’s assistant certified by the National Committee on Certification of Physician’s Assistants or certified by the State medical certifying authority, or a State or local medically trained health official.
2. Has successfully completed a competency based training program on performing the duties of a CPA.
3. Has literacy and language skills appropriate to address the needs of diverse participants.

Section H. The local agency ensures that the CPA performs the following roles and responsibilities within a participant-centered framework to meet participant needs:

1. Assesses and documents a participant’s risk(s).
2. Prescribes food packages.
3. Provides nutrition education, including breastfeeding promotion and support that is responsive to the identified needs/interests of each participant.
4. Identifies the need for individual care plans.
5. Refers participants to other health and social services and provides appropriate follow-up to referrals.
6. Implements individual care plans for low-low risk participants.
7. When the CPA is a qualified nutritionist, implements individual care plans for high-risk participants, otherwise, identifies and refers high-risk participants to a qualified nutritionist.
8. Documents nutrition services provided, including referrals and follow-up to referrals.
9. Ensures that screening and referrals for lead testing and immunizations using a documented immunization record is performed.

Section M. The local agency has access to a qualified nutritionist to provide nutrition services to high-risk participants. The nutritionist has the following qualifications:

1. Has successfully completed a training program approved by the State agency on the provision of WIC nutrition services to high-risk participants AND
2. (Preferably) has credentials of a Registered Dietitian (R.D.) or eligible for registration with the Academy of Nutrition and Dietetics’ Commission on Dietetic Registration; if applicable, has State license or certified as a nutritionist/dietitian OR
3. Holds a Bachelor’s degree in the field of nutrition from an accredited college or university OR
4. Holds a Master’s or Doctoral degree in nutrition from an accredited college or university.

**Maryland WIC Policy 5.03**

A Care Plan including referral documentation, if appropriate, shall be generated by a CPA for a participant with one or more of the criteria below shall be considered as at high nutritional risk.

Pregnant, Breastfeeding, or Postpartum Woman:
- Alcohol or illegal drug use
- Birth defect, limited to delivery of an infant with a neural tube defect or cleft palate
- Gestational diabetes (GDM)/History of gestational diabetes
- History of Preeclampsia
- Hypertension/prehypertension
- Post Bariatric Surgery
- Vegan or fasting diet
- Lead poisoning: blood lead level at or above 5 micrograms per deciliter
- Low Hemoglobin/Hematocrit, limited to hemoglobin less than 10 g/dl or hematocrit less than 30 percent
- Medical condition, nutrition-related

Pregnant Woman:
- Fetal growth restriction
- Hyperemesis gravidarum
- Multi-fetal gestation
- Underweight and current weight loss or inadequate weight gain
- Breastfeeding complication(s) or potential complication(s)
• Breastfeeding mother of infant at Nutritional Risk

Breastfeeding Woman:
• Breastfeeding complication(s) or potential complication(s)
• Breastfeeding Mother of Infant at Nutritional Risk

Infant or Child
• Failure to thrive
• Fetal Alcohol Syndrome (FAS)
• Lead poisoning: blood lead level at or above 5 micrograms per deciliter
• Low Hemoglobin/Hematocrit, limited to hemoglobin less than 10 g/dl or hematocrit less than 30 percent
• Medical condition, nutrition related

Infant:
• Breastfeeding complication(s) or potential complication(s)
• Low birth weight or prematurity (born at less than 37 completed weeks of gestation)
• Small for Gestational Age (SGA)
• Underweight: weight for length at or below the 2.3\textsuperscript{rd} percentile

Child:
• Underweight: weight for height at or below the 5\textsuperscript{th} percentile
• Hypertension/prehypertension

WOW identifies as \textit{High Risk (Nutrition Care)}, only those participants with the above criteria. However, local agencies may expand the criteria to include others, such as overweight children or pregnant adolescents.

High risk services shall be performed by a qualified Competent Professional Authority, preferably a licensed dietitian/nutritionist.
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Alcohol Use or Any Illegal Drug Use

Categories: PG, BE/BP, WPP

Defined as:

- **Pregnant Woman**: any alcohol or illegal drug use
- **Breastfeeding or Postpartum Woman**: alcohol use as defined below or any illegal drug use

A woman identified with alcohol or illegal drug use should have Nutrition Care counseling.

**Best Practice**: provide Nutrition Care follow-up in 3-6 months.

**Breastfeeding is contraindicated for women identified with this risk criterion.**

**Justification:**

Drinking alcoholic beverages during pregnancy can damage the developing fetus and result in a reduced growth rate of the fetus, low birth weight, birth defects, mental retardation, and Fetal Alcohol Syndrome. Since there is no safe level of alcohol consumption during pregnancy, a pregnant woman should not drink. Excessive alcohol can also lead to nutritional deficiencies in the woman as well as liver disease and certain types of cancer.

Drug use during pregnancy can result in stillbirth, miscarriage, low birth weight, and fetal abnormalities, especially of the central nervous system. Growth retardation, behavioral problems and cognitive deficits caused by the mother’s drug use may occur.

Drugs and alcohol appear in human milk and exert chemical effects in the infant. Lethargy and decreased feeding are known to occur following exposure.

The WIC Program has a mandate to provide information about the dangers of substance abuse to all newly certified participants or their caregivers and to provide referral information regarding substance abuse counseling and treatment to all pregnant and breastfeeding or postpartum women. A woman who is pregnant may be receptive to supportive counseling that encourages her to avoid substances that can harm her fetus.

The substance-abusing woman should be encouraged to seek treatment and be given information about substance abuse programs in her community.
Procedure:

Assess alcohol intake and drug use:

- **For a pregnant woman,** ANY use
- **For a breastfeeding or postpartum woman,** alcohol use is defined as:
  - Routine current use of 2 or more drinks* per day; or
  - Binge drinking, 5 or more drinks* on the same occasion on at least 1 day in the past 30 days; or
  - Heavy drinking, 5 or more drinks* on the same occasion on 5 or more days in the previous 30 days

* One serving or standard size drink is:

  - 1 can beer (12 fluid ounces);
  - 5 ounces wine; or
  - 1/2 fluid ounces liquor (1 jigger gin, rum, vodka, whiskey (86 proof), vermouth, cordials, or liqueurs).

To interpret abuse of over-the-counter or prescription medications, refer to **Medical condition, nutrition-related, Drug-Nutrient Interactions.**

A woman undergoing **methadone** treatment may be certified with this risk criterion as “Illegal Drug Use.”
Breastfeeding Complications or Potential Complications - Woman

(6021) Categories: BE/BP, PG

Defined as: A breastfeeding woman with any of the complications or potential complications for breastfeeding below.

Refer a woman identified with breastfeeding complications or potential complications to the breastfeeding specialist.

Best Practice: see participant immediately; if not possible, within five days.

Justification:

Breastfeeding complications or potential complications can result in inadequate intake and/or Failure to Thrive in the infant. Complications can also cause the mother to produce a lower milk supply. Severe engorgement, often caused by infrequent or ineffective nursing, can create problems such as poor latch-on and pain and may result in a diminished milk supply. A clogged duct results from incomplete emptying of the breast.

Failure of milk to come in by 4 days postpartum could result from maternal illness or perinatal complications. Persistent nipple pain, cracks, and bleeding are symptomatic of incorrect positioning or infection. Impaired milk flow can lead to a diminished milk supply and inadequate intake by the infant. Latch-on by the infant can be difficult when nipples are flat or inverted, but can be corrected by appropriate interventions. Mastitis is a breast infection causing a flu-like illness that can threaten the health of the mother as well as the success of breastfeeding. Medical treatment is necessary.

The woman over 40 years of age may be at risk of a reduced milk supply as a result of breast changes. Tandem nursing may increase the nutritional requirements of the mother. Care must be taken to ensure adequacy of breast milk.

Procedure:

Determine if the woman has any of these complications or potential complications:

- **severe breast engorgement**—review positioning, engorgement and breast soreness.
- **recurrent plugged ducts**
- **failure of milk to come in by 4 days postpartum**—review feeding frequency, duration, and building up milk supply.
- **cracked, bleeding, or severely sore nipples**—review positioning and latch-on. Discuss use of breast shells and/or breast pumps, as appropriate.
- **flat or inverted nipples**—review positioning and latch-on. Discuss use of breast shells and/or breast pumps, as appropriate.
- **mastitis**—advise the mother to continue breastfeeding and to seek the advice of her health care professional.
- **age 40 years or older**—review signs of getting enough milk and building up milk supply.
- **tandem nursing** (breastfeeding siblings who are not twins) -- check adequacy of weight gain for both children. Review feeding routine to check that one sibling is not taking the supply of milk from the infant who requires breast milk as his source of nutrition.

Refer to the *Maryland WIC Breastfeeding Kardex* for information about the complications above.
Breastfeeding Complications or Potential Complications – Infant
(6031)  Categories: IBE/IBP

Defined as: A breastfed infant with any of the complications or potential complications for breastfeeding listed as “a” through “e” below.

An infant with breastfeeding complications or potential complications should be referred to the breastfeeding specialist. Best Practice: see participant immediately; if not possible, within 5 days.

Justification:
- Breastfeeding complications or potential complications can result in inadequate intake and/or Failure to Thrive in the infant. Complications can also cause the mother to produce a lower milk supply.
- A weak or ineffective suck may be due to prematurity, sleepiness, or a medical or physical problem and can result in inadequate breast milk intake and a diminished milk supply in the mother.
- Difficulty with latch on may be due to maternal nipple conditions or positioning.
- Inadequate urination or stooling may be an indicator of an inadequate intake of breast milk. The infant is at risk of Failure to Thrive and the mother, of a diminished milk supply.
- Jaundice occurs when bilirubin accumulates in the blood and the skin or whites of the eyes take on a yellowish color. Jaundice can be caused by a variety of reasons, which range from normal physiologic processes to true medical problems. Sometimes early jaundice is caused by inadequate breast milk feeding and can be overcome by frequent breast milk feedings. It is best to refer individuals with jaundice to their health care professionals who can determine the cause and recommend treatment.

Procedure:
Using collected information, determine if the breastfed infant has any of these complications or potential complications for breastfeeding:
- weak or ineffective suck—review positioning, getting baby attached to the breast, and waking a sleepy baby.
- difficulty latching on to the breast—review positioning and getting baby attached to the breast.
- less than 6 wet diapers per day
- inadequate stooling (for age as determined by a physician or other health care professional)
- jaundice—determine what the health care professional has recommended. Refer the caregiver to the infant’s health care professional if the infant has not been seen for this condition.

Refer to the Maryland WIC Breastfeeding Kardex for information about the complications above.
Breastfeeding Infant of Mother at Nutritional Risk
(7021) **Categories: IBE/IBP**

Defined as: Breastfeeding infant of mother at nutritional risk.

**Justification:**

A breastfed infant is dependent upon the mother’s milk as the primary source of nutrition. Special attention should, therefore, be given to the health and nutritional status of the mother.

**Procedure:**

This risk criterion shall be assigned to the breastfeeding infant of a mother at nutritional risk. The priority level of the risk criterion is based upon the mother’s priority, I or IV.

**Refer breastfeeding mothers with any of the risk criteria below to the breastfeeding specialist and the CPA for Nutrition Care counseling:**

- Underweight
- Low Hemoglobin/Hematocrit
- Elevated Blood Lead
- Breastfeeding Complications/Potential Complications
- Pregnant Woman Currently Breastfeeding
- Alcohol or Illegal Drug Use
- Maternal Smoking
- Medical Condition, Nutrition-Related

Review collected information before providing counseling. Refer to the *Maryland WIC Breastfeeding Kardex*.

**Participant Focused Counseling:**

- The mother of a breastfed infant can:
  - State the eating, feeding, and lifestyle practices she can follow to promote optimal health, growth, and development.
  - State strategies to follow as her infant grows and circumstances change, to ensure breastfeeding success.
Breastfeeding Mother of Infant at Nutritional Risk

(6011) Categories: BE/BP, PG

Defined as: A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk. Mother must be at same priority as at-risk infant.

Justification:
A breastfed infant is dependent upon the mother’s milk as the primary source of nutrition. Special attention should be given to the health and nutritional status of the mother. The interconceptional period is an opportune time to assist the woman in adopting healthful dietary and lifestyle practices.

Procedure:
This risk criterion shall be assigned to a breastfeeding mother of an infant at nutritional risk. The priority level of the risk criterion is based upon the infant’s priority, I, II, or IV.

Refer participants whose infants have been identified with any risk criteria below to the breastfeeding specialist and to the CPA for Nutrition Care counseling:

- Underweight
- Inadequate Growth
- Failure to Thrive
- Low Hemoglobin/Hematocrit
- Elevated Blood Lead
- Breastfeeding Complications/Potential Complications
- Medical Condition, Nutrition Related
- Low Birth Weight
- Prematurity
- Small for Gestational Age

Review dietary and lifestyle practices. Refer to the Maryland WIC Breastfeeding Kardex.

Participant Focused Counseling: The breastfeeding mother can state the food and lifestyle choices she can make to promote optimal health for herself and her breastfed infant.
Complementary Feeding Process
(4281) Categories: IBE, IBP, IFF, C-1

Defined as: An infant or child who has begun to or is expected to begin to 1) consume complementary foods and beverages, 2) eat independently, 3) be weaned from breast milk or infant formula, or 4) transition from a diet based on infant/toddler foods to one based on the Dietary Guidelines for Americans is at risk of inappropriate complementary feeding.

Justification:

Complementary feeding is the gradual addition of foods and beverages to the diet of an infant and young child. The process of adding complementary foods should reflect the physical, intellectual, and behavioral changes as well as the nutrient needs of the infant or child. Caregivers may not recognize signs of developmental readiness and may offer foods and beverages that are inappropriate in type, amount, consistency, and/or texture.

To manage the process of complementary feeding successfully, caregivers must make decisions about what, when, where, and how to offer foods according to the child’s:

- Energy and nutrient requirements;
- Fine, gross, and oral motor skills;
- Emerging independence and desire to learn to self-feed; and
- Need to learn healthy eating habits through exposure to a variety of nutritious foods.

Procedure:

This risk factor may be assigned only to infants and children from 4 through 23 months and for whom a complete nutrition assessment has been performed and for whom no other risk is identified.

Participant Focused Counseling:

Anticipatory guidance is the focus of the session. The caregiver can state the stage-appropriate feeding practices she can follow that promote optimal health, growth, and development of her child.
**Depression**

*(3611) Categories: PG, BE/BP, WPP*

Defined as: Presence of clinical depression, including postpartum depression, diagnosed, documented, or reported by a physician, clinical psychologist, or someone working under a physician’s orders, or as self-reported by applicant/participant/caregiver.

A participant identified with depression should have Nutrition Care counseling.

**Best Practice: Provide Nutrition Care follow-up in 3-6 months.**

**Justification:**

Depression is common during pregnancy, especially the last trimester. Women who experience depression during pregnancy are less likely to seek prenatal care. They may also suffer from episodes of nausea/vomiting or initiate/increase the use of drugs, alcohol and nicotine. They are at risk for preeclampsia, preterm delivery or delivery of low birth weight infants, and have higher perinatal mortality rates.

Depression among pregnant adolescents is almost twice as high as among their adult counterparts and non-pregnant adolescents, because the physiologic and psychological changes of pregnancy are superimposed on the normal developmental changes of adolescence. Teens who are under stress, lack social and/or family support, experience significant loss, or have attention, learning, or conduct disorders are at greater risk for developing clinical depression. Depression in young people often occurs with mental disorders, substance abuse disorders, or physical illnesses, such as diabetes. They are more likely to delay or refuse prenatal care and have subsequent short-interval pregnancies (within 24 months) and poor pregnancy outcomes.

**Postpartum depression** is related to the influence of reproductive hormones on stress hormones, immune markers, or sleep quality, and lasts longer than “baby blues” which peak four to five days after delivery, and resolve by the 10th postnatal day.

**Breastfeeding is protective of maternal mood.** Breastfeeding reduces the stress responses commonly found in the post-partum period. The hormones associated with lactation, oxytocin and prolactin have both antidepressant and anxiolytic (anti-anxiety) effects. (However, breastfeeding problems like nipple pain can increase the risk of depression and should be addressed promptly.)

**Breastfeeding mothers may experience more restful sleep.** It is well documented that new mothers experience sleep disturbances, independent of their feeding choices. This lack of sleep can lead directly to an increase in inflammation and increase in maternal stress, which can lead to depression in the early postpartum period. Several small studies showed that breastfeeding mothers actually get more sleep than their bottle/formula-feeding counterparts.
**Procedure:**
During the nutrition assessment, be sensitive to the questions related to depression. If the woman responds affirmatively about feelings that have lasted more than two weeks, encourage follow-up with her health care provider, other resources available in the local area, and/or reliable resources on line (see below).

**Participant Focused Counseling:**

Awareness of a mother’s mental health status can assist the WIC nutrition professional in providing individualized breastfeeding support. Depressed mothers should be encouraged to continue breastfeeding as it can protect infants from the harmful effects of maternal depression. Additionally, if breastfeeding is going well, it may assist in a mother’s recovery from depression.

Nutrition issues that should be discussed:

- Eating a healthy diet. Research has identified likely links between nutrient deficiency and mood for folate, vitamin B-12, vitamin D, calcium, iron, selenium, zinc, and Omega-3 fatty acids
- Asking her health care provider about omega-3 fatty acid supplements
- Being physically active. Exercise is anti-inflammatory and boosts mood. Routine exercise helps individuals with depression lower inflammation over time and is a positive coping strategy for stress. Exercise can help boost mood in the short term, but it is the cumulative impact of regular exercise that can stave off depression significantly.
- Getting enough sleep
- Referrals for counseling care. The following are web-based resources for State and local agencies to locate reliable services:
  - The *Substance Abuse and Mental Health Services Administration* (SAMHSA) Mental Health Treatment Locator is found at [http://www.samhsa.gov/](http://www.samhsa.gov/) and provides comprehensive information on mental health resources and/or facilities. This website provides informational materials about different mental health conditions. The SAMHSA's National Helpline is also available 24-hour-a-day, 365-day-a-year to provide referrals to local support networks and resources for individuals dealing with mental health issues or substance abuse problems at 1-800-662-HELP (4357).
  - *MentalHealth.gov* provides one-stop access to U.S. government mental health information and resources from the *Centers for Disease Control and Prevention*, *FindYouthInfo.gov*, *MedlinePlus* and *National Institutes of Health*, National Institute of Mental Health (NIMH) and *SAMHSA*. Resources are available for the general public, health and emergency preparedness professionals, policy makers, government and business leaders, school systems and local communities.
  - *Mental Health America's* website can be used to help individuals locate mental health treatment services, including affordable treatment for those without insurance, in their community. This website also includes links to other sites that provide specialized treatment referrals for specific illnesses and information about the specific illness.
Elevated Blood Lead  
(2111) Categories: All

Defined as:
Blood lead level (BLL) of ≥ 5 μg/deciliter within the past 12 months.*
*Current Centers for Disease Control and Prevention reference value.

A participant who has a venous blood lead level of ≥ 5 ug/dl or higher should have Nutrition Care counseling.

Best Practice: see participant immediately; if not possible, within five days. Provide Nutrition Care follow up in one month.

Each pregnant or breastfeeding women should be offered the Lead Screening Tool and directed to discuss any positive responses with her health care provider.

Justification:

Infants and children:
Elevated blood lead is most common in children, especially those living in low income, migrant, or new refugee households, because children absorb lead more readily than adults and their developing nervous system is particularly vulnerable to the effects of lead. Elevated blood lead levels in children have been associated with decreased IQ, academic failure, and behavioral problems. CDC recommends blood lead screening for all children at high risk for elevated BLLs with follow-up screening within 12 months.

Pregnant women:
Lead poisoning in a pregnant woman results in lead crossing the placenta and can have a harmful effect on the fetus.

Causes:
- Pica (eating nonfood substances persistently for a month or more) including
  - soil, clay, ice, starch, baking powder, chalk and paint.
  - lead containing items, such as lead-contaminated soil and pottery
Cultural practice:
- Africa, Asia, and Central America.
- In the US, more frequently in the South and in immigrant populations.
- In areas of the U.S. where pica is viewed negatively, women may not admit to engaging in these practices thus, it places the pregnant woman and her fetus at risk.

**Breastfeeding women:** Lead can be passed to the infant through breast milk.

Key Recommendations for Initiation of Breastfeeding:
- Mothers with BLLs < 40 μg/dL should breastfeed.
- Mothers with confirmed BLLs ≥ 40 μg/dL should begin breastfeeding when their blood lead levels drop below 40 μg/dL. Until then, they should pump and discard their breast milk.

Key Recommendations for Continuation of Breastfeeding (2):
- Breastfeeding should continue for all infants with BLLs below 5 μg/dL.
- Infants born to mothers with BLL ≥ 5 μg/dL and <40 μg/dL can continue to breastfeed unless there are indications that the breast milk is contributing to elevating BLLs.

**Procedure:**
When a participant has been diagnosed with lead poisoning:
- Evaluate iron status, as iron deficiency anemia and elevated blood lead frequently occur together.
- Evaluate calcium intake: Inadequate dietary calcium intake generally affects lead absorption. Results from some studies indicate that dietary calcium (when consumed at Adequate Intake levels) competitively inhibits lead absorption.
- Evaluate vitamin C intake: The antioxidant, vitamin C, has been shown to have natural chelating properties, enhancing the urinary elimination of lead from the body.
- Review lifestyle/dietary habits that explain or contribute to lead exposure, including:
  - Eating dirt, clay, or other non-foods (pica)
  - Review eating habits for protective nutrients: regular meal times, foods rich in iron, calcium, and vitamin C
Nutrition Education:
- Adequate intake of calories and nutrients such as calcium, iron, and zinc help protect against lead uptake.
- Certain housekeeping practices can minimize the risk of exposure to lead.

Participant Focused Counseling:
- Offer lead brochure
- Offer to discuss using WIC foods high in calcium, iron, and vitamin C to protect against lead absorption.
- Suggest a woman who eats dirt, clay, or other non-foods discuss this habit with physician.
- Recommend all pregnant and breastfeeding women review the Lead Screening Tool, and discuss any items answered “Yes” or “Don’t Know” with her health care provider.
Failure to Thrive
(Categories: IBE, IBP, IFF, C-1, C2-4)

Defined as: Diagnosis of Failure to Thrive (FTT) by a health care professional as self reported by applicant/participant/caregiver; or as reported or documented by a physician or someone working under physician's orders.

An infant or child identified with FTT should have Nutrition Care counseling.
Best Practice: see participant immediately; if not possible, within 5 days, with a Nutrition Care follow-up in 1-3 months

Justification:

Failure to Thrive (FTT) is a serious growth problem with an often complex etiology. It may be a mild form of protein-energy malnutrition (PEM) that is manifested by a reduction in the rate of growth. Regardless of the etiology of FTT, there is inadequate nutrition to support weight gain. Education, referrals, and service coordination can aid the mother/caregiver in developing skills, knowledge, and or assistance to care for an infant or child with Failure to Thrive.

Procedure:

Determine if the infant or child has a diagnosis of Failure to Thrive.
Review collected information about feeding practices, medical conditions, and caregiver lifestyles that could lead to a poor rate of growth.
Fetal Alcohol Syndrome (FAS)
(3821) Categories: IBE, IBP, IFF, C-1, C 2-4

Defined as: Presence of condition diagnosed by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. Fetal alcohol syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.

An infant or child identified with FAS should have Nutrition Care counseling.
Best Practice: see participant immediately; if not possible, within 5 days. Provide Nutrition Care follow-up in 3-6 months.

Justification:
FAS is an irreversible, preventable birth defect attributable to alcohol consumption by the mother during pregnancy.

FAS may be a cause of Failure to Thrive and is accompanied by a pattern of poor growth during childhood. Infants with FAS may have poor ability to suck, leading to feeding problems. FAS infants are often irritable and have difficulty sleeping.

Procedure:
Determine if the participant has a diagnosis of Fetal Alcohol Syndrome.

Participant Focused Counseling:
The goals of nutrition counseling are to focus on feeding strategies and assuring that the infant or child’s calorie and nutrient needs are met. The caregiver may need support and encouragement.
Fetal Growth Restriction (FGR)
(3361) **Category: PG**

Defined as: Diagnosed condition by a physician as self reported by applicant/participant/caregiver or as reported or documented by a physician or someone working under physician’s orders.

**A woman identified with fetal growth restriction should have Nutrition Care counseling.**

**Justification:**

Fetal growth restriction (FGR) is usually defined as a fetal weight < 10th percentile for gestational age. It may be diagnosed by a physician using serial measurements of fundal height and abdominal girth and can be confirmed using ultrasonography.

FGR usually leads to birth of an infant that is small for gestational age (SGA). The severely growth restricted infant is at increased risk of fetal and neonatal death as well as polycythemia, and long-term neurocognitive complications. FGR is also associated with increased risk of chronic diseases such as cardiovascular disease in adulthood.

FGR may be caused by congenital anomalies or infections in the fetus or may be associated with maternal height, pre-pregnancy weight, birth interval, and maternal smoking.

**Procedure:**

Determine if the woman has been diagnosed with Fetal Growth Restriction. Apply to a pregnant woman only.

**Participant Focused Counseling:**

A pregnant woman diagnosed with FGR can benefit from nutrition counseling to promote optimal nutrient intake, appropriate weight gain, and avoidance of tobacco, alcohol, and drugs.
**Foster Care**

(9031) **Categories: IBE, IBP, IFF, C-1, C 2-4**

Defined as: entering the foster care system during the previous 6 months or moving from one foster care home to another foster care home during the previous 6 months.

**Note:** This risk factor must be manually assigned in WOW and a note must be written to document it.

**Justification:**

Research findings have shown that foster children have a higher frequency of mental and physical problems, often the result of abuse and neglect suffered prior to entry into the foster care system. When compared to other Medicaid-eligible children, foster care children have higher rates of chronic conditions such as asthma, diabetes, and seizure disorders.

Because the foster care system often lacks a comprehensive health component, the social and medical histories of foster children in transition are frequently unknown to the foster care providers applying for WIC benefits for the children.

The nutrition education, referrals, and service coordination provided by WIC will support the foster parent in developing the knowledge and skills to ensure that the foster child receives appropriate nutrition and health care.

**Procedure:**

Determine that the child has entered into or transferred within foster care during the previous 6 months.

Staff using this risk criterion should also evaluate and document other nutritional risks as well as problems that may require follow up or referral to other health care programs. This risk criterion should be used as the sole risk criterion **only** if careful assessment of the applicant's nutritional status indicates that no other risk criteria based on anthropometric, biochemical, medical, or dietary risk criteria can be identified.

This nutritional risk cannot be used for consecutive certifications while the child remains in the same foster home.

**Participant Focused Counseling:**

The foster care provider can state the feeding practices she can follow to promote optimal growth and development of the child.
Gestational Diabetes

Category: PG

Defined as: Diagnosed by a physician and self reported by applicant/participant/caregiver. Gestational Diabetes is any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

A pregnant woman identified with Gestational Diabetes should have Nutrition Care counseling. Best Practice: see participant immediately; if not possible, within 5 days. Provide additional Nutrition Care follow-up in 3 months.

Justification:

Uncontrolled Gestational Diabetes can result in stillbirth, polycythemia, or respiratory distress syndrome. Although rarely seen in GDM, congenital anomalies, neural tube defects, and/or cardiac abnormalities may occur if a woman has GDM in the early first trimester. Women with Gestational Diabetes are at increased risk for pregnancy complications and for Type II diabetes later in life. Diet and physical activity are the cornerstones of treatment. A woman with Gestational Diabetes should be monitored for compliance with diet and to ensure that blood sugar levels are maintained within the acceptable range. Close monitoring by the health care professional is essential.

Procedure:

Determine if the woman has been diagnosed with Gestational Diabetes.

Review collected information about dietary and lifestyle practices.

Participant Focused Counseling:

A woman with Gestational Diabetes can benefit from nutrition counseling that enables her to understand and follow the carbohydrate-controlled meal plan prescribed by her health care professional. Breastfeeding should be strongly encouraged as it is associated with maternal weight loss and reduced insulin resistance for both mother and offspring.
High Maternal Weight Gain
(1331) Categories: PG, BE/BP, WPP

Defined as:

**Pregnant Women**, including adolescents*

- A high rate of weight gain, such that in the 2nd and 3rd trimesters, for singleton pregnancies, a participant gains more weight per week than recommended based on her prepregnancy weight:

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<thead>
<tr>
<th>Pregnancy Weight Classification</th>
<th>BMI</th>
<th>Total Weight Gain (pounds) per week</th>
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<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
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<tr>
<td>Normal Weight</td>
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<tr>
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<tr>
<td>Obese</td>
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<td>&gt;0.6</td>
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<td>Multi-fetal Pregnancies</td>
<td></td>
<td>See Justification for more information</td>
</tr>
</tbody>
</table>

OR

- High weight gain at any point in pregnancy, such that using an IOM-based weight gain grid, a pregnant woman’s weight plots at any point above the top line of the appropriate weight gain range for her weight gain category.

**Breastfeeding or Non-Breastfeeding Women**, including adolescents* (most recent pregnancy only): a total gestational weight gain exceeding the upper limit of IOM’s recommended range based on BMI for singleton pregnancies

<table>
<thead>
<tr>
<th>Pregnancy Weight Classification</th>
<th>BMI</th>
<th>Total Weight Gain (pounds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
<td>&gt;40</td>
</tr>
<tr>
<td>Normal Weight</td>
<td>18.5 to 24.9</td>
<td>&gt;35</td>
</tr>
<tr>
<td>Overweight</td>
<td>25 to 29.9</td>
<td>&gt;25</td>
</tr>
<tr>
<td>Obese</td>
<td>≥ 30</td>
<td>&gt;20</td>
</tr>
<tr>
<td>Multi-fetal Pregnancies</td>
<td></td>
<td>See Justification for more information</td>
</tr>
</tbody>
</table>
Justification:

Women with high maternal weight gain are at increased risk for cesarean delivery, and delivering large for gestational age infants that can lead to complications during labor and delivery. There is a strong association between higher maternal weight gain and both postpartum weight retention and subsequent maternal obesity. High maternal weight gain may be associated with glucose abnormalities and gestational hypertension disorders. Childhood obesity is one of the most important long-term health outcomes related to high maternal weight gain. The IOM prenatal weight gain recommendations based on prepregnancy weight status categories are associated with improved maternal and child health outcomes.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines: normal weight women should gain 37-54 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds. For underweight women with multiple fetuses, a consistent rate of weight gain is advisable. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy. Education by the WIC nutritionist should address a steady rate of weight gain that is higher than for singleton pregnancies.

Procedure:

**Pregnant Woman:** Determine if the pregnant woman has had a weight gain of 7 pounds or more over a one-month period. Use self-reported information or information from the health care professional. Probing may be required to determine the amount of weight gained if a self-report is used.

**Breastfeeding or Postpartum Woman:** Using data self-reported or from the health care professional, determine if the total weight gain for the most recent pregnancy exceeds the IOM recommended maximum number of pounds, based upon pre-pregnancy weight status.

**Participant Focused Counseling:** The supplemental foods, nutrition education, and counseling related to the weight gain guidelines provided by the WIC Program may improve maternal weight status and infant outcomes. In addition, WIC nutritionists can play an important role, through nutrition education and physical activity promotion, in assisting postpartum women to achieve and maintain a healthy weight.

* Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women as well.
High Parity and Young Age
(3331) Categories: PG, BE/BP, WPP

Defined as: Woman under age 20 at date of conception who has had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome.

Note: This risk factor must be manually assigned in WOW and a note must be written to document it.

Justification:

According to the Institute of Medicine, evidence suggests that significant nutritional risk may be associated with high parity and young age and a short interpregnancy interval. Studies have shown a higher risk for delivery of a low birth weight infant for the mother under the age of 20 who is also multiparous. Referral for family planning services may be appropriate.

Procedure:

Determine the woman's age at date of conception. The date of conception is defined as the 14th day following the first day of the last menstrual period. Use a gestation wheel to determine date of conception. Apply as follows:

- **Pregnant woman**: current pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy
- Determine the number of prior pregnancies and their duration.
- Review collected information about dietary and lifestyle practices.

Participant Focused Counseling:

- A pregnant woman with high parity and young age can state the food and lifestyle choices she can make that promote a positive pregnancy outcome.
- A non-pregnant woman with high parity and young age can state the food, physical activity, and lifestyle choices she can make to promote optimal health, especially for a future pregnancy.
  - Being active as a family and helping the older infant and young toddler to be active;
  - Delaying any screen time until the child is at least two years of age.
**High Weight-for-Length (Infants/Children < 24 Months of Age)**

(1151) **Categories: IBE, IBP, IFF, C-1**

Defined as: ≥ 97.9 percentile weight-for-length as plotted on the CDC/WHO Birth to 24 months gender specific growth charts.

**Justification:**

CDC, WHO, and WIC use a cut-off value of ≥ 97.9 percentile weight for length in an infant 0 to ≤24 months. The WIC Program plays an important role in public health efforts to reduce the prevalence of obesity by actively identifying and enrolling infants and young children who may be at risk of overweight/obesity in later childhood or adolescence.

**Procedure:**

- Obtain current length measured to the nearest 1/8 inch. Record measurement in the participant's record.
- Determine the exact age of the infant or child.
- For an infant or child < 24 months of age who was born at 37 weeks or earlier, adjust the age before plotting, following the procedure in Table GAA.
- Plot Weight for Length on the CDC/WHO Birth to < 24 months growth chart. If the plotted point lies at or above the 97.9 percentile, assign the risk criterion.
- Review collected information for possible causes of high weight for length.

**Participant Focused Counseling:**

When identifying this risk, it is important to communicate with parents/caregivers in a way that is supportive and nonjudgemental, and with a careful choice of words that convey an empathetic attitude and minimize embarrassment or harm to a child’s self esteem. The American Medical Association recommends more neutral terms like weight disproportional to height, excess weight, and high weight for length when communicating with the parent/caregiver.

Educate parents/caregivers on behaviors that can lead to healthy body weight, including:

- Recognizing fullness cues;
- Delaying introduction of solids until six months of age;
- Offering a variety of nutritious foods of appropriate texture;
- Not overly restricting foods;
- Comforting the infant/child by holding, reading, or rocking instead of feeding.
History of Birth of a Large for Gestational Age (LGA) Infant
(3371) Categories: PG, BE/BP, WPP

Defined as: Birth of an infant weighing $\geq 9$ pounds ($\geq 4000$ grams).

Justification:

An infant who is large for gestational age (also known as macrosomia) is at increased risk for fetal and neonatal complications including shoulder dystocia, meconium aspiration, and asphyxia. The incidence of maternal complications is also high.

Women with a previous delivery of an infant weighing $\geq 9$ pounds are at an increased risk of giving birth to a large for gestational age infant. LGA may be an indicator of maternal diabetes or a predictor of future diabetes.

Procedure:

Use information provided by the woman or her health care professional to determine if she has delivered a large for gestational age infant. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy
- Review information collected about dietary and lifestyle practices and health conditions such as gestational diabetes that could lead to a large for gestational age infant.

Participant Focused Counseling:

- A pregnant woman with a history of birth of an LGA infant can state the food, physical activity, and lifestyle choices she can make that are associated with a positive pregnancy outcome.
- A non-pregnant woman with a history of delivery of an LGA infant can state the food, physical activity, and lifestyle choices she can make to achieve good health.
- A postpartum woman who expresses interest in losing weight can set a goal for appropriate weight loss and state the food, physical activity, and/or lifestyle choices she can make to achieve her goal.
History of Birth with Nutrition-Related Congenital or Birth Defect
(3391)  **Categories: PG, BE/BP, WPP**

Defined as: A woman who has given birth to an infant with a nutrition-related birth defect, such as a neural tube defect.

*A woman who has delivered an infant with a nutrition-related birth defect should have Nutrition Care counseling.*

**Justification:**

The single greatest risk criterion for delivery of an infant with a neural tube defect (a defect of the brain and spinal cord) is a personal or family history of such a defect. More than 50 percent of recurrences may be prevented by consuming supplemental folic acid (400 micrograms per day) before conception. Other nutrients, such as vitamin A consumed in excess or zinc consumed inadequately, have been linked to birth defects, such as cleft palate.

**Procedure:**

Use information provided by the woman or her health care professional to determine if she has delivered an infant with a nutrition-related birth defect. Apply as follows:

- **Pregnant woman:** any pregnancy
- **Breastfeeding or postpartum woman:** most recent pregnancy

Review information collected about dietary and lifestyle practices for restrictive eating, failure to consume adequate folic acid, or the use of tobacco, alcohol, or drugs that could be linked to birth defects.

**Participant Focused Counseling:**

A woman who has delivered an infant with a nutrition-related birth defect can state the food and lifestyle choices she can make that are associated with a positive pregnancy outcome, such as:

- Consuming foods rich in folic acid, vitamin A, and zinc; and
- Avoiding tobacco, alcohol, or drugs.
History of Gestational Diabetes

Categories: PG, BE/BP, WPP

Defined as: History of Gestational Diabetes diagnosed by a health professional as self reported by applicant/participant/caregiver. Gestational Diabetes is any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

A woman who has a history of gestational diabetes should have Nutrition Care counseling.

Best Practice: A pregnant woman with a history of gestational diabetes should have a Nutrition Care follow-up in 3 months.

Justification:

Uncontrolled Gestational Diabetes can result in respiratory distress syndrome, increased rate of stillbirth and pregnancy complications, and type 2 diabetes later in life. Although rarely seen in GDM, diagnosis in early first trimester can result in congenital abnormalities and neural tube defects.

Studies have found that the risk factors for subsequent GDM include insulin use in the index pregnancy, obesity, diet composition, physical inactivity, failure to maintain a healthy BMI and weight gain between pregnancies. In addition, if a woman’s lipid levels are

Procedure:

Using information provided by the woman or her health care professional, determine if she has a history of Gestational Diabetes. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: during most recent pregnancy for a woman
- Review collected information about relevant dietary or lifestyle practices.

Participant Focused Counseling:

- Breastfeeding has been shown to lower blood glucose level and to decrease the incidence of type 2 diabetes in women with a history of GDM. Exercise also has a beneficial effect on insulin action by enhancing peripheral tissue glucose uptake. Medical Nutrition Therapy is an essential component in the care of a woman with a history of GDM.
- Diet and physical activity is the cornerstone of treatment.
- A postpartum woman who expresses interest in losing weight can set a goal for appropriate weight loss and state the food, physical activity, and/or lifestyle choices she can make to achieve her goal.
History of Low Birth Weight (LBW)

Categories: PG, BE/BP, WPP

Defined as: Birth of an infant weighing ≤ 5 pounds, 8 ounces (≤ 2500 grams).

Justification:

Low birth weight is usually associated with prematurity. It is linked to low maternal weight as well as the use of substances such as tobacco, alcohol, or drugs. A history of birth of one preterm or low birth weight infant increases the risk of subsequent preterm or low birth weight infants.

Procedure:

Use information provided by the woman or her health care professional to determine if she has delivered a low birth weight infant. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy
- Review collected information about dietary or lifestyle practices that could be associated with the birth of a low birth weight infant.

Participant Focused Counseling:

A woman with a history of a low birth weight infant can state the food or lifestyle choices she can make to lower her risk of such an outcome.
History of Preeclampsia
(3041) Categories: PG, BE/BP, WPP

Defined as: Presence of the condition diagnosed by a physician as self-reported by applicant/participant/caregiver. Preeclampsia is defined as pregnancy-induced hypertension (>140mm Hg systolic or 90mm Hg diastolic) with proteinuria developing usually after the twentieth week of gestation. Clinical symptoms of preeclampsia may include: edema, renal failure, and the HELLP (Hemolysis, Elevated Liver enzymes, and Low Platelets) syndrome.

Justification:

Preeclampsia is a leading cause of maternal death and a major contributor to maternal and perinatal morbidity. Women who have had preeclampsia in a prior pregnancy have an increased risk of recurrence (about 20% overall). The risk is greater in women who have had preeclampsia occurring early in pregnancy or who have had preeclampsia in more than one pregnancy. Additionally, maternal pre-pregnancy obesity with BMI > 30 is the most prevalent risk factor for preeclampsia.

Risk factors for preeclampsia include:

- Pre-pregnancy obesity BMI > 30
- Preeclampsia in a prior pregnancy
- Nulliparity (no prior delivery)
- Maternal age > 35 years
- Endocrine disorders (e.g., diabetes); autoimmune disorders (e.g., lupus); renal disorders
- Multi-fetal gestation
- Genetics
- Black race

Procedure:

Use information provided by the woman or her health care professional to determine if she has a history of preeclampsia. Apply as follows:
Postpartum Woman

Women who have had preeclampsia should be advised that they are at risk for recurrence of the disease and development of cardiovascular disease (CVD) later in life. WIC nutrition education can emphasize measures that support the prevention of preeclampsia in a future pregnancy such as reaching or maintaining a healthy BMI and lifestyle between pregnancies, consuming a nutritionally adequate diet consistent with the Dietary Guidelines for Americans, and engaging in regular physical activity.

Pregnant Woman

The WIC Program provides supplemental foods rich in nutrients, especially calcium and vitamin D, which research has shown to have a protective effect on preeclampsia. During the nutrition education, WIC can encourage actions or behaviors that also have been shown to have a protective effect against preeclampsia: early prenatal care, taking a prenatal vitamin, and engaging in physical activity. WIC can also discourage smoking and alcohol consumption and counsel pregnant women to gain recommended weight based on pre-pregnancy BMI and to return to pre-pregnancy weight or a healthy BMI of < 25 for the benefit of future pregnancies.

Participant Focused Counseling:

There are few established nutrient recommendations for the prevention of preeclampsia. However, vitamin D may be important because it influences vascular structure and function, and regulates blood pressure.

Also, calcium may prevent preeclampsia among women with very low baseline calcium intake.

There is no treatment for preeclampsia. The condition resolves itself only when the pregnancy terminates or a placenta is delivered. Early prenatal care, therefore, is vital to the prevention of the onset of the disease.

WIC nutrition education encourages practices shown by research to have a protective effect against developing preeclampsia. These include:

- Gaining recommended weight based on pre-pregnancy BMI, in order to help return to a healthy postpartum weight
- Scheduling early prenatal care visits
- Consuming a diet adequate in calcium and vitamin D
- Taking prenatal vitamins
- Engaging in regular physical activity
- Discontinuing smoking and alcohol consumption
History of Preterm or Early Term Delivery

Categories: PG, BE/BP, WPP

History of preterm and/or early term delivery is defined as follows:
• Preterm: Delivery of an infant born <36 6/7 weeks.
• Early Term: Delivery of an infant born >37 0/7 and <38 6/7 weeks.

Use information provided by the woman or her health care professional to determine if she has delivered a premature infant. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy

**Justification:**

Prior spontaneous preterm delivery is highly associated with recurrence in subsequent pregnancies. A history of one previous preterm birth is associated with a recurrent risk of 17-37%; the risk increases with the number of prior preterm births and decreases with the number of term deliveries.

Typically a pregnancy lasts about 40 weeks. Premature or preterm birth, however, is defined as a birth that occurs between 20 and 37 weeks of pregnancy, according to the American College of Obstetricians and Gynecologists (ACOG). In the past, the period from 3 weeks before until 2 weeks after the estimated date of delivery was considered a “term” pregnancy, with the expectation that a baby would have similar health outcomes if they were born any time during this interval. In 2013, ACOG released a committee opinion that the label “term” should be replaced with the designations **early term** (≥37 0/7 weeks and ≤38 6/7 weeks gestation) and **full term** (≥39 0/7 weeks and ≤40 6/7 weeks gestation) to more accurately describe these groups of infants.

Prematurity affects about 12% of all live births in the U.S., and about 50% of these preterm births were preceded by preterm labor. In 2011, the annual rate of premature births in the United States reached 11.7%, nearly two times the rate in European nations. Preterm births also account for approximately 70% of newborn deaths and 36% of infant deaths.

Despite advances in neonatal care, preterm birth remains a leading cause of infant death in the United States. More infants die from pre-term related problems than any other single cause. Preterm birth strains society’s healthcare resources due to its long-term...
effects on the health of the newborn. Premature infants may have physical problems that have nutritional implications, including immature sucking, swallowing and immature digestion and absorption of carbohydrates and lipids. Preterm infants are at risk for a number of illnesses/health conditions that range from minor to severe complications depending on the circumstances. (See risk 142 Preterm or Early Term Delivery for more details.)

Several factors have been found to increase the risk of preterm delivery. Epidemiologic studies have consistently reported low socioeconomic status, nonwhite race, maternal age of ≤ 18 years or ≥ 40 years, and low pre-pregnancy underweight as risk factors. Studies suggest even modest restrictions in maternal nutrition around the time of conception can lead to premature births and long-term adverse health effects for offspring. Other factors associated with a risk of preterm birth may be identified before pregnancy, at conception, or during pregnancy include:

- Low maternal weight gain during pregnancy
- Maternal infections, maternal hypertension, gestational diabetes
- Smoking, indoor pollution
- Maternal stress, teen pregnancy, multiple fetuses
- Sexually transmitted diseases, low psychosocial health status
- Previous or present pregnancy complications
- Lack of perceived social support, poor housing quality

A recent study indicated that maternal obesity is also an independent risk factor for preterm delivery (10). Complications associated with obesity (BMI > 30) prior to conception that increase the risk for preterm delivery include (11):

- Gestational Diabetes Mellitus, hypertension, preeclampsia
- Cesarean Delivery, Clinical/Health/Medical: History of Preterm or Early Term Delivery
- Postpartum weight retention

Additional concerns related to obesity include potential intrapartum, operative, and postoperative complications and difficulties related to anesthesia management. Obese women are also less likely to initiate and sustain breastfeeding

**Participant Focused Counseling:**

A woman with a history of preterm delivery can state the food or lifestyle choices she can make (such as appropriate weight and avoidance of tobacco, alcohol, and drugs) to lower her risk of preterm delivery.
History of Spontaneous Abortion, Fetal Death, Neonatal Loss
(3211) Categories: PG, BE/BP, WPP

Defined as: A spontaneous abortion (miscarriage) that occurs at < 20 weeks gestation, a fetal death (death at ≥ 20 weeks gestation), or a neonatal death (death occurring from birth through the first 28 days of life).

Justification:

Previous fetal and neonatal deaths are strongly associated with preterm low birth weight. There is also an increase in subsequent preterm deliveries in women who have experienced one or more second trimester spontaneous abortions. The extent to which nutritional interventions can decrease the risk for repeat poor pregnancy outcomes depends upon the degree to which poor nutrition was responsible for the poor pregnancy outcomes. The risk for future small for gestational age outcomes is greater for a woman with a history of 2 or more spontaneous abortions (SAB’s). SAB’s may also be indicators of neural tube defects.

Nutritional deficiencies and excesses have been shown to result in low birth weight and pregnancy loss. Prenatal weight gain is one of the most important correlates of birth weight and fetal growth restriction. All women of childbearing age should be advised to consume 400 micrograms of folic acid daily.

Procedure:

Determine if the woman has a history of miscarriage (SAB) or fetal or neonatal death. Apply as follows:

- **Pregnant woman**: any pregnancy. A pregnant woman must have had ≥ 2 miscarriages to apply this risk factor
- **Breastfeeding woman**: most recent pregnancy with one or more infants still living
- **Postpartum woman**: most recent pregnancy

Participant Focused Counseling:

Review collected information about dietary and lifestyle practices (such as restrictive eating practices, failure to consume 400 micrograms of folic acid daily, or tobacco, alcohol or drug use) that could contribute to poor pregnancy outcome.

Educate on possible nutrition-related causes. Discuss behavior changes participant is willing to make. Assist participant in setting simple goals to achieve those changes. Refer to behavior change programs (e.g., smoking cessation) as appropriate.
HIV/AIDS

(3524) Categories: ALL

Defined as: a chronic virus infection that reduces an individual’s ability to fight off infections and diseases. When HIV progresses to AIDS, the immune system becomes extremely weakened and can no longer protect against other infections or opportunistic illnesses that would not harm healthy individuals, but can be life-threatening to people infected with HIV.

A participant determined to have HIV/AIDS should have Nutrition Care counseling.

Justification:

The Human Immunodeficiency Virus (HIV) destroys white blood cells found in the immune system, also known as CD4 (cluster of differentiation) or T cells (T lymphocytes).

HIV is transmitted only through blood, semen, pre-semenal fluid, rectal fluids, vaginal fluids, and breast milk from an HIV-infected person. HIV can lead to Acquired Immunodeficiency Syndrome (AIDS) if left untreated.

Individuals who are aware of their HIV status and are undergoing antiretroviral therapy (ART) to stop the replication of the virus, can typically live decades. Those unaware of their status or who are not on ART can usually remain in this stage up to about ten years before progressing to the AIDS stage.

Getting tested is the only way individuals know they are infected with HIV. The Centers for Disease Control and Prevention (CDC) recommends that all pregnant women get tested early in their pregnancy by an opt-out measure. An early diagnosis in pregnant women can reduce the transmission of HIV in babies to 2%, if the expectant mother receives Active Antiretroviral Therapy (ART) during pregnancy, labor, and delivery, and avoids breastfeeding. There is a 20% chance of transmission if the HIV positive mother does not follow these prevention measures.

PrEP (Pre-Exposure Prophylaxis) is a daily pill containing two medicines (tenofovir and emtricitabine), recommended for HIV negative people who are at substantial risk of becoming infected with HIV. PrEP, when taken consistently, reduces HIV transmission by up to 92%.
Participant Focused Counseling:

WIC can improve the management of chronic infectious diseases through WIC foods, nutrition education, counseling, and referrals to community resources that provide support in the long-term management of chronic infectious diseases.

Dietary recommendations depend on the symptoms experienced by the HIV positive participant. A discussion using open-ended questions can determine the participant’s symptoms, and openness to exploring dietary approaches to reducing symptoms, using the following options.

A participant with **unintended weight loss or wasting**, may be dealing with

1. Poor food intake due to medication side effects, sore mouth, or mental health issues
2. Altered metabolism due to disease progression
3. Nutrient malabsorption caused by gastrointestinal problems from either the medications or the virus itself.

For these participants, the main goals are to maintain or increase body weight, retain or increase lean body mass, and take in adequate macro- and micro-nutrients.

- These participants usually require a higher protein diet
- They may need a multivitamin supplement, since most are lower in vitamins A, B6, C, and E. **Specific supplements should be recommended only by the health care provider.** Note: Iron supplements leading to iron overload encourage disease progression from HIV to AIDS. In addition, supplements of vitamin A and Zinc can have a negative impact on adults living with HIV/AIDS.

Goals for **asymptomatic participants or those with stable weight** should focus on adequate nutrition to prevent wasting. On recommendation of the health care provider, they can take a multivitamin or mineral supplement.

Although people with HIV are able to manage the disease and live longer with Highly Active Antiretroviral Therapy (HAART), the side effects can cause gastrointestinal problems, lipid disorders, and insulin resistance/glucose intolerance should:
• Reduce total fat and cholesterol
• Increase dietary fiber
• Increase physical activity
• Reduce alcohol consumption
• Reduce consumption of simple sugars

**HIV/AIDS and Food Safety**
Participants with HIV are more susceptible to food-borne illness due to a weakened immune system. WIC nutritionists should encourage them to:
• Store and prepare foods safely
• Check expiration dates
• Avoid raw or semi raw foods like meat, non-pasteurized dairy foods, and soft cheeses.
• Infants born to HIV-positive mothers often are carefully monitored for their HIV status for the first six months of life, and may be referred to WIC as HIV positive, even though their status may not yet be established.

Pediatricians may request ready-to-feed or liquid concentrate infant formula, since powdered infant formula is not sterile and may not be microbiologically safe. If so requested, liquid concentrate formula is appropriate and allowable for an infant diagnosed as HIV positive.

**HIV/AIDS Care and Support**
HIV-affected families often lack the financial and psychosocial support needed to deal with their diagnosis, as well as the social stigma which can reduce their compliance with medical treatment needed to control the disease. They must get care, stay in care, and adhere to their medical plan. WIC agencies should refer participants to health care services and community resources, including other nutrition assistance programs to improve health outcomes.
The following table summarizes the WIC Nutrition Services that can help improve the health and birth outcomes of participants with HIV/AIDS.

**NUTRITION AND HEALTH TIPS TO MANAGE HIV/AIDS SYMPTOMS**

**All Categories**

- Use MyPlate as the guide for dietary needs.
- Consult health care providers when using supplements and herbs to avoid adverse reactions or medication interactions that could reduce effectiveness.
- Eat small, frequent meals when gastrointestinal problems are present or persistent.
- Eat soft foods with manageable textures at tolerable temperatures when oral lesions and dental problems are present (i.e. mashed potatoes, scrambled/boiled eggs, bananas, non-citrus juices, puddings, custards, milk, cooked vegetables, rice, oatmeal, non-fizzy drinks, cottage cheese, non-spicy foods).
- Add canned tuna, beans, cheese, peanut butter, dried milk for inexpensive extra protein.
- Add moderate amounts of concentrated sources of calories to diet when needed (e.g., butter, cream cheese, gravies, whole milk, ice cream).
- Consume nutritious, high caloric foods when appetite is normal or has returned.
- Drink adequate water to stay hydrated, replace fluid loss from diarrhea and vomiting, and help medications move through the body.
- Consume foods high in fiber or fiber supplements to slow digestion if foods are moving too quickly through the body.
- Eat yogurt or foods with *Lactobacillus acidophilus* culture to help with bacterial over-growth resulting from prolonged use of antibiotics.
- Avoid caffeinated beverages to prevent dehydration.
- Avoid or reduce sugar-free foods with sorbitol as diarrhea may be exacerbated.
- Consult with health care provider about use of complete oral nutritional supplements to help nutritional status.
- Avoid alcohol and illegal drugs for overall good health and to help protect the liver.
- Use pancreatic enzymes when medically prescribed to help with digestion.
- Prepare and store food safely.
- Avoid expired and moldy foods or foods with rotten spots.
- Participate in weight-bearing exercises to strengthen and maintain bones.
• Refer HIV-affected families to other community resources for food, housing, and medical resources to improve compliance with HIV treatment.

Women
• Advise infected pregnant women to consume a diet adequate in nutrients, achieve appropriate weight gain, and discuss taking a multivitamin with their health care provider.
• Educate mothers with HIV/AIDS to avoid breastfeeding. This is especially important for recent immigrants and refugees from developing nations, as the recommendations are different in developing countries. In some developing countries, breastfeeding is encouraged due to the lack of available clean water to prepare infant formula and other sanitation problems.
• More information about women and HIV can be found at:
  o http://www.womenshealth.gov/hiv-aids/
  o http://www.cdc.gov/hiv/risk/gender/pregnantwomen/facts/

Infants
• Inform mothers/caregivers that formula feeding is the standard for infants born to HIV positive mothers in the United States, as breastfeeding is not recommended – especially to the immigrant and refugee population.
• Ensure that liquid concentrate infant formula, when prescribed with medical documentation, is provided to HIV-exposed infants or babies born to HIV positive mothers, even if the infant has tested negative for HIV.
• Discourage giving pre-chewed food, regardless of HIV status, as the individual’s HIV status, who is pre-chewing the food is unknown.
• More information about infants and HIV can be found at:
  o http://www.cdc.gov/hiv/risk/gender/pregnantwomen/facts/

Children
• Discourage giving pre-chewed food, regardless of HIV status, as the individual’s HIV status, who is pre-chewing the food is unknown.
• More information about children and HIV can be found at:
  o http://www.cdc.gov/hiv/risk/gender/pregnantwomen/facts/
Hepatitis
(3523) Categories: ALL

Defined as: inflammation of the liver.

A participant determined to have Hepatitis should be referred to the CPA for Nutrition Care counseling.

Justification:

Hepatitis is most often caused by viruses, but can also be caused by excessive alcohol intake, toxins, and medicines such as acetaminophen and some other conditions linked to liver inflammation.

Regardless of the type of hepatitis, infected individuals with signs of the infection will typically experience anorexia, nausea, vomiting, diarrhea, jaundice, epigastric pain, tiredness, and weakness, all of which affect one’s diet and health. Darker urine and pale stools may also be present. Viral hepatitis is the leading cause of liver cancer and the most frequent need for liver transplants in the United States. Because symptoms of all kinds of hepatitis are the same, diagnosis by laboratory testing or an epidemiologic link to a confirmed case is required.

Procedure:
WIC can improve the management of acute or chronic Hepatitis infections through WIC foods, nutrition education, counseling, and referrals to community resources that provide support in the long-term management of Hepatitis infections.

WIC Nutrition Services for Acute Infectious Hepatitis:
- Encourage sufficient calorie intake to help meet increased nutrition needs.
- Recommend the Dietary Guidelines to ensure healthy eating pattern
- Provide suggestions to address poor appetite
- Provide education on safe food handling and storage practices

WIC Nutrition Services for All Types of Hepatitis:
- Recommend testing to pregnant women and high-risk individuals.
- Encourage abstinence from alcohol.
- Provide information on high calorie, high protein, and moderate fat diets, as recommended by health care provider.
- Discuss high calorie consumption at breakfast to reduce nausea. (Typically, nausea is less common in the morning.)
- Recommend, in consultation with health care provider, consumption of high calorie and protein liquid formula between meals to boost calorie intake.
- Encourage a bland diet with extra fluids depending on the severity of nausea and vomiting.

The chart below summarizes differences in Hepatitis types, and additional WIC Nutrition Services that can help improve the health and outcomes of participants with Hepatitis.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>TRANSMISSION</th>
<th>PREVENTION/TREATMENT</th>
<th>WIC NUTRITION SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE INFECTIONS: Must be present within the past 6 months.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Fecal-oral route&lt;br&gt;Household member&lt;br&gt;Sexual partner&lt;br&gt;Fecal contaminated food/water</td>
<td>70% asymptomatic&lt;br&gt;&lt;strong&gt;Prevention:&lt;/strong&gt; Proper hygiene&lt;br&gt;Food safety&lt;br&gt;Vaccination</td>
<td>Encourage vaccine for children, adolescents, high risk adults; Promote BF as safe except with cracked/bleeding nipples. Stop breastfeeding until nipples heal, and continue to pump to maintain milk supply. Discourage pre-chewing infant food</td>
</tr>
<tr>
<td>E</td>
<td>Uncommon in US.&lt;br&gt;Fecal-oral, usually drinking water.&lt;br&gt;Uncooked/undercooked meat and shellfish&lt;br&gt;Travel to developing countries</td>
<td>No treatment or vaccine; Symptoms usually resolve; Pregnant: 10-30% death rate in 3rd trimester&lt;br&gt;&lt;strong&gt;Prevention:&lt;/strong&gt; Clean drinking water and good sanitation&lt;br&gt;Supportive therapy/hospitalization.</td>
<td>Avoid contaminated water</td>
</tr>
</tbody>
</table>

<p>| ACUTE AND CHRONIC INFECTIONS: Acute infections must be present in last 6 months. Chronic infections may last a lifetime | | | |
| B | Infected blood, needles, body fluids at work; Asian &amp; Pacific islanders most at risk; | Interferon &amp; antiviral drugs&lt;br&gt;&lt;strong&gt;Prevention:&lt;/strong&gt; | Encourage vaccine for newborns, adolescents, at risk adults; |</p>
<table>
<thead>
<tr>
<th>TYPE</th>
<th>TRANSMISSION</th>
<th>PREVENTION/TREATMENT</th>
<th>WIC NUTRITION SERVICES</th>
</tr>
</thead>
</table>
|      | Those undergoing dialysis; Those who are HIV infected; Immigrant/refuge status; Sexual intercourse with infected person; Mother to child at birth (both vaginal & Cesarean section births) | Hepatitis B vaccine;                                                               | Promote BF as safe except with cracked/bleeding nipples  
Stop breastfeeding until nipples heal, and continue to pump to maintain milk supply.  
Discourage pre-chewing infant food                                                                                      |
| C    | Present in blood & body fluids: Sharing needles; Sexual activity; Transfusion/organ transplant before July 1992; Sharing razor, toothbrush, or nail clippers; Tattoos & piercings from unlicensed facilities Mother to child at birth       | No vaccine                                                                         | Promote BF as safe except with cracked/bleeding nipples  
Stop breastfeeding until nipples heal, and continue to pump to maintain milk supply.                                                                 |
| D    | Uncommon in the US. Contracted only when person has Hepatitis B first. Contact with blood and body fluids; Sexual activity with infected person; Mother to child transmission at delivery; Sharing drug paraphernalia, razors, or toothbrushes; Direct contact with blood of infected person | No vaccine, except Hepatitis B for prevention; Interferon may be helpful           | Recommend Hepatitis B vaccine                                                                                                      |
**Homelessness**

(8011) **Categories: All**

Defined as: A woman, infant, or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

- a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations;
- an institution that provides a temporary residence for individuals intended to be institutionalized;
- a temporary accommodation of not more than 365 days in the residence of another individual; or
- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

**Procedure:**

Determine if the participant is homeless, as defined above.

Review dietary and lifestyle practices.

**Participant Focused Counseling:**

The goals of nutrition counseling are:

- to assist the homeless participant in making decisions about the selection, storage, and preparation of foods to promote optimal nutritional status.
- To advise and support the caregiver of the homeless participant so she is able to make the best decisions regarding food selection, storage, and preparation, despite living conditions.
**Hyperemesis Gravidarum**

(3011) **Category: PG**

Defined as: Current diagnosis of Hyperemesis Gravidarum, diagnosed by a physician as self reported by applicant/participant/caregiver. Hyperemesis Gravidarum is severe nausea and vomiting to the extent that a pregnant woman becomes dehydrated and acidotic.

*A pregnant woman identified with Hyperemesis Gravidarum should have Nutrition Care counseling.*

**Best Practice: Provide Nutrition Care follow-up in 1-3 months**

**Justification:**

A pregnant woman with Hyperemesis Gravidarum is at risk for weight loss, dehydration, and metabolic imbalances and should be closely followed by her health care professional. A pregnant woman who cannot tolerate any food or beverage (even water) without vomiting should contact her health care professional immediately.

**Procedure:**

- Determine if the woman has been diagnosed with and currently has Hyperemesis Gravidarum.
- Review collected information about dietary and lifestyle practices.

**Participant Focused Counseling:**

A woman with Hyperemesis Gravidarum can benefit from nutrition counseling that offers strategies for reducing the symptoms of nausea and vomiting.
Hypertension and Prehypertension

Categories: PG, BE/BP, WPP, C 3-4

Defined as: Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver as follows:

- **Adult hypertension** (high blood pressure) is defined as persistently high arterial blood pressure with systolic blood pressure above 140mm Hg or diastolic blood pressure above 90mm Hg.
- **Adult prehypertension** includes readings between 130/80 and 139/89. People with prehypertension are twice as likely to develop hypertension.
- **Hypertension during childhood** is age-specific, and is defined as blood pressure readings greater that the 95th percentile for age, gender, and height on at least three separate occasions. Blood pressure reading between the 90th and 95th percentiles is considered prehypertension.

A participant identified with hypertension or prehypertension should have Nutrition Care counseling. Best Practice: Provide Nutrition Care follow-up in 3-6 months.

**Justification:**

Untreated hypertension leads to many degenerative diseases, including congestive heart failure, end-stage renal disease, and peripheral vascular disease.

Hypertensive disorders of pregnancy include Chronic Hypertension, Preeclampsia, Eclampsia, Preeclampsia superimposed on Chronic Hypertension, and Gestational Hypertension.

There is no cure for hypertension; however, lifestyle modifications can prevent high blood pressure and are critical in the management of hypertension and prehypertension.

Children with high blood pressure are more likely to become hypertensive adults. Therefore they should have their blood pressure checked regularly beginning at the age of three. Blood pressure and overweight status have been suggested as criteria to identify hypertensive children.
Procedure:
Use information provided by the woman or her health care professional to determine if she has hypertension or prehypertension.

Participant Focused Counseling:

**Adult hypertension management** includes lifestyle changes and medication. In prehypertensive individuals, lifestyle changes can prevent or delay the onset of hypertension. In hypertensive individuals, dietary intervention can reduce blood pressure, and delay drug treatment. Apply as follows:

Support lifestyle changes to manage hypertension and prehypertension such as:

- Consuming a diet consistent with the Dietary Guidelines for Americans or following the DASH (Dietary Approaches to Stop Hypertension) eating plan, if recommended by a physician
- Limiting dietary sodium
- Engaging in regular physical activity
- Achieving and maintaining a healthy weight
- Smoking cessation

**Prevention in overweight children** should aim at achieving moderate weight loss or preventing further weight gain. Lifestyle changes conducive to weight management in children include:

- Portion control
- Reducing sugar-containing beverages and energy-dense snacks
- Eating more fresh fruits and vegetables
- Regular meals, especially breakfast
- Decreasing sedentary activities
- Increasing physical activity

The WIC Program provides fruits, vegetables, low fat milk, and cheese, which are important components of the DASH eating plan. WIC nutritionists provide nutrition education and counseling to reduce sodium intakes, achieve/maintain proper weight, promote physical activity, and make referrals to smoking cessation programs, which are the lifestyle interventions critical to the management of hypertension/prehypertension.
Late to Prenatal Care
(3341) Category: PG

Defined as: Prenatal care beginning after the 1st trimester (after completed week 13 of gestation).

Justification:

Women who do not receive early or adequate prenatal care are more likely to deliver premature, growth retarded, or low birth weight infants. Women with medical or obstetric problems, as well as young adolescents, may need closer management with the frequency of prenatal visits determined by the severity of the identified health problem.

Procedure:

Determine if the woman did not have her first prenatal care visit before she completed 13 weeks of gestation. This risk criterion applies to a pregnant woman only.

A woman who has not contacted a health care professional to schedule a prenatal appointment should be given referral information as appropriate.

Participant Focused Counseling:

WIC interventions such as referrals to prenatal care and encouragement to keep scheduled prenatal appointments and to follow the advice of health care professional(s) promotes optimal birth outcomes.

A pregnant woman late to prenatal care can:

- State one or more steps she can take to get early and adequate prenatal care.
- State the food and lifestyle choices she can make that promote a positive pregnancy outcome.
Large for Gestational Age (LGA)
(1531) Categories: IBE, IBP, IFF

Defined as: Birth weight of \( \geq 9 \) pounds (\( \geq 4000 \) grams). Presence diagnosed by a physician as self-reported by applicant/participant/caregiver.

Justification:

Infant mortality rates are higher among full-term infants who weigh > 9 pounds (> 4000 grams).

LGA is associated with congenital birth defects (especially congenital heart conditions) and developmental and intellectual retardation. LGA may be due to uncontrolled maternal diabetes. It can contribute to childhood obesity that may persist into adult life.

Procedure:

Determine if the infant’s birth weight was 9 pounds or greater.

Review collected information to determine if feeding practices are present that could promote a rapid rate of weight gain, such as an early introduction of solid foods.

Participant Focused Counseling:

The caregiver can state the feeding practices she can follow to promote optimal growth and development in her child.
Limited Ability of Caregiver to Make Feeding Decisions
(9021) Categories: All

Defined as: A woman (pregnant, breastfeeding, or non-breastfeeding) or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food, including:

- ≤ 17 years of age;
- Mentally disabled/delayed and/or have diagnosed mental illness;
- Physically disabled, limiting food preparation ability; OR
- Currently using or history of drug or alcohol abuse.

Note: This risk factor must be manually assigned in WOW and a note must be written to document it.

Justification:
- The mother or caregiver 17 years of age or younger generally has limited exposure and skills needed to care for and feed a dependent.
- Cognitive limitation in a parent or primary caregiver has been recognized as a risk criterion for Failure to Thrive as well as abuse and neglect.
- The mentally handicapped caregiver may not exhibit the necessary parenting skills to promote beneficial feeding interactions with the infant.
- Maternal mental illnesses such as severe depression and maternal substance abuse are strongly associated with abuse and neglect.
- Physical handicaps such as blindness or para- or quadriplegia may restrict or limit the caregiver’s ability to prepare and offer a variety of foods.

Procedure:
Determine if the woman or the infant/child’s primary caregiver has a limited ability to make appropriate feeding decisions and/or prepare food for the reasons stated above.

Participant Focused Counseling:
- Education, referrals and service coordination can aid the mother/caregiver in developing skills, knowledge, and or assistance to properly care for a dependent.
- The goals of nutrition counseling are to provide risk- and age-appropriate information and support that will enable the woman or caregiver with a limited ability to make feeding decisions to improve nutritional status.
Listeriosis

Categories: ALL

Defined as: infection caused by the bacteria *Listeria monocytogenes* within the past six months. It is most commonly transmitted through contaminated food, however it is also naturally present in the soil, water, and animals, including poultry and cattle.

A participant determined to have Listeriosis should be referred to the CPA for Nutrition Care counseling.

Justification

Listeriosis is especially dangerous due to its ability to grow in cold temperatures, unlike many other pathogens. Common food sources include ready-to-eat deli meats and hot dogs, unpasteurized milk and dairy products, raw sprouts and others. Symptoms include fever, stiff neck, confusion, weakness, vomiting, and diarrhea.

**Pregnant women and newborns** are at exceptionally high risk for listeriosis. Pregnant women are 10-20 times as likely as the general population to become infected. It can lead to miscarriage, stillbirth, or lifelong health issues for the child.

Participants with weakened immune systems are also at higher risk.

**Participant Focused Counseling**

Use a conversation with open-ended questions to determine typical food habits and risks for Listeriosis, and possible approaches the participant can take to manage or prevent the infection. Possible options include:

- Prevention by safe food handling and storage
- Recommend alternatives to raw milk and dairy products
- With an existing infection,
  - Get sufficient calories to meet increased nutrient needs using the US Dietary Guidelines
  - Offer suggestions to address poor appetite.
- Provide education on safe food handling and storage practices
Low Birth Weight or Very Low Birth Weight
(1411) (1412) Categories: IBE, IBP, IFF, C-1

Defined as:

- **LBW:** Infant born with a birth weight ≤5 pounds, 8 ounces (≤ 2500 grams)
- **VLBW:** Infant born with a birth weight ≤ 3 pounds, 5 ounces (≤1500 grams)

An infant identified with VLBW should have Nutrition Care counseling.
Best Practice: se participant immediately; if not possible, within 5 days. Provide Nutrition Care follow-up in 1-3 months.

An infant identified with LBW should have Nutrition Care counseling.
Best Practice: provide Nutrition Care follow-up in 3-6 months.

Justification:
Low birth weight is one of the most important biological predictors of infant death and of deficiencies in physical and mental development during childhood among those babies who survive. It continues to be a strong predictor of growth in early childhood.

Procedure:

- Determine if the infant or child’s birth weight was 5 pounds, 8 ounces or less.
- Review collected information for appropriateness of feeding practices.

Participant Focused Counseling:
The goal of nutrition counseling is to assist and support the caregiver in establishing and maintaining feeding practices that support the optimal growth of the infant.
Low Head Circumference
(1521) Categories: IBE, IBP, IFF, C-1

Defined as:

Head circumference less than 2.3rd % when plotted on the CDC/WHO Birth to < 24 months gender specific Head Circumference for Age growth chart. Presence diagnosed by a physician as self-reported by applicant/participant/caregiver or as reported or documented by a physician or someone working under physician’s orders.

Justification:

Low head circumference (LHC) is related to a variety of genetic, nutrition, and health factors. While LHC alone does not necessarily indicate abnormal brain development, it may be indicative of future nutrition and health risk, particularly poor neurocognitive abilities. LHC is associated with VLBW, pre-term birth, and socioeconomic status, and is in part related to nutrition factors.

Participant Focused Counseling:

WIC Counselors can assist families in making nutritionally balanced food choices to promote optimal growth, and provide referrals to medical providers and other available local resources.
**Low Hemoglobin/Hematocrit**

*(2011)* **Categories: All**

Defined as:

**Infants and children** 9 months of age and older: Hemoglobin ≤ 10.9 g/dl or hematocrit ≤ 32.8%

**Women:** Cut-off values for hemoglobin or hematocrit that are established by the CDC. (See Table A)

A participant who has a hemoglobin value < 10g/dl (or hematocrit < 30%) should have Nutrition Care counseling.
**Best Practice:** Provide Nutrition Care follow-up in 3-6 months.

A participant with hemoglobin <9 should have Nutrition Care counseling.
**Best Practice:** See participant immediately; if not possible, within 5 days.

**Justification:**

Hemoglobin and hematocrit reflect the amount of functional iron in the body, and are the most frequently used tests to screen for iron deficiency anemia. Iron deficiency is the most common cause of anemia in women and children. It may be caused by a diet low in iron, insufficient assimilation of iron from the diet, or increased iron requirements due to growth, blood loss, or pregnancy.

Anemia can impair energy metabolism, temperature regulation, immune function, and work performance.

- In infants and children, even mild anemia may delay mental and motor development. Risk increases with duration and severity of anemia. Early damages are unlikely to be reversed through later therapy.
- During pregnancy, anemia may increase the risk of prematurity, poor maternal weight gain, low birth weight, and infant mortality.
- While neither an Hgb nor Hct test are direct measures of iron status and do not distinguish among different types of anemia, these tests are useful indicators of iron deficiency anemia.

**Procedure:**

Obtain a blood hemoglobin or hematocrit test result.
Infants and Children:

- An infant must be tested between 9 and 12 months of age.
- A child must be tested once, between 12 and 24 months of age (ideally at 15 to 18 months of age or 6 months after the infant’s test), then annually, between 24 and 60 months, provided the test result is above the cut-off value or at a 6 month interval if the test result is equal to or below the cut-off value.
- Compare the result to the cut-off value. If the hemoglobin is ≤ 10.9 g/dl or hematocrit ≤ 32.8%, assign the risk criterion.

Women: Use Table A for the assessment.

- On Table A, locate the woman’s category in the left column.
- For a pregnant woman, you must also know her last completed week of gestation at the time of the blood test.
- For a non-pregnant woman, you must know her age.
- Determine the number of cigarettes she smokes, as applicable. Locate the column across the top of the table that reflects her smoking status.
- Where her category and smoking status intersect, you will find the hemoglobin or hematocrit cut-off value. Compare this value to your test result.
- If her hemoglobin or hematocrit value is equal to or less than the cut-off value, assign the risk criterion.

Participant Focused Counseling:

- With the participant or caregiver of a child with low hemoglobin: based on interest, discuss risks of low iron status, and benefits of better iron status.
- Offer Maryland WIC iron brochure, and discuss feeding practices that ensure optimal iron status, such as:
  - Choosing/offering a variety of age-appropriate, nutritious foods and foods high in iron and vitamin C
  - Weaning from a bottle;
  - Not offering tea or excessive amounts of milk.
Low Maternal Weight Gain

Category: PG

Defined as: A pregnant woman’s weight gain is below the minimum recommended for the completed week of gestation.

A woman who is both underweight and has low maternal weight gain should have Nutrition Care counseling.

Justification:

Low maternal weight gain in the second and third trimesters is associated with an increased risk of small for gestational age (SGA) infants, especially in underweight and normal weight women, failure to initiate breastfeeding, and preterm birth among underweight, and to a lesser extent, normal weight women.

The recommended rate of weight gain for women with singleton pregnancies is based on pre-pregnancy weight status. The total recommended weight gain is as follows:

- **Underweight status** (BMI <18.5): 28 to 40 pounds
- **Normal weight status** (BMI 18.5-24.9): 25 to 35 pounds*
- **Overweight status** (BMI 25.0-29.9): 15 to 25 pounds*
- **Obese status** (BMI ≥ 30.0): at least 11-20 pounds*

*Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women also.

For normal weight women pregnant with twins, total recommended weight gain is 37-54 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds. Weight gain should be 4-6 pounds in the 1st trimester and about 1.5 pounds per week during the 2nd and 3rd trimesters. For triplet pregnancies, overall gain should be about 50 pounds with a steady gain of about 1.5 pounds per week. For underweight women with multiple fetuses, a consistent weight gain of 1.5 pounds per week during the second and third trimesters is associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy.
Procedure:

Use Table I-P for the assessment.

- Obtain current height and weight measurements.
- Obtain pre-pregnancy weight (self report or from health care professional).
- Record height and weight measurements in the woman’s record.
- Use Table W to determine pre-pregnancy weight status.
- Subtract the woman’s pre-pregnancy weight from her current weight to determine the number of pounds gained.
- Determine the last completed week of gestation when height and weight measurements were taken.
- Using Table I-P, locate the completed week of gestation in the left-hand column. Read across the columns to locate the woman’s pre-pregnancy weight status.
- If she has gained equal to or less than the number of pounds in the column, she has low maternal weight gain.

Note: Do not evaluate this risk criterion for a woman pregnant with twins, triplets, or more.

Review collected information about dietary or lifestyle practices or medical conditions that could explain low maternal weight gain.

Participant Focused Counseling:

The pregnant woman can explain how maternal weight gain affects the growth of her infant and state the food, physical activity, and lifestyle choices she can make to gain weight appropriately.
**Maternal Smoking**  
(3711) **Categories: PG, BE/BP, WPP**

Defined as: Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigars.

**Justification:**

Use of tobacco by a woman who is pregnant can result in preterm delivery of a low birth weight infant, miscarriage, stillbirth, and abnormalities in placental attachment to the uterus. An infant born to a woman who smokes while pregnant is at a higher risk of Sudden Infant Death Syndrome (SIDS) and respiratory problems. Maternal smoking and exposure to second-hand smoke increases a child’s risk of having asthma and other respiratory problems. The chemical components of tobacco smoke, such as nicotine, may reduce the volume of breast milk.

Women who smoke are at risk for chronic and degenerative diseases. Smokers have a higher metabolic turnover of vitamin C. Smoking impairs folate status and is inversely related to intake of vitamins A and C, folate, iron, and dietary fiber. The WIC food package is a source of the nutrients that may be lacking in the diets of women who smoke.

Women who smoke should be given information about smoking cessation programs in the community.

**Procedure:**

Determine if the woman smokes cigarettes or other tobacco products.

A pregnant or breastfeeding woman who is using a nicotine patch to reduce smoking may be certified with this risk criterion. Use of a nicotine patch is not recommended during pregnancy or lactation. Manually add the risk factor and document with a note.

Refer to the *Maryland WIC Breastfeeding Kardex* for information about smoking by breastfeeding women.

**Participant Focused Counseling:**

The woman who smokes can:

- State the health risks to her and her infant; and
- State the food and/or supplement choices she can make to obtain adequate vitamin C and folic acid.
- State the actions she can take to reduce tobacco smoke exposure to her children.
Maternal Weight Loss
(3711) Category: PG

Defined as: Any weight loss below pre-pregnancy weight through completed week 13 of gestation or a weight loss of 2 pounds or more during the 2nd and 3rd trimesters (weeks 14 to 40 of gestation).

Justification:

Weight loss during pregnancy may indicate underlying dietary or lifestyle practices or health or social conditions associated with poor pregnancy outcomes.

Possible cause(s) of weight loss should be explored in order to provide appropriate guidance.

Procedure:

- If the woman is evaluated during the first 13 weeks of pregnancy, use self-report or data from her health care professional to document a weight loss below her pre-pregnancy weight or compare her current weight to her pre-pregnancy weight to determine if she weighs less now than before she became pregnant.

- If the woman is evaluated during weeks 14 to 40 of gestation, compare two weight measurement values using self-reported information or data from the health care professional to document that a weight loss of 2 or more pounds has occurred.

- Professional judgment should be used when evaluating this risk criterion, taking into consideration the participant’s pre-pregnancy weight status as well as adequacy of current weight gain.

Participant Focused Counseling:

- Review collected information about dietary or lifestyle practices or medical conditions that could explain weight loss.
- Based on the pregnant woman’s area of interest, review
  - how maternal weight gain affects the growth of her infant
  - the risks of low weight gain and benefits of appropriate weight gain
  - WIC foods and eating habits that can help with healthy weight gain
  - New food choices and eating pattern that she would like to try.
May Not Meet Dietary Guidelines
(4011) Categories: PG, BE/BP, WPP, C 2-4

Defined as: Women and children age 2 and older, who meet the eligibility requirements of category, income, and residency may be presumed to be at nutritional risk based on Failure to meet the Dietary Guidelines for Americans (consuming fewer than the recommended number of servings from one or more of the basic food groups, based on energy needs).

Justification:

Research has found that less than one percent of all women and children age 2-5 meet the recommendations for all food groups. Furthermore, members of low-income households are less likely to meet recommendations than more affluent ones.

According to the Institute of Medicine, “evidence exists to conclude that nearly all low-income women in the childbearing years, and children age 2 and older are at dietary risk, vulnerable to nutrition insults, and may benefit from WIC services.”

By presuming dietary risk, “WIC retains its potential for preventing and correcting nutrition-related problems.”

Procedure:

This risk factor may be assigned only to women and children age 2 and older for whom a complete nutrition assessment has been performed and for whom no other risk is identified.

Participant Focused Counseling:

Anticipatory guidance is the focus of the session.

- Guide participant in choosing healthy foods and age appropriate physical activities.
- Reinforce positive lifestyle behaviors.
- Discuss nutrition-related topics of interest to participant, such as food shopping, meal preparation, feeding relationships, and family meals.
- Refer as appropriate to the Supplemental Nutrition Assistance Program (SNAP), community food banks, and other available nutrition assistance programs.
Medical Condition, Nutrition Related
(3411-3621) Categories: All

Defined as: Any condition listed below that has been diagnosed by a physician as self reported by applicant/participant/caregiver or as reported or documented by a physician or someone working under physician’s orders.

Participants identified with one of these risk criteria should have Nutrition Care counseling.

Procedure:

Use collected information to determine that the participant has a diagnosed medical condition listed below. The condition must currently affect nutritional status.

Section 246.7(i)(6) of the WIC Program regulations requires that the State Agency ensure that appropriate documentation is included in the applicant’s WIC record to substantiate the nutrition risk condition(s) used to certify the applicant, and to validate conformance with the definition of the nutrition risk condition(s). When a self-report of a medical diagnosis is given, the CPA or CPPA must validate the presence of the condition by asking the following questions:

- Is this condition current and being treated by a health care professional?
- Is this condition being controlled by diet or medication or both?
- What dietary instructions have been prescribed?
- What medication has been prescribed?

The name and contact information for the medical professional should be obtained to allow communication and verification, if necessary. When determined appropriate, a consent form for release of confidential information may be completed and signed by the applicant/participant or caregiver in order to allow collection of pertinent medical or diet information to support the nutrition risk determination, and to assist the CPA in supporting the nutritional plan of care for the participant.

Expanded background material on each of the following conditions can be found in the Nutrition Care Manual.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Explanation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia nervosa (3582)</td>
<td>Anorexia nervosa is a disorder characterized by a disturbed sense of body image and morbid fear of becoming fat. Women with eating disorders may begin pregnancy in a poor nutritional state. They are at risk of developing chemical imbalances, nutritional deficiencies, and poor weight gain. Women may reduce eating disorder practices while pregnant, but regress during the postpartum period. Regression may be especially harmful if the woman is breastfeeding her infant. A woman with Anorexia Nervosa should be referred for Nutrition Care counseling. Best Practice: provide Nutrition Care follow-up in 3-6 months.</td>
</tr>
<tr>
<td>Asthma, moderate persistent or severe persistent (3601)</td>
<td>Asthma must be diagnosed as <em>moderate persistent or severe persistent</em> that requires the daily use of an inhaled anti-inflammatory agent or an oral corticosteroid.</td>
</tr>
<tr>
<td>Bronchitis Present in the last 6 months. (3526)</td>
<td>An acute infection that occurs when the airways in the lungs swell and produce mucus, resulting in a cough. It typically occurs after a chest cold and is usually caused by a virus. Since bronchitis is rarely caused by bacteria, antibiotics are not needed or recommended, and can harm both children and adults. Bronchitis typically resolves on its own in two weeks, but cough may last 8 weeks. Pain relievers should be appropriate for the age of the child. Only acetaminophen should be used for infants under 6 months of age. Prevention rests on good hygiene, updated immunizations, and not smoking.</td>
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<tr>
<td>Bulimia (3581)</td>
<td>Bulimia is a disorder characterized by a disturbed sense of body image and morbid fear of becoming fat. Women with eating disorders may begin pregnancy in a poor nutritional state. They are at risk of developing chemical imbalances, nutritional deficiencies, and poor weight gain. Women may reduce eating disorder practices while pregnant, but regress during the postpartum period. Regression may be especially harmful if the woman is breastfeeding her infant.</td>
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<tr>
<td>Cancer (3471)</td>
<td>Nutritional status at the time of diagnosis is associated with outcome of treatment. The type of cancer and the stage of disease progression determine the type of medical treatment and nutrition management.</td>
</tr>
<tr>
<td>Cardiorespiratory diseases (3604)</td>
<td>Cardiorespiratory diseases affect normal physiological processes and can be accompanied by growth failure, failure to thrive, and malnutrition due to low calorie intake and hypermetabolism.</td>
</tr>
<tr>
<td>Celiac disease <em>(or Celiac Sprue; Gluten Enteropathy;)</em></td>
<td>Inflammatory condition of the small intestine precipitated by the ingestion of gluten, a protein in</td>
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<tr>
<td>Condition</td>
<td>Description</td>
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<td>---------------------------------</td>
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<tr>
<td><strong>Non-tropical Sprue</strong></td>
<td>(3541) Wheat, rye, some oats, and barley in individuals with genetic predisposition. Eating gluten-containing foods can lead to diarrhea, weight loss, and malabsorption of other nutrients, and damage to small intestine. Lifelong strict avoidance of these grains is essential. Nutrition counseling can help these participants meet their nutrient needs and help in compliance.</td>
</tr>
<tr>
<td><strong>Cerebral palsy</strong></td>
<td>(3485) Oral motor dysfunction is associated with cerebral palsy (CP). Infants and children often have poor growth due to eating impairment (difficulty spoon feeding, biting, chewing, sucking, cup drinking, swallowing.) Texture modification, increased calories and nutrients, and referral to feeding clinics are often required.</td>
</tr>
<tr>
<td><strong>Cleft lip or palate</strong></td>
<td>(3492) Severe cleft lip or palate often cause difficulty with chewing, sucking, and swallowing even after extensive repairs. Nutrition care may be needed for adequate growth, development, and health maintenance.</td>
</tr>
<tr>
<td><strong>Congenital Hyperthyroidism</strong></td>
<td>(3444) Excessive thyroid hormone levels at birth, either transient (due to maternal Grave’s disease), which is treated with antithyroid drugs and subsides within several weeks, or persistent (due to genetic mutation).</td>
</tr>
<tr>
<td><strong>Congenital Hypothyroidism</strong></td>
<td>(3443) Congenital hypothyroidism due to maternal iodine deficiency is the leading cause of preventable mental retardation. Unless treated within 18 days after birth, the mental retardation will be irreversible.</td>
</tr>
<tr>
<td><strong>Crohn’s disease</strong></td>
<td>(3423) Weight loss, growth impairment, and malnutrition are prevalent. Nutrition care is essential.</td>
</tr>
<tr>
<td><strong>Cystic fibrosis</strong></td>
<td>(3602) Cystic fibrosis is a genetic disorder of children, adolescents, and young adults which stresses nutritional status by affecting appetite and intake. Catch-up growth requires extra calories to overcome energy deficit. <strong>Best Practice: Contact Cystic Fibrosis Center and/or Specialist RD before counseling and assigning food package</strong></td>
</tr>
<tr>
<td><strong>Developmental, Sensory, or Mental Disability</strong></td>
<td>(3621) Infants and children are at risk for nutritional problems. Pregnant and postpartum women may have chewing and swallowing problems that limit intake and increase malnutrition risk. Nutrition educations, referrals, and service coordination are important early interventions. <strong>Consider contacting Specialist RD before counseling and assigning food package.</strong></td>
</tr>
<tr>
<td><strong>Diabetes Mellitus</strong></td>
<td>(3431) Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action, or both. Control of diabetes through diet, exercise, and/or medication can reduce the degree of organ damage that occurs over time. Dietary guidelines for diabetes management vary depending upon the type of diabetes.</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
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</tr>
<tr>
<td>Down Syndrome</td>
<td>Hereditary or congenital condition at birth that causes a physical or metabolic abnormality. The current condition must alter nutritional status metabolically, mechanically, or both. Special attention to nutrition may be required to achieve adequate growth and/or to maintain health.</td>
</tr>
<tr>
<td>Drug-nutrient interactions</td>
<td>Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization to the extent that nutritional status is compromised. Common nutrition-related side effects of drugs include altered taste sensation, gastric irritation, appetite suppression, altered GI motility, and altered nutrient metabolism and function, including enzyme inhibition, vitamin antagonism, and increased urinary loss of vitamins. Abuse of prescribed or over-the-counter drugs may be applied only if the abuse can be documented to interfere with nutrient intake or absorption to the extent that nutritional status is compromised. The CPA should consult a standard reference to evaluate the impact of a medication on nutritional status. <strong>Consider contacting Specialist RD before counseling and assigning food package.</strong></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>People with epilepsy are at nutrition risk due to prolonged anti-convulsion therapy, inadequate growth, and physical injuries from seizures. Children on a ketogenic diet require growth monitoring, and increased energy and protein while maintaining ketogenic status. Women on antiepileptic drugs are at higher risk for infants with neural tube defects, and may require folic acid supplementation.</td>
</tr>
<tr>
<td>Food Allergies</td>
<td>Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food. The only way to avoid a food allergy is to eliminate the food. Nutrition counseling is required to help the participant obtain essential nutrients from other food sources and improve strict dietary avoidance. <strong>This risk criterion is restricted to documented allergy to one or more of the following: cow’s milk/milk products; eggs; soy; wheat and other grains; fish or shellfish; peanuts; or tree nuts.</strong> Allergies to cow’s milk, eggs, wheat and soy generally resolve in early childhood. Allergy to peanuts and tree nuts typically persist into adulthood. Rechallenges should be done only under a doctor’s care. <strong>Consider contacting Specialist RD for participant with multiple complex food allergies before counseling or assigning food package.</strong></td>
</tr>
<tr>
<td>Gall Bladder Disease</td>
<td>Includes gallstones, or obstructing bile duct causing pain and cramps, and inflammation of the gallbladder caused by bile duct obstruction. Since lipids stimulate gallbladder contraction, a low fat diet with 25% to 30% of total calories as fat is recommended. Greater fat restriction is not recommended. Supplementation with fat soluble vitamins may be needed.</td>
</tr>
<tr>
<td>Gastrointestinal anomalies</td>
<td>Hereditary or congenital condition at birth that causes a physical or metabolic abnormality. The current condition must alter nutritional status metabolically, mechanically, or both. Special attention to nutrition may be required to achieve adequate growth and/or to maintain health. The goals of nutrition counseling vary depending upon the disorder.</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
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<td>-----------------------------------------------</td>
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</tr>
<tr>
<td><strong>Gastroesophageal Reflux Disease (GERD)</strong></td>
<td>GERD is irritation and inflammation of the esophagus due to reflux of gastric acid into the esophagus. Nutrition Care for adults includes avoiding eating for 3 hours before going to bed, and avoiding fatty foods, coffee, and alcoholic beverages.</td>
</tr>
<tr>
<td><strong>Heart Disease</strong></td>
<td>The current condition or treatment for the condition must be severe enough to affect nutritional status. The effect upon nutritional status varies according to the condition.</td>
</tr>
<tr>
<td><strong>Hyperthyroidism</strong></td>
<td>Excessive thyroid hormone production (known as Grave’s disease) causing increased energy expenditure and weight loss with increased appetite. Normal weight is usually regained after medical treatment. Monitor weight status and diet adequacy.</td>
</tr>
<tr>
<td><strong>Hypothyroidism</strong></td>
<td>Thyroid gland makes inadequate thyroid hormone, sometimes due to inadequate iodine intake during pregnancy and lactation, causing infants with irreversible brain damage and maternal complications such as anemia, preeclampsia, miscarriage, premature delivery, and postpartum thyroid disease. Encourage iodine sufficiency, including 150 mcg iodine supplement. Monitor weight status.</td>
</tr>
<tr>
<td><strong>Inborn Errors of Metabolism</strong></td>
<td>Includes but not limited to Phenylketonuria (PKU); Maple Syrup Urine Disease (MSUD); Galactosemia; Homocystinuria; Tyrosinemia; Histidinemia; urea cycle disorders; Glutaric Aciduria; Methylmalonic Acidemia; Glycogen Storage Disease; galactokinase deficiency; fructosealdolase deficiency; Propionic Acidemia; or Hypermethioninemia. Appropriate dietary management may include the use of special formulas. Contact appropriate metabolic dietitian before assigning formula or food package: Children's National Medical Center in DC--202-476-6287 Johns Hopkins--410-955-3071 University of Maryland Hospital--410-328-3335</td>
</tr>
<tr>
<td><strong>Juvenile Rheumatoid Arthritis</strong></td>
<td>JRA is the most common pediatric rheumatic disease and most common cause of chronic arthritis among children. JRA puts individuals at risk of anorexia, weight loss, failure to grow, and protein energy malnutrition.</td>
</tr>
<tr>
<td><strong>Kidney disease</strong></td>
<td>Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections involving the bladder. A pregnant woman with renal disease may develop a preeclampsia-like syndrome and the growth of her fetus may be limited. Women with chronic renal disease often have proteinuria and may develop azotemia. Contact Specialist RD before counseling and assigning food package</td>
</tr>
<tr>
<td><strong>Lactose intolerance</strong></td>
<td>Documentation should indicate that the ingestion of dairy products causes the following GI disturbances: nausea, diarrhea, abdominal bloating, and/or cramps and that the avoidance of dairy products eliminates them. Nutrition counseling can offer strategies for avoiding symptoms while</td>
</tr>
</tbody>
</table>
consuming dairy products or to obtain nutrients such as calcium from alternate sources when dairy products or foods containing dairy products must be avoided. Secondary lactase deficiency results from small bowel injury and resolves when primary problem is resolved. Usually in infants. Congenital lactase deficiency is a rare disorder of a few infants that presents with intractable diarrhea when human milk or formula is introduced. Developmental lactase deficiency is relative lactase deficiency among pre-term infants <34 weeks gestation. May benefit from lactase supplemented feedings or lactose-reduced formula.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lupus Erythematosus (3605)</td>
<td>An autoimmune disorder that increases risk of infections, malaise, anorexia, and weight loss. In pregnant women there is increased risk of spontaneous abortion and late pregnancy losses (after 28 weeks gestation)</td>
</tr>
<tr>
<td>Multiple sclerosis (3482)</td>
<td>Individuals with MS may have chewing and swallowing problems requiring food texture changes. Obesity and malnutrition frequently occur due to immobility and steroid and antidepressant use.</td>
</tr>
<tr>
<td>Muscular dystrophy (3491)</td>
<td>A familial disease characterized by progressive muscle wasting and atrophy. Rapid functional changes can result in children gaining weight too rapidly. Focus nutrition education on healthy foods for a balanced diet while limiting simple sugars and fat.</td>
</tr>
<tr>
<td>Neural tube defects (3483)</td>
<td>Limited mobility or paralysis, hydrocephalus, limited feeding skills, and genitourinary problems put children with neural tube defects at increased risk of abnormal growth and development. Ambulatory disability, atrophy of the lower extremities, and short stature place NTDs-affected children at high risk for increased BMI. Monitor for growth and appropriate feeding practices.</td>
</tr>
<tr>
<td>Nutrient deficiency diseases (3411)</td>
<td>Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro- and micronutrients. Diseases include: Protein-Energy Malnutrition, Scurvy, Rickets, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Cheilosis, Menkes Disease, or Xerophthalmia.</td>
</tr>
<tr>
<td>Pancreatitis (3427)</td>
<td>Reduced secretion of pancreatic enzymes leads to malabsorption, and tissue necrosis can occur. A high carbohydrate, low-fat, low protein diet may be helpful.</td>
</tr>
<tr>
<td>Parasitic infections (3522)</td>
<td>Parasites are organisms that live on or in a host, and survive by getting their food at the detriment of the host. Pregnant women and children are most at risk from certain parasites. Toxoplasmosis, from uncooked meat or from soil, is the leading cause of death from foodborne illness in the US. Other frequent parasites include Giardia, Cryptosporidium, lice, and pinworms. Risk of parasitic infections are reduced by wearing gloves when contacting soil, and covering sand boxes when not in use. Good hygiene and proper food handling and storage are preventive.</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>Some participants with Parkinson’s disease required protein redistribution diets to increase efficacy of</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
</tr>
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<td>-------------------------------</td>
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</tr>
<tr>
<td>Peptic Ulcer (3425)</td>
<td>Focus of treatment is elimination of Helicobacter pylori infection with antibiotic and proton pump inhibitor therapy. Dietary advice is to avoid alcohol, coffee, chocolate, and some spices.</td>
</tr>
<tr>
<td>Pneumonia (3528)</td>
<td>An infection of the lungs caused by viruses, bacteria, or fungi severe enough to affect nutritional status. The infectious disease must be present within the past 6 months. Chronic, prolonged, or repeated infections adversely affect nutritional status through increased nutrient requirements as well as through decreased ability to take in or utilize nutrients. Children younger than 5 years of age are at especially high risk of pneumonia. When contracted during pregnancy, pneumonia causes increased negative outcomes including low birth weight, pre-term birth, and respiratory failure for the mother. Effective vaccinations are available for bacterial and viral pneumonia. Regular handwashing and disinfecting of frequently touched surfaces are also effective for prevention.</td>
</tr>
<tr>
<td>Post bariatric surgery (3420)</td>
<td>Surgery to promote weight loss in morbid obesity presents risks for nutritional deficiencies, requiring daily nutritional supplements and eating nutritionally dense foods. Consider contacting Specialist RD for current supplements and eating plan before counseling and assigning food package.</td>
</tr>
<tr>
<td>Postpartum thyroiditis (3445)</td>
<td>Postpartum thyroiditis can be either transient or permanent dysfunction occurring in the first year after delivery. Often resolution is spontaneous.</td>
</tr>
<tr>
<td>Pre-diabetes (3631)</td>
<td>Impaired Fasting Glucose (IFG) and/or Impaired Glucose Tolerance (IGT) are referred to as pre-diabetes. These conditions are characterized by hyperglycemia that does not meet the diagnostic criteria for diabetes mellitus. Individuals are at relatively high risk for the development of type 2 diabetes and cardiovascular disease (CVD). Dietary recommendations include monitoring calories, reduced carbohydrate intake, high fiber consumption, and increased physical activity.</td>
</tr>
<tr>
<td>Short bowel syndrome (3426)</td>
<td>SBS is the result of extensive small bowel resection in infants or adults. Supplementation with fat soluble vitamins and vitamin B12 may be needed. The pediatric client’s nutritional status must be assessed and growth closely monitored.</td>
</tr>
<tr>
<td>Sickle cell anemia (not trait) (3496)</td>
<td>An inherited disorder that can affect every organ of the body. Good nutrition with adequate calories, iron, folate, vitamin E and vitamin C with good hydration are key to minimize complications. Hemoglobin tests are not required if health care provider submits diagnosis, since hemoglobin will always be low. HCP hemoglobin records should be provided when possible. A note should be entered into the record.</td>
</tr>
<tr>
<td>Thalassemia (3494)</td>
<td>Hereditary or congenital condition at birth that causes a physical or metabolic abnormality. The current condition must alter nutritional status metabolically, mechanically, or both. Special attention to nutrition may be required to achieve adequate growth and/or to maintain health. Hemoglobin</td>
</tr>
</tbody>
</table>
Tests are not required if health care provider submits diagnosis, since hemoglobin will always be low. HCP hemoglobin records should be provided when possible. A note should be entered into the record.

<table>
<thead>
<tr>
<th>Disease</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis (3527)</td>
<td>A disease caused by the growth of pathogenic microorganisms in the body severe enough to affect nutritional status. The infectious disease must be present within the past 6 months. Chronic, prolonged, or repeated infections adversely affect nutritional status through increased nutrient requirements as well as through decreased ability to take in or utilize nutrients.</td>
</tr>
<tr>
<td>Ulcerative colitis (3428)</td>
<td>Gastrointestinal disorders increase nutritional risk in a number of ways, including restricted food intake, abnormal deglutition, impaired digestion of food in the intestinal lumen, generalized or specific nutrient malabsorption, or excessive gastrointestinal losses of endogenous fluids and nutrients. Frequent loss of nutrients through vomiting, diarrhea, malabsorption, or infections can result in malnourishment and lowered disease resistance. Nutrition management plays a prominent role in the treatment of gastrointestinal disorders.</td>
</tr>
</tbody>
</table>
Meningitis

(3521) **Categories: ALL**

Defined as: inflammation of the protective membranes of the brain and spinal cord known as meninges.

A participant determined to have Meningitis should be referred to the CPA for Nutrition Care counseling.

**Justification:**

Meningitis is typically caused by an infection of the fluid surrounding the brain and spinal cord. Most commonly meningitis is caused by a bacterial or viral infection, but it can also result as a response to physical injury, cancer, or certain drugs. Meningitis is severe, and treatment differs depending on the cause, so it is important to have a correct diagnosis of the agent responsible for the disease.

**Bacterial Meningitis:**

While most people with meningitis recover, bacterial meningitis is usually severe, and can result in serious complications, including brain damage, hearing loss, or learning disabilities.

The causes of bacterial meningitis vary by age group, and include variants of Streptococcus, Listeria, Neisseria, Haemophilus, and E. coli. In addition, *Cronobacter* may cause meningitis in infants in the first two months of life, but is very rare (about 4-6 infections per year). *Cronobacter* infections have been associated with use of powdered infant formula. The recommendation for prevention is to follow the manufacturer’s preparation instructions.

Meningitis symptoms include sudden onset of fever, headache, and stiff neck. Other symptoms include nausea, vomiting, sensitivity to light, and confusion. Diagnosis must be confirmed through laboratory testing of blood or cerebrospinal fluid. Bacterial meningitis is effectively treated with antibiotics, but it is important to begin treatment as early as possible. The most effective prevention is vaccination, as well as properly preparing and refrigerating foods, and avoiding certain foods.

**Viral Meningitis:**
Viral meningitis is the most common type, and it is often less severe than the bacterial type. Children younger than five and people with weakened immune systems are at higher risk of developing the disease, with infants younger than one month old and those with weakened immune systems more likely to develop severe illness.

Laboratory tests are required to confirm the illness, which usually resolves without treatment in 7-10 days. However, those with meningitis caused by the herpes virus or influenza may benefit from antiviral medication. Risk can be reduced by the following:

- Washing hands with soap and water, especially after changing diapers, using the toilet, or coughing or blowing your nose
- Avoiding touching faces with unwashed hands.
- Avoiding close contact with infected people.
- Cleaning and disinfecting household surfaces that are frequently touched.
- Staying home when sick.
- Having children vaccinated against other viruses that can cause meningitis, including measles, mumps, chicken pox, and flu.

**Participant Focused Counseling**

Through open-ended questions, determine the symptoms the participant faces. Based on the symptoms, discuss the options the participant is willing to take, as follows:

- Encourage adequate calories and healthy foods to meet the elevated needs of the participant during the infection and recovery.
- Discuss suggestions to address poor appetite.
- Offer education on good hygiene practices, and proper food preparation and storage techniques.
- Encourage vaccinations for both bacteria and viruses known to cause meningitis.
- Review instructions for preparation of powdered formula. Use “teach back” for assurance that participant understands formula preparation to protect the infant.
**Migrant Farm Worker; Migrant Farm Worker Status**

(8021) **Categories: All**

Defined as: Categorically eligible women, infants, and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

**Justification:**

Data on the health and/or nutritional status of migrants indicate significantly higher rates of infant mortality, malnutrition, and parasitic disease (among migrant children) than among the general U.S. population. Migrancy has been stipulated as a condition that predisposes persons to inadequate nutritional patterns or nutrition-related medical conditions.

**Procedure:**

- Determine if the participant is a migrant farm worker (or dependent).
- Review dietary and lifestyle practices.

**Participant Focused Counseling:**

The goals of nutrition counseling are to assist the migrant farm worker (or dependent) in making decisions about the selection, storage, and preparation of foods to promote optimal nutritional status.

- Review WIC foods appropriate for the participant(s).
- Review safe handling food practices.
- Referrals and service coordination with other programs may also be appropriate.
Mother in WIC or WIC-Eligible While Pregnant
(7011) **Categories: IBE, IBP, IFF**

Defined as: An infant under 6 months of age whose mother was a WIC Program participant during pregnancy or whose mother’s medical records document that the woman was at nutritional risk during pregnancy with a priority I risk.

**Justification:**

WIC participation during pregnancy is associated with improved pregnancy outcomes. An infant whose nutritional status has been maintained through WIC services during gestation and early infancy may decline in nutritional status without these services and return to a state of elevated risk for nutrition-related health problems.

An infant whose mother was at nutritional risk during pregnancy but did not receive WIC benefits may also be thought of as at risk for morbidity and mortality in the infancy period.

WIC participation during infancy is associated with lower infant mortality, decreased anemia, and improvements in head circumference, length, and weight.

**Procedure:**

Use mother’s WOW record as documentation of her participation while pregnant.

Documentation of the nutritional risk of the mother who did not participate in WIC while pregnant must be written as a note in the infant’s WOW record. Priority I risk criteria are detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally-related medical conditions.

**Participant Focused Counseling:**

- Promote breastfeeding.
- Review feeding practices that promote optimal growth and development of the infant.
- Provide appropriate WIC brochures.
Multi-fetal Gestation
(3341) Categories: PG, BE, BP, WPP

Defined as: More than one fetus in the current pregnancy for a pregnant woman or the most recent pregnancy for a breastfeeding or postpartum woman.

A woman pregnant with multiple fetuses should have Nutrition Care counseling.
Best Practice: Provide Nutrition Care follow-up in 3 months.

Justification:

Multi-fetal gestations are associated with low birth weight, fetal growth restriction, placental and cord abnormalities, preeclampsia, anemia, shorter gestation, and an increased risk of infant mortality.

Pregnant or breastfeeding women with twins have a greater requirement for all nutrients than women with only one infant. Postpartum, non-breastfeeding women who deliver twins are at greater nutritional risk than women who deliver one infant.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines: normal weight women should gain 37-54 pounds; overweight women, 31-50 pounds, and obese women, 25-42 pounds. There was insufficient information to develop even provisional guidelines for underweight women with multiple fetuses. A consistent rate of weight gain is advisable. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low birth weight deliveries in twin pregnancy. In triplet pregnancies, the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy. Education by the WIC nutritionist should address a steady rate of weight gain that is higher than for singleton pregnancies.

Procedure:
Determine if the woman is or was pregnant with 2 or more fetuses. Apply as follows:
• Pregnant woman: current pregnancy
• Breastfeeding or postpartum woman: most recent pregnancy

Participant Focused Counseling:
Review collected information about dietary and lifestyle practices. A woman pregnant with multiple fetuses, the woman who delivered more than one infant, or the mother breastfeeding more than one infant can state the food and lifestyle choices she can make that promote a positive pregnancy outcome.
**Neonatal Abstinence Syndrome**

*(3831) Categories: IBE, IBP, IFF*

Definition: Neonatal abstinence syndrome (NAS) is a drug withdrawal syndrome that occurs among drug-exposed (primarily opioid-exposed) infants as a result of the mother’s use of drugs during pregnancy. NAS is a combination of physiologic and neurologic symptoms that can be identified immediately after birth and can last up to 6 months after birth.

**Justification:**

Neonatal abstinence syndrome occurs when an infant is born dependent on prescription or illicit drugs the mother was taking during pregnancy. NAS is a combination of withdrawal symptoms that involve multiple bodily systems. It is most commonly associated with chronic opioid exposure during fetal development; however, can also result from chronic intrauterine exposure to other substances including: benzodiazepines, barbiturates, selective serotonin reuptake inhibitors and ethanol. Although these non-opioid substances can lead to NAS, these infants typically respond well to non-pharmacological methods of intervention.

Withdrawal in the newborn varies based on the type of substance, dose, and timing of exposure. Opioid is a general term for a variety of illicit and prescription drugs that decrease pain. Prescription opioid pain relievers include oxycodone, hydrocodone, codeine, morphine, and fentanyl. Opioids are water soluble and are, therefore, able to move easily across the placenta to the infant. This transfer of opioids increases as gestational age increases.

Participants who take any form of opioid, including prescription opioids as directed for chronic pain, can become addicted. Due to the risk of the transmission of infectious diseases such as HIV and Hepatitis C, women who become pregnant while using illicit opioids, such as heroin, are often put on opioid maintenance therapy. Opioid maintenance therapy involves the prescribed use of either methadone or buprenorphine. These prescribed opioids can still lead to NAS; however, since they are not injected, they decrease the risk of the mother contracting blood borne infectious diseases. Opioid maintenance therapy can also help protect the fetus from repeated opioid withdrawal in utero.

Infants born with NAS are often premature, have low birth weights, and are growth-restricted. In addition to exposure to substances in utero, additional factors, including social, nutritional, physical, and mental health problems can also contribute to the health status of the infant. An increased risk of birth defects such as spina bifida, hydrocephaly, glaucoma, gastroschisis, and heart defects are associated with early pregnancy opioid use.

**Neonatal Abstinence Syndrome Symptoms**
Symptoms of NAS generally involve the central nervous system, autonomic nervous system, and the gastrointestinal tract. The severity of the infant’s symptoms is commonly assessed using the Modified Finnegan Score Sheet. The Modified Finnegan Score Sheet consists of 21 symptoms that are associated with NAS. Following the determination of a baseline score, infants are assessed every 4 hours unless the severity of the symptoms requires more frequent monitoring.

The following list includes symptoms associated with NAS:

- Loud, high-pitched crying, sweating, yawning
- Sleep disturbances, feeding difficulties, poor weight gain
- Excessive sucking, regurgitation, diarrhea

**Neonatal Abstinence Syndrome Treatment**

Infants with NAS typically have longer hospital stays, serious complications, and costly treatment. The first treatment option for infants with NAS is to manage symptoms without medication by rooming in with the mother, encouraging skin-to-skin contact, swaddling, having a calm environment, avoiding overstimulation, and supporting breastfeeding. Infants who are at risk for NAS and who room-in with their mothers are not only at a lower risk of needing pharmacological treatment for NAS, but they also have a shortened hospital stay. If withdrawal is severe or if the initial treatment is not successful in managing symptoms, medications such as morphine, methadone, phenobarbital or clonidine may be used. An infant given these medications may have side effects that could include: slow or shallow breathing, slow heart rate, difficulty waking-up, excessive sleepiness, constipation, and fewer wet diapers.

**Nutritional Considerations for Neonatal Abstinence Syndrome**

The timing and type of feedings play an important role in the management of NAS symptoms. Infants with NAS may have impaired feeding behaviors such as excessive sucking, regurgitation, diarrhea and poor feeding that is characterized by fussiness, crying, and sleepiness. Infants with NAS have higher caloric requirements due to their energy expenditure. This combined with the impaired feeding behaviors may result in difficulty with weight gain. The American Academy of Pediatrics (AAP) recommends breastfeeding if not contraindicated. The AAP also recommends that infants with NAS be fed frequent small volumes of human milk or high calorie formula, as needed, in a quiet and calm environment, to aid the infant in tolerating feedings and improving digestion and to allow for adequate growth.

The Academy of Breastfeeding Medicine recommends breastfeeding for women who are on a prescribed stable dose of methadone maintenance because the concentrations of methadone in human milk are low. Studies have indicated that, although the amount of
methadone in human milk is dependent on the mother's dose, the methadone transferred in human milk averages less than 2.8% of the maternal dose. Breastfeeding has been found to provide protection against the development of NAS symptoms and lessen the severity of symptoms, which would decrease the need for pharmacological intervention for the infant. The amount of methadone that is in human milk is small and therefore, it is thought that breastfeeding, and not the methadone in human milk, is responsible for its protective impact against NAS. Gradual weaning, when mutually desired by the mother and infant, is recommended for breastfeeding women who are being treated for opioid addiction. Gradual weaning (rather than an abrupt stop to breastfeeding) decreases the risk of the infant developing NAS.

**Implications for WIC Nutrition Services**

NAS can be a difficult subject to talk about with WIC participants due to the stigma of addiction. In the WIC clinic, caregivers may not be forthcoming with the infant’s diagnosis of NAS and an addiction history of the mother may not be available at the initial assessment. WIC staff can assist caregivers by:

- Educating to recognize infant hunger cues.
- Reviewing feeding frequency and/or formula type and amount to help manage gastrointestinal symptoms of NAS.
- Providing growth monitoring to assess adequate weight gain.
- Encouraging supportive interventions to include:
  - Skin-to-skin contact
  - Swaddling
  - Quiet environment with little stimulation
- Encouraging breastfeeding unless medically contraindicated.
- Providing referrals for support services such as drug and alcohol counseling, parenting support, and medical evaluations.
- Encouraging mothers who are on medication-assisted therapy (e.g., methadone or buprenorphine) and who are breastfeeding, to speak with their health care provider if they have questions about the timing and dose of their medication.
- Educating mothers who are on medication-assisted therapy and who are breastfeeding on the importance of gradual weaning when mutually desired by the mother and infant.
**Nutrition Practice – Child**

**Categories:** C-1, C 2-4

Defined as: Routine feeding practices that may result in impaired nutrient status, disease, or health problems. Specific practices are shown below.

**Justification:** Inappropriate nutrition practices may lead to poor nutritional status in children.

<table>
<thead>
<tr>
<th>INAPPROPRIATE FEEDING PRACTICE</th>
<th>JUSTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feeding inappropriate beverages as the primary milk source, such as:</strong></td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Reduced fat (2%), lowfat (1%), or fat free (skim) milk before 2 years of age, <strong>unless overweight or obesity is a concern for a specific child.</strong></td>
<td>Children under age 2 who drink milk reduced in fat content may not receive adequate fat or calories in the diet and may be at risk for poor growth. Reduction in dietary fat intake is not recommended until after the age of 2.</td>
</tr>
<tr>
<td>• Rice or soy-based beverages that are inadequately fortified.</td>
<td></td>
</tr>
<tr>
<td>• Goat’s milk, sheep’s milk, or imitation or substitute milk inadequately fortified.</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding any sugar containing beverages, such as Kool-Aid, punch, sodas, tea or sports drinks.</strong></td>
<td>Abundant epidemiological evidence shows that sugar-especially sucrose-is the major dietary factor affecting the prevalence and progression of dental caries. Consumption of foods and beverages high in fermentable carbohydrates, such as sucrose, increases the risk of early childhood tooth decay. Excessive intake of nutrient-poor, high calorie foods by children between 13 and &lt; 24 months of age can reduce the appetite for other foods, especially those high in iron. Fewer nutrients are available to support growth needs.</td>
</tr>
<tr>
<td><strong>Using nursing bottles, cups, or pacifiers improperly, such as:</strong></td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Using a nursing bottle to feed any beverage other than breast milk or formula.</td>
<td>Inappropriate use of nursing bottles, cups, or pacifiers increase the risk for tooth decay, earaches, and choking. Pediatric dentists recommend that parents be encourage to have infants drink from a cup as they approach their first birthday, and that infants are weaned from the bottle by 12-14 months of age.</td>
</tr>
<tr>
<td>• Putting the toddler to bed with the bottle.</td>
<td></td>
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<tr>
<td>• Using a nursing bottle beyond 14 months of age.</td>
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<tr>
<td>• Allowing unrestricted use of a bottle or cup.</td>
<td></td>
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<tr>
<td><strong>Using feeding practices that disregard the developmental stage of the child, such as:</strong></td>
<td>The interactions between caregiver and child during feeding (referred to as the feeding relationship) affect a child’s ability to progress in eating skills and to consume a nutritionally adequate</td>
</tr>
<tr>
<td>• Not recognizing or disregarding the child’s cues for hunger and</td>
<td></td>
</tr>
</tbody>
</table>
- Forcing the child to eat certain foods or to “eat everything on the plate” or sit at the table for more than 30 minutes to finish eating.
- Using dessert or other “special” foods as a reward or bribe.
- Feeding foods inappropriate in consistency, size, or shape that could cause choking.
- Not allowing the child to learn to self-feed; routinely forcing the child to finish eating by taking over feeding.
- Restricting meals and snacks (less than 3 meals and 2 nutritious snacks per day).
- Severely limiting the child’s food intake, such as feeding the child only the foods that the caregiver likes or never offering a variety of foods because she thinks the child will not eat them. An entire food group is not offered (such as no Milk group foods) and there is no medical reason to do so.

<table>
<thead>
<tr>
<th>Feeding a diet very low in calories and/or essential nutrients, such as a vegan or macrobiotic or other highly restrictive diet.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly restrictive diets prevent adequate intake of calories and nutrients, interfere with growth and development, and may lead to other adverse physiological effects. A vegan diet is the consumption of plant origin foods (no meat, poultry, fish, eggs, milk, cheese or other dairy products). While a vegan diet may offer health benefits, lack of planning can result in an inadequate intake of calories, protein, vitamins B-12 and D, calcium, iron, and zinc. Such a diet requires attention to planning.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeding foods that could be contaminated with harmful bacteria or toxins, such as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpasteurized juice or dairy products and undercooked meats may contain pathogens that cause serious, potentially fatal foodborne illness. Raw vegetable sprouts can cause Salmonella or E. coli 0157.</td>
</tr>
</tbody>
</table>

- Feeding unpasteurized juice, milk, or cheese.
- Feeding deli or processed meats or hotdogs without further cooking them.
- **Feeding raw or undercooked meat, fish, shellfish, poultry, or eggs.**
- **Feeding raw vegetable sprouts.**
- Feeding local fish or seafood listed on the MDE advisory as DO NOT EAT.
Feeding dietary supplements that are inappropriate and/or excessive, such as:

- Giving any vitamin, mineral, or herbal supplement (unless prescribed by health care provider).
- Giving a child’s multivitamin supplement inappropriately (does not follow directions on the label).
- Giving any herbal remedy or herbal tea such as chamomile, comfrey, sassafras, or senna.

The use of non-prescribed or non-recommended dietary supplements, including single or multivitamins or minerals or the use of herbal remedies including teas may result in toxicity and harmful nutrient interactions.

Teas with potentially harmful effects on children include licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, poke root, poke weed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Mate, kola nut or gotu kola, and chamomile.

Routinely not providing essential dietary supplements.

- Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride.
- Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride.
- Not providing 400 IU of vitamin D if a child consumes less than 1 liter (1 quart) of vitamin D fortified milk or formula. Since 1 quart is above the recommendation for pre-school children, most children will require a supplement.

Fluoride decreases the susceptibility of teeth to dental caries. Once fluoride is an integral part of the tooth structure, teeth become stronger and more resistant to decay. It is recommended that when the water supply contains less than 0.3 parts per million (ppm) of fluoride, children between the ages of 12 and < 36 months of age consume 0.25 milligrams of fluoride daily and children 36 to 72 months of age consume 0.50 milligrams of fluoride daily. When the water supply contains 0.3 - 0.6 ppm fluoride, children 36 to 72 months of age should take 0.25 milligrams of fluoride daily.

Participant Focused Counseling:

Based on the participant’s willingness to explore change, review the risks related to the feeding practice, the benefits of change, and steps participant is willing to take to change the potentially harmful practices.
Nutrition Practice – Infant

Categories: IBE, IBP, IFF

Defined as: Routine feeding practices that may result in impaired nutrient status, disease, or health problems. Specific practices are listed below.

**Justification:** Inappropriate nutrition practices may lead to poor nutritional status in infants.

<table>
<thead>
<tr>
<th>INAPPROPRIATE FEEDING PRACTICE</th>
<th>JUSTIFICATION</th>
</tr>
</thead>
</table>
| • Routinely limiting the frequency of nursing of the exclusively breastfed infant to less than 8 times in a 24 hour period if the infant is <2 months of age  
• Scheduled feeding is used instead of demand feeding. Refer the infant to the breastfeeding specialist. | The American Academy of Pediatrics and others advocate breastfeeding as the preferred method of infant feeding during the first 12 months of life. Frequent breastfeeding is critical to establish and maintain an adequate milk supply for the infant. Inadequate frequency of breastfeeding can lead to lactation failure in the mother and dehydration and poor weight gain in the infant. |
| Using a substitute for breast milk or FDA-approved iron-fortified formula as the primary nutrient source. Examples include:  
• Low iron formula without iron supplementation of FDS-approved mixture of low-iron and iron-fortified formulas  
• Cow, goat, or sheep milk  
• Evaporated or sweetened-condensed milk  
• Soy or rice-based beverages  
• Other beverages such as non-dairy creamer or homemade concoctions | For non-breastfed infants, iron-fortified infant formula is recommended. Use of a low iron formula may deplete the infant’s iron stores, leading to anemia and poor growth. Cow, goat, or sheep milk, imitation milks, and substitute milks do not contain nutrients (such as iron or folic acid) in appropriate amounts for infants. The protein is more difficult to digest and can lead to blood loss and anemia. |
| Over- or under-dilution of formula by:  
• Not following manufacturer’s mixing instructions to stretch formula  
• Not following specific prescription instructions | Overdilution of formula can lead to poor growth, Failure to Thrive, or water intoxication (that can be fatal). Underdilution of formula concentrates calories and protein, and increases the renal solute load in the kidneys. Overweight, dehydration, and metabolic acidosis can occur. |
| Using nursing bottles or cups inappropriately, such as:  
• Using the bottle to feed fruit juice, fruit drinks, soda, gelatin water, chicken broth, corn syrup or sugar solutions, tea, or ice water | Inappropriate uses of a nursing bottle, such as feeding sugar-sweetened beverages may displace nutrients supplied by breast milk or formula. Feeding foods like cereal in a bottle may displace... |
### Lack of Sanitation in the Preparation, Handling, or Storage of Infant Formula or Expressed Breast Milk, Such As:

- Bottles, nipples, or equipment for breastmilk or formula preparation are not properly washed and rinsed.
- Formula, bottles, nipples, or equipment for formula or breastmilk are not sterilized before the infant is 4 months of age.
- **Formula is not prepared and/or stored by manufacturer's OR health care provider's instructions.**
- **The breast pump is not cleaned per manufacturer's instruction.**
- Well, cistern, or spring water that has not been tested and certified as pathogen-free by a certified testing agency such as a health department is used to prepare formula or is fed to the infant.
- There is no stove, refrigerator, freezer, or sink in the home or the equipment is not working.
- The infant is fed formula or expressed breast milk left from a prior feeding.
- The infant is fed breastmilk or prepared formula held at room temperature for more than one hour.
- The infant is fed prepared formula held in the refrigerator longer than 24 hours (if made from powder) or 48 hours (if made from concentrate).
- **Freshly expressed unrefrigerated human milk is added to frozen human milk**
- **Freshly pumped chilled human milk is added to frozen human milk in an amount that is greater than the amount of

### Diluted Cereal or Other Solid Foods.

- Allowing the infant to fall asleep or be put to bed with the bottle at naps or bedtime.
- Allowing the infant to use the bottle or cup without restriction (used as a pacifier).
- Propping the bottle when feeding.
- Allowing an infant to carry around and drink throughout the day from a covered or training cup.

### Nutrients Provided by Breast Milk or Formula and May Lead to Choking.

Allowing the infant to fall asleep with the bottle or propping the bottle when feeding the infant may result in Early Childhood Caries, ear infections, and choking.

Prepared infant formula or expressed breast milk is perishable and must be handled and stored properly to be safe for consumption. Lack of sanitation may cause a gastrointestinal infection.
**frozen human milk.**

- The infant is fed breast milk that has been previously frozen, thawed and then held in the refrigerator for over 24 hours before feeding.
- **Human milk is thawed/heated in a microwave.**
- Thawed human milk is refrozen.
- Feeding donor human milk received directly from another person or through the internet

**Offering complementary foods (solids, table, or family foods) that are inappropriate in type, timing or feeding methods, such as:**

- Feeding sugar or corn syrup in any beverage or putting it on a pacifier.
- Feeding any food other than breast milk or formula before 6 months of age.

Before 6 months of age, the infant's gastric and enzymatic secretions and digestive and renal capacity are low, making digestion of solid foods inefficient and potentially harmful. Nutrients supplied by breast milk or iron-fortified formula may be displaced. Developmentally, the infant is not ready to accept solids. The extrusion reflex is strong, resulting in foods being pushed out of the mouth. Offering sugar-sweetened beverages or excessive amounts of juice may prevent consumption of essential nutrients from breast milk, formula, or other more appropriate foods.

After 6 months of age, complementary foods are gradually added to supplement the nutrients and calories provided by breast milk or iron-fortified formula.

**Feeding a very nutritionally inadequate diet such as:**

- Not allowing the infant to consume any more food than the caregiver initially provides.
- Following a strict vegan or macrobiotic diet.
- Other diets very low in calories and/or essential nutrients.

Highly restrictive diets prevent adequate intake of calories and nutrients, interfere with growth and development, and may lead to other adverse physiological effects.

An infant held to a rigid feeding schedule may be underfed or overfed. Caregivers insensitive to signs of hunger and satiety or who exert control over feeding may inappropriately restrict or encourage excessive intake.

**Using feeding practices that disregard the developmental stage of the infant, such as:**

- Not recognizing or disregarding the infant's cues for hunger or fullness (putting the infant on a strict feeding schedule instead of feeding on demand) or forcing an infant to eat a certain type or amount of food.

A critical developmental period exists in which the infant learns progressively how to accept, manipulate, and swallow solid foods. Between the ages of 6 and 7 months, the infant develops the ability to self-feed finger foods that are easily chewed and swallowed. Foods that are inappropriate in size, shape, or consistency may cause choking and result in asphyxiation.
- Feeding foods that could cause choking, such as potato or other snack chips, hot dogs, raw vegetables, raw hard fruits, or large pieces of meat.
- Feeding food in a bottle or syringe-nipple feeder and not by spoon.
- Not supporting the infant’s growing need for independence with self-feeding (only spoon feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils.)
- Not advancing the textures of foods (puree; mashed; chopped; tiny pieces of foods) according to the infant’s developmental readiness.

**Feeding foods that could be contaminated with harmful bacteria or toxins, such as:**
- Honey or unpasteurized fruit or vegetable juice
- Undercooked or raw meat, fish, shellfish, poultry, or eggs
- Local fish or seafood listed on the MDE advisory as DO NOT EAT.
- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese
- **Raw vegetable sprouts (alfalfa, clover, bean, and radish)**
- Deli meats, hot dogs, and processed meat unless heated to steaming

**Feeding dietary supplements that are inappropriate and/or excessive, such as:**
- Feeding any vitamin or mineral supplement (unless prescribed by health care professional.)
- Feeding any herbal remedy or herbal tea such as chamomile, comfrey, or senna.
- Feeding “gripe” water.

**Not giving a dietary supplement recognized as essential by national public health policy, such as:**
- Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride.
- Infants who are exclusively breastfed, or are ingesting less than

Honey in any form may contain spores of *Clostridium botulinum*, which if consumed by an infant, may create a deadly toxin inside the gastrointestinal tract and lead to death. Unpasteurized juice and undercooked meats may contain pathogens that cause serious, potentially fatal foodborne illness.

The use of unprescribed dietary supplements, including single or multivitamins or minerals or the use of herbal remedies including teas may result in toxicity and harmful nutrient interactions.

Fluoride decreases the susceptibility of teeth to dental caries. Once fluoride is an integral part of the tooth structure, teeth become stronger and more resistant to decay. It is recommended that when the water supply contains less than 0.3 parts per million (ppm) of fluoride, infants 6 months of age and older consume 0.25 mg daily.
| 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D. | milligrams of fluoride daily. |
**Nutrition Practice – Woman**  
*Categories: PG, BE, BP, WPP*

Defined as: Routine use of nutrition practices that may result in impaired nutrient status, disease, or health problems. Specific practices are listed below.

<table>
<thead>
<tr>
<th><strong>INAPPROPRIATE NUTRITION PRACTICE</strong></th>
<th><strong>JUSTIFICATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Severely limits intake of food sources of important nutrients, such as avoiding an entire food group like the Milk Group.</td>
<td>Highly restrictive diets prevent adequate intake of calories and nutrients and may lead to other adverse physiological effects.</td>
</tr>
<tr>
<td>Consumes plant foods only (vegan or macrobiotic diet).</td>
<td>While a vegan diet may offer health benefits, lack of planning can result in an inadequate intake of calories, protein, vitamins B-12 and D, calcium, iron, and zinc. Foods should be chosen carefully.</td>
</tr>
<tr>
<td>- Routinely fasts, limits meals to one a day, follows a very low calorie diet, or purges foods once eaten.</td>
<td>Women consuming highly restrictive diets are at risk for nutrient deficiencies, especially during critical development periods such as pregnancy.</td>
</tr>
<tr>
<td>- Follows a very low calorie diet or a low carbohydrate/high protein diet.</td>
<td></td>
</tr>
<tr>
<td>Consumes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences. Such supplements include unprescribed multi- or single vitamins or minerals or herbal remedies.</td>
<td>Taking inappropriate or excessive amounts of single or multivitamin or mineral supplements or herbal remedies can lead to adverse effects, including harmful nutrient interactions, toxicity, and harm to the fetus. While many herbal teas may be safe, some have undesirable effects, particularly on infants fed breast milk from mothers who consume the tea.</td>
</tr>
<tr>
<td>Currently or recently craves or consumes non-foods, such as clay, dry cornstarch, laundry starch, freezer frost, or baking soda.</td>
<td>Pica is the practice of eating nonfood items. It is linked to lead poisoning, anemia, excess calories, small bowel obstruction, and parasitic infection. It may alter the absorption of or displace nutrients, resulting in a deficiency. Consuming certain foods can pose a health risk to pregnant women and their fetuses. Effects on the infant include: neurological damage, fetal or neonatal death, or prematurity.</td>
</tr>
<tr>
<td>If pregnant, consumes foods that could be contaminated with pathogens or toxins, such as raw or undercooked meat, fish, shellfish, or eggs; fish or shellfish contaminated with mercury; deli meats or hot dogs not cooked to steaming-hot; unpasteurized fruit</td>
<td>Food contaminated with bacteria, viruses, or parasites can cause vomiting, diarrhea, abdominal pain, premature delivery, miscarriage, fetal death, and severe illness or death of the newborn.</td>
</tr>
</tbody>
</table>
or vegetable juices, milk or other dairy products; soft, unaged cheeses like feta, blue-vein, or Mexican style cheeses.

- If pregnant, does not consume 27 milligrams of iron daily, either as a prenatal vitamin or an iron supplement.
- If not pregnant, does not consume 400 micrograms of folic acid daily, either from a folic acid or multivitamin supplement or from highly fortified breakfast cereal.
- If pregnant or breastfeeding, does not consume a 150 mcg iodine supplement daily.

The Centers for Disease Control & Prevention (CDC) recommends that pregnant women be prescribed a 27 milligram daily dose of iron during the 2nd and 3rd trimesters to meet iron needs. The CDC also recommends that women capable of becoming pregnant consume 400 micrograms of folic acid daily.

The American Thyroid Association recommends that women receive prenatal vitamins containing 150 mcg iodine daily during pregnancy and lactation. The iodine content of prenatal vitamins in the U.S. is not mandated, so iodine content should be reviewed to assure adequate intake to prevent adverse function in children.

**Participant Focused Counseling:**

When a woman is identified with a nutrition practice risk factor, review the risks related to the practice, and the benefits of change. Determine her willingness to explore change, and discuss the steps the participant is willing to take to change the potentially harmful practices.
Obese (Child)  
(1131) Categories: C 2-4

Defined as: BMI/age ≥ 95th percentile on CDC growth chart for a child 2 to 5 years of age.

**Justification:**

The rapid rise in the prevalence of obesity in children is one of the most important public health issues in the United States today.

Research on BMI and body fatness shows that the majority of children with BMI/age at or above the 95th percentile have high adiposity, and an increased risk for future adverse health outcomes and/or developmental diseases.

The causes are complex. Both genetic and environmental factors contribute to obesity risk.

Obesity can result from excessive energy intake, decreased calorie expenditure, or impaired regulation of energy metabolism. Having a Body Mass Index (BMI) for age at the 95th percentile or higher identifies children with a greater likelihood of being overweight as adolescents and adults.

It is recommended that an obese child undergo a medical assessment and careful evaluation to identify any underlying health risks or secondary complications.

Overweight in early childhood may signify problematic feeding practices such as excessive consumption of high calorie foods and beverages or family behaviors such as too many hours spent watching television. Such practices, if continued, may contribute to diet and inactivity-related health risks in adulthood.

**Procedure:**

- Obtain current height measured to the nearest 1/8 inch and weight measured to the nearest 4 ounces. Record measurements in the participant’s record.
- Calculate BMI using the procedure found in Table BMI.1. Plot the BMI value on the BMI/age growth chart.
- If the plotted point is at or greater than the 95th percentile, assign the risk criterion.
- Review collected information for routine dietary practices that could promote a faster rate of weight gain, such as drinking milk and other beverages from a baby bottle; excessive snacking (more than 3 snacks per day); or forcing the child to eat. Inquire about usual activity and television watching.
Participant Focused Counseling:

Do not use the medical term “obese” when discussing the child’s weight with the caregiver. Frame the Participant Focused Counseling discussion to make achieving the child’s optimal growth a shared goal of the WIC program and the parents/caregivers. Make clear that BMI/age ≥95th percentile is a medical condition that can be addressed.

- Educate parents/caregivers on behaviors that can lead to healthy body weight, including:
  - Recognizing fullness cues
  - Offering a variety of nutritious foods;
  - Not overly restricting foods;
  - Offering the child foods lower in fat, such as 1% or fat free milk and low fat cheese, or selecting beans as well as peanut butter;
  - Comforting the child by holding, reading, or rocking instead of feeding;
  - Being active as a family;
  - Reducing screen and electronics time.

- Discuss the behavior changes parents/caregivers are willing to address.
- Discuss strategies that might work for the family.
- If parents/caregivers are willing, help them set a simple, measurable goal.
- Enter the goal in WOW.
Oral Health Conditions

(3811) Categories: All

Defined as: Diagnosis of oral health conditions by a physician or a health care professional working under the orders of a physician or adequate documentation by the CPA or CPPA.

- **Women and Children**: includes, but not limited to tooth decay, periodontal disease, tooth loss and/or ineffectively replaced teeth that impair the ability to ingest food in adequate quantity or quality.
- **Pregnant woman**: includes gingivitis of pregnancy.
- **Infants and Children**: includes the presence of Early Childhood Caries (baby bottle tooth decay) or smooth surface decay of the maxillary anterior teeth or the primary molars.

Justification:

Missing more than seven teeth in adults seriously affects the ability to chew foods and can restrict food intake, resulting in a diet that is poor in nutritional quality. Diet quality tends to decline as dental impairment increases, including decreases in vitamin A, fiber, calcium, and other nutrients because hard-to-chew nutritious foods like fruits and vegetables decline, while high calorie, high fat processed foods increase.

Periodontal infection is a significant risk criterion for preeclampsia, can result in placental-fetal exposure and, when coupled with a fetal inflammatory response, can lead to preterm delivery. Periodontal disease and caries may also increase the woman’s risk of atherosclerosis, rheumatoid arthritis and diabetes.

There is evidence that gingivitis of pregnancy results from end tissue deficiency of folic acid that will respond to folic acid supplementation as well as plaque removal.

Early childhood caries result from inappropriate feeding practices, especially frequent sugar consumption. Healthful dietary and oral hygiene practices can prevent the loss of primary teeth, and potential speech problems.

Children with special health care needs (including prematurity and intrauterine malnutrition, GERD, failure to thrive and other weight gain and growth problems, craniofacial malformations, compromised immune function, and Down syndrome) can increase the risk of oral health problems and can also make the overall effects of poor oral health more severe.

Referral to dental services should be made as appropriate.

**Procedure**: Determine the presence of oral health conditions in the woman, infant, or child. Self-reported information is acceptable.

The presence of obvious dental decay or tooth loss may also be documented by observation by WIC staff. Review collected information about dietary practices that may increase the risk of dental problems.
Participant Focused Counseling:

With woman with oral health conditions, discuss:

- Dietary and oral health practices that lower risk of dental problems including use of fluoride toothpaste and rinsing nightly with alcohol-free, over-the-counter mouth rinse with 0.05% sodium fluoride.
- Preparing easy-to-chew foods, as needed

With caregiver of an infant or child with oral health conditions, discuss:

- Feeding practices that promote optimal oral health, such as reducing frequency of sugary food and drink; weaning directly from bottle to open cup by 12 months of age; not propping baby bottle, and, if necessary, giving only water in bottle at bedtime
- Oral health strategies that reduce cavity risk, such as daily oral hygiene appropriate for age, routine dental checkups, and not sharing cups or utensils between adult and child.
- Use of fluorides for the prevention and control of caries is documented to be both safe and highly effective, including using tiny amounts of fluoride toothpaste as soon as teeth erupt. Parents and caregivers may have questions and concerns about fluoride content in water supplies and in infant formula. Fluoridated water can be found in communities that supplement tap water with fluoride and it may also be found in well water. The CDC’s My Water’s Fluoride website: http://apps.nccd.cdc.gov/MWF/Index.asp allows consumers in currently participating States to learn the fluoride status of their water system.
- Emphasize noncariogenic vs high cariogenic foods, using the chart below:

<table>
<thead>
<tr>
<th>Noncariogenic Foods</th>
<th>Low Cariogenic Foods</th>
<th>High Cariogenic Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheese, cottage cheese, plain yogurt</td>
<td>Flavored milk</td>
<td>Breakfast bars, granola bars</td>
</tr>
<tr>
<td>Chicken, eggs, unflavored cow’s milk</td>
<td>Fresh fruits</td>
<td>Cake, cookies, candies**</td>
</tr>
<tr>
<td>Popcorn, nuts and seeds*</td>
<td>Whole grain products</td>
<td>Doughnuts, pretzels, soda crackers</td>
</tr>
<tr>
<td>Seltzer, flavored club soda</td>
<td></td>
<td>Raisins and other dried fruit</td>
</tr>
<tr>
<td>Vegetables</td>
<td></td>
<td>Sweetened drinks, including fruit juice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sweetened dry cereal</td>
</tr>
</tbody>
</table>

*choking hazard for infants and toddlers

**Sticky candy and/or slowly eaten candy are extremely cariogenic

Overweight (Woman)
(1111) Categories: PG, BE/BP, WPP

Defined as:
1. **Pregnant Woman**: Pre-pregnancy Body Mass Index (BMI) ≥ 25.0*.
2. **Postpartum or Breastfeeding (less than 6 months postpartum) Woman**: Pre-pregnancy Body Mass Index (BMI) ≥ 25.0*.
3. **Breastfeeding (6 months or more postpartum) Woman**: Current Body Mass Index (BMI) ≥ 25.0*.

*Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women as well.

Justification:
Maternal overweight and obesity are associated with higher rates of cesarean delivery, gestational diabetes mellitus, preeclampsia, and other pregnancy-induced hypertensive disorders, as well as postpartum anemia. Several studies have established an association between obesity and increased risk for hypertension, dyslipidemia, diabetes mellitus, cholelithiasis, coronary heart disease, osteoarthritis, sleep apnea, stroke and certain cancers. Since obesity can result from the over-consumption of excess calories from foods lacking in other nutrients, the obese woman may be malnourished.

Procedure:

**Pregnant Woman**:
- Use Table W for the procedure. Measure height to the nearest 1/8 inch. If the height fraction is between 1/8 and 3/8 of an inch, round down to the nearest whole number. If it is between 5/8 and 7/8 of an inch, round up to the nearest whole number.
- Obtain pre-pregnancy weight (self-report or from health care professional). Using the woman’s current height and pre-pregnancy weight, determine her weight status according to Table W. Record height and weight measurements in the woman’s record.

**Breastfeeding or Postpartum Woman**:
- For a postpartum or breastfeeding woman (less than 6 months postpartum) use current height and pre-pregnancy weight to determine weight status according to Table W.
- For a breastfeeding woman (6 months or more postpartum) use current height and weight measured to the nearest 4 ounces to determine weight status according to Table W. Record height and weight measurements in the woman’s record.
- Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks, fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Prepregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the prepregnancy weight. In most cases, therefore,
prepregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery.

- Review collected information about dietary and lifestyle practices or medical conditions that could lead to overweight.

**Participant Focused Counseling:**

When a woman is determined to be overweight, review the related risks, and the benefits of change. Determine her willingness to explore change, and discuss the steps the participant is willing to take to change to improve her weight status.
Overweight/At Risk of Overweight (Infant, Child)
(1141) **Categories: IBE, IBP, IFF, C 1-4**

Defined as:

- **Overweight**: BMI/age ≥ 85th to less than the 95th percentile on CDC growth chart for a child 2 to 5 years of age.
- **At risk of overweight**: an infant whose biological mother was obese at the time of conception, or any infant or child whose biological mother or father is obese.

**Justification:**

Increasingly, attention is being focused on the need for comprehensive strategies that focus on preventing overweight/obesity and a sedentary lifestyle for all ages. Scientific evidence suggests that the presence of obesity in a parent greatly increases the risk of overweight in preschoolers, even when no other obvious signs of increasing body mass are present.

**Procedure: Child 2 to 5 years of age:**

1. Obtain current height measured to the nearest 1/8 inch and weight measured to the nearest 4 ounces. Record measurements in the participant’s record.
2. Calculate BMI using the procedure in **Table BMI.1**. Plot the BMI value on the BMI/Age growth chart.
3. If the plotted point is between the 85th to below the 95th percentiles, assign the risk criterion.
4. Review collected information for routine dietary practices that could promote a faster rate of weight gain, such as drinking milk and other beverages from a baby bottle; excessive snacking (more than 3 snacks per day); or forcing the child to eat. Inquire about usual activity and television watching.

**Procedure: Infant or Child ≤ 24 months of age:**

- If infant is less than one year of age, ask biological mother for her height and weight at the time of conception. **Or**
- If the child is over one year of age, ask the biological mother for her height and weight. If mother is pregnant or has had a baby in the past six months, ask for her preconception height and weight. **Or**
- If the biological father is present at the certification, ask for his height and weight. If biological mother or father provides height and weight information, use **Table BMI.2** to calculate BMI ≥30.
- Parents are not required to give their height and weight information.
Participant Focused Counseling:

Do not use the medical term “overweight” when discussing the child’s weight with the caregiver. Frame the Participant Focused Counseling discussion to make achieving the child's optimal growth a shared goal of the WIC program and the parents/caregivers.

Make clear that BMI/age between the ≥85th percentile and the 95th percentile is a medical condition that can be addressed.

- Educate parents/caregivers on behaviors that can lead to healthy body weight, including:
  - Recognizing fullness cues;
  - Offering a variety of nutritious foods;
  - Not overly restricting foods;
  - Offering the child foods lower in fat, such as 1% or fat free milk and low fat cheese, or selecting beans as well as peanut butter;
  - Comforting a child by holding, reading, or rocking instead of feeding;
  - Being active as a family;
  - Reducing screen and electronics time.
- Discuss the behavior changes parents/caregivers are willing to address.
- Discuss strategies that might work for the family.
- If parents/caregivers are willing, help them set a simple, measurable goal.
- Enter the goal in WOW.
Pica Practice
(425.9)  Category: ALL

Defined as: Self-reported by applicant/participant/caregiver. Routine ingestion of nonfood items (Pica).

A participant identified with Pica practice should have Nutrition Care counseling.

Justification: Pica is the compulsive eating of nonnutritive substances and can have serious medical implications. Pica is observed most commonly in areas of low socioeconomic status and is more common in women (especially pregnant women) and in children. Pica has also been seen in children with obsessive-compulsive disorders, mental retardation, and sickle cell disease. Complications of this disorder include: iron-deficiency anemia, lead poisoning, intestinal obstruction, acute toxicity from soil contaminants, and infestations of parasitic worms.

Procedure:
During the nutrition assessment, establish that the woman or child frequently eats non-food items.

Participant Focused Counseling:
- Through open-ended questions, determine what nonfood items the participant eats.
- Ask what participant knows about the risks related to pica.
- Ask permission to share the known risks.
- Determine if the participant has had a blood lead test if child, pregnant, or breastfeeding.
- Share Pica handout, and Lead handout.
- Suggest participant complete the lead risk review, then discuss with health care provider.
- Explore nutrition practices that help prevent lead absorption:
  - Evenly spaced meals throughout the day.
  - Foods high in calcium: milk, cheese, yogurt
  - Foods high in iron: lean meat, fish, poultry, eggs, peas and beans
  - Foods high in vitamin C: oranges and citrus fruit, berries and melons, dark green leafy vegetables, and potatoes.
Possibility of Regression
(5011) Categories: C 1-4

Defined as: A participant previously certified as eligible for the Program may be considered to be at nutritional risk in the next certification period if the CPA or CPPA determines there is a possibility of regression in nutritional status without the benefits that the WIC Program provides.

Possibility of Regression may be used one time only.

Justification:
On occasion, a participant’s nutritional status or dietary practices may be improved such that s/he rises above the cut-off value of the initial risk condition by the end of the certification period. Removal of such individuals from WIC can result in a situation where the recently improved nutritional status deteriorates quickly, so that s/he re-enters the Program at equal or greater nutritional risk than before. WIC Program regulations permit State agencies to certify previously certified individuals who do not currently demonstrate a nutrition risk condition if they may regress to one or more previously identified risk conditions because they no longer receive WIC benefits.

Procedure:
When recertifying a child, if no other risk criterion can be found, Possibility of Regression may be used as a risk criterion. Risk criteria that the child might regress to include:

- Underweight
- Overweight (child age 2 and older, only)
- Risk for Overweight (child age 2 and older, only)
- Low Hemoglobin/Hematocrit
- Elevated Blood Lead
- Dental Problems
- Failure to Thrive
- Nutrition Practice – Child
- Nutrition-related Medical Condition

Participant Focused Counseling: The goals of nutrition counseling are to reinforce and support category- and age-appropriate guidelines as well as strategies for nutritional risk reduction to promote the nutritional well being of the participant.
Pregnancy at a Young Age

Categories: PG, BE/BP, WPP

Defined as: Conception occurs before 18 years of age.

Justification:

Pregnancy before growth is complete is a nutritional risk because of the potential for competition for nutrients between the woman and her fetus. The pregnant adolescent may consume less than the recommended amounts of protein, iron, and calcium and is more likely to be underweight. Concerns about body image may prevent adequate weight gain. Low birth weight infants are more frequently born to pregnant adolescents. The adolescent mother has special needs for support and encouragement. Adolescent mothers are less likely to breastfeed, and should be supported in their efforts. They can benefit from counseling that includes strategies for combining breastfeeding and school or work. Referral for family planning services may be appropriate.

Procedure:

- Using a self-report of birth date and date of last menstrual period, determine the age at date of conception. The date of conception is defined as the 14th day following the first day of the last menstrual period.
- Use a gestation wheel to determine date of conception. Apply as follows:
  - Pregnant woman: current pregnancy
  - Breastfeeding or postpartum woman: most recent pregnancy
- Review collected information to identify lifestyle or dietary practices that may prevent adequate and appropriate food intake.
- For the adolescent mother who is breastfeeding, assess knowledge and skills for breastfeeding success.
- Review the related risks, and the benefits of change.
- Determine her willingness to explore change.
- Discuss the steps the participant is willing to take to change/ improve her nutritional status.
- Review strategies for making the change.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.

Participant Focused Counseling:

The pregnant adolescent or adolescent mother can state the food, physical activity, and lifestyle choices she can make that are associated with good health.
Pregnant Woman Currently Breastfeeding

(3381) Category: PG

Defined as: A breastfeeding woman who is now pregnant.

This risk factor must be manually assigned in WOW and a note must be written to document it.

Refer a pregnant woman who is breastfeeding an infant less than 12 months of age to the breastfeeding specialist.

Justification:

Breastfeeding during pregnancy can influence the mother’s ability to meet the nutrient needs of her growing fetus and breastfed infant. Pregnancy hormones generally cause the expectant mothers breast milk volume to decline and composition to change. If the mother conceived while her nursing infant was solely or predominantly breastfed, the infant could fail to receive adequate nutrition. Nipple tenderness could become a problem. Oxytocin released during breastfeeding might trigger uterine contractions and premature labor.

Procedure:

- Determine if the pregnant woman is breastfeeding another child.
- A woman who is pregnant and breastfeeding an infant or child may be at risk for premature labor and should be advised to talk with her health care professional to learn the signs of premature labor.
- The breastfed infant of a pregnant woman who is breastfeeding should be assessed for adequate growth.

Participant Focused Counseling:

- Review collected information to identify lifestyle or dietary practices that may prevent adequate and appropriate food intake.
- Discuss the steps the participant is willing to take to ensure her nutritional status.
- Review strategies for making the change.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.
Preterm or Early Term Delivery

Categories: IBE, IBP, IFF, C-1

Defined as:
Preterm and early term delivery are defined as follows:
• Preterm: Delivery of an infant born \( \leq 36 \frac{6}{7} \) weeks gestation.
• Early Term: Delivery of an infant born \( 37 \frac{0}{7} \) and \( \leq 38 \frac{6}{7} \) weeks gestation.

An infant identified as preterm or early term should have Nutrition Care counseling.

Justification:

Prematurity affects about 12% of all live births in the U.S., and about 50% of these preterm births were preceded by preterm labor. In 2011, the annual rate of premature births in the United States reached 11.7%, nearly two times the rate in European nations. Preterm births also account for approximately 70% of newborn deaths and 36% of infant deaths. Factors that increase the risk of preterm delivery include low socioeconomic status, nonwhite race, maternal age of \( \leq 18 \) years or \( \geq 40 \) years, low pre-pregnancy weight, history of prior preterm births, low weight gain during pregnancy, maternal obesity, hypertension, diabetes, or sexually transmitted diseases.

Despite advances in neonatal care, preterm birth remains a leading cause of infant death in the United States. Preterm infants may have health problems because their organs did not have enough time to develop in the womb. Babies that are born too early may have a number of health conditions, including:
• Low or very low birth weight
• Increased caloric needs
• Feeding difficulties due to a lack of reflexes for sucking and swallowing
• Immature digestion and impaired absorption of carbohydrates and lipids
• Breathing problems like chronic lung disease/ bronchopulmonary dysplasia and apnea
• Cerebral palsy, an impairment of the brain that controls movement and muscle tone
• Developmental delay and poorer cognitive function
• Vision problems like retinopathy of prematurity (ROP), which may cause blindness
• Behavioral problems and psychiatric disorders
• Increased risk for necrotizing enterocolitis (NEC) due to their immature gastrointestinal systems
• Increased risk for Sudden Infant Death Syndrome (SIDS)
• Temperature control problems.
• Heart problems, Hypoglycemia, Hearing problems, anemia and jaundice
• Immature immune systems, which may result in infections.

The Benefits of Breastfeeding

Preterm infants often need special medical care in a neonatal intensive care unit (NICU) and may need to stay there for days or even months. Breastfeeding is recommended as the normative standard for infant feeding and nutrition for all infants, especially preterm babies. Breastfeeding preterm infants has been associated with positive health outcomes for these infants, including:
• Improved motor maturity and cognitive ability
• Reduced risk of NEC
• Reduced risk of ROP and retinal detachment

Additionally, mothers of preterm infants produce milk that is designed to meet the baby’s particular nutritional needs during the first few weeks of life. It is higher in protein and minerals, such as salt, and contains different types of fat that are easier to digest and absorb compared to fats in the milk of mothers of full term babies. The fat in human milk also helps to enhance the development of the baby’s brain and neurologic tissues, which is especially important for premature infants.

Human milk is also easier for babies to digest than infant formula and avoids exposing the baby’s immature intestinal lining to the cow’s milk proteins found in premature infant formula. Preterm infants who are breastfed are less likely to develop intestinal infections than babies who are formula fed, and the colostrum produced in the first few days contains high concentrations of antibodies that will help the baby fight infection.
Breastfeeding preterm infants, especially if they are in the NICU, may present unique challenges for breastfeeding dyads. These mothers will benefit from extra breastfeeding support due to the delay of direct breastfeeding, reliance on breast pumps, and the stress of having a sick newborn. Even if the baby cannot breastfeed directly from the breast at first, the mother can be encouraged to express her milk to ensure that her supply is maintained. Supportive care for infants in the NICU may include the use of a feeding tube. Expressed human milk can be passed through the tube, therefore, it is important for the mother to discuss her feeding decisions with her baby’s doctor. Preterm infants sometimes need additional calories and nutrients to facilitate adequate growth, and in such cases a human milk fortifier may be prescribed by a health care provider.

Preterm infants who are not breastfed may require the use of a formula higher in calories and nutrients to support their growth. According to the American Academy of Pediatrics (AAP), soy formulas are typically not recommended for low birth weight preterm infants, as their use may result in less weight gain and lower serum albumin and phosphorus levels than cow’s milk-based formulas.

In addition to breastfeeding, skin-to-skin care or kangaroo care (holding your baby naked or in just a diaper on your bare chest), can help preterm infants breathe better, gain weight, keep their body at the right temperature, and prepare them for breastfeeding. All caregivers can provide skin-to-skin care, not just the mother.

**Late Preterm Birth**

Infants born at 34 0/7 through 36 6/7 weeks gestation, called late preterm infants, are sometimes mistaken for term infants since their size and weight may be similar. However, caregivers, healthcare providers, nutritionists, and lactation consultants must be aware that these babies are physiologically and metabolically immature. In addition to the health conditions previously mentioned for preterm infants, it is important to be aware that late preterm babies have an increased risk of morbidity and mortality which is often related to feeding problems. Due to their immaturity, late preterm infants may have more challenges with breastfeeding because they tire easily and have less stamina, which results in greater difficulty with latching, sucking, and swallowing. Mothers of late preterm infants will benefit greatly from timely lactation assessment and support since feeding difficulties, slow weight gain, failure to thrive, hypoglycemia, and jaundice are very common in these babies.
Growth Patterns

Preterm infants have different patterns of growth compared to term infants. Plotting the growth of preterm infants using their adjusted gestational age is an essential component of care until they reach 24 to 36 months of age. (See the Clarification section for more information on how to determine adjusted gestational age.) Most preterm infants, however, show catch-up growth in weight, length, and head circumference after their initial postnatal growth failure. If catch-up growth occurs, it usually starts early in the first months of life and is often achieved within the first years of life.

The effects of preterm birth can continue beyond infancy. Children who were born prematurely are at an increased risk for the following:

- Neurodevelopmental problems
- Intellectual/cognitive impairments, which can lead to learning disabilities and the need for special education services
- Motor problems
- Feeding difficulties such as problems with chewing and swallowing, late development of feeding skills, food refusal, eating behavior problems, and poor appetite
- Emotional problems such as anxiety and depression
- Behavioral concerns such as attention problems and hyperactivity

Procedure:

All preterm infants and children (up to 2 years of age) who have reached the equivalent age of 40 weeks gestation, shall be assessed for growth using the Centers for Disease Control and Prevention (CDC) Birth to 24 Months gender specific growth charts adjusting for gestational age as follows:

1. Document the infant/child’s gestational age (at delivery) in weeks. (Mother/caregiver can self-report, or referral information from the medical provider may be used.)
2. Subtract the child’s gestational age in weeks from 40 weeks (gestational age of term infant) to determine the adjustment for prematurity in weeks.
3. Subtract the adjustment for prematurity in weeks from the child’s chronological postnatal age in weeks to determine the child’s gestation-adjusted age.
Example:
Randy was born prematurely on March 19, 2011. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2011, clinic visit, his chronological postnatal age is 12 weeks. What is his gestation-adjusted age?

30 = gestational age in weeks
40 - 30 = 10 weeks adjustment for prematurity
12 - 10 = 2 weeks gestation-adjusted age
His measurements would be plotted on a growth chart as a 2-week-old infant.

Note: Preterm infants (< 36 6/7 weeks gestation) who have not reached the equivalent age of 40 weeks gestation may be assessed for growth using a growth chart for low birth weight (LBW) or very low birth weight (VLBW) infants (e.g., Infant Health and Development Program [IHDP]) consistent with the protocols of the local medical community in which the WIC clinic operates. The CDC does not recommend the use of the CDC Growth Charts for preterm infants who have not reached the equivalent age of 40 weeks gestation.

Participant Focused Counseling:

- The goals of nutrition counseling are to assist and support the caregiver in establishing and maintaining feeding practices that support the optimal growth of the infant.
- The caregiver may need to be advised that timetables for feeding solid foods may not apply to a premature infant. She should be advised to consult with her infant’s health care professional regarding when to offer solid food.
- Review collected information for appropriateness of feeding practices.
**Recent Major Surgery, Physical Trauma, Burns**

(3529) **Categories: ALL**

Defined as: major surgery (including cesarean sections), physical trauma or burns severe enough to compromise nutritional status. Any occurrence:

- Within the past two (≤ 2) months may be self-reported.
- More than two (≥ 2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.

A participant determined to have had a recent major surgery, physical trauma, or burns should be referred to the CPA for Nutrition Care counseling.

**C-section is not usually designated as high risk**

**Justification:**
The body’s response to injuries increases nutrient requirements needed for recovery, and can lead to malnutrition. These changes increase calorie and protein needs, as well as many vitamins, minerals, fatty acids, and amino acids. Proper wound healing is critical in recovery. Even after a wound is closed, metabolic rate and need for additional nutrition can remain high. Factors that can prevent proper wound healing, or can increase the time needed for a wound to heal include: malnutrition prior to the event, infections, diabetes, poor blood flow, obesity, age, heavy alcohol use, stress, medications, and smoking. Because healing is complex and affected by many factors, there is no set recovery time based only on the type and severity of injury. For some it could take a couple of weeks, for others it may take months.

**Major Surgery and Wound Healing**

Major surgeries are those that involve a risk to the life of the individual, and include operations on organs within the body. Removal of a portion of the large or small intestine, heart surgery, and bariatric surgery are examples.

Cesarean sections are considered a major surgery, and therefore, require additional assessment and education in the WIC clinic. In the US, the rate of cesarean delivery rose from about 20% to about 30% for singleton births in 2011. Reasons for cesarean delivery include multiples pregnancy, failure of labor to progress, medical concerns for the infant, problems with the placenta, a large infant, breech position, maternal infections, and medical conditions in the mother (diabetes, high blood pressure).
**Physical Trauma**
Physical trauma can include fractures, wounds, hospitalization from blunt force trauma, penetrating trauma, and trauma from surgery. Physical trauma can also result from domestic or child abuse, with additional acute or ongoing psychological and emotional trauma that result in poor appetite, poor food choices, and using food for coping.

**Burns**
Burns can be caused by heat (including hot surfaces, fires, and hot liquids), chemicals, electricity, sunlight, or nuclear radiation. A first-degree burn only affects the outer layer of the skin (epidermis). A second-degree burn damages the epidermis, and the dermis (the layer beneath). Third-degree burns damage the epidermis, dermis, and the tissue under the skin.

Burns are also classified by the size of the area burned, known as Percent Total Body Surface Area or TBSA. The larger the area of the burn, the greater the risk for infection and fluid loss. Inhalation burns occur inside an individual’s lungs and internal organs.

**Implications for WIC Nutrition Services**
Most surgeries, physical traumas, and burns are unexpected. The education and supplemental food that WIC provides can help ensure that the individual is in good nutritional health prior to the surgery, physical trauma, or burn. Following the event, the individual will be at increased nutritional risk until the injury has completely healed.

WIC staff can improve outcomes by:
- Reviewing nutritional intake to assure that vitamins and minerals meet the RDAs (unless the amounts that exceed the RDAs are recommended by their health care provider).
- Reviewing calorie and protein intake to be sure they preserve lean muscle mass and body weight.
- Recommending the participant discuss a multivitamin supplement with the health care provider when diet cannot meet the RDAs for vitamins and minerals.
- Referring to community resources for smoking cessation, support groups, food assistance, and safe living environments (in cases of physical abuse).
- Referring to a lactation specialist if women experience difficulty breastfeeding following a cesarean section.
Recipient of Abuse
(9011) Categories: All

Defined as: Battering or child abuse/neglect within past 6 months as self-reported, or as documented by a social worker, health care provider, or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel.

An employee of a local department who, in the course of employment, receives a report of suspected child abuse or neglect communicated formally or informally to the employee, or who otherwise has reason to suspect that child abuse or neglect has occurred, shall immediately report the information to the Child Protective Services unit within the local department for prompt investigation.

Justification:
Woman:
- Battering during pregnancy is associated with increased risks of low birth weight, pre-term delivery, and placenta infection, as well as poor nutrition and health behaviors.
- Battered women are more likely to have low maternal weight gain, be anemic, consume an unhealthy diet, and abuse drugs, alcohol, and cigarettes.

Infants/Children:
- Serious neglect and physical, emotional, or sexual abuse have life-long consequences for children.
- Nutritional neglect is the most common cause of poor growth in infancy and may account for as much as half of all cases of non-organic failure to thrive.

Procedure, Woman:
Homicide is the leading cause of pregnancy-associated death in Maryland. The majority were intimate partner homicides.
- Discretely place intimate partner violence posters and shoe cards in WIC ladies’ rooms, not waiting rooms where they can be viewed by abusing partners.
- Ask all WIC participants the WOW question concerning fear for personal or child safety.
- Assure confidentiality.
- Ask in a private place when partner is present.
- If the answer is positive, educate on the dangers of partner violence, and offer discreet help.
- If in imminent danger, offer to make the phone call to connect the participant to the local domestic violence service provider before she leaves the WIC clinic, or connect with the Maryland Network Against Domestic Violence: [www.mnadv.org](http://www.mnadv.org) which provides
comprehensive domestic violence services in each county.

- If the participant is not ready to act, offer discreet information for follow up, such as getting a shoe card from the ladies room, going online to www.dhmh.maryland.gov/ipv, or calling the National Domestic Violence Hotline: 1-800-799-SAFE (7233).

Procedure, Infant or Child:

Maryland law requires that:

- An individual who has reason to believe that a child has been abused or neglected shall immediately notify a local law enforcement agency or a local department.
- An employee of a local department who, in the course of employment, receives a report of suspected child abuse or neglect communicated formally or informally to the employee or who otherwise has reason to suspect that child abuse or neglect has occurred, shall immediately report the information to the Child Protective Services unit within the local department for prompt investigation.

Participant Focused Counseling:

- Assess the level of danger to the participant/child with open-ended questions.
- Educate about the risks of intimate partner violence.
- Offer to provide information or make the necessary contact with a domestic violence support network.
Short Interpregnancy Interval

(3321) Categories: PG, BE/BP, WPP

Defined as: An interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy.

Note: this risk is specific to live births, and does not include miscarriage or stillbirth in the calculation.

Justification

Adverse maternal and infant health outcomes have been associated with short interpregnancy intervals. An interval of 18-24 months has been associated with the lowest risk.

Outcomes associated with short IPI have included perinatal and neonatal complications such as preterm birth, low birth weight, small for gestational age, birth defects, and autism.

Findings from a small pilot study found coordination of primary health care and social support services reduced adverse pregnancy outcomes and the average number of pregnancies conceived within 18 months among low income women who previously delivered a very low birth weight baby.

A 2007 US survey found that, among childbearing age women, those aged 18-24 years were least aware of the need for folic acid prior to pregnancy and least likely to report daily use of supplements containing folic acid. Only 17% of women age 18-24 years were likely to hear about folic acid from their health care provider.

Referral for family planning services may be appropriate.

Procedure:

Apply as follows:

- **Pregnant woman**: current pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy
  - Determine if the woman has been pregnant and had a live birth before.
  - Determine the time interval between the 2 pregnancies:
  - Obtain the date when her most recent baby was born. For a pregnant woman, the date will be for the birth preceding this current pregnancy. For a breastfeeding or postpartum woman, the date will be for the birth that preceded her most recent
pregnancy.
- Obtain the date of the last menstrual period prior to this current pregnancy for a pregnant woman. Obtain the date of the last menstrual period for the most recent pregnancy for a breastfeeding or postpartum woman.
- Estimate the date of conception as occurring on the 14th day following the first day of the last menstrual period.
- Subtract the date of the last live birth from the date of conception. The difference is the time interval between the 2 pregnancies.

**Participant Focused Counseling:**

Through open ended questions and discussion, determine the participant’s concerns and interest in:

- **Health care referrals for family planning, early prenatal care, and folic acid supplementation.**
  - WIC can help to reduce the risk of adverse pregnancy outcomes by:
    - Encouraging postpartum women and their partners to meet with their healthcare provider to discuss developing a reproductive plan and birth spacing as appropriate.
    - Encouraging folic acid supplementation.
    - Encouraging healthful eating by following the Dietary Guidelines for Americans.

- **Education:**
  - Given that half of all pregnancies nationwide are unintended, the above areas have the potential to improve health outcomes for women, infants, and children,
  - Discuss the topics of interest or concern to the participant using the WIC Guide to a Healthy New Mom, including her interest in easy ways to use her WIC foods.
Short Stature/At Risk of Short Stature  
(1211) Categories: IBE, IBP, IFF, C 1- 4

Defined as:

- Length/age ≤ 5th percentile, CDC/ WHO growth chart Birth to ≤ 24 months, or
- Stature/Age ≤ 10th percentile, CDC growth chart 2 to 5 years of age.

Explanation:

- CDC uses the cut off value of ≤ 2.3 percentile length for age to define short stature in an infant or child from Birth to < 24 months and ≤ 5th percentile for a child 2 to 5 years.
- CDC uses ≤ 5th percentile to define at risk of short stature in an infant or child from Birth to < 24 months, and > 5th percentile to ≤ 10th percentile for a child 2 to 5 years.

Justification:

Short stature may be an indicator of chronic undernutrition related to the lack of total calories and to a poor quality of diet that is low in nutrients such as protein, zinc, vitamin A, and calcium. Short stature may also result from disease conditions such as endocrine disturbances or from congenital conditions such as Fetal Alcohol Syndrome. Participation in WIC is associated with improved growth in height (as well as weight).

Procedure:

- Obtain current length or height measured to the nearest 1/8 inch. Record measurement in the participant’s record.
- Determine the exact age of the infant or child. When plotting on the 2 to 5 years CDC growth chart, round the child’s age to the nearest whole month.
- For an infant or child < 24 months of age who was born at 37 weeks or earlier, adjust the age before plotting, following the procedure in Table GAA.
- Plot Length for Age on the CDC/WHO 0 to < 24 months growth chart. If the plotted point lies at or below the 5th percentile, assign the risk criterion.
- Plot Stature for Age on the CDC 2 to 5 years growth chart. If the plotted point lies at or below the 10th percentile, assign the risk criterion.
- Review collected information for possible causes of short stature. Inquire about the parent’s height.
Participant Focused Counseling:

- Review collected information to identify feeding or dietary practices that may prevent adequate and appropriate food choices for the infant/child.
- Discuss the steps the participant is willing to take to ensure the child’s nutritional status.
- Review strategies for making the improvements.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.
**Slowed/Faltering Growth Pattern**

(1135) **Categories: IBE, IBP, IFF**

Defined as:

- Infants Birth to 2 weeks: Excessive weight loss after birth, ≥ 7% birth weight loss
- Infants 2 weeks to 6 months of Age: Any weight loss, using 2 separate measurements taken at least 8 weeks apart

An infant determined to have slowed/faltering growth pattern should have Nutrition Care counseling, and, if breastfeeding, be referred to the breastfeeding specialist.

**Justification:**

*Growth faltering* is a growth rate below what is appropriate for an infant’s age and sex. It can affect length, weight, and head circumference, resulting in values lower than expected. Growth faltering may include *weight faltering* (a drop in weight-for-age) or *slowed growth* where both weight and length growth are slower than expected, for example, a drop in weight after a minor illness. (Note: what appears to be growth faltering could be due to a measurement or plotting error.)

**Normal Growth Patterns**

Understanding normal infant growth is important, because infants gain weight differently depending on how they are fed.

- **Breastfed infants** gain weight rapidly during the first three or four months of life, then the rate of growth slows.
- **Formula fed infants**, by comparison, grow more slowly for the first three or four months, then weight gain escalates.

The normal decrease in the breastfed infant’s rate of growth is sometimes misunderstood as inadequate milk supply, leading to early introduction of solid foods or inappropriate and unnecessary formula feeding.

Normal infant growth is:

- steady and predictable, and demonstrates health and nutritional status. The overwhelming majority of infants have no growth problems.
- pulsating, happening in spurts, with periods of slow or no measurable growth.
- adjustable to genetic potential, with catch-up and catch-down periods
- seasonal, with length velocities faster during spring and summer, and stagnant over other months
Excessive Weight Loss after Birth
Almost all normal infants lose weight after birth, but the amount of weight loss varies. It is usual for breastfed infants to lose up to 7% of birth weight, while formula fed infants lose about 5% of birth weight. Healthy infants typically regain their birth weight within 8-10 days after birth. However, if a breastfed infant loses 7% of birth weight in the first 72 hours after birth, the mother-infant dyad should be evaluated, and any problems resolved immediately. At this time, early screening and lactation support can reduce the newborn’s risk of dehydration and failure to thrive

Weight loss of up to 10% of birth weight is the maximum acceptable loss for newborn infants. Any additional loss is a potential emergency. Contributing factors include:
- Hospital practices like epidurals, pacifier use, low or non-nutritive feedings, or strict feeding schedules.
- Maternal factors such as retained placenta, number of children, anxiety, and poor maternal knowledge.
- Infant factors such as birth weight, gestational age, gender, and feeding method
- For breastfed infants, poor positioning, latch and/or milk transfer

Any Weight Loss 2 Weeks to 6 Months
Although infants begin to grow more slowly from 3 to 18 months of age, they should not lose weight after 2 weeks of age. Any such weight loss requires follow up.
Growth faltering can be caused by
- Inadequate calorie intake, malabsorption, or increased metabolic needs
- Dehydration, feeding problems, malnutrition, or growth failure
- Milk protein allergy or gastrointestinal reflux
- Lead poisoning, HIV, Celiac disease, cystic fibrosis, congenital heart disease, or inborn errors of metabolism
- Neglect

Procedure:
If growth faltering is suspected, consider the following:
- Rule out
  - maternal neglect, maternal depression, or emotional deprivation
  - inadequate calorie intake due to inappropriate formula mixing, breastfeeding problems, or early introduction of solid foods
- Monitor growth monthly, and use two separate weight measurements at least 8 weeks apart as data markers.
Screening for Slow or Faltering Growth Pattern

Changes in growth can be the first sign of a pathological condition regardless of its cause. Recognition of poor growth in early life can identify infants who may be at risk for growth faltering. Early intervention can prevent growth retardation, which may be irreversible when it occurs early in life. Intervention can also prevent long-term consequences such as short stature, poor learning ability, low adult wages, and when paired with later weight gain, increased risk for nutrition-related chronic diseases.

Screening for slow or faltering growth is a preventive health measure which requires careful growth monitoring and critical thinking skills. Although one measure of weight-for-age may cause concern, it does not show growth faltering. Screening should use multiple growth indicators, including risk for underweight, short stature, failure to thrive, and low head circumference (when available). These may be warning signs of the need for early intervention.

In many situations, poor growth will likely be caused by a combination of factors, which require a combination of intervention strategies for successful health outcomes. Environmental health factors to consider include:

- Adequate nutrition and nutrient dense foods including a history of human milk or formula feeding
- Appropriate introduction of complementary foods
- Maternal conditions that can affect lactation: mastitis, prolonged labor, C-section, hypo- or hyperthyroidism, diabetes, low birth weight, prepregnancy BMI > 27, pregnancy-induced hypertension, flat/inverted nipples, vitamin B12 deficiency
- Mealtimes routine and eating/feeding behavior
- Growth faltering in light of familial growth patterns
- Neglect
- Lack of social support
- Adverse social and psychological environment
- Depressed or poor mental abilities of parent/caregiver
- Lack of parental education and nutrition knowledge

Participant Focused Counseling:

- Provide early postpartum breastfeeding support to minimize dehydration and/or failure to thrive
- Refer to lactation specialist for latch and other assistance
- Use “tell me how you know your baby is hungry/full” to explore knowledge and practice. Review baby behavior hunger and satiety cues and division of responsibility as needed.
- Explore breastfeeding or formula feeding schedule, and discuss adjustments if necessary.
- Review formula mixing technique using, “Tell me how you mix the formula.” Review correct mixing technique if necessary, and follow with teach back to assure improved understanding and knowledge.
• Discuss mom’s food package to be sure it meets her needs. Adjust if needed. Discuss ways mom might improve her own calorie intake.
• Review accuracy of weight, length, and head circumference (if available) measurements.
• Refer to allied health professionals such as physician, early childhood intervention, social services, and home visiting programs as appropriate
Small for Gestational Age (SGA)
(1511) Categories: IBE, IBP, IFF, C-1

Defined as: Diagnosis by a physician as self-reported by applicant/participant/caregiver or someone working under physician’s orders.

An infant who is Small for Gestational Age should have Nutrition Care counseling.

An infant who is Small for Gestational Age and Low Birth Weight should have follow-up Nutrition Care in 3-6 months.

Justification:

Fetal growth restriction can lead to an infant who is born small for gestational age (SGA) at birth. SGA infants often have congenital abnormalities, a slower physical growth and, possibly, slower mental development. These effects may persist into childhood. SGA infants are at a higher risk of mortality.

Procedure:

- Determine if the infant has been diagnosed as small for gestational age.
- Review collected information for appropriateness of feeding practices.

Participant Focused Counseling: The goal of nutrition counseling is to support the caregiver in establishing and maintaining feeding practices that promote the growth and development of the infant. Where appropriate, encourage follow up with or refer to health care professionals, those infants and children who do not attain a normal growth pattern.
**Transfer**
(5021, 5023, 5024, 5025) **Categories: All**

Defined as: Person with a current and valid Verification of Certification (VOC) document from another WIC State or local agency.

**Justification:**

According to federal regulations, once a WIC participant has been determined to be eligible for program benefits by a local agency, the service delivery area into which the participant moves is obligated to honor the terms of participation.

**Procedure:**

Obtain and review the VOC. This criterion should be used only when the VOC document does not reflect a specific nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the Maryland WIC Program. The VOC is valid until the certification period expires, and shall be considered as proof of eligibility for program benefits. If the local agency receiving the VOC has a waiting list for participants, the transferring participant shall be placed on the list ahead of all other waiting applicants.
**Underweight (Woman)**

*(1011) Categories: PG, BE/BP, WPP*

Defined as:

- **Pregnant woman**: prepregnancy Body Mass Index (BMI) <18.5*
- **Postpartum or breastfeeding woman (< 6 months postpartum)**: prepregnancy or current BMI < 18.5*
- **Breastfeeding woman (6 months or more postpartum)**: Current Body Mass Index (BMI) < 18.5*.

*Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women as well.

A woman who is underweight and has low maternal weight gain should have Nutrition Care counseling.

**Justification:**

Underweight women who become pregnant are at a higher risk for delivery of a low birth weight baby, fetal growth restriction, and perinatal mortality. Pre-pregnancy underweight is also associated with complications such as Cesarean delivery.

Being underweight may indicate poor nutritional status, inadequate food consumption, environmental stress, lifestyle habits, and/or an underlying medical condition.

**Procedure:**

**Pregnant Woman:**

- Use Table W for the procedure. Measure height to the nearest 1/8 inch. If the height fraction is between 1/8 and 3/8 of an inch, round down to the nearest whole number. If it is between 5/8 and 7/8 of an inch, round up to the nearest whole number.
- Obtain pre-pregnancy weight (self-report or from health care professional). Using the woman's current height and pre-pregnancy weight, determine her weight status according to Table W. Record height and weight measurements in the woman’s record.

**Breastfeeding or Postpartum Woman:**

- For a postpartum or breastfeeding woman (less than 6 months postpartum) use current height and pre-pregnancy weight or current weight measured to the nearest 4 ounces to determine weight status according to Table W.
- For a breastfeeding woman 6 months or more postpartum, use current height and weight measured to the nearest 4 ounces to determine weight status according to Table W. Record height and weight measurements in the woman’s record.
• Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks, fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Prepregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the prepregnancy weight. In most cases, therefore, prepregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery.

• The one exception is the woman with a BMI of <18.5 during the immediate 6 months after delivery. Underweight, at this stage, may indicate inadequate weight gain during pregnancy, depression, an eating disorder, or disease, all of which need to be addressed.

**Participant Focused Counseling:**

• Review collected information to identify lifestyle or dietary practices that may prevent adequate and appropriate food intake.
• Discuss the steps the participant is willing to take to ensure her nutritional status.
• Review strategies for making the change.
• If willing, help her set a simple, measurable goal.
• Enter the goal in WOW.
Underweight/At Risk of Underweight (Child)

(1031) Categories: IBE/IBP, IFF, C 1- 4

Defined as:
- Weight for Length ≤ 5\textsuperscript{th} percentile, CDC/WHO growth chart Birth to ≤ 24 months, or
- BMI/Age ≤ 10\textsuperscript{th} percentile, CDC growth chart 2 to 5 years of age.

Specifically:
**Underweight**: CDC, WHO, and WIC use a cut-off value of
- ≤ 2.3 percentile weight for length in an infant Birth to ≤ 24 months, or
- ≤ 5\textsuperscript{th} percentile BMI/Age for a child age 2 to 5 years.

**At risk of underweight**: WIC uses the cutoff value of
- > 2.3 and ≤ 5\textsuperscript{th} percentile Wt/lgth for an infant/child Birth to ≤ 24 months and
- > 5 and ≤10\textsuperscript{th} percentile BMI/age for a child age 2 to 5 years.

An infant or child Birth to 24 months with a Weight for length at or below the 2.3 percentile should have Nutrition Care counseling, with a Nutrition Care follow-up in 3 months.

A child 2 to 5 years of age with a BMI/age below the 5\textsuperscript{th} percentile, should have Nutrition Care counseling, with a Nutrition Care follow-up in 3-6 months.

Justification:

While progress along the lower percentiles may represent normal growth for some children, it may also be an indicator of inadequate calorie and nutrient intake.
Procedure:

- Obtain current length or height measured to the nearest 1/8 inch. Obtain current weight measured to the nearest 1 ounce for infants and children < 24 months of age and to the nearest 4 ounces for children ≥ 24 months of age. Record measurements in the participant’s record.
- For an infant or child less than 24 months of age whose length is measured in recumbent position, plot weight for length on the gender-specific CDC/WHO growth chart Birth to ≤ 24 months. For a child 2 years of age and older whose height is measured standing up, compute BMI using the procedure in Table BMI.1. Plot the BMI value on the CDC BMI/age growth chart for 2-5 year olds.
- For an infant or child < 24 months of age who was born at 37 weeks or earlier, adjust the age before plotting, following the procedure in Table GAA.
- If the plotted percentile is less than or equal to the 5th percentile, assign the risk criterion.
- Review collected information for possible causes of underweight, such as not offering 3 meals and 2 snacks per day or restricting food intake.

Participant Focused Counseling:

- Review collected information to identify feeding or dietary practices that may prevent adequate and appropriate food choices for the infant/child.
- Discuss the steps the participant is willing to take to ensure the child’s nutritional status.
- Review strategies for making the improvements.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.
Tables and Lists
### Table A  Low Hemoglobin/Hematocrit Cut-off Values for Women

<table>
<thead>
<tr>
<th>Category</th>
<th>Hemoglobin or hematocrit value is less than or equal to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cigarettes per day</td>
</tr>
<tr>
<td></td>
<td>0 to 9</td>
</tr>
<tr>
<td></td>
<td>Hgb</td>
</tr>
<tr>
<td>Pregnant through 13 weeks</td>
<td>10.9</td>
</tr>
<tr>
<td>Pregnant 14 through 26 weeks</td>
<td>10.4</td>
</tr>
<tr>
<td>Pregnant 27 through 40 weeks</td>
<td>10.9</td>
</tr>
<tr>
<td>Breastfeeding or Postpartum</td>
<td></td>
</tr>
<tr>
<td>12 to &lt; 15 years</td>
<td>11.7</td>
</tr>
<tr>
<td>Breastfeeding or Postpartum</td>
<td></td>
</tr>
<tr>
<td>15 to &lt; 18 years</td>
<td>11.9</td>
</tr>
<tr>
<td>Breastfeeding or Postpartum</td>
<td></td>
</tr>
<tr>
<td>18 + years</td>
<td>11.9</td>
</tr>
</tbody>
</table>
Table W  Weight Status of Pregnant, Breastfeeding and Postpartum Women

Procedure:  Measure and record the woman’s height.  If the height fraction is between 1/8 and 3/8 of an inch, round down to the nearest whole number.  If it is between 5/8 and 7/8 of an inch, round up to the nearest whole number.

To evaluate Underweight:

- If the woman is pregnant or less than 6 months postpartum, use either:
  - her pre-pregnancy weight (self-report or from health care professional) or
  - a current weight measured to the nearest 4 ounces.
- If she is a breastfeeding woman 6 months or more postpartum, use her current weight measured to the nearest 4 ounces.
- Record weight measurements in the WIC record.

To evaluate Overweight:

- If the woman is pregnant or less than 6 months postpartum, use her pre-pregnancy weight (self-report or from health care professional).
- If she is a breastfeeding woman 6 months or more postpartum, use her current weight measured to the nearest 4 ounces.
- Record weight measurements in the WIC record.

On Table W, which follows:

- Locate height in the left column on the following chart.
- Read across the weight columns until you find where her weight falls.
- Her weight status is indicated at the top of the column.
- She has a risk criterion if she is underweight, overweight, or obese.
<table>
<thead>
<tr>
<th>Height is:</th>
<th>Weight Status of Pregnant, Breastfeeding, and Postpartum Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ft. &amp; in.</td>
<td>Underweight (BMI &lt; 18.5)</td>
</tr>
<tr>
<td>4' 8&quot;</td>
<td>56&quot;</td>
</tr>
<tr>
<td>4' 8 1/2&quot;</td>
<td>56-1/2&quot;</td>
</tr>
<tr>
<td>4' 9&quot;</td>
<td>57&quot;</td>
</tr>
<tr>
<td>4' 9 1/2&quot;</td>
<td>57-1/2&quot;</td>
</tr>
<tr>
<td>4'10&quot;</td>
<td>58&quot;</td>
</tr>
<tr>
<td>4' 10 1/2&quot;</td>
<td>58-1/2&quot;</td>
</tr>
<tr>
<td>4'11&quot;</td>
<td>59&quot;</td>
</tr>
<tr>
<td>4' 11 1/2&quot;</td>
<td>59-1/2&quot;</td>
</tr>
<tr>
<td>5' 0&quot;</td>
<td>60&quot;</td>
</tr>
<tr>
<td>5' 1/2&quot;</td>
<td>60-1/2&quot;</td>
</tr>
<tr>
<td>5' 1&quot;</td>
<td>61&quot;</td>
</tr>
<tr>
<td>5' 1-1/2&quot;</td>
<td>61-1/2&quot;</td>
</tr>
<tr>
<td>5' 2&quot;</td>
<td>62&quot;</td>
</tr>
<tr>
<td>5' 2-1/2&quot;</td>
<td>62-1/2&quot;</td>
</tr>
<tr>
<td>5' 3&quot;</td>
<td>63&quot;</td>
</tr>
<tr>
<td>5' 3-1/2&quot;</td>
<td>63-1/2&quot;</td>
</tr>
<tr>
<td>5' 4&quot;</td>
<td>64&quot;</td>
</tr>
</tbody>
</table>
### Table W

**Weight Status of Pregnant, Breastfeeding and Postpartum Women, continued**

<table>
<thead>
<tr>
<th>Height is:</th>
<th>Underweight (BMI &lt; 18.5)</th>
<th>Normal Weight (BMI 18.5-24.9)</th>
<th>Overweight (BMI 25.0-29.9)</th>
<th>Obese (BMI ≥ 30.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight (in pounds) is:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ft. &amp; in.</td>
<td>In.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5' 4-1/2&quot;</td>
<td>64-1/2&quot;</td>
<td>≤ 109</td>
<td>109 1/4</td>
<td>- 147 1/2</td>
</tr>
<tr>
<td>5' 5&quot;</td>
<td>65&quot;</td>
<td>≤ 110 3/4</td>
<td>111</td>
<td>- 149 3/4</td>
</tr>
<tr>
<td>5' 5-1/2&quot;</td>
<td>65-1/2&quot;</td>
<td>≤ 112 1/2</td>
<td>112 3/4</td>
<td>- 152</td>
</tr>
<tr>
<td>5' 6&quot;</td>
<td>66&quot;</td>
<td>≤ 114 1/4</td>
<td>114 1/2</td>
<td>- 154 1/2</td>
</tr>
<tr>
<td>5' 6-1/2&quot;</td>
<td>66-1/2&quot;</td>
<td>≤ 116</td>
<td>116 1/4</td>
<td>- 156 3/4</td>
</tr>
<tr>
<td>5' 7&quot;</td>
<td>67&quot;</td>
<td>≤ 117 3/4</td>
<td>118</td>
<td>- 159 1/4</td>
</tr>
<tr>
<td>5' 7-1/2&quot;</td>
<td>67-1/2&quot;</td>
<td>≤ 119 1/2</td>
<td>119 3/4</td>
<td>- 161 1/2</td>
</tr>
<tr>
<td>5' 8&quot;</td>
<td>68&quot;</td>
<td>≤ 121 1/4</td>
<td>121 1/2</td>
<td>- 164</td>
</tr>
<tr>
<td>5' 8-1/2&quot;</td>
<td>68-1/2&quot;</td>
<td>≤ 123</td>
<td>123 1/4</td>
<td>- 166 1/2</td>
</tr>
<tr>
<td>5' 9-1/2&quot;</td>
<td>69-1/2&quot;</td>
<td>≤ 126 3/4</td>
<td>127</td>
<td>- 171 1/4</td>
</tr>
<tr>
<td>5' 10&quot;</td>
<td>70&quot;</td>
<td>≤ 128 1/2</td>
<td>128 3/4</td>
<td>- 173 3/4</td>
</tr>
<tr>
<td>5' 10-1/2&quot;</td>
<td>70-1/2&quot;</td>
<td>≤ 130 1/4</td>
<td>130 1/2</td>
<td>- 176 1/4</td>
</tr>
<tr>
<td>5' 11-1/2&quot;</td>
<td>71-1/2&quot;</td>
<td>≤ 134</td>
<td>134 1/4</td>
<td>- 181 1/4</td>
</tr>
<tr>
<td>6' 0&quot;</td>
<td>72&quot;</td>
<td>≤ 136</td>
<td>136 1/4</td>
<td>- 183 3/4</td>
</tr>
<tr>
<td>6' -1/2&quot;</td>
<td>72-1/2&quot;</td>
<td>≤ 137 3/4</td>
<td>138</td>
<td>- 186 1/2</td>
</tr>
<tr>
<td>6' 1&quot;</td>
<td>73&quot;</td>
<td>≤ 139 3/4</td>
<td>140</td>
<td>- 189</td>
</tr>
<tr>
<td>6' 1-1/2&quot;</td>
<td>73-1/2&quot;</td>
<td>≤ 141 3/4</td>
<td>142</td>
<td>- 191 1/2</td>
</tr>
</tbody>
</table>
Table I-P Low Maternal Weight Gain

Procedure:

- Determine pre-pregnancy weight status by using Table W.
- Subtract the pre-pregnancy weight from the current weight to determine the pounds gained.
- Determine the last completed week of gestation.
- Locate the week of gestation in the left column of the table below.
- Move across the columns to the woman’s pre-pregnancy weight status.
- If she has gained equal to or less than the number of pounds in the box, she has the risk criterion, Low Maternal Weight Gain.

Note: Do not evaluate this risk criterion for a woman pregnant with twins, triplets, or more.
Table I-P  Low Maternal Weight Gain

<table>
<thead>
<tr>
<th>Completed Week of Gestation</th>
<th>Underweight pounds:</th>
<th>Normal Weight pounds:</th>
<th>Overweight/Obese pounds:</th>
<th>Completed Week of Gestation</th>
<th>Underweight pounds:</th>
<th>Normal Weight pounds:</th>
<th>Overweight/Obese pounds:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>21</td>
<td>11 1/2</td>
<td>9 1/2</td>
<td>5 1/2</td>
</tr>
<tr>
<td>2</td>
<td>1/4</td>
<td>1/4</td>
<td>N/A</td>
<td>22</td>
<td>12 1/2</td>
<td>10 1/2</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>1/2</td>
<td>1/2</td>
<td>1/4</td>
<td>23</td>
<td>13 1/4</td>
<td>11 1/4</td>
<td>6 1/2</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>3/4</td>
<td>1/2</td>
<td>24</td>
<td>14</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>1 3/4</td>
<td>1 1/4</td>
<td>1/2</td>
<td>25</td>
<td>14 3/4</td>
<td>12 3/4</td>
<td>7 1/2</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>1 1/2</td>
<td>3/4</td>
<td>26</td>
<td>15 3/4</td>
<td>13 1/2</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>2 1/2</td>
<td>1 3/4</td>
<td>3/4</td>
<td>27</td>
<td>16 3/4</td>
<td>15</td>
<td>8 3/4</td>
</tr>
<tr>
<td>8</td>
<td>2 3/4</td>
<td>2</td>
<td>1</td>
<td>28</td>
<td>17 1/2</td>
<td>15 1/4</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>3 1/4</td>
<td>2 1/4</td>
<td>1</td>
<td>29</td>
<td>18 1/2</td>
<td>15 3/4</td>
<td>9 1/2</td>
</tr>
<tr>
<td>10</td>
<td>3 1/2</td>
<td>2 1/2</td>
<td>1 1/4</td>
<td>30</td>
<td>19 1/4</td>
<td>16 3/4</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>2 3/4</td>
<td>1 1/2</td>
<td>31</td>
<td>20</td>
<td>17 1/2</td>
<td>10 1/2</td>
</tr>
<tr>
<td>12</td>
<td>4 1/2</td>
<td>3</td>
<td>1 1/2</td>
<td>32</td>
<td>21</td>
<td>18 1/2</td>
<td>11</td>
</tr>
<tr>
<td>13</td>
<td>4 3/4</td>
<td>3 1/4</td>
<td>1 3/4</td>
<td>33</td>
<td>21 3/4</td>
<td>19</td>
<td>11 1/2</td>
</tr>
<tr>
<td>14</td>
<td>5 1/2</td>
<td>4 1/4</td>
<td>2 1/4</td>
<td>34</td>
<td>22 3/4</td>
<td>19 3/4</td>
<td>11 3/4</td>
</tr>
<tr>
<td>15</td>
<td>6 1/2</td>
<td>4 3/4</td>
<td>2 3/4</td>
<td>35</td>
<td>23 1/2</td>
<td>20 3/4</td>
<td>12 1/4</td>
</tr>
<tr>
<td>16</td>
<td>7 1/2</td>
<td>5 1/2</td>
<td>3 1/4</td>
<td>36</td>
<td>24 1/2</td>
<td>21 1/2</td>
<td>12 3/4</td>
</tr>
<tr>
<td>17</td>
<td>8</td>
<td>6 1/2</td>
<td>3 1/2</td>
<td>37</td>
<td>25</td>
<td>22 1/4</td>
<td>13 1/4</td>
</tr>
<tr>
<td>18</td>
<td>8 3/4</td>
<td>7 1/4</td>
<td>4</td>
<td>38</td>
<td>26 1/4</td>
<td>23</td>
<td>13 3/4</td>
</tr>
<tr>
<td>19</td>
<td>9 3/4</td>
<td>8</td>
<td>4 1/2</td>
<td>39</td>
<td>26 3/4</td>
<td>24</td>
<td>14 1/4</td>
</tr>
</tbody>
</table>
Table BMI.1: Calculation of Body Mass Index

Body Mass Index (or BMI) is a comparison of a person’s weight against height using a simple equation:

\[ \text{BMI} = \frac{\text{Weight}}{\text{Height} \times 703} \]

Weight is measured to the nearest quarter pound (4 ounces) and height to the nearest 1/8 inch. These fractions must be converted to decimals for use in the BMI equation. The table below shows how to convert the fractions to decimals. If you use an electronic scale that displays weight in tenths of a pound, use the displayed weight value, such as 31.1 pounds, etc.

<table>
<thead>
<tr>
<th>Fraction:</th>
<th>Decimal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/8</td>
<td>= .125</td>
</tr>
<tr>
<td>1/4 (2/8)</td>
<td>= .25</td>
</tr>
<tr>
<td>3/8</td>
<td>= .375</td>
</tr>
<tr>
<td>1/2 (4/8)</td>
<td>= .5</td>
</tr>
<tr>
<td>5/8</td>
<td>= .625</td>
</tr>
<tr>
<td>3/4 (6/8)</td>
<td>= .75</td>
</tr>
<tr>
<td>7/8</td>
<td>= .875</td>
</tr>
</tbody>
</table>

Example: Measured weight is 31 1/4 pounds. Use 31.25 pounds in the equation.

Example: Measured height is 37 4/8 inches. Use 37.5 in the equation.

Interpretation of BMI/age
The BMI value you obtain must be plotted on a CDC gender specific growth chart: BMI/age for Children 2 to 5 years old. Compare the plotted point on the growth chart to the cutoff values below to determine if a child 2 years of age or older has a risk criterion.

| Underweight/At risk of underweight | \leq 10^{th} \text{ percentile, BMI/Age} |
| At Risk of Overweight              | Infant or child whose biological parent has a self-reported BMI \geq 30 |
| Overweight                        | \geq 85^{th} to less than the 95^{th} percentile |
| Obese                             | \geq 95^{th} \text{ percentile} |
Table BMI.2:

Abbreviated Body Mass Index (BMI) Table (Self-reported by mother or father)*

<table>
<thead>
<tr>
<th>Height</th>
<th>Height in inches</th>
<th>Weight (lbs) equal to BMI 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>4' 10&quot;</td>
<td>58</td>
<td>143</td>
</tr>
<tr>
<td>4' 11&quot;</td>
<td>59</td>
<td>148</td>
</tr>
<tr>
<td>5' 0&quot;</td>
<td>60</td>
<td>153</td>
</tr>
<tr>
<td>5' 1&quot;</td>
<td>61</td>
<td>158</td>
</tr>
<tr>
<td>5' 2&quot;</td>
<td>62</td>
<td>164</td>
</tr>
<tr>
<td>5' 3&quot;</td>
<td>63</td>
<td>169</td>
</tr>
<tr>
<td>5' 4&quot;</td>
<td>64</td>
<td>174</td>
</tr>
<tr>
<td>5' 5&quot;</td>
<td>65</td>
<td>180</td>
</tr>
<tr>
<td>5' 6&quot;</td>
<td>66</td>
<td>186</td>
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<td>5' 7&quot;</td>
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<td>5' 8&quot;</td>
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<td>5' 9&quot;</td>
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<tr>
<td>5' 10&quot;</td>
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<td>5' 11&quot;</td>
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<tr>
<td>6' 2&quot;</td>
<td>74</td>
<td>233</td>
</tr>
<tr>
<td>6' 3&quot;</td>
<td>75</td>
<td>240</td>
</tr>
</tbody>
</table>

*This table may be used to determine parental (male or female) obesity (BMI > 30)
Table GAA: Calculation of Gestation-Adjusted Age for Infants Born at 37 Weeks or Earlier

All infants and children less than 2 years of age, born at 37 weeks gestation or earlier require gestational age adjustment prior to plotting a growth chart. (3)

Procedure:
- Obtain the infant or child’s gestational age in weeks. The caregiver can self-report this information or it can be provided by the infant’s health care professional.
- Subtract the gestational age in weeks from 40 weeks to determine the adjustment for prematurity.
- Subtract the adjustment for prematurity from the infant or child’s chronological age in weeks to determine the gestation-adjusted age.
- Use the gestation-adjusted age to plot weight for age and length for age on the CDC/WHO growth chart Birth to > 24 months.

Note: The infant must reach 40 weeks gestation-adjusted age in order to plot the CDC growth chart 2 to 5 years. Do not plot measurements on the growth chart if the infant has not yet reached 40 weeks gestation-adjusted age.

___
3FNS Policy Memorandum 98-09, Revision 7, Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants.
LIST 1: Nutrition Practice – Woman

Woman Routinely:
- Severely limits intake of food sources of important nutrients, such as avoiding an entire food group (like dairy products)
- Consumes plant foods only (vegan or macrobiotic diet)
- Routinely fasts, limits meals to one a day, follows a very low calorie diet, or purges foods once eaten
- If pregnant, consumes foods potentially contaminated with pathogens or toxins
- Consumes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences, including unprescribed multi- or single vitamins or minerals or herbal remedies
- Currently or recently craves or consumes non-foods, such as clay, dry cornstarch, laundry starch, freezer frost, or baking soda
- If pregnant, does not consume 27 milligrams of iron daily, either as a prenatal vitamin or an iron supplement
- If not pregnant, does not consume 400 micrograms of folic acid daily, either from a folic acid or multivitamin supplement or from highly fortified breakfast cereal
- If pregnant or breastfeeding, does not consume 150 micrograms of iodine daily, either from an iodine or multivitamin supplement

Refer to Risk Criteria Guidelines for more information.

LIST 2: Breastfeeding Complications or Potential Complications – Woman

- Severe breast engorgement
- Recurrent plugged ducts
- Failure of milk to come in 4 days postpartum
- Cracked, bleeding, or severely sore nipples
- Flat or inverted nipples
- Mastitis
- Age 40 years or older
- Tandem nursing (nursing 2 siblings who are not twins)

Refer to Risk Criteria Guidelines for more information.

LIST 3: Breastfeeding Complications or Potential Complications – Infant

- Weak or ineffective suck
- Difficulty latching on to breast
- Less than 6 wet diapers a day or inadequate stooling for age, as determined by physician or other health care provider
- Jaundice

Refer participant with a breastfeeding complication to the breastfeeding specialist.
LIST 4: Nutrition Practice – Infant

Infant is routinely fed:

- Cow, goat, sheep milk, evaporated or sweetened condensed milk, soy or rice milk, non-dairy creamer
- Any beverage in a bottle other than breast milk, formula, or water
- Water before 6 months of age
- Any solid foods (like cereal) before 4 months of age
- Foods that are low in calories and/or essential nutrients
- Herbal remedies or teas
- Potentially harmful foods: honey; unpasteurized juice, milk, cheese; unheated processed meats; local DO NOT EAT seafood

If exclusively breastfed (no food or formula): in 24 hours is breastfed < 8 times if < 2 months old; or < 6 times if ≥ 2 months, but < 6 months old.

If exclusively breastfed or drinking <1 liter (1 quart)/day of vitamin D fortified formula, and not taking a 400 IU vitamin D supplement daily.

If ≥ 6 months and ingesting less than 0.25 mg of fluoride daily when the water supply contains < 0.3 ppm fluoride.

Caregiver routinely:

- Over- or under-dilutes formula
- Adds cereal, sugar, or other foods to the bottle
- Puts infant to bed with bottle or allows use of bottle or cup without restriction
- Props bottle to feed infant
- Uses water from a well, spring, or cistern that has not been certified as pathogen-free
- Saves expressed breast milk or formula left in the bottle after feeding
- Leaves expressed breast milk or formula unrefrigerated for ≥ one hour
- Keeps expressed breastmilk in refrigerator > 48 hours
- Keeps formula in refrigerator > 24 hours (made from powder) or > 48 hours (made from concentrate)
- Does not recognize/ignores infant’s hunger/fullness cues. Follows rigid feeding schedule or forces infant to eat when full
- Does not allow infant to learn to self-feed
LIST 5: Nutrition Practice – Child

Child is routinely fed:
- Reduced fat (2%), lowfat (1%), or fat free milk before 2 years of age
- Rice or soy based beverages that are inadequately fortified
- Sugar containing drinks like Kool Aid, punch, soda, or sports drinks
- Any drink other than breastmilk or formula from a bottle
- Foods that could cause choking
- Vitamins or other supplements not recommended by a health care professional
- Herbal remedies or teas
- Foods that could be contaminated with pathogens or toxins

Caregiver routinely:
- Allows use of bottles after 14 months of age
- Allows unrestricted use of bottle or cup or puts child to bed with bottle
- Does not recognize/ignores child’s hunger and fullness cues
- Forces child to eat certain foods or “clean the plate”
- Uses special foods as a reward or bribe
- Does not allow child to learn to self feed
- Does not offer 3 meals and 2 nutritious snacks at scheduled times
- Serves only food that caregiver likes or does not offer a variety of foods because child “won’t eat them”
- Avoids entire food groups such as dairy products
- Feeds foods very low in calories and/or essential nutrients (vegan, macrobiotic, other highly restricted diet
- Does not provide a daily source of fluoride
- Does not provide 400 IU vitamin D supplement if child does not drink 1 quart vitamin D fortified milk or formula daily
- Allows child to eat non-foods, like dirt
- Does not provide a source of iron for infants ≥ 6 months old (iron fortified formula, meat, infant cereal, supplement)

LIST 6: Limited Ability of Caregiver to Make Feeding Decisions:

Primary caregiver of an infant/child is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food, limited to:
- Primary caregiver is ≤ 17 years of age; primary caregiver is mentally disabled/delayed and/or has a mental illness such as clinical depression diagnosed by a physician or licensed psychologist; primary caregiver is physically disabled to a degree that food preparation abilities are restricted.
Frequently Asked Questions

Q. A pregnant woman tells me that she used to smoke cigarettes, but has now stopped. Can I assign the risk criterion Maternal Smoking?

A. No. The woman must still smoke at the time of her certification.

Q. Should I tell a breastfeeding woman who is now pregnant to stop breastfeeding her baby?

A. No. Refer a pregnant woman who is breastfeeding an infant less than 12 months of age to the breastfeeding specialist in your local agency. Advise her to inform her health care professional that she is still breastfeeding if she has not already done so.

Q. How do I know if my community water supply contains fluoride in order to determine adequacy of fluoride intake?

A. Your local agency should contact the local water utility to find out if the water supplied to the community contains fluoride.

Q. A caregiver told me that she gave her 8 month old baby some potato chips as finger foods but was told to stop, so she no longer gives them to the baby. Can I assign the risk criterion, Nutrition Practice - Infant?

A. No. The feeding practice must be current.
Q. Several of the risk criteria specify “routinely.” Does this mean every day?

A. Not necessarily. “Routine” is defined as a feeding, dietary, or lifestyle practice that currently occurs on more than one occasion. For example, if a pregnant woman tells you she has a beer “once in a while,” she is still drinking alcohol while pregnant. This is not every day, but it is routine. The practice can harm her unborn baby. Assign the risk criterion Alcohol or Illegal Drug Use and counsel her to stop drinking while she is pregnant.

Q. What if I am not sure that I can use a risk criterion for a participant?

A. Do not guess. If you are a CPPA, talk to a CPA about the risk criterion before you use it. If you are a CPA, talk with one of the State WIC nutritionists. If you are unsure that a risk criterion exists, do not assign the risk criterion.

Q. When I certify a postpartum woman and she tells me that she delivered at 42 weeks gestation, should I add extra pounds to table H?

A. No. The maximum number of pounds she should gain during pregnancy is based upon 40 weeks gestation only.

Q. Can I use verbal information that is not found on the Nutrition History to assign a risk criterion?

A. If the information provides documentation of a risk criterion that we use in the Maryland WIC Program, you may use it to assign the risk. However, you must write a note that documents the risk criterion and its source in the participant’s WOW record.
Q. Should I assign the risk criterion, *Nutrition Practice – Child*, for a child born prematurely, but still on the bottle after 14 months of age?

A. Depending upon the child’s degree of prematurity, the health care professional may recommend that the caregiver postpone weaning to a cup, so that weaning may not be achieved by 14 months of age. Do not apply the risk criterion in this case. If you are a CPPA, you may wish to discuss interpretations of this risk criterion with a CPA.

Q. If a mother has been told by her health care professional to concentrate the calories in the formula by adding less water than the label specifies, can I assign *Nutrition Practice - Infant*?

A. No. If the health care professional advised the mother to follow special directions when making formula, do not assign the risk criterion.

Q. If a pregnant woman’s estimated date of delivery (EDD) is different from the EDD calculated from her last menstrual period date, how do I determine date of conception?

A. If the EDD has been determined by a sonogram, use the EDD stated by the woman.

Q. If a pregnant woman does not know how many weeks pregnant she was when she went for her first prenatal care visit, how can I evaluate Late to Prenatal Care?

A. If the woman knows the date that she went, you can calculate the number of weeks of gestation at the time of the visit by using a gestation wheel. You will need the date of her last menstrual period and the date she went for prenatal care.
Q. How can I apply the risk criterion *Fetal Death ≥ 20 weeks* or *Neonatal Loss* to a breastfeeding woman? Her baby is living.

A. True. This risk criterion only applies to a breastfeeding woman who was pregnant with multiple fetuses (twins or more) and lost one of the infants due to miscarriage or death at birth or during the first 28 days of life. She is breastfeeding the infant who survived.

Q. Can I use a gestation wheel that is different from the one the State WIC Office provides?

A. Not for certifying WIC participants. There are differences in gestation wheels. To consistently apply risk criteria to WIC participants in the State of Maryland, you must use the wheel provided by the State.

Q. When I use Table H, do I need to know the woman’s pre-pregnancy weight to determine if she gained more weight than the cut-off value?

A. Yes. In order to evaluate high weight gain in a breastfeeding or postpartum woman, you must know her pre-pregnancy weight status.

Q. Why can’t I evaluate either *Low Maternal Weight Gain* or *High Maternal Weight Gain* for a woman pregnant with twins or who recently delivered twins?

A. Because there are no scientifically-derived cutoff values to accurately assess the weight gain of a woman who is pregnant with twins, triplets, or more, USDA has chosen to not allow *Low Maternal Weight Gain* or *High Maternal Weight Gain* to be assigned to these women. However, USDA does encourage WIC staff to discuss weight gain recommendations with women who are pregnant with twins or triplets. Refer to the risk criterion *Multi-fetal Gestation* for information about the recommended weight gain for women pregnant with twins or triplets.
Q. Is Low Birth Weight the same thing as Small for Gestational Age (SGA)?

A. No. Low birth weight is usually associated with Prematurity. The infant was likely growing at a normal rate as a fetus but was born early or preterm. A Small for Gestational Age infant is one born full term, but the infant’s birth weight is below what would be expected at 40 weeks. The infant's growth as a fetus did not progress in a normal manner. There may be different feeding issues for a low birth weight versus a Small for Gestational Age infant.
### CHART: Maryland WIC Program Risk Factors for Women, Infants, and Children

**NC**=Nutrition Care (high risk)  **BF**=Refer to BF specialist  **M**=Manually assign risk  **X**=Lower risk  **BP**= Best Practice

<table>
<thead>
<tr>
<th>RISK</th>
<th>CUT OFF VALUE/EXPLANATION</th>
<th>PG</th>
<th>BE</th>
<th>BP</th>
<th>WPP</th>
<th>IBE</th>
<th>IBP</th>
<th>IFF</th>
<th>C1</th>
<th>C2-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol or Illegal Drug Use</td>
<td>PG = Any amount; BE/BP/WPP: ≥ 2 drinks/day All = drugs, any amount. CPA initial contact, then BP: CPA follow up 3-6 months.</td>
<td>NC</td>
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<td>BF Complications/potential</td>
<td>Woman: Use LIST 2, Infant: Use LIST 3 BP: Initial BF contact within 5 days</td>
<td>BF</td>
<td>BF</td>
<td>BF</td>
<td>BF</td>
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<tr>
<td>BF Infant of Woman at Nutritional Risk</td>
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<td>BF</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
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<td>Complementary Feeding Process</td>
<td>Assign only if no other risk found. Documented complete nutrition assessment required. Applies 4 to 23 months</td>
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<td>Depression</td>
<td>CPA initial contact, then BP: CPA follow up 3-6 months</td>
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<td>Failure to Thrive</td>
<td>BP: Initial CPA contact within 5 day, CPA follow up 1-3 months</td>
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<td>VC</td>
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<td>Fetal Alcohol Syndrome</td>
<td>CPA initial contact, then BP: CPA follow up 3-6 months</td>
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<td>Foster Care</td>
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<td>Gestational Diabetes</td>
<td>BP: Initial CPA contact within 5 days. CPA follow up 3 months</td>
<td>NC</td>
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<td>High Maternal Weight Gain</td>
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<td>High Parity and Young Age</td>
<td>Age &lt; 20 at date of conception w/3 prior pregnancies lasting ≥ 20 weeks</td>
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<tr>
<td>High Weight for Length</td>
<td>≥ 97.9 percentile on Birth to 24 months growth chart. For &lt;37 wks gestation, correct age using Table GAA before plotting growth chart.</td>
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<td>BP</td>
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<tr>
<td>History of Birth of a Large for Gestational Age Infant ≥ 9 pounds</td>
<td>PG = any pregnancy&lt;br&gt;BE/BP/WPP = Any prior pregnancy</td>
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<tr>
<td>History of Birth w/ Nutrition Related Congenital/ Birth Defect</td>
<td>Neural Tube Defect; Cleft Palate. PG = any pregnancy. BE/BP/WPP = Any prior pregnancy</td>
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<td>History of Gestational Diabetes</td>
<td>PG = any pregnancy. <strong>BP:</strong> CPA follow up 3 months&lt;br&gt;BE/BP/WPP = Any prior pregnancy</td>
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<tr>
<td>History of Low Birth Weight (≤ 5 lb 8 oz)</td>
<td>PG = any pregnancy&lt;br&gt;BE/BP/WPP = Most recent pregnancy</td>
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<td>History of Preeclampsia</td>
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<tr>
<td>History of Preterm or Early Term Delivery</td>
<td>PG = any pregnancy&lt;br&gt;BE/BP/WPP = Most recent pregnancy</td>
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<td>X</td>
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<td>History of Spontaneous Abortion PG: 2 or more @ &lt;20 wks; Fetal Death (≥ 20 wks)</td>
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<tr>
<td>Hyperemesis Gravidarum</td>
<td><strong>BP:</strong> CPA follow up 1-3 months</td>
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<td>Hypertension / Prehypertension (Woman)</td>
<td>Prehypertension = BP 130/80 – 139/89 mm Hg&lt;br&gt;Hypertension = Systolic ≥ 140, Diastolic ≥ 90mmHg&lt;br&gt;<strong>BP:</strong> CPA initial contact, then CPA follow up 3-6 months</td>
<td>NC</td>
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<tr>
<td>Hypertension / Prehypertension Child Age 3+</td>
<td>Hypertension: &gt; 95&lt;sup&gt;th&lt;/sup&gt; % for age, gender, height on ≥3 occasions&lt;br&gt;Prehypertension = BP 90-95%</td>
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<td>Late to Prenatal Care</td>
<td>Prenatal care beginning after completed week 13 of gestation</td>
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<tr>
<td>Large for Gestational Age</td>
<td>Birth weight ≥ 9 pounds</td>
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<tr>
<td>Limited Ability of Caregiver to Make Feeding Decisions</td>
<td>Mother/caregiver ≤ 17 years, physical/mental disability, drug use</td>
<td>M</td>
<td>M</td>
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<tr>
<td>Listeriosis</td>
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<tr>
<td>Low Birth Weight/</td>
<td>LBW: Infant born ≤ 5 pounds, 8 ounces. CPA initial</td>
<td>NC</td>
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<tr>
<td>Very Low Birth Weight</td>
<td>contact, then <strong>BP:</strong> CPA follow up 3-6 months</td>
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<td>VLBW: Infant born ≤ 3 pounds, 5 ounces. <strong>BP:</strong> Initial CPA contact within 5 days. CPA follow up 1-3 months.</td>
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<td>Low Head Circumference</td>
<td>HC ≤ 2.3% on Birth to 24 months growth chart</td>
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<td>Low Hemoglobin/Hematocrit: Infant/child ≥ 9 months</td>
<td>Hgb ≤ 10.9/Hct ≤32.8. CPA initial contact, then <strong>BP:</strong> CPA follow up 3-6 months Hgb &lt;9: <strong>BP:</strong> Initial CPA contact within 5 days</td>
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<td>Hgb &lt; 10/Hct &lt; 30 Hgb &lt;9: Initial CPA contact within 5 days</td>
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<td>Low Hemoglobin/Hematocrit: Woman</td>
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<td>Use Table A Hgb &lt; 10/Hct &lt;30%</td>
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<tr>
<td>Low Maternal Weight Gain</td>
<td>Use Table IP (A women with underweight and low maternal weight gain = NC)*</td>
<td>X*</td>
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<td>Maternal Smoking</td>
<td>Any kind, any amount</td>
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<td>Maternal Weight Loss</td>
<td>Wt loss below pre-pregnancy wt through week 13; loss of ≥ 2 lbs, weeks 14-40</td>
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<td>May Not Meet Dietary Guidelines</td>
<td>Only if no other risks. Document complete nutritional assessment.</td>
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**Medical Condition, Nutrition Related:**

- **AIDS**
  - CPA initial contact, then **BP:** CPA follow up 3-6 months
  - Not applicable

- **Anorexia Nervosa**
  - CPA initial contact, then **BP:** CPA follow up 3-6 months
  - Not applicable

- **Asthma, moderate or severe persistent**
  - With short stature or obesity
  - Not applicable

- **Asthma, moderate or severe persistent**
  - Diagnosed, requires daily use of inhaled anti-inflammatory agent or oral corticosteroid
  - X  X  X  X  X  X  X  X

- **Bronchiolitis**
  - X  X  X  X  X
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<th>PG</th>
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<td>Multi-Fetal Gestation</td>
<td>Pregnant with twins, triplets, or more. CPA contact, then BP: CPA follow up 3 months.</td>
<td>NC</td>
<td>NC</td>
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<tr>
<td>Neonatal Abstinence Syndrome</td>
<td>NC</td>
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</tr>
<tr>
<td>Nutrition Practices, Child</td>
<td>Use LIST 4: some require manual entry</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Nutrition Practices, Infant</td>
<td>Use LIST 3: some require manual entry</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>Nutrition Practices, Woman</td>
<td>Use LIST 1: some require manual entry</td>
<td></td>
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<tr>
<td>Obese</td>
<td>BMI/Age ≥ 95th % CDC growth chart Age 2 to 5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Oral Health Conditions</td>
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<td>X</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Overweight</td>
<td>Use Table W</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>Overweight/Risk of Overweight</td>
<td>Overweight: BMI/Age ≥ 85 to &lt; 95% CDD 2 to 5 yrs Risk Overweight: Infant/Child whose biological parent is obese</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Pica</td>
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<tr>
<td>Possibility of Regression</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pregnancy at a Young Age</td>
<td>Age ≤ 18 at date of conception</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pregnant Woman Currently BF</td>
<td>Refer to BF specialist</td>
<td>M/BF</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Preterm or Early Term Delivery</td>
<td><strong>Preterm</strong>: Delivery of an infant born ≤36 6/7</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
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</tr>
<tr>
<td>RISK</td>
<td>CUT OFF VALUE/EXPLANATION</td>
<td>PG</td>
<td>BE</td>
<td>BP</td>
<td>WPP</td>
<td>IBE</td>
<td>IBP</td>
<td>IFF</td>
<td>C1</td>
<td>C2-4</td>
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<td>weeks gestation.</td>
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<tr>
<td><strong>Early Term:</strong> Delivery of an infant born ≥37 0/7 and ≤38 6/7 weeks gestation.</td>
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</tr>
<tr>
<td>Recipient of Abuse</td>
<td>Suspected child abuse/neglect must be reported</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Short Interpregnancy Interval</td>
<td>Interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Short Stature/Risk of Short Stature</td>
<td>Length/Age ≤ 5 %, WHO chart, Birth to 2 years Stature/Age ≤ 10th %, CDC chart, 2 to 5 years Use Table GAA if also premature</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Slowed/Faltering Growth</td>
<td>Birth to 2 weeks: Loss of ≥ 7% of birth weight 2 weeks to 6 months of age: Any weight loss.</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Small for Gestational Age (SGA)</td>
<td>Must be diagnosed. Small for gestational age plus low birth weight: CPA initial contact, then <strong>BP:</strong> CPA follow up 3-6 months.</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td></td>
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</tr>
<tr>
<td>Transfer</td>
<td>Birth to 2 weeks: Loss of ≥ 7% of birth weight 2 weeks to 6 months of age: Any weight loss.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Underweight (Woman)</td>
<td>Pregnant: prepregnancy BMI &lt; 18.5 Postpartum/BF woman (&lt; 6 months postpartum): prepregnancy or current BMI &lt; 18.5 Breastfeeding woman (≥ 6 months postpartum) Current BMI &lt; 18.5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Underweight (Woman) with Low Maternal Weight Gain</td>
<td>As above, with low maternal weight gain. CPA contact, then CPA follow up in 3 months</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underweight/Risk of Underweight (Infant/Child)</td>
<td>Underweight: ≤ 2.3 % Birth to 24 months. CPA contact, then CPA follow up 3 months. ≤ 5 % BMI/Age 2 to 5 years = NC*. CPA initial contact, then CPA follow up 3-6 months Risk of Underweight: &gt; 2.3 to ≤ 5 % birth to 24 mo &gt; 5 to ≤ 10 % 2 to 5 years</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
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<td>Vegan or Raw Foods Diet</td>
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<td>NC</td>
<td>NC</td>
<td>NC</td>
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</tr>
</tbody>
</table>

**Attachment 2.31A**

**11/08/2017**

**Page 152**
A. Policy

Local agencies shall obtain, document, and evaluate weight and height (or length) measurements for each applicant in order to determine nutritional risk, prescribe the most appropriate food package, and provide nutrition education.

B. Procedure

1. The local agency shall:

   a. Obtain and maintain equipment for weight, height, and length measurements in accordance with Policy and Procedure 7.62.

   b. Measure weight and length of infants at the time of certification and mid-certification.

   c. Measure weight and height/length of women and children at the time of certification and mid-certification or obtain measurements taken by the applicant’s health care provider within 60 days prior to the certification date.

      i. When obtaining measurements from another source, ensure that weight and height of pregnant women were taken during the pregnancy and for non-pregnant women, after the pregnancy ended.

      ii. Documentation of the medical source shall be entered as a comment on the participant’s medical screen in the management information system with the date that the medical procedure was performed entered in the date field.

   d. Follow the procedures described in Attachment 2.32A to collect weight and height or length measurements.

   e. Enter the weight and height or length measurements and the date that they were taken in the Medical Screen of the applicant’s/participant’s record.
f. Interpret weight and height/length data using growth charts, prenatal weight grids, and any identified risk factors.

g. Consider relevant assessment information before deciding upon the intervention. Refer to 2.31A Nutritional Risk Criteria, Guidelines for Interpretation and the video, Screening for Nutritional Risk, Weight and Height Evaluation, Collecting.

Attachment 2.32A Procedures to Collect Weight and Height/Length Measurements:

References
1. 7 CFR 246.7 (e)
2. COMAR 10.54.01.06 C (2)
3. WIC Policy Memorandum 98-09, Revision 9
4. WIC Nutrition Services Standards, Standard 7
5. SFP 06-056, Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy
6. PL 111-296 The Healthy Hunger-Free Kids Act of 2010

Revisions
October 2011 Updated the tools referred to in B.1.g Changed 4 ounces to 1 ounce in measuring weight of a woman or older child in attachment 2.32A

May 2012 Revised B.1.c to allow local agencies to accept data for anthropometric measurements taken by the applicant’s health care provider within 60 (instead of 30) days prior to the certification date.

October 2012 Added “and mid-certification” to 1.b. and 1.c. Added Reference #6. Deleted references to WOW. Corrected name of Attachment 2.31A and deleted reference to an outdated video. Clarified language in and changed references to CDC Birth to 36 month growth charts to WHO Birth to 24 months growth charts in 2.32A.

October 2013 added language B.1.c.ii about documenting measurements received from another medical source. Had previously been on Policy 2.02

October 2014 Attachment 2.32A Clarified where to order manual cert materials, added language on converting 16ths and rounding decimals
Procedures to Collect Weight and Height or Length Measurements

Weight of an Infant or Child Under 2 Years of Age:

A pediatric beam balance scale or electronic scale shall be used. 1

1. Cover the scale tray with table paper.
2. Zero-balance the beam balance scale. For an electronic scale, set the scale to zero.
3. The infant must wear a dry diaper only. The child should wear light indoor clothing, no shoes, and have a dry diaper.
4. Place the child in the center of the tray. The infant should be on her back. The child can sit.
5. Check that the child or caregiver is not touching the scale and that the caregiver is not holding onto the child.
6. If using a beam balance scale, move the weights until the indicator is centered.
7. Read the weight value to the nearest one (1) ounce.
8. Remove the infant or child from the scale.
9. If using a beam balance scale, return all weights to zero.
10. Record the weight in pounds and ounces in the Medical screen.

Weight of a Woman or Child 2 Years of Age and Older:

An adult beam balance scale or electronic scale shall be used. 1

1. Place a piece of paper on the scale platform where the applicant will stand.
2. The applicant should wear light indoor clothing. Shoes should be removed.
3. Zero-balance the beam balance scale. Set the electronic scale to zero.
4. Ask the applicant to stand in the middle of the platform. Arms should rest at the sides of the body.
5. Check that the applicant is not holding onto the scale.
6. If using a beam balance scale, move the weights until the indicator is centered.
7. Read the weight value to the nearest ounce.
8. Ask the applicant to step off of the scale.
9. If using a beam balance scale, return all weights to zero.
10. Record the weight in pounds and ounces in the Medical screen.

---

1 Refer to P & P 7.62, Equipment for Performing Weight and Height Measurements.
Length of an Infant or Child Under 2 Years of Age:

A length board shall be used. 1

1. Place a sheet of “table” paper on the length board.
2. Ask the caregiver to undress the infant or child.
3. Place the child on his back on the board. The top of his head must touch the headpiece.
4. Ask the caregiver to help by holding the child’s head firmly against the headpiece. The caregiver can cup her hands over the child’s ears.
5. Check that the child’s head and body lie in a straight line and that his eyes look up. There should be space between the chin and the chest.
6. Place one hand over both legs, just above the knees and firmly push both legs down, straightening them against the board.
7. Check that the child’s head is still firmly against the headpiece.
8. Slide the foot piece firmly against both heels. Both feet should be flat against the foot piece and toes should point up.
9. Read the length value to the nearest 1/8 inch.
10. Slide the foot piece back. Remove the child from the length board.
11. Record the length in inches and eighths of an inch in the Medical screen.

Height of a Woman or Child 2 Years of Age and Older:

A stadiometer shall be used. 1

1. Remove shoes, excess clothing* and hair ornaments. Undo braids or ponytails.
2. Ask the applicant to stand with feet slightly apart and to position heels, buttocks, and shoulder blades against the wall or stadiometer.
3. Check that the applicant’s knees are straight, head is erect, and eyes look straight ahead. Arms should rest at the sides of the body.
4. Gently lower the headpiece until it rests on the top of the head. Check that the applicant’s head is not tilted up or down.
5. Hold the headpiece firmly. Ask the applicant to step away from the wall.
6. Read the height value to the nearest 1/8 inch.
7. Record the height in inches and eighths of an inch in the Medical screen.

* Very thick socks or very long pants could affect the height measurement of a young child.

If the Child Does Not Cooperate with the Measurement

If an infant or child will not cooperate with the measurement, the accuracy of the weight and height measurements may be affected. Enter “Uncooperative” in the Comments field in the Anthropometric Data grid in the Medical screen.

1 Refer to P & P 7.62, Equipment for Performing Weight and Height Measurements.
If You Need to Round or Convert the Measurement

Heights and lengths that are measured in $\frac{1}{16}$s will be converted to $\frac{1}{8}$s as per the chart below.

<table>
<thead>
<tr>
<th>1/16</th>
<th>0/8</th>
<th>9/16</th>
<th>5/8</th>
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<tbody>
<tr>
<td>2/16</td>
<td>1/8</td>
<td>10/16</td>
<td>5/8</td>
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<tr>
<td>3/16</td>
<td>1/8</td>
<td>11/16</td>
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<td>4/16</td>
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<td>5/16</td>
<td>2/8</td>
<td>13/16</td>
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<td>6/16</td>
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<td>7/8</td>
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<tr>
<td>7/16</td>
<td>3/8</td>
<td>15/16</td>
<td>1 inch</td>
</tr>
<tr>
<td>8/16</td>
<td>4/8</td>
<td>16/16</td>
<td>1 inch</td>
</tr>
</tbody>
</table>

Weights that are obtained from digital scales that measure pounds and or ounces in decimals will be entered into the management information system as follows:

1. Pounds measured in decimals will be entered into the pound column of the Anthropometric Data grid in the Medical screen. No ounces are entered in the ounce column. Tab off the pound column and the management information system will convert the pounds entered as a decimal into pounds and ounces and display the values in the appropriate columns.

2. Ounces measured in a decimal must be rounded before the value is entered in the management evaluation system. Less than .5 round down. .5 and above round up.
Tools for training staff on how to collect weight, height and length data and to interpret the results are available from the Training Center:

- Training module, Weight and Height Measurements
- Video, Screening for Nutritional Risk, Weight and Height Evaluation, Collecting

The following tools must be used to assess weight and height (or length) risk factors when performing manual certifications. These tools can be ordered by calling the Training Center.

- Table I-C, Inadequate Growth in Infants and Children
- Table W, Weight Status of Pregnant, Breastfeeding and Postpartum Women
- Table I-P/H, Inadequate Weight Gain During Pregnancy/High Maternal Weight Gain
- Precise Plot
- Gestation Wheel
- WHO growth charts, Birth to 24 Months, Boys and Girls
- CDC growth charts, 2 to 5 Years, Boys and Girls
A. Policy

A blood test to screen for iron deficiency/iron deficiency anemia, such as a hemoglobin or hematocrit test, shall be performed and/or documented at the time of certification/mid-certification for applicants with no other nutritional risk factor present. For applicants with at least one qualifying risk factor, such tests shall be performed and/or documented within 90 days of the date of certification. The test may be performed by the local agency or obtained from the applicant’s health care provider.

The results of the blood test shall be used to determine nutritional risk, prescribe the most appropriate food package, and provide nutrition education.

B. Procedure

1. The local agency staff shall:

   a. Obtain a hemoglobin or hematocrit test result from applicants and participants according to the schedule below:

      Pregnant Woman • Once, during the current pregnancy.

      Breastfeeding Woman • Once, following the termination of pregnancy, ideally performed 4 to 6 weeks postpartum.

      • At the mid-certification visit, if the postpartum test meets the cut-off value for “Low Hemoglobin/Hematocrit.”

      Postpartum Woman • Once, following the termination of pregnancy, ideally performed 4 to 6 weeks postpartum.

      Infant • Once, between the ages of 9 and 12 months.
Child

- Once, between the ages of 12 and 24 months, ideally at 15 to 18 months of age, or 6 months after the infant’s blood test.
- Annually, between 24 and 60 months at the time of certification.
- At a 6 month interval, if the previous test result meets the cut-off value for “Low Hemoglobin/Hematocrit.”

b. When performing the blood test, ensure that equipment is properly used and maintained and that federal and state regulations regarding laboratory testing are followed. Refer to Policy and Procedure 7.64 for additional information.

c. When performing a hemoglobin test, follow the procedures described in Attachment 2.33A.

d. Document the blood test result and the date that the test was taken in the Medical Screen of the applicant/participant’s record. Documentation from a non WIC medical source shall be entered as a comment on the participant’s medical screen in the management information system with the date that the blood test result was performed entered in the date field.

e. When the risk factor Low Hemoglobin/Hematocrit is identified, consider relevant assessment information before deciding upon the intervention. Refer to 2.31A Nutritional Risk Criteria, Guidelines for Interpretation.

f. Document the intervention in the applicant/participant’s record.

2. The local agency shall assure that if the blood test is performed on an applicant between the age of 9 months and the first birthday – or on a participant between the age of 9 months and the end of the infant certification period – and is used to certify the participant as a child, it will be used to fulfill the blood test requirement for an infant and not for a child between the ages of 12 and 24 months. The participant shall be scheduled for another hemoglobin test before 24 months of age, ideally at 15 to 18 months of age.

3. If an applicant has had or will have a blood test performed by his/her health care provider, the local agency may defer bloodwork. The local agency must have a procedure to ensure that the test result is obtained within 90 days of the date of certification/mid-certification. Such a
procedure may include monthly issuance of food instruments. The local agency must make every effort to obtain the test result.

Should the participant fail to provide the test result, despite efforts by the local agency to obtain it, the participant is not to be terminated from the Program. The local agency must document in the participant’s record, the attempts made to obtain the result and why these attempts failed. Local agency bloodwork collection procedures shall be monitored during management evaluations.

4. The blood test requirement may be waived by the local agency only if:

a. The applicant’s religious beliefs won’t allow him or her to have blood drawn. A statement of the applicant’s refusal must be included in his/her record.

b. An applicant has a medical condition (such as hemophilia or osteogenesis imperfecta “fragile bones”) in which the procedure for obtaining the blood sample could cause harm, or sickle cell anemia or thalassemia, in which the participant will always have low hemoglobin that cannot be addressed by diet. Documentation from the applicant’s health care provider is required and must be included in the participant’s record. WIC staff should attempt where possible, to obtain bloodwork data from the applicant’s health care provider.

Attachment: 2.33A Procedure for Hemoglobin Testing

References:

1. 7 CFR 246.7(e)(1)(B)(3)
2. FNS Policy Memorandum 92-10, Bloodwork Protocols
3. SFP-041
4. WIC Nutrition Services Standards, Standard 7
5. SFP 06-056, Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy

Revisions:

10/11 Updated reference in B.1.e
10/12 Added reference to mid-certification in A. Policy and B. Procedure.
10/13 Added clarifying language to B.1.d
10/15 Updated acceptable medical conditions which result in waiving blood test requirement.
Procedure for Hemoglobin Screening

Staff performing the hemoglobin test shall follow standard precautions to avoid accidental contamination from viruses such as the Human Immunodeficiency Virus (HIV) or Hepatitis B. Newly hired staff shall attend a blood borne pathogens training\(^1\) prior to handling blood. Existing staff shall attend a blood borne pathogens refresher training on an annual basis.

Procedure for performing the hemoglobin screen using the HemoCue Hemoglobin Analyzer

1. Ask the applicant to sit in a chair. If a child, ask the caregiver to hold the child in her lap. Explain why and how the hemoglobin screen is done using correct terminology.

2. Assemble the hemoglobin test supplies on a clean paper towel placed on the work surface:
   - alcohol pad
   - lancet
   - microcuvette\(^2\)
   - gauze pad
   - bandage (may be partially opened)

3. Put on a new pair of disposable gloves; check that there are no holes or tears.

4. Select the puncture site. Use the middle or ring finger (with rings removed) for adults and older children. The big toe or side of the heel may be used for an infant or young child.

5. Prepare the hand for puncture. The hand should be warm and relaxed to obtain an adequate blood flow. Keep the hand extended down to help blood flow.

6. Clean the puncture site with the alcohol pad. Wipe it dry with a clean gauze pad.

7. Using a rolling movement of your thumb, press the finger from the top knuckle towards the tip to stimulate blood flow. When the thumb reaches the fingertip, maintain pressure and puncture the side of the fingertip with the lancet.

8. Discard the used lancet in the puncture-proof container.

9. Wipe away the first 3 drops of blood with a dry gauze pad. Continue to apply pressure until another drop of blood forms. The blood sample must be large enough to fill the microcuvette completely.

10. Holding the square end of the microcuvette, touch the middle of the blood drop with the long pointed edge. Allow the microcuvette to completely fill up with blood in one continuous step.

11. Apply gauze to the puncture site after filling the microcuvette. Ask the participant or caregiver to hold the gauze and apply gentle pressure against the puncture site. Advise elevating the hand to help stop the bleeding.

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\(^1\) This training is to be provided by authorized local health department or medical clinic staff.

\(^2\) Handle microcuvettes with care. Check the date on the bottle to be sure it has not expired. Remove only the number of microcuvettes to use immediately. Close the lid and keep the container closed.
12. Remove excess blood from the microcuvette by gently touching both of the flat sides of the filled microcuvette on a dry gauze pad or tissue. Wipe the microcuvette as if spreading butter.

13. Inspect the microcuvette to be sure there are no air bubbles in the middle of the sample.

14. Place the microcuvette into the microcuvette holder and gently slide the holder into the HemoCue machine.

15. Place a bandage on the participant’s finger.

16. Read the result that appears in the HemoCue window.

17. Remove the microcuvette from the cuvette holder and discard it in the puncture-proof container. Remove and discard gloves and other waste in the appropriate waste container. Wash hands.

18. Record the hemoglobin result in the Bloodwork Data grid in the Medical Screen of the applicant’s record.

19. Interpret the test results. If the risk factor Low Hemoglobin/Low Hematocrit is identified, provide and document the intervention in the participant’s record.

20. At the end of each day, clean the blood test equipment and area where the blood test is performed. Use gloves when cleaning. Follow local agency procedures.

21. If a blood spill occurs during testing, use the approved cleaning agent to clean the area. Cleanup should take place as soon as possible. Use gloves and paper towels and dispose of them in the proper container.

22. Never eat, drink, or store food or beverages or other items where the blood test is performed.

Tools for training staff on how to perform the blood test and interpret the test results are available from the Training Center:

- Training Module, Blood Testing
- Video, Screening for Nutritional Risk, Blood Test Evaluation
MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.34
Effective Date: October 1, 1996
Revised Date: February 5, 2019

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Nutrition and Health Information Requirement

A. Policy

Local agencies shall obtain, document, and interpret nutrition and health information for each applicant in order to determine nutritional risk, provide nutrition education and referral information, and prescribe the most appropriate food package.

B. Procedure

1. When collecting and evaluating nutrition and health information from applicants, the local agency shall:

   a. Enter relevant information into each applicant/participant’s record, using the Medical and Nutrition History screens in the management information system in order to identify and document nutrition and health-related risk factors.

   b. Information must be entered/updated at each certification, recertification and mid-certification visit.

   c. Interpret relevant information to provide the most appropriate intervention for the participant that is based upon identified risk factors and participant concerns.

Attachment:
2.34A Provision of Nutrition Services

References:
1. 7 CFR 246.7(e)
2. COMAR 10.54.01.06 C (2)
3. WIC Policy Memorandum 98-09, Revision 9
4. WIC Nutrition Services Standards, Standard 7
5. SFP 06-056 Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy
Revisions:
  10/11 Deleted reference to old training module.

  10/12 Changed age for nutrition history forms to Birth to 3 months and 4 to 12 months. Clarified when information is entered/updated. Added participant focused language. Attachment 2.34A: Changed wording of #13. Attachment 2.34B: Changed wording of #8 and #9. Attachment 2.34C: Changed wording of #7. Attachment 2.34D: Changed wording of #10.

  10/15 Removed references to paper versions of forms. Removed 2.34A, 2.34B, 2.34C, 2.34D.

  02/19 Added Attachment 2.34A: Edited 2.38A to include certification and mid-certification and renamed as 2.34A. Removed b. Child 1 to 2 years old. Renamed c. as b. Child 1 to 4 years old. Renamed d. as c. Breastfeeding Woman. Added d. Pregnant Woman with steps 1 to 8.
Provision of Nutrition Services

WIC certifiers shall provide nutrition services during certification and mid-certification visits for each participant category as follows:

a. Infant

1) Review contact information.
2) Update amount of breastfeeding, even if same as previous visit (if applicable).
3) Update breastfeeding questions on introduction of supplemental foods (if applicable).
4) If breastfeeding status has changed, update breastfeeding status and introduction of supplemental foods questions and reason breastfeeding ended (if applicable), change participant category and food package per policy.
5) Review medical history thoroughly; complete and make changes as necessary. If there are no changes, click the No Changes checkbox.
6) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
7) Complete bloodwork (if required per Policy and Procedure 2.33).
8) Update immunization record.
9) Complete nutrition history. During an MCV, click the New checkbox. All new answers are required.
10) Assess risk factors.
11) Review growth chart.
13) Make required referrals and others as needed.

b. Child 1 to 4 years old

1) Review contact information.
2) Update amount of breastfeeding, even if same as previous visit (if applicable).
3) Update breastfeeding questions on introduction of supplemental foods (if not completed).
4) If breastfeeding status has changed, update breastfeeding status and reason breastfeeding ended questions (if applicable).
5) Complete medical history:
   a) Begin with: “Tell me about any recent illnesses or changes to your child’s health or dental health since you were here last.”
   b) Ask the physically active play question.
   c) Make any necessary changes. If there are no changes, click the No Changes checkbox.
6) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
7) Complete bloodwork (if required per Policy and Procedure 2.33).
8) Update immunization record if less than 2 years of age.
9) Review nutrition history:
   a) Begin with: “Tell me about meal times,” or “Tell me how your child is eating.”
   b) Make any necessary changes. If there are no changes, click the No Changes checkbox.
10) Assess risk factors.
11) Review growth chart.
13) Make required referrals and others as needed.

c. Breastfeeding Woman

1) Begin with: “How’s breastfeeding going?” or “What questions or concerns about breastfeeding do you have at this time?”
2) Review medical history:
   a) Begin with: “Tell me about any changes to your physical or emotional health since your last WIC visit.”
   b) Ask physical activity question.
   c) Make any necessary changes. If there are no changes, click the No Changes checkbox.
3) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
4) Complete bloodwork (if required per Policy and Procedure 2.33).
5) Review nutrition history:
   a) Begin with: “Tell me about any changes you’ve made in what you’re eating or drinking.”
   b) Make any necessary changes. If there are no changes, click the No Changes checkbox.
5) Assess risk factors.
6) Review weight status.
8) Make required referrals and others as needed.

d. Pregnant Woman

1) Review contact information.
2) Review medical history:
   a) Begin with: “Tell me about any changes to your physical or emotional health since your last WIC visit.”
   b) Ask physical activity question.
   c) Make any necessary changes. If there are no changes, click the No Changes checkbox.
3) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
4) Complete bloodwork (if required per Policy and Procedure 2.33).
5) Review nutrition history:
   a) Begin with: “Tell me about any changes you’ve made in what you’re eating or drinking.”
   b) Make any necessary changes. If there are no changes, click the No Changes checkbox.
6) Assess risk factors.
7) Review weight status.
9) Make required referrals and others as needed.
Policy and Procedure 2.34B has been removed.
Policy and Procedure 2.34C has been removed.
Policy and Procedure 2.34D has been removed.
Policy and Procedure 2.35 has been removed.
A. Policy

WIC certification services may be provided in the hospital to individuals receiving maternity or postpartum services when the WIC clinic is within a hospital or there is a signed agreement between the local WIC agency and the hospital. The purpose of performing hospital certifications is:

1. To provide WIC Program services including eligibility determination, breastfeeding promotion and support, nutrition education, health and social service referrals, a food instrument and benefits for supplemental foods as appropriate to pregnant women, breastfeeding and non-breastfeeding postpartum women, and/or their newborn infants at the earliest possible date.

2. To provide outreach to potential WIC participants to promote awareness of WIC Program services and eligibility requirements.

B. Procedure

1. When certifying a pregnant woman who will be delivering at a hospital where the local agency performs certifications, the certifier shall inform the woman that she and her newborn infant may be able to be certified while she is in the hospital and encourage her to bring her proof of identity, proof of residence, and proof of income or adjunct eligibility to the hospital.

2. Hospital certifications may be performed by a Competent Professional Authority (CPA) or Competent Paraprofessional Authority (CPPA).
3. Potential or current WIC participants who live outside the service area of the local agency providing hospital certifications shall not be given a hospital certification. Those who are potentially WIC-eligible shall be given the WIC outreach brochure and encouraged to call the appropriate local agency (one that is convenient to where she lives or works) as soon as possible for a certification appointment.

4. All Maryland WIC policies and procedures related to providing certifications in clinics shall be followed in performing hospital certifications.

5. All client information shall be collected and maintained in a confidential manner.

6. A hospital identification bracelet may be used and appropriately documented in the Notes section of the participant’s record as proof of identity. (Refer to Policy and Procedure 2.23.)

7. Hospital records may be used for proof of residence and to obtain adjunct eligibility information (such as an applicant’s Medical Assistance number) if access to the records has been granted to the WIC certifier through an agreement between the local agency and the hospital. The certifier shall verify and appropriately document an applicant’s or an applicant’s family member’s current participation in a qualifying program for adjunctive eligibility. (Refer to Policy and Procedure 2.05.)

8. All applicable nutrition risks shall be identified and documented in the management information system. If the WIC certifier has the hospital’s permission to access the hospital record, information may be obtained from it. The date for weight, height/length, and hemoglobin/hematocrit measurements shall be recorded as the date when the measurements were actually performed, not the date they were obtained from the medical record. Hemoglobin or hematocrit measurements for postpartum women must have been performed during the postpartum period. If a hemoglobin or hematocrit test result cannot be obtained, the measurement may be performed (ideally between 4 to 6 weeks postpartum) and/or documented within 90 days of the date of certification, if the applicant has at least one qualifying risk factor. (Refer to Policy and Procedures 2.32 and 2.33.)
9. Nutrition education and breastfeeding support shall be provided and documented for each participant as appropriate to the participant’s risks, needs, and interests identified and prioritized during the nutrition risk assessment. (Refer to Policy and Procedures 5.01 and 5.09.)

10. The food package shall be tailored to the participant’s needs and preferences and its content explained to the participant. The Authorized Foods List and Using your Maryland eWIC Card shall also be explained to the participant. (Refer to Policy and Procedures 3.01, 5.09, and 4.10.)

11. CPPAs who are performing hospital certifications shall fax medical documentation for exempt infant formulas, medical foods, soy beverages, and tofu to a Competent Professional Authority (CPA) for approval prior to issuance. (Refer to Policy and Procedures 3.02 and 3.03.)

12. All laptops and printers shall be secured to a cart when being transported to and used in patient rooms. They shall be stored in a locked room designated for this purpose in the hospital unless they are returned to the WIC clinic each day.

13. The following is recommended best practice for follow-up of breastfeeding infants. All breastfeeding infants certified in the hospital shall be given a follow-up appointment within one month. During this visit, assistance with breastfeeding should be provided, weight and length measurements taken, participant category changes and food package adjustments made, and breast pumps issued as appropriate.

Revisions: 10/12 Deleted references to WOW, Minor language change/clarification in B.6 6/17 Updated language in policy to reflect eWIC terminology.
A. Policy

Local WIC agencies may choose to use volunteers to stretch resources and increase the quality and quantity of services provided to WIC participants. Volunteers may assist with a variety of tasks ranging from administrative support to nutrition education activities, depending on the qualifications of the volunteer. Volunteers shall be given orientation as to the importance of maintaining the confidential nature of participant information. They shall sign a confidentiality statement and they shall not be allowed access to the management information system.

B. Procedure

1. The job duties of volunteers shall be restricted to activities not involving access to applicant/participant information in WOW.

   a. Examples of appropriate volunteer activities include:

      1) Administrative

         a) Copying materials
         b) Stuffing envelopes with appointment notices

      2) General

         a) Sanitizing toys

         b) Assisting with group education sessions by greeting participants/directing their flow
c) Assisting with language interpretation
d) Leading activities with children such as interactive play, reading or storytelling in waiting area – if appropriately trained to work safely with children, as per local agency health department/sponsoring agency policy

3) Outreach

a) Assisting with outreach at health fairs
b) Conducting customer satisfaction surveys in person or over the phone

4) Nutrition education/breastfeeding promotion and support

a) Creating posters, displays, bulletin boards, educational/resource materials – if qualified and supervised
b) Assisting with cooking demos and food tasting
c) Providing group nutrition education – if qualified and supervised
d) Setting up/breaking down for group education sessions or breastfeeding showers
e) Special projects such as grocery store tours – if qualified and supervised

b. Examples of inappropriate volunteer activities include:

1) Answering the telephone
2) Calling participants to re-schedule missed appointments
3) Performing anthropometric/biochemical measurements
4) Individual nutrition or breastfeeding counseling

2. Volunteers are subject to the same confidentiality restrictions as WIC employees (refer to Policy and Procedure 7.70). During orientation of volunteers, specific confidentiality requirements governing the WIC Program shall be discussed and the volunteer shall sign an agreement stating that they:

a. Understand the policy and procedures of the Program regarding confidentiality, and
b. Agree to keep applicant/participant information confidential.
3. Volunteers shall not drive local agency vehicles.

4. Local agencies shall adhere to any additional policies and procedures pertaining to use of volunteers that are required by their health department or sponsoring agency.

5. Dietetic Interns (other than Maryland WIC employees who are participating in the Virginia/Maryland WIC Dietetic Internship Program):

Local agencies may provide dietetic interns from area or distance internship programs with WIC experience as part of their community nutrition rotation. The primary objective of a dietetic intern's WIC experience is exposure to aspects of WIC as a community nutrition program such as eligibility determination, participant benefits, funding, federal regulations, and the emphasis on participant-focused counseling and breastfeeding promotion and support. Like volunteers, interns are subject to the same confidentiality restrictions as WIC employees. Their orientation shall include discussion of the importance of maintaining the confidential nature of applicant/participant information, they shall sign a confidentiality statement, and they shall not be allowed access to the management information system. Appropriate activities for an intern include observing the certification process, individual counseling sessions, and group education sessions. Actual provision of individual counseling/group education or performance of anthropometric/biochemical measurements by the interns is permissible if supervised by a Competent Professional Authority (CPA) who is present at the time the service is provided or performed.

Revisions:
1/17 Removed Preparing ID folders for the day under examples of Administrative activities. Removed distributing/collection health history forms or surveys under examples of General activities. Changed reference to check pickup to group education sessions.
6/17 Removed all references to checks.
Policy and Procedure 2.38 has been merged into Policy and Procedure 2.10.
Policy and Procedure 2.38A has been removed.
Policy and Procedure 2.38B has been removed.
Policy and Procedure 2.38C has been removed.
Policy and Procedure 2.38D has been removed.