

CERTIFICATION POLICIES AND PROCEDURES

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**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.00
Effective Date: October 1, 1993
Revised Date: October 1, 2015**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Overview of the Certification Procedure

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. An Identification (ID) Folder and an explanation of its importance and of the requirement that it be presented to pick up and redeem food instruments.
 - vii. A list of WIC authorized foods and vendors.
 - viii. An explanation of the need to return to the clinic for future appointments, as appropriate.
 - ix. A written appointment date and time to obtain the next allotment of food instruments and secondary nutrition education contact.
 - x. Information about how to contact the clinic.
 - xi. Encouragement to participate in the local agency's nutrition education activities.
 - xii. Encouragement to keep and be on time for all appointments
 - xiii. Instruction to explain Program information including the use of the ID Folder and 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)

Revisions:

04/08	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.

Policy and Procedure 2.01 has been renamed as Policy and Procedure 7.60.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.02
Effective Date: October 1, 1990
Revised Date: October 1, 2015**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Certification of Applicant

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 verifies residency, income, identity 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 manual certification 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.

Maryland WIC Program Manual

Certification Mid-Certification Form

Clinic:	Certification Date:
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Family Information	Last Name	First Name	MI	Designee
Head of Household				<input type="checkbox"/>
Proxy #1				<input type="checkbox"/>
Proxy #2				<input type="checkbox"/>

	Street Address	Mailing Address <input type="checkbox"/> Same as Street Address
Street		<input type="checkbox"/> No Mailing
City, State, Zip		
County		

Phone	Type	Land Fax	Mobile Text	Comment	No Calls
Primary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appt Rem	Call Text		<input type="checkbox"/> Yes <input type="checkbox"/> No

Phone	Type	Land Fax	Mobile Text	Comment	No Calls
Primary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appt Rem	Call Text		<input type="checkbox"/> Yes <input type="checkbox"/> No

E-mail Address	Family Size
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Income Information					
Income Provider Name	Interval	Amount	Source	Documentation	Note
					<input type="checkbox"/> N/A MCV
					<input type="checkbox"/> Foster Child
					# of Expected Infants _____

Additional Family Information	
Primary Language if not English	<input type="checkbox"/> Translator Required
Proof of Residence	<input type="checkbox"/> Documented <input type="checkbox"/> N/A MCV
Voter Registration	<input type="checkbox"/> Documented Internet Usage <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pickup Interval	<input type="checkbox"/> Trimonthly <input type="checkbox"/> Bimonthly <input type="checkbox"/> Monthly
Referred From	
Disability	
Other Information	<input type="checkbox"/> Military <input type="checkbox"/> Migrant <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Residential Facility

Participant Information (Woman)

Last Name		First Name		MI		DOB	
			Proof of Identity:	<input type="checkbox"/> N/A MCV			
Adjunct Eligibility	<input type="checkbox"/> MA <input type="checkbox"/> Food Stamps <input type="checkbox"/> TCA		Proof of Pregnancy				
Card Number			Source of Health Care				
Physician Name			Telephone Number				

Hispanic or Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enrollment in other Federal Programs	
American Indian or Alaska Native		Medical Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asian		TCA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Black or African American		Food Stamps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Native Hawaiian or Other Pacific Islander			
White			

Cert Action

LMP	EDD	Actual Delivery Date				
Category	Cert Start	Cert End	Cert Reason	Term Date	Term Reason	Comment

Pregnancy Information

<p>1. When did you see a doctor for this pregnancy?</p> <p><input type="checkbox"/> Haven't <input type="checkbox"/> Date of 1st visit: <input type="text"/></p> <p>1a. What has your doctor told you about getting flu and Tdap shots while you're pregnant.</p> <p>2. What special concerns does your care providers have?</p> <p><input type="checkbox"/> Twins, triplets or more <input type="checkbox"/> Weight loss while pregnant <input type="checkbox"/> Hyperemesis gravidarum <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Fetal growth restriction (IUGR) <input type="checkbox"/> None or unknown</p>	<p>3. Is this your first pregnancy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date last pregnancy ended: <input type="text"/></p> <p>3a. Tell me about any medical issues with your past pregnancies.</p> <p><input type="checkbox"/> Baby born 5 pounds, 8 ounces or less <input type="checkbox"/> Baby born 9 pounds or more <input type="checkbox"/> Baby born 37 weeks or earlier <input type="checkbox"/> Baby born with a birth defect <input type="checkbox"/> Two or more miscarriages less than 20 weeks <input type="checkbox"/> Pregnancy loss (20 weeks or more) <input type="checkbox"/> Stillbirth or death before 1 month of age <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> History of Preeclampsia <input type="checkbox"/> None of these</p>	<p>WPP/BE/BP:</p> <p>1. Tell me about this last pregnancy.</p> <p><input type="checkbox"/> Baby born 5 pounds, 8 ounces or less <input type="checkbox"/> Baby born 9 pounds or more <input type="checkbox"/> Baby born 37 weeks or earlier <input type="checkbox"/> Twins, triplets or more <input type="checkbox"/> Baby born with a birth defect <input type="checkbox"/> Miscarriage (less than 20 weeks) <input type="checkbox"/> Pregnancy loss (20 weeks or more) <input type="checkbox"/> Stillbirth or death before 1 month of age <input type="checkbox"/> Caesarean "C" section <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> History of Preeclampsia <input type="checkbox"/> None of these</p> <p>2. Were you ever pregnant before this last time? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Date last pregnancy ended? <input type="text"/></p>
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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
 Milk Shellfish
 Soy Fish
 Eggs Wheat
 Nuts 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

Date	LBS	OZ	IN	1/8 IN	Weeks	Hgb	Comment
Pre Pregnancy Weight			Weight at Delivery				

Participant Information (Infant – Child)

Last Name		First Name		MI		DOB	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		Proof of Identity	<input type="checkbox"/> N/A MCV			
Adjunct Eligibility	<input type="checkbox"/> MA <input type="checkbox"/> Food Stamps <input type="checkbox"/> TCA						
Card Number			Source of Health Care				
Mom's ID Number							
Physician Name			Telephone Number				

Hispanic or Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enrollment in other Federal Programs
American Indian or Alaska Native		Medical Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No
Asian		TCA <input type="checkbox"/> Yes <input type="checkbox"/> No
Black or African American		Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No
Native Hawaiian or Other Pacific Islander		
White		

Cert Action (Infant – Child)

Immunization Status:		Record Date Given:					
Immunization Document:	<input type="checkbox"/> Yes <input type="checkbox"/> No	DTaP #1		DTaP#2			
Signed Consent:	<input type="checkbox"/> Yes <input type="checkbox"/> No	DTaP#3		DTaP#4			
Breastfeeding Now:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount of BF	<input type="checkbox"/> Exclusive <input type="checkbox"/> Mostly (<14oz formula) <input type="checkbox"/> Some (>14oz formula)				
Ever Breastfed:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Age when routinely fed something other than breast milk?			Food Type		
Date/Age BF Ended		_____ months _____ weeks _____ days					
Category	Cert Start	Cert End	Cert Reason	Term Date	Term Reason	Comment	Wait

Medical Information (Infant – Child)

No Yes Specify

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

Wt/Ht/Bloodwork

Date	LBS	OZ	IN	1/8	R/S	Hgb	Comment
Infant Premature	<input type="checkbox"/>	Weeks of Gestation	Birth Weight	_____ lbs _____ oz		Lead Test	
						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

Participant Information (Infant – Child)

Last Name		First Name		MI		DOB	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		Proof of Identity	<input type="checkbox"/> N/A MCV			
Adjunct Eligibility	<input type="checkbox"/> MA <input type="checkbox"/> Food Stamps <input type="checkbox"/> TCA						
Card Number			Source of Health Care				
Mom's ID Number							
Physician Name			Telephone Number				

Hispanic or Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enrollment in other Federal Programs
American Indian or Alaska Native		Medical Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No
Asian		TCA <input type="checkbox"/> Yes <input type="checkbox"/> No
Black or African American		Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No
Native Hawaiian or Other Pacific Islander		
White		

Cert Action (Infant – Child)

Immunization Status:		Record Date Given:					
Immunization Document:	<input type="checkbox"/> Yes <input type="checkbox"/> No	DTaP #1		DTaP#2			
Signed Consent:	<input type="checkbox"/> Yes <input type="checkbox"/> No	DTaP#3		DTaP#4			
Breastfeeding Now:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount of BF	<input type="checkbox"/> Exclusive <input type="checkbox"/> Mostly (<14oz formula) <input type="checkbox"/> Some (>14oz formula)				
Ever Breastfed:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Age when routinely fed something other than breast milk?			Food Type		
Date/Age BF Ended		_____ months _____ weeks _____ days					
Category	Cert Start	Cert End	Cert Reason	Term Date	Term Reason	Comment	Wait

Medical Information (Infant – Child)

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

Wt/Ht/Bloodwork

Date	LBS	OZ	IN	1/8	R/S	Hgb	Comment
Infant Premature <input type="checkbox"/>	Weeks of Gestation		Birth Weight	_____ lbs _____ oz		Lead Test <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

Risk Factors		
Participant #1		
Participant #2		
Participant #3		

Nutrition Education Topics		
Participant #1		
Participant #2		
Participant #3		
Goal:		

Referrals			
Nutrition Care	Immunizations	Dental	Food Stamps
Breastfeeding	Health Care	MA	Additional Food Resources
Local Provider:			

Food Package	
Schedule Day:	
Package Type Issued:	

Next Appointment						
CPU	PSV	IND	MCV	NC	BFF	Note:

Comments / Notes		
<p>Initials of staff member who entered information into WOW verifying completion _____</p> <p>Initials of staff member who documented manual check issuance in WOW _____</p>		
Family called to notify them their checks are ready:	<input type="checkbox"/> Left message <input type="checkbox"/> Person answered	Date of contact: _____
PSV scheduled for family to pick-up checks Date: _____	<input type="checkbox"/> Family has transportation concerns and requested staff mail checks <input type="checkbox"/> Address verified <input type="checkbox"/> Next appointment made and is entered in WOW <input type="checkbox"/> Appointment reminder mailed with checks	

Codes

Proof of Residency	Proof of Identity	
Confirmation of Residency Form Drivers License Homeless Shelter Lease MVA Identification Migrant Camp Resident No Proof Official Mail Other (system note required) Utility Bill	Birth Certificate/Registration Drivers License Hospital Birth Record Immunization Record Other (system note required) Proof of Age/Majority Proof of Identity Affidavit Proof of Identity Card Social Security Card Immigration/Naturalization Record Military Records, ID Card or Discharge Papers	Crib Card Health Passport MAP Card Marriage License No Proof Passport/Visa School ID VOC WIC Folder
Proof of Pregnancy	Source of Income	Income Verification
Health Care Provider's Note No Proof Not Applicable Other (system note required) Physical Appearance Pregnancy Test Results/Sonogram VOC WIC Referral Form	Alimony or Child Support Collateral Verification Form Contributions from Other Persons Dividends or Interest on Savings or Bonds, Income From Estate Foster Care Military LES Net Income From Farm and Non-Farm Self-Employment Pending Public Assistance or Welfare Payments Retirement Savings or Checking Account Social Security Unemployment Compensation VOC Cards/Transfers Wages, Salary, Commissions, Fees or Cash Payments for Service Worker's Compensation	Collateral Verification Contributions from Other Persons Dividends or Interest on Savings or Bonds Foster Child Status Verification Income Tax Returns Letter from Employer Military LES No Proof Other Cash Income Received or Withdrawn from Any Source Pay Stubs Private Pensions or Annuities Retirement Pensions or Veteran Payment Self-Employment Social Security Documentation Social Services Budget Letter Unemployment Insurance VOC card W-2 Form (copy)

Name _____

Women

Please answer all questions below.

1 Tell me about any problems you have with eating.

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> No time to eat |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Can't find the foods I like |
| <input type="checkbox"/> Mouth pain | <input type="checkbox"/> Don't feel like eating | <input type="checkbox"/> 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bread, tortillas, or crackers | <input type="checkbox"/> Orange or red vegetables | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Cold or hot cereal | <input type="checkbox"/> Green vegetables | <input type="checkbox"/> Cheese or yogurt |
| <input type="checkbox"/> Noodles, macaroni, or rice | <input type="checkbox"/> Dry beans /canned beans | <input type="checkbox"/> Hot dogs, sausage, coldcuts or bacon |
| <input type="checkbox"/> Fish or shellfish | <input type="checkbox"/> Tofu | <input type="checkbox"/> Ice cream or pudding |
| <input type="checkbox"/> Fruit | <input type="checkbox"/> Peanut butter or nuts | <input type="checkbox"/> Cookies, cake, pie or donuts |
| <input type="checkbox"/> Green leafy salads | <input type="checkbox"/> Meat, chicken, or turkey | <input type="checkbox"/> Chips, fried snacks, or popcorn |

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
- 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 _____ Birth date _____ Birth weight and length _____

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

- Recurrent plugged ducts
- Severe breast engorgement
- Tandem nursing of 2 siblings (not twins)
- Other: _____
- None of these

2. How often does your baby eat: _____ times in 24 hours. About how long does it take? _____ mins.

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

- Sucks on hand
- Fussing
- 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 _____

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 breastmilk? 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

(Infant) Birth – 5 months

-Continued

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

(Infant) 6 – 12 months

Baby's name _____ Birth date _____ Birth weight and length _____

Please tell us how feeding is going.

1. What does your baby drink?

- | | | | | | |
|---|-------|---------------------------------|---------------------------------|---------------------------------------|------------------------------|
| <input type="checkbox"/> Breast milk | from: | <input type="checkbox"/> Breast | <input type="checkbox"/> Bottle | <input type="checkbox"/> Cup with lid | <input type="checkbox"/> Cup |
| <input type="checkbox"/> Formula ___oz./day | from: | | <input type="checkbox"/> Bottle | <input type="checkbox"/> Cup with lid | <input type="checkbox"/> Cup |
| <input type="checkbox"/> Plain water | from: | | <input type="checkbox"/> Bottle | <input type="checkbox"/> Cup with lid | <input type="checkbox"/> Cup |
| <input type="checkbox"/> 100% fruit juice | from: | | <input type="checkbox"/> Bottle | <input type="checkbox"/> Cup with lid | <input type="checkbox"/> Cup |
| <input type="checkbox"/> Sugar-sweetened drinks | from: | | <input type="checkbox"/> Bottle | <input type="checkbox"/> Cup with lid | <input type="checkbox"/> Cup |
| <input type="checkbox"/> Cow or other milk | from: | | <input type="checkbox"/> Bottle | <input type="checkbox"/> Cup with lid | <input type="checkbox"/> Cup |
| <input type="checkbox"/> Other _____ | | | | | |

2. How often do you feed your baby breast milk or formula:

Breast milk _____ times in 24 hours.

Formula _____ times in 24 hours.

Skip to question 8 if you do not bottle-feed your baby.

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 Food: _____

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

(Infant) 6 – 12 months

-Continued

8. What foods have you offered your baby?

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Baby cereal | <input type="checkbox"/> Green vegetables | <input type="checkbox"/> Dry beans or tofu | <input type="checkbox"/> Baby dinners | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Regular cereal | <input type="checkbox"/> Orange vegetables | <input type="checkbox"/> Meat/Meat sticks | <input type="checkbox"/> Baby desserts | |
| <input type="checkbox"/> Noodles or rice | <input type="checkbox"/> Other vegetables | <input type="checkbox"/> Chicken or turkey | <input type="checkbox"/> Cookies/Sweets | |
| <input type="checkbox"/> Bread or tortillas | <input type="checkbox"/> Fruit | <input type="checkbox"/> Eggs | <input type="checkbox"/> 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: _____

1. 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?

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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Bread or tortillas | <input type="checkbox"/> Green vegetables | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Crackers | <input type="checkbox"/> Orange or red vegetables | <input type="checkbox"/> Cheese or yogurt |
| <input type="checkbox"/> Cereal | <input type="checkbox"/> Fish or shellfish | <input type="checkbox"/> Hot dogs, sausage or coldcuts |
| <input type="checkbox"/> Noodles or macaroni | <input type="checkbox"/> Meat or chicken | <input type="checkbox"/> Ice cream or pudding |
| <input type="checkbox"/> Rice | <input type="checkbox"/> Dry bean/canned beans | <input type="checkbox"/> Cookies, cake, pie, or donuts |
| <input type="checkbox"/> Fruit | <input type="checkbox"/> Tofu | <input type="checkbox"/> Hard or chewy candy or fruit snacks |
| <input type="checkbox"/> Potatoes or corn | <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Chips, popcorn, or nuts |

8. Child drinks from: Cup Cup with lid Baby Bottle

9. What does your child drink?

- Breast milk
- 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? _____

	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
Alcohol/Drug Use	◆	◆	◆	◆					
Breastfeeding Complication(s) _____		◆	◆		◆	◆			
Breastfeeding Infant of Mother at Nutritional Risk		◆	◆		◆	◆			
Breastfeeding Mother of Infant at Nutritional Risk		◆	◆		◆	◆			
Elevated Blood Lead ≥ 15.0 ug/dl in last 12 months	◆	◆	◆		◆	◆	◆	◆	◆
Failure to Thrive (FTT) Diagnosis					◆	◆	◆	◆	◆
Fetal Alcohol Syndrome (FAS) Diagnosis					◆	◆	◆	◆	◆
Fetal Growth Restriction (FGR) Diagnosis	◆								
Gestational Diabetes (GDM) Diagnosis	◆								
History of Gestational Diabetes	◆	◆	◆	◆					
Hyperemesis Gravidarum Diagnosis	◆								
Hypertension/prehypertension	◆	◆	◆	◆				◆	◆
Low Birth Weight ≤ 5 lb, 8 oz					◆	◆	◆		
Low Hemoglobin/Hematocrit < 10.0 g or $< 30\%$	◆	◆	◆	◆	◆	◆	◆	◆	◆
Low Maternal Weight Gain or Loss + Underweight	◆								
Medical Condition _____	◆	◆	◆	◆	◆	◆	◆	◆	◆
Multi-Fetal Gestation	◆								
Pregnant Woman Currently Breastfeeding	◆								
Prematurity < 37 completed weeks gestation					◆	◆	◆		
Small for Gestational Age Diagnosis					◆	◆	◆		
Special Diet: Vegan, Fasting, High Protein/Low Carb	◆	◆	◆	◆					
Underweight Weight/length or BMI/age $\leq 5\%$					◆	◆	◆	◆	◆
Other _____									

 WIC Staff Signature

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.03
Effective Date: January 31, 1992
Revised Date: October 1, 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Certification Waiting List

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: 1 7CFR 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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.04
Effective Date: October 1, 1990
Revised Date: October 1, 2014**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Residency Requirements

A. Policy

To be certified as eligible for the WIC Program, the applicant must reside in Maryland and 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 agency staff shall electronically sign the Participant's Rights and Responsibilities. Refer to Policy and Procedure 2.02 for instructions.

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

Attachments:

References: 7 CFR 246.7 (c) (2)(i)
COMAR 10.54.01.04A
FNS Instruction 803-1 Rev

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.05
Effective Date: October 1, 1998
Revised Date: April 11, 2016**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Income Eligibility Requirements

A. Policy

To be certified as eligible for the WIC Program, a family, 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" (see Policy and Procedure 2.06 to determine family size) shall have a gross income which is less than or equal to 185% of Federal Poverty Income Guidelines (See Attachment 2.05A). Income guidelines shall be adjusted annually each spring and be implemented concurrently with the Medicaid income guidelines.

An applicant is considered "adjunct" or automatically income eligible for the WIC Program if:

1. The applicant is participating in one of the following programs:
 - a. Temporary Cash Assistance (TCA);
 - b. Food Supplement Program;
 - c. Medical Assistance;
 - 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. A member of the applicant's biological family is:
 - a. Receiving TCA; or is
 - b. A pregnant women or an infant:
 - i. currently participating in the Medical Assistance Program; or
 - ii. certified eligible for the Maryland Children Insurance Program.

The applicant/parent/caregiver or designee must present documentation showing eligibility/participation in one of these programs and must also self-declare household income.

B. Procedure

Local agencies shall require that all applicants provide proof of all family or household gross income or proof of adjunct eligibility. This shall be documented in the management information system.

1. Family Income

- a) Refer to Attachment 2.05B for the acceptable types of income. Documentation may consist of but is not limited to:
 - i. Pay stubs;
 - ii. Social security benefits documentation;
 - iii. Child support documentation;
 - iv. Unemployment benefits documentation
- b) In determining the income eligibility of an applicant, local agencies shall consider the income of the family during the past 12 months and the family's current rate of income to determine which indicator more accurately reflects the family status. Current income is defined as income received by the household within 30 days prior to application.
- c) Persons from families with adult members who are unemployed shall be eligible based on income during the period of unemployment if the loss of income causes the current rate of income of the family to be less than the income guidelines for program eligibility.
- d) 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.
- e) Payments or benefits provided under certain federal programs listed in federal regulations 7CFR 246.7(d)(2)(iv) or acts and loans, not including amounts to which the applicant/parent/caregiver has constant or unlimited access, are excluded from consideration as income by federal legislative prohibition.
- f) 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.
- g) Income determination for military personnel is the total entitlements

found on the Leave and Earnings Statement (**LES**) less any funds received for Quarters allowance, which will be shown as the Basic Allowance for Housing (**BAH**), any payments received from the Family Supplemental Subsistence Allowance (**FSSA**), any Cost of Living Outside of the Continental United States (**OCONUS COLA**) allowance, and any prepayments to the Veteran's Educational Assistance Program (**GI BILL**).

COMBAT PAY

There are two categories of **combat pay** that can also be deducted: Hostile Fire Pay/Imminent Danger Pay (**HFP/IDP**) and Hardship Duty Pay (**HDP**). In order to be excluded from WIC income eligibility determination, the pay must have been received:

- i. in addition to the service member's basic pay;
- ii. as a result of the service member's deployment to or service in an area that has been designated as a combat zone; and
- iii. by the service member prior to his/her deployment to or service in the designated combat zone.

EXTENSION PAY

There are two categories of Extension Pay that can also be deducted: Deployment Extension Incentive Pay (**DEIP**) and Deployment Extension Stabilization Program (**DESP**). The additional pay is given to active-duty service members who agree to extend their military service by completing deployment with their units without re-enlisting. Any DEIP or DESP payment provided to service members serving at their home station is considered income as they are no longer considered deployed.

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

- h) Local agencies shall allow participants up to 30 days after certification to provide income documentation. If documentation is not provided by the end of the 30 day certification, 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 income before the temporary certification period expires. 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 does not have any income, collateral verification of their situation is required. Request that the applicant complete the Collateral Verification Zero Income form attesting to the accuracy of the applicant's level of income (Refer to Attachment 2.05C).

- i) Valid VOC cards may serve as documentation of income eligibility for transferring participants and for in-stream migrant farmworkers and their family members. If a VOC card reflects that a migrant farmworker's certification period has expired, the VOC card may still serve as income documentation if the VOC card reflects that an income determine was made within the past 12 months.

2. **Participant Adjunct Income Eligibility**

Local agencies shall require proof of adjunct eligibility as described below. The source of adjunct eligibility and verification shall be documented in WOW.

- a) Documentation of an applicant's participation in one of the following programs whose income requirements are equal to or less than 185% of the poverty income guidelines:
 - i. Temporary Cash Assistance (TCA);
 - ii. Food Supplement Program;
 - iii. Medical Assistance;
 - iv. Certain other means tested programs as approved by the state WIC office and that:
 - Routinely require documentation of income;
 - Have income guidelines at or below those of WIC; and
 - Show the applicant's period of eligibility in the program.
- b) Documentation of a biological member of the applicant's family who is:
 - i. Receiving TCA; or is
 - ii. A pregnant women or an infant:
 - a. currently participating in the Medical Assistance Program; or
 - b. certified eligible for the Maryland Children Insurance Program.

- c) Local agency staff shall verify an applicant's or a member of an applicant's family's current participation, if applicable as described above, in Medical Assistance (Medical Care Programs) and Temporary Cash Assistance (TCA) and the Food Supplement Program (Independence cards) in the following manner:

Medical Care Programs (Medical Assistance): telephone the Medical Assistance Program Eligibility Verification System (EVS) at:

1-866-710-1447

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

1-800-997-2222

If using an approved means tested program, documentation may include a notification letter that identifies the respective program and the person's period of eligibility.

3. **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 according to B. 2. to verify current participation in Medical Assistance.

1 The WIC Program can not accept an applicant's participation in the Family Planning Program because there is no periodic review of income eligibility. Income eligibility for the Family Planning Program is determined for a period of five years.

4. **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, income shall be re-evaluated. While current and annual income may be assessed, local agency staff should select the method which best reflects the family's income status, not the method most likely to render them eligible. The local agency staff should document their basis for the decision in the participant's record.
- b) Participants and family members who were determined income eligible solely on the basis of their participation in Temporary Cash Assistance (TCA); Food Supplement Program; Medical Assistance; or any other program that determined them adjunctively income eligible may not be disqualified from the WIC Program during their certification period because they no longer participate in one of the adjunct income eligible programs. 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 at a WIC appointment after their certification or recertification appointment, all members of the family participating in the WIC Program based on the participant's adjunct income eligibility shall be disqualified at that time.

Attachment(s)

2.05A	Maryland Income Guidelines
2.05B	Types of Income
2.05C	Collateral Verification Zero Income
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. 4. SFP 99-078
5. WIC Policy Memorandum #2013-3, 4/26/2013

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 Attachments 2.05E & 2.05F
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.

INCOME GUIDELINES

Income Eligibility Guidelines for Maryland WIC Program Benefits

Effective April 11, 2016

185 Percent of 2016 Federal Poverty Income Guidelines

Family Size	Annual Income	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$718
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
For each additional family member add	+\$7,696	+\$642	+\$321	+\$296	+148

Maryland WIC

Better Nutrition Brighter Future

Guía Para Evaluar Ingresos

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

Efectivo a partir de Abril 11, 2016

El Porcentaje de acuerdo a la Guía Federal de Ingresos
de Pobreza 2016 es 185

Grupo Familiar	Ingreso Anual	Ingreso Mensual	Dos veces al mes	Ingreso Quincenal	Ingreso Semanal
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$718
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
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7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
Para cada miembro de la familia adicione	+\$7,696	+\$642	+\$321	+\$296	+148

Maryland WIC

Better Nutrition Brighter Future

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 State WIC Program
Collateral Verification
Zero Income**

Applicant or Parent Name: _____
Last First Middle Initial

Address: _____

City/Zip Code: _____

Telephone: _____ Family Size: _____

I, _____, certify that I have zero income.
(Applicant/Parent)

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.

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 on-base or off-base. **BAH is not counted as income in determining eligibility.**

CAREER ENLISTED FLYER INCENTIVE PAY (CEFIP)

A 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 \$730 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.

COST OF LIVING ALLOWANCE (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. is different from Overseas Continental United States (OCONUS) COLA which is provided to military personnel residing in designated overseas high-cost living areas. **COLA is counted as income in determining WIC eligibility. OCONUS COLA is not counted as income and should be deducted when determining WIC eligibility.**

DEPLOYMENT EXTENSION INCENTIVE PAY (DEIP)

Additional pay given to active-duty Army service members who agree to extend their military service by completing deployment outside the United States with their units without re-enlisting.

DEPLOYMENT EXTENSION INCENTIVE PAY (DESP)

Additional pay given to Army National Guard service members who agree to extend their military service by completing deployment outside the United States with their units without re-enlisting.

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 (FLPP)

An officer or enlisted member of the Armed Forces who has been certified as proficient in a foreign language within the past 12 months (or 12 months plus 180 days when called or recalled to active duty in support of contingency operations) may be paid Foreign Language Proficiency (FLPP).

HARDSHIP DUTY PAY

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.

HOSTILE FIRE/IMMINENT DANGER PAY (HFP)

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. One day spent in a designated HFP area qualifies the member for an entire month of pay.

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 can be any amount between \$300 per month and full retired pay.

RE-ENLISTMENT BONUS (SRB)

SRB may be paid to an enlisted member who meets certain conditions. Reenlistment 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.

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

Cannot be Deducted from Total Entitlements	Can be Deducted from Total Entitlements
Basic Allowances (BAS)	Basic Allowance for Housing (BAH)
Career Enlisted Flyer Incentive Pay (CEFIP)	Combat Pay: <ul style="list-style-type: none"> • Hostile Fire/Imminent Danger Pay (HFP) • Hardship Duty Pay (HDP)
Career Sea Pay	
Clothing Allowance	
Cost Of Living Allowance (COLA)	Extension Pay: <ul style="list-style-type: none"> • Deployment Extension Incentive Pay (DEIP) only when deployed • Deployment Extension Stabilization Program (DESP) only when deployed
Extension Pay: <ul style="list-style-type: none"> • Deployment Extension Incentive Pay (DEIP) when at their home station • Deployment Extension Stabilization Program (DESP) when at their home station 	
Family Separation Allowance (FSA)	Overseas Continental United States Cost Of Living Allowance (OCONUS COLA)
Foreign Language Proficiency Pay (FLPP)	Payments into the Veteran's Educational Assistance Program (GI BILL)
Military Survivor Benefits Plan (SBP)	
Payments received from the Veteran's Educational Assistance Program (GI BILL)	
Selective Re-Enlistment Bonus (SRB)	
Special Duty Assignment Pay (SDAP)	

Policy and Procedure 2.05F
has been removed.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.06
Effective Date: October 1, 2003
Revised Date: October 1, 2013**

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.09
Effective Date: March 18, 1992
Revised: October 1, 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Processing Standards for Applications

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.

Reference(s):

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.10
Effective Date: October 1, 1990
Revised Date: October 1, 2013**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Certification Periods

A. Policy

1. Program benefits shall be based on certification periods established in the management information system and will extend to the end of the month involved in accordance with the following time frames:
 - a. Pregnant women shall be certified for the duration of their pregnancy and for up to 6 weeks postpartum.
 - b. Postpartum women shall be certified up to 6 months after the end of their pregnancy.
 - c. Breastfeeding women shall be certified up to the infant's first birthday as long as they are breastfeeding.
 - d. Infants certified before six months of age will be certified until the infant turns one year old.
 - e. Infants certified from age six months to age one will be certified for six months from the date of the certification.
 - f. Children certified at age one year or older will be certified for one year from the date of the certification.
2. If a local agency does not have sufficient appointment times to conduct a subsequent certification for a participant whose certification period is due to expire, then that participant's certification period may be shortened or extended by not more than 30 days on a case-by-case basis if categorically eligible.
3. If the nutritional risk determination is based on data taken before the time of entrance into the Program, the certification intervals for participants other than pregnant women shall be based on the date of admittance to the Program.

B. Procedure

Local agencies shall abide by the above policy.

Reference(s):

1. 7CFR 246.7 (g)(1)(i-v)
2. COMAR 10.54.01.13

Revisions

1. 12/06 Extended Cert periods to the end of the month.
2. 10/10 Changed reference from 7CFR 246.7 (f) to 246.7(g)
3. 10/12 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.
4. 10/13 Updated references to 7CFR 246.7 (g)(1)(i-v) and COMAR 10.54.01.13

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.11
Effective Date: October 1, 1995
Revised Date: October 1, 2013**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Notice of Eligibility or Ineligibility and the Right to Fair Hearing

A. Policy

The WIC Program regulations have established the following time frames to inform applicants and participants of their ineligibility or eligibility:

1. Pregnant women, infants, migrant farm workers and their family members shall be notified of their eligibility or ineligibility within 10 days of the date of the first physical request for Program benefits, except that the State Agency may provide an extension of the notification period to a maximum of 15 days for those local agencies submitting a written request, including a justification of the need for an extension.
2. All other applicants shall be notified within 20 days of their first request to participate.
3. A person found ineligible for the Program during a certification visit shall be advised in writing using the Ineligibility Notice (Attachment 2.11A) within the above time frames of the ineligibility. Local agency staff shall complete the Ineligibility Notice (Attachment 2.11A) and inform the applicant or the parent or guardian of an infant or child applicant:
 - a. The reasons for the ineligibility;
 - b. The name and telephone number of the person to contact about their ineligibility; and
4. An applicant or participant may request a fair hearing within sixty (60) days of the determination of ineligibility either in writing (Attachment 2.11B) or orally, stating the desire to present their case to a higher authority. Local agency staff shall complete a Request for a Fair Hearing (Attachment 2.11B) and advise the applicant or the parent or guardian of an infant or child applicant or participant that notification of a hearing date will be provided by the Office of Administrative Hearings. The request for a fair hearing must be transmitted to the Office of Administrative Hearings on the DHMH Transmittal Form (Attachment 211.C).

B. Procedures

1. A person found ineligible for the Program at any time during the certification period shall be advised in writing 15 days before termination of eligibility of the reasons for ineligibility and of the right to a fair hearing. A local agency may, however, disqualify and terminate a person without the 15 days notification when the participant fails to pick up food instruments for two consecutive issue months and has been advised of this policy at certification as outlined on the Participant Rights and Responsibilities (Attachment 2.12A).
2. The local agency must reassess a participant's income eligibility during the certification period if the local agency receives information indicating that the participant's household income has changed. However, such assessments are not required in cases where sufficient time does not exist to effect the change. Sufficient time means 90 days or less before the expiration of the certification period.
3. A person who was determined to be adjunctively income eligible cannot be disqualified solely on the basis of a determination that they no longer participate in TCA, Medicaid, Food Supplement Program or another qualified State administered program or are no longer a member of a family which contains a TCA recipient or a pregnant woman or an infant receiving Medicaid. The local agency shall disqualify such an individual during a certification period, if on the basis of a reassessment of Program eligibility, the individual who is no longer adjunctively income eligible does not meet the income eligibility requirements of the Program.
4. When an Ineligibility Notice is given to the applicant/caregiver or designee, it must be documented in Alerts in the management information system. Local agencies shall maintain a file containing copies of the completed Ineligibility Notice and the income and /or residency documentation provided by the applicant/caregiver or designee that was used to determine the applicant ineligible.
5. Participants who 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 DHMH Appeals

References:

- 1. CFR 246.7 (h)
- 2. COMAR 10.54.01.06 D
- 3. FNS Instruction 803-15

Revisions:

- 4/99 Changed AFDC to TCA
- 6/99 New address on Attachment 2.11B
- 10/03 WICWINS references
- 10/07 New A. 5. Reassess income when informed during a certification period.
New A.8. Categorically ineligible
- 4/08 Used the name "Ineligibility Notice" when referring to Attachment 2.11A
- 10/08 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
- 1/09 Changed Food Stamp to read Food Supplement Program in A.6.
- 10/10 Changed "in communication notes" to "Alerts." Changed reference from 7CFR246.7 (l) to 246.7 (j).
- 10/11 Deleted obsolete reference to WOW in A.7 Changed reference from 7CFR 246.7(j) to 7CFR 246.7(h)
- 10/13 Revised wording to reflect changes due to revised/electronic format of the Participant Rights and Responsibilities.



Maryland WIC Program

Ineligibility Notice

January 6, 2009

August Test
3332 Main Street
Baltimore, MD 21200

Garrett County WIC Program
1025 Memorial Drive
Oakland, MD 21550

WIC Applicant/Participant Test Augustchild (200457226):

Based on the information we have, it has been determined that you are not eligible to receive food from the WIC Program at this time for the following reason(s):

- 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.
- You have not picked up checks for two consecutive months and will not receive any food benefits after _____. If you ask for a hearing before that date, you will still receive food benefits until the court decides your case.
- Other: _____

If you think this is not correct, please call _____ 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 benefits, you may request a hearing on the denial by filling in the Participant's Request for Fair Hearing, which has been included with this letter, and giving it to the WIC clerk or mailing it to the address below by Saturday, March 7, 2009.

Garrett County WIC Program
1025 Memorial Drive
Oakland, MD 21550

Attn: Carol Bass

You may also telephone your request for a Fair Hearing by calling the Garrett County WIC Program by Saturday, March 7, 2009. 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 denied food benefits when you first apply or at a recertification, you can ask for a hearing, but you will not receive any food while you wait for the hearing.

Local WIC Representative

PARTICIPANT'S REQUEST FOR 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 think is important to your appeal).

Date: _____ Signature: _____

WIC Applicant/Participant	Please make any corrections here (print clearly)
August Test	_____
3332 Main Street	_____
Baltimore, MD 21200	_____
WIC Participant ID: 200457226	Telephone # (____) _____
WIC Family ID: 2255036	Date of Birth: 03/03/2006

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 sends to you. Complete this form and mail it to:

Garrett County WIC Program
1025 Memorial Drive
Oakland, MD 21550

Attn: Carol Bass

You may also telephone your request to the WIC Office by calling .

Send or Fax To: Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031
410-229-4262
Fax 410-229-4268

TRANSMITTAL FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)
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: _____
LAST FIRST MI

(#2) Name: _____
LAST FIRST MI

Address: _____

ZIP _____
Telephone No: _____

Address: _____

ZIP _____
Telephone No: _____

Department's Representative(s)

(#1) Name: _____
LAST FIRST MI

(#2) Name: _____
LAST FIRST MI

Address: _____

ZIP _____
Telephone No: _____

Address: _____

ZIP _____
Telephone No: _____

Appeal Category: Women, Infants and Children's Program

PLEASE ATTACH APPEAL LETTER AND ANY CORRESPONDENCE RELATING TO CASE

Send or Fax To: Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031
410-229-4262
Fax 410-229-4268

TRANSMITTAL FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)
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: _____
 LAST FIRST MI

(#2) Name: _____
 LAST FIRST MI

Address: _____

Address: _____

 ZIP _____

 ZIP _____

Telephone No.: _____

Telephone No.: _____

Department's Representative(s)

(#1) Name: _____
 LAST FIRST MI

(#2) Name: _____
 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 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's 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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.12
Effective Date: October 1, 1990
Revised Date: October 1, 2015

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Participant Rights and Responsibilities

A. Policy

1. Participants or their parents/legal guardians, or designees must be advised of their Program rights and responsibilities. These Program rights and responsibilities are listed on the *Maryland WIC Program Participant 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 that the applicant may appeal any decision made by the WIC agency regarding eligibility, and information on the method for requesting a fair hearing.
 - c. A statement encouraging participation in 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, participant, parent/legal guardian or proxy.
 - 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 Health and Mental Hygiene.

2. The parent/ legal guardian may allow a designee to sign for the parent or legal guardian.

B. Procedure:

1. Certification Using Management information System:
Local agencies shall ensure that all participants or their parents or legal guardians, or designees:
 - a. Prior to signing, read, or have read to them, the *Maryland WIC Program Participant Rights and Responsibilities*;
 - b. Prior to signing, are informed that they are receiving a copy of the *Maryland WIC Program Participant 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 Participant Rights and Responsibilities* and that they have received a copy of the *Maryland WIC Program Participant Rights and Responsibilities*;
2. Manual Certifications:
Local agencies shall ensure that all participants or their parents or legal guardians, or designees:
 - a. Prior to signing, read, or have read to them, the *Maryland WIC Program Participant Rights and Responsibilities*;
 - b. Prior to signing, are informed that they are receiving a copy of the *Maryland WIC Program Participant 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 Participant Rights and Responsibilities* and that they have received a copy of the *Maryland WIC Program Participant Rights and Responsibilities*.

Local agency staff shall complete the Residency & Income, Nutritional Information, and Nutritional Risk Eligible areas of the form.

A signature of a Competent Professional Authority or Competent Paraprofessional Authority must be present to signify who has completed each portion of the certification. If different persons are completing the other areas, then those areas must contain a signature.

Attachments:

2.12A Certification by the Applicant/ Participant/Designee

References:

7 CFR 246.7 (i)(j)
COMAR 10.54.01.07

Revisions

10/99
5/03
5/09 deleted sentence in B7 regarding initials
2/10 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.

MARYLAND WIC PROGRAM Participant Rights and Responsibilities

My Rights

- **WIC foods:** I will get checks to buy healthy foods. I understand that WIC does not give all the food or formula needed for a month.
- **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 for a Request for Fair Hearing Form if someone tells me I cannot be on WIC and I do not agree. A Fair Hearing is a meeting with the Maryland Office of Administrative Hearings where I will be given an opportunity to make a case against the Program's decision to deny WIC Program benefits for me or my child.
- **Common courtesy:** WIC and store staff will treat me with courtesy and respect. I can tell WIC staff if I am not treated with respect.
- **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 agree to give true and complete information about:

- My identity, pregnancy status and address.
- The number of 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).

I agree to follow the rules below. I will:

- Always bring my WIC ID folder to every clinic and store visit.
- Provide all documents requested by the WIC Program in a timely manner.
- Use WIC foods and formula only for the person on WIC.
- Sign my WIC check only after the store cashier sees my WIC ID and writes in the purchase amount.
- Not make changes to my WIC checks.
- Follow the rules in the WIC Authorized Foods List booklet.
- Report lost, stolen or destroyed checks to WIC staff.
- Not use or attempt to use WIC checks that were reported lost, stolen, or destroyed that have been replaced.
- Make sure any person I name to use my checks knows the WIC Rights and Responsibilities. I will teach him or her how to use my checks properly.
- Keep my WIC appointments or call the clinic to reschedule. If I fail to pick-up checks two times in a row I may be removed from the Program.
- Not sell, give away or trade my WIC checks, 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.
- Not damage or destroy WIC 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 checks from more than one WIC clinic each month.

I understand that:

- 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 Department of Health and Mental Hygiene 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.

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 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/Parent/Guardian/Designee	Signature of WIC Staff
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For Manual Certifications Only:

- Residency & Income
 Nutrition Information
 Nutrition Risk Eligible

Signature	Signature	Signature
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The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usdagov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.13
Effective Date: October 1, 1995
Revised Date: October 1, 2014**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Transferring Participants and the Use of the Verification of Certification Cards

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. Update the address, phone number, family size and head of household, as necessary. Add any new family members and respond to any Alerts.
- iii. Retrieve and destroy the participant ID folder issued from the sending local agency and issue a new ID folder with the receiving local agency stamp.
- iv. Determine what issuance month(s) checks have been issued to the participant and follow the local agency guidelines for assigning a schedule day and issuing checks, if appropriate.
- v. 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.

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 information described in Attachment 2.13 A. 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.
- 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. 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.
- e. Honor all nutritional risk conditions from other WIC programs for the duration of the certification period stated on the VOC.
- f. Retrieve and destroy the participant ID folder issued from the sending local agency and issue a new ID folder with the receiving local agency stamp
- g. Determine what issuance month(s) checks have been issued to the participant. Retrieve and destroy any remaining checks for the

current issue month, and issue/prorate replacement checks for that period in accordance with the local agency schedule day and check issuance policy.

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. The income determination shall be waived for migrant farm workers and their family members if the income eligibility has been determined within 12 months.

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)
COMAR 10.54.01.07 K
FNS Instruction 803-11
SFP 91-117
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	<u>Revised wording to include the new Participant Rights and Responsibilities form procedures.</u>
10/01/2014	Added proof of identity in B. 2. Incoming Transfers section b. per WIC Policy Memorandum 2001-4

Maryland WIC Program Verification Of Certification

VOC No.
100014584
Date Printed: 10/11/2007

Participant Name: Kid Test

Date of Birth: 04/22/2006

Eligibility Begins: 03/22/2007

Bloodwork Data:

Termination Date: 10/01/2007

Priority: 3

Ends: 09/30/2007

Term Reason: Failure To Recertify

Height: 2 ft 7 in.

Weight: 29 lbs. 2 oz.

Participant Number: 200424391

Income Determ Date: 08/15/2007

Last Check Received

First Date To Spend: 04/12/2007

Last Date To Spend: 05/12/2007

Nutritional Risks:

Routine Feeding Practices

Asthma, Moderate or Severe Persistent

Signature and Title

Test Local Agency
State Office
Baltimore, MD 21201
(410) 767-1111

Head of Household/Designee Signature

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.14
Effective Date: October 1, 1998
Revised Date: October 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Eligibility of Aliens and Alien Students

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.15
Effective Date: October 1, 2011**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Eligibility of Persons Affiliated with Institutions

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 AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.16
Effective Date: October 1, 1992
Revised Date: October 1, 2015**

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. Applicants/participants must be seen by the WIC certifying staff at the time of each certification/mid-certification. This is expected to occur at the clinic site except in most unusual circumstances (for example, a pregnant woman confined to bedrest by her physician or a medically fragile infant or child), provided a health care provider individually certifies that a visit to the clinic would be detrimental to the physical well being of the applicant.

The determination of eligibility cannot be delegated to a health care provider who provides referral data to the WIC Program. In order to evaluate the reasonableness of the information, the competent professional authority (CPA) or competent paraprofessional authority (CPPA) should physically assess the applicant. Referral data for children have occasionally shown patterns of weight loss or poor linear growth. The competent professional authority must physically assess the child in order 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.

B. Procedure

1. All applicants for program services must be physically seen by WIC program staff at the time of certification unless extraordinary circumstances exist. In those cases where a health care provider individually certifies that such action will be detrimental to the physical well being of the applicant, the applicant may request a waiver of the policy from the Local Agency.
 - a. The applicant or their parent/guardian must present to the Local Agency an individual certification from the health care provider 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.

- b. Upon receipt of a letter requesting a waiver of the policy, the Local Agency will attempt to arrange for an alternate method of certifying the applicant. Alternate methods, which may be used, include scheduling the applicant to come to the clinic or WIC office after the end of normal clinic hours or on a day when clinic is not being held.
 - c. If the Local Agency cannot arrange an alternate method of certification, the certification may be completed by using information provided by the health care provider as long as it meets the regulatory requirements of not being more than 60 days old for heights and weights and 90 days old for bloodwork and is obtained while the applicant is in the same participant category.
2. All participants must be present at mid-certification visits unless extraordinary circumstances exist. 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. Refer to Policy and Procedure 2.32, 2.33 and 2.38.
 3. Any actions taken by the Local Agency that differ from the required certification/mid-certification procedures must be fully documented by the Agency in the applicant/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

Revisions:

10/10 Added reference CFR 246.7 (o)
10/12 Added mid-certification language. Added B.2.a-c. Improved formatting.
10/13 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.
10/15 In B.1.b., deleted reference to arranging for a home visit.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM

POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.17
Effective Date: October 1, 2001
Revised Date: October 1, 2015

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: WIC Overseas Program

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:

<http://www.tricare.mil/wic/>

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

FOR OFFICIAL USE ONLY

WIC Overseas Participant Profile Report

Visit Date: Thursday, July 29, 2010

TEST A NEWPARTINFANT

WIC Overseas Site ID : 3005 Camp Foster, Japan

Participant ID : 01/0001

Encounter Type : New Certification

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

Participant Category : Infant

Economic Unit : 3

Gender : Female

Address : 123 ALA

DOB : 07/22/2010

APO, AE, 96386

Age : 7 Days

Home Phone :

Work Phone :

Participant Type : Dependent of a member of the armed forces stationed overseas

Home Email :

Sponsor Name : TEST T TEST

Grade : E-1

DEROS: 12/22/2010

Non-Sponsor Name :

Home Phone :

Address : 123 ALA
APO, AE, 96386

Work Phone :

Work Email :

Source of
Health Care:

MTF : AKAMINE LC

PCM : DR. ELIZABETH LEONARD

VOC

Measurements	Value	Date	Nutritional Risks	Priority
Hematocrit:			103 Underweight or at risk of becoming underweight	1
Weight :	8.00	07/29/2010	411 Inappropriate Nutrition Practices for Infants	4
Length :	17.00	07/29/2010		

Draft Use Dates : 07/29/2010 - 08/27/2010

08/28/2010 - 09/26/2010

09/27/2010 - 10/26/2010

Food Package : IBP1-3PBF

Food Instrument 12 - 12/12.3/12.4/
12.5/12.6/12.9 oz. cans powder Enfamil
Gentlease/GS Gentle Plus/
GS Protect Plus/Similac Sensitive/
Similac Advance/Enfamil Premium Lipil/
Enfamil LipilFood Instrument 22 - 12/12.3/12.4/
12.5/12.6 oz. cans powder Enfamil
Gentlease/GS Gentle Plus/
GS Protect Plus/Similac Sensitive/
Similac Advance/Enfamil Premium Lipil;
OR 1 - 12.9 oz. can powder Enfamil LipilFood Instrument 31 - 12/12.3/12.4/
12.5/12.6/12.9 oz. can powder Enfamil
Gentlease/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:

Date:

Competent Professional Authority

Print Name: TEST TEST

08/12/10

Competent Professional Authority Signature

WIC OVERSEAS PROGRAM CONTACTS

	Business Phone Business Fax	Address
PROGRAM MANAGER	1-(877) 267-3728 or 1-(210) 341-3336	WIC Overseas Program 2161 NW Military Highway Suite 214 San Antonio, TX 78213
GERMANY	Business Phone Business Fax	Address
Ansbach, Germany	011-49-981-18-3739 011-49-981-18-3570 011-49-981-183-7739 011-49-987-183-7570	ANSBACH WIC Overseas Program Bleidorn Kaserne Building 5090 Ansbach, 91522 Germany Schlesierstrasse Bliedom Kaserne
Bamberg, Germany	011-49-951-300-7913 011-49-951-300-7483	BAMBERG WIC Overseas Program Warner Kaserne Weissenburger Street 10 Building 7029 Bamberg, 96502 Germany
Baumholder, Germany	011-49-678-36-8001 011-49-678-36-8049	BAUMHOLDER WIC Overseas Program Building 8746, 2 nd Floor, Room 201 Baumholder, 55774 Germany
Bitburg, Germany	011-49-656-561-9093 011-49-656-561-9092	BITBURG WIC Overseas Program Bitburg AF Base Annex Geb 2002-French Caserne, Room 209 Bitburg Flugplatz Bitburg, 54634Germany
Garmisch, Germany	See Schweinfurt	
Grafenwoehr	011-49-9641-83-6821 011-49-9641-83-6785	GRAFENWOEHR WIC Overseas Program Building 207 Wilbur Road, Room 1, First Floor 92655 Grafenwoehr, Germany
Heidelberg, Germany	01149-6221-338-9460 Fax 01149-6221-338-9462 011-49-6221-338-9460 011-49-6221-338-9462	HEIDELBERG WIC Overseas Program Patrick Henry Village Building 4531, 1st floor Heidelberg, 69124 Germany
Hohenfels, Germany	011-49-9472-83-4601 011-49-9472-83-4600	HOHENFELS WIC Overseas Program Building 10A General Patton Drive Room 116 Camp Nainhof, Hohenfels, 92366, Germany
Illeshiem, Germany	011-49-9481-83-601 011-49-9481-83-602 011-49-9481-83-4601 011-49-9481-83-4602	ILLESHIEM WIC Overseas Program Storck Barracks, Building 6510 Rm 202 Illeshiem, 91471 Germany
Kleber	011-49-6314-11-7545 011-49-6314-11-7581	KLEBER WIC Overseas Program Building 3209 Rm 18, 67657, Kaiserslautern

		Germany
Mannheim, Germany	<i>See Heidelberg</i>	
Ramstein, Germany	011-49-6371-47-4466 011-49-6371-47-9383	RAMSTEIN WIC Overseas Program Ramstein Air Base GEB 2118 Flugplatz Ramstein, 66877Germany 66878
Schweinfurt, Germany	011-49-9721-96-6791 011-49-9721-96 8984	SCHWEINFURT WIC Overseas Program Poplar St., Bldg 574 Askren Manor 97421 Schweinfurt, Germany
Spangdahlem	011-49-656-561-9093 011-49-656-561-9092	Spangdahlem WIC Overseas Program Spangdahlem Flugplatz, Arnold Blvd. Bldg 319, 1 st Floor Spangdahlem Air Base 54530 Germany
Stuttgart, Germany	011-49-7031-15-3351 011-49-7031-15-3347	STUTTGART WIC Overseas Program Panzer Kaseme Panzerstrasse 2959 Geb 2915, Room 311 71032 Boeblingen Germany
Vilseck, Germany	011-49-9662-83-3790 011-49-9662-83-3791	VILSECK WIC Overseas Program Rose Barracks Sued Lager GEB 221 Vilseck, 92249 Germany
Wiesbaden, Germany	011-49-611-505-5348 011-49-611-565-79619	WIESBADEN WIC Overseas Program 1 Crestview Housing 3 Marsweg GEB 7005 Wiesbaden, 65191 Germany
ITALY/SPAIN	Business Phone Business Fax	Address
Aviano , Italy	011-39-0434-30-7473 011-39-0434-30-4640	AVIANO WIC Overseas Program US Air Force Base Building 1472 Aviano (PN) 33081 Italy
Livorno, Italy	011-39-050-54-7957 011-39-050-54-7958	LIVORNO WIC Overseas Program Army Community ealth Clinic Camp Darby Building 504 , Room 25 56018 Tirrenia (Pisa), Italy
Naples, Italy	011-39-081-811-4960 011-39-081-811-4961	NAPLES WIC Overseas Program Village Forum Building 2072, Room W30 Naples Naval Support Site Gricignano, Italy
Sigonella, Italy	011-39-095-56-319 6 011-39-095-56-3197	SIGONELLA WIC Overseas Program NAS Sigonella Building 319 Strada Statale 417 Catania Gela, , Zia Lisa 95121
Vicenza, Italy	011-39-0444-71-6258 011-39-0444-71-6257	VICENZA WIC Overseas Program US Army Base - Caserma Ederle Unit 31401, Building 169 Caserma Ederle Vicenza, 36100 Italy
Norway	Business Phone Business Fax	Address

Stavanger <i>(RAF Lakenheath)</i>	011-44-1638-52-1728 011-44-1638-52-1762 011-44-1638-52-1758	Lakenheath WIC Overseas Program Airman and Family Readiness Center Building 950 RAF Lakenheath Brandon, Suffolk IP27-9PN United Kingdom
Portugal	Business Phone Business Fax	Address
Lajes	011-351-295-57-1440 011-351-295-57-1442	Lajes WIC Overseas Program 65 th MDG Unit 7745 Building 425 Room 121 Lajes, 9760 Portugal
Libson	<i>See Aviano (Italy)</i>	
Spain	Business Phone Business Fax	Address
Rota	011-34-956-82-2921 011-34-956-82-2924	Rota WIC Overseas Program Family Fleet Support Center Naval Rota Dalmau Del Pino #3293 Rota, 11520 Spain
U.K.	Business Phone Business Fax	Address
Alconbury/ Upwood Molesworth/	011-44-1480-84-3158 011-44-1480-84-3159	ALCONBURY WIC Overseas Program Airman and Family Readiness Center Building 671, 2 nd FL F23 Huntingdon, Cambridgeshire PE284DA United Kingdom
Croughton,	011-44-1280-70-8248 011-44-1280-70-8322	CROUGHTON WIC Overseas Program RAF Croughton Building 140, Room 129 Near Brackley Northants, NN13 5NQ United Kingdom
Menwith Hill,	011-44-1423-77-7106 011-44-1423-77-7459	MENWITH HILL WIC Overseas Program Building 528 Room 13 RAF Menwith Hill Station Harrogate North Yorkshire HG3 2RF, United Kingdom
RAF Lakenheath,	011-44-1638-52-1728 011-44-1638-52-1762 011-44-1638-52-1758	LAKENHEATH WIC Overseas Program Airman and Family Readiness Center Building 950 RAF Lakenheath Brandon, Suffolk IP27-9PN United Kingdom
NETHERLANDS	Business Phone Business Fax	Address
Schinnen/Treebeek	011-31-46-443-7489 011-31-46-443-7496	USAG Schinnen WIC Overseas Program DPW Building 18 Room 105 Borgerweg 10, 6365 CW, Schinnen Netherlands
BELGIUM	Business Phone Business Fax	Address
SHAPE/ Brussels, Belgium	011-32-65-44-5971 011-32-65-44-5989	SHAPE WIC Overseas Program 401 Rue D'Oslo Building 401, Room 115 SHAPE, 7010 Belgium
TURKEY	Business Phone Business Fax	Address
Incirlik	011-90-322-316-1237 011-90-322-316-1238	INCIRLIK WIC Overseas Program Incirlik Air Base Building 3850, Room FS-14

		Unit 7075Incirlik Hava USSU Adana Turkey, 01000
CUBA	Business Phone Business Fax	Address
Guantanamo Bay, Cuba	011-53-99-2186 011-53-99-2182	GTMO WIC Overseas Program PSC 1005 Box 11 FPO AE 09593-0111
KOREA	Business Phone Business Fax	Address
Area 1	See Seoul (Includes Camp Red Cloud)	
Camp Casey	011-8231-869-3436 011-8231-869-3134	Camp Casey WIC Overseas Program ACS Area 1 SA Building 2451 Dongducheon City, 483010 Republic of Korea
Camp Humphreys	011-82-031-690-6909 011-82-031-690-6295	CAMP HUMPHREYS WIC Overseas Program Department of the Army Army Community Service, Building 1127 USAG Humphreys, 451701 Republic of Korea
Osan	011-82-31-661-3806 011-82-31-661-3804	OSAN WIC Overseas Program Osan AFB Building 768 Room 136 Osan, 447010 Republic of Korea
Seoul	011-82-2-7917-6074 011-82-2-7917-6107	SEOUL WIC Overseas Program Brian Allgood Community Hospital Unit 15244 Building S-7005 Rm 1502 Seoul, Youngsan 100011 Republic of Korea
Daegu	011-82-53-470-9424 011-82-53-470-9423	DAEGU WIC Overseas Program Building 1425 Camp Henry, Daegu, 700010 Republic of Korea
JAPAN	Business Phone Business Fax	Address
Atsugi	011-81-467-63-4559 011-81-467-63-4869	Atsugi WIC Overseas Program BHC Atsugi Building 984 Room 114 NAF Atsugi, Atsugi Kichi, Ayase-Shi Kanagawa-Ken US Naval Bass 252-1101
Camp Courtney	011-81-6117-22-9424 011-81-6117-22-9082	Camp COURTNEY WIC Overseas Program Camp Courtney, Building 4408, Room 5/6 Okinawa, Japan 904-2200
Camp Foster	011-81-6117-45-9302 011-81-6117-45-9307	Camp FOSTER WIC Overseas Program Building 5674, 21st Street Isa, Ginowan, Okinawa, Japan 904-0100
Camp Kinser	011-81-611-737-4899 011-81-611-737-4890	Camp KINSER WIC Overseas Program Building 107 Room 127 Camp Kinser, Japan 901-2100
Camp Zama	011-81-46-407-8960 011-81-46-407-5710	Camp ZAMA WIC Overseas Program Camp Zama Building 502 Kanagawa-Ken, Zama-shi Camp Zama, 228- 8920, Japan
Iwakuni	011-81-827-79-4928 011-81-827-79-4408	IWAKUNI WIC Overseas Program Building 635 MCAS Iwakuni Box 14100 Kanyau-Chi, Misumi-Cho Iwakuni-Shi, Japan 740-0029
Kadena Air Base	011-81-6117-32-9427 011-81-6117-32-6262	KADENA WIC Overseas Program Unit 5268 FM 270

		Davis Ave, Building 428 Kadena Air Base Okinawa City, Okinawa Japan 904-0000
Misawa	011-81-3117-66-5596 011-81-3117-66-9585	MISAWA WIC Overseas Program 1-Chrome Hirahata Misawa-Shi, Building 696 Misawa, 033-0000 Japan
Negishi	011-81-45-281-4849	NEGISHI WIC Overseas Program USNH NEGISHI MEDICAL CLINIC Building 19043 Naka-Ku, Minosawa Yokohama-Shi, Japan 231-0856
Sasebo	011-81-956-50-8781 011-81-956-50-8782	SASEBO WIC Overseas Program US Naval Base DDYJ Detachment Sasebo, Building 138 Tatagami-Cho Sasebo-ChiSasebo, Japan 857-0063
Yokosuka	011-81-46-816-9426 011-81-46-816-2614	YOKOSUKA WIC Overseas Program Building 3365 Room 326 Yokosuka Naval Base TOMARI-CHO, 1-Banchi Yokosuka, Japan 238-0001
Yokota	011-81-3117-55-5490 011-81-3117-55-5493	YOKOTA WIC Overseas Program Unit 5074, Building 4018 Yokota AB Fussa, Japan 197-0000

Information obtained: August 2, 2012

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.18
Effective Date: October 1, 1993
Revised Date: October 1, 2003**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Record Retention File

A. Policy

When an applicant has been determined to be eligible for the WIC Program, WOW maintains a historical participant data which includes information used to make the eligibility determination for identity, income, residency, and nutritional risk; the initial nutrition education contact; and the documentation for providing non-contract formula to an infant, if appropriate.

Local agency clinics shall maintain files for a period of three and one half (31/2) years for the following:

1. The local agency copy of the Applicant's Rights and Responsibilities signed by the applicant/caregiver or designee;
2. Check receipts and manual registers signed by the applicants, caregivers and designees;
3. Fair Hearing forms and documentation, for applicants determined to be ineligible for WIC Program benefits; and
4. Incoming VOC from other states and the WIC Overseas Program.

B. Procedure

Local agencies shall abide by the above policy.

References: CFR 246.7
COMAR 10.54.01

Revisions October 2002 – WICWINS References

**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: October 1, 2015**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Identification Folder

A. POLICY

1. A standard statewide Identification (ID) Folder shall be issued by local agencies for participants in a family or to the parent or caregiver of infant and child participants or to the participant. One folder shall be issued to each family. If there is more than one member of a family on the WIC Program only one folder shall be issued. This folder shall be used for identification of the participants, the parent or caretaker of infant and child participants, and their proxy(ies) during clinic visits and for issuance and redemption of food instruments.
2. The ID Folder shall be issued at the initial certification for the first family member and continues to be valid as long as there is a member of the family participating in the WIC Program. When a member of the family is no longer participating in the WIC Program, that name can be crossed out, preferably with a wide felt pen.
3. Replacement ID Folders shall be issued for the following reasons:
 - a. If a participant or proxy name should change during the certification period;
 - b. If the existing ID Folder is no longer in usable condition;
 - c. If the participant claims their ID Folder has been lost, stolen or destroyed; or
 - d. If there is no space left in the section used to list participants or to document appointments.

Old ID Folders shall be collected and destroyed.

B. PROCEDURE

1. The front of the Identification (ID) Folder is the official identification for WIC participants, the caretaker of infant or child participants and their proxy(ies). 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.
2. The ID Folder is validated by using the stamp containing the local agency and county code (See 5D, below) **and** the stamp containing the local agency's name and telephone number (see 5E, below).
3. All local agencies shall inform participants, parents or the caregiver of infant and child participants and their proxy(ies) how to properly use the WIC ID Folder and WIC food instruments. If the proxy is not present for instruction, it is the responsibility of the participant or the parent or caretaker for infant or child participants to inform the proxy of proper use of the WIC ID Folder and the food instruments.
4. If, for any reason, food instruments are mailed to the participant, under no circumstances shall the ID Folder be mailed with the food instruments. The ID Folder must be mailed separately (certified, return receipt requested) to ensure protection from theft.
5. The ID Folder shall be completed by local agency staff in the following manner (See 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 participant/parent or caregiver shall print the name(s) of the proxy(ies). Instruct the participant, parent, or the caretaker of infant and child participants to obtain the signature of their proxy(ies). If the proxy is not assigned at the clinic, the participant/parent or caregiver will be instructed to call the local agency to add the proxy name to the WOW system.

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

- D- Validate the ID Folder by using the stamp containing the local agency and 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. |

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.20
Effective Date: October 1, 1996
Revised Date: October 1, 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Designee/Proxy Authorization

A. Policy

1. The local agency shall inform the participant/parent or caregiver at the time of certification that:
 - a. The participant/parent or caregiver may designate a proxy or proxies, not to exceed two, to receive and/or redeem WIC checks on their behalf.
 - b. The participant/parent or caregiver 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 the participant/parent or caregiver agrees, local agency staff shall document in the participant's record.
 - c. It is the participant/parent or caregiver's responsibility to inform their proxy/designee how to pick up and redeem WIC checks; and
 - d. The proxy/designee is subject to program sanctions as specified in Policy and Procedure 4.23 for improper check use or conduct.
2. A participant/parent or caregiver 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. The local agency may prohibit changing a proxy/designee during check distribution.
3. A participant/parent or caregiver may retain the same proxy/designee or proxies/designees 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/proxy/designee shall not participate in any way in executing a certification or the issuance of WIC checks for a participant when they are acting as a proxy/designee for a participant as stated in Policy and Procedure 4.09.

B. Procedure

1. Choosing a proxy/designee
 - a. The local agency shall ask the participant/parent or caregiver 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 checks.
 - 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 participant/parent or caregiver 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 participant/parent or caregiver agrees, local agency staff shall document in the participant's record.
 - d. The local agency shall instruct the participant/parent or caregiver to have their proxy (ies)/designee (s) sign the WIC ID Folder on the appropriate line(s).
2. The participant/parent or caregiver shall be responsible to instruct their proxy (ies)/designee (s) how to pick up and redeem the WIC checks.
3. The proxy/designee shall present the participant's WIC ID Folder bearing both the head of the household and the proxy (ies)/designee (s) signatures when picking up WIC checks at the local agency. The local agency shall ensure that the proxy (ies)/designee (s) name is listed on the WOW Check Receipt before issuing the WIC checks to the proxy/designee. The local agency may request identification from the proxy/designee to ensure that the person requesting the WIC checks is an authorized proxy/designee.
4. The proxy/designee shall present the participant's WIC ID Folder bearing both the head of household and the proxy (ies)/designee (s) signatures when redeeming WIC checks at an authorized WIC vendor.
5. The proxy/designee shall be subject to the sanctions listed in Policy and Procedure 4.23.
6. A participant/parent or caregiver 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.

Attachments:

References: 7 CFR 246.12(r)(1)

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.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.21
Effective Date: October 1, 1998
Revised Date: October 2011**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Homeless Individuals

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.

d. Nutritional risk as outlined in Policy and Procedure 2.31.

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 Certification 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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.22
Effective Date: October 1, 2012

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Appointment Waiting List

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.23
Effective Date: October 1, 1992
Revised Date: October 1, 2014**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Establishment of Applicant Identity

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 at the initial certification.
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.
 6. Confirmation record: Official copy bearing the seal of the issuing church.
 7. School identification card **with** photo.
 8. Military records. This may include a military identification card or

discharge papers.

9. Marriage certificate/marriage license.
10. Driver's license.
11. Age of Majority identification card.
12. Passport, Visa and Health Passport.
13. Immigration or Naturalization record.
14. Social Security Card.
15. Medical Assistance Program (MAP) card.
16. VOC.
17. Any other documentation that establishes the applicant's identity.

Local agencies shall document the type of proof presented in 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. The WIC Participant Identification Folder shall be acceptable proof of an applicant's identity at check pick up appointments and subsequent certifications and when using WIC checks at authorized stores.
- D. 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 before the temporary certification period expires.

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

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: _____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.24
Effective Date: April 1, 1993
Revised Date: October 1, 2015

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Establishment of Participant Category

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.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM

POLICY AND PROCEDURE MANUAL

Policy and Procedure Number 2.25

Effective Date: October 1, 2008

Revised Date: October 1, 2013

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Voter Registration

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 card;
 - 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 card 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
10/12 Corrected typo in C.2.c
10/13 Revised wording to include the revised Participant Rights and Responsibilities form procedures.

After This Form Is Filled Out, You Must Sign And Mail It To Your County Board of Elections.
 It Cannot Be Processed If It Is Faxed or E-mailed, Because It Requires An Original Signature.

MARYLAND VOTER REGISTRATION APPLICATION

TO REGISTER, YOU MUST

- Be a U.S. citizen;
 - Be a Maryland resident;
 - Be at least 16 years old*;
 - Not be under guardianship for mental disability or if you are, you have not been found by a court to be unable to communicate a desire to vote;
 - Not have been convicted of buying or selling votes;
 - Not have been convicted of a felony, or if you have, you have completed serving a court-ordered sentence of imprisonment, including any term of parole or probation for the conviction.
- *You may register to vote if you are at least 16 years old but cannot vote unless you will be at least 18 years old by the next general election.

DEADLINE INFORMATION

- This application must be postmarked no later than 21 days before an election.
- If your application is complete and you are found to be qualified, a Voter Notification Card will be mailed to you.
- The submission of this form to an individual other than an official, employee, or agent of a County Board of Elections does not assure that the form will be submitted or filed in a timely manner.

YOU CAN USE THIS FORM TO

- Register to vote in federal, state, county, and municipal elections in Maryland.
- Change your name, address, or party affiliation.

INSTRUCTIONS

- If you do not have a current, valid Maryland driver's license or MVA ID card, you must enter the last 4 digits of your social security number. The statutory authority allowing officials to request the last 4 digits of your social security number is Election Law Article, § 3-202. The number will only be used for registration and other administrative purposes. It will be kept confidential.
- Complete Items 1-11 in Voter Registration Application. Sign and date Item 12. If you are registered to vote in another Maryland county or another state, you must complete Items A-B in Last Voter Registration.
- You must register with a party if you want to take part in that party's primary election, caucus or convention. Check one box only.
- Address and mail the application to your County Board of Elections, using the list on the back panel.

VOTER REGISTRATION APPLICATION PLEASE COMPLETE IN BLACK INK

1	Are you at least 16 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answer NO to either question, do not complete this form.				
2	Check boxes that apply and complete Items 3-12.				
	<input type="checkbox"/> New Registration <input type="checkbox"/> Name Change <input type="checkbox"/> Party Affiliation Change <input type="checkbox"/> Address Change				
3	Last Name				First Name
			Middle	Suffix	
4	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		5	Birth Date:	
			Month	Date	Year
6a	MARYLAND Driver's License or MVA ID Number MANDATORY (if you have neither see instructions)				
6b	Social Security Number (last 4 digits)				6c
	<input type="checkbox"/> Check here if you do not have either a current, valid Maryland driver's license / MVA ID card or a Social Security Number				
7	Maryland Residence Address:	Street Number	Street Name	Apt. No.	City or Town
				Zip Code	County
8	Mailing Address (if different from Item 7)				<input type="checkbox"/> Check here if you reside in Baltimore City.
9	Party (check one):				
	<input type="checkbox"/> Democratic Party <input type="checkbox"/> Republican Party <input type="checkbox"/> Green Party <input type="checkbox"/> Libertarian Party <input type="checkbox"/> Americans Elect Party <input type="checkbox"/> Unaffiliated (independent of any party) <input type="checkbox"/> Other - Specify _____				
10	CONTACT INFORMATION				
	Daytime Phone:		Email (optional):		
11	<input type="checkbox"/> Check here if you would like information on polling place assistance for elderly, disabled or voters unable to write or read the ballot. <input type="checkbox"/> Check here if you would like information on working as an election judge for your County Board of Elections.				
	Under penalty of perjury, I hereby swear or affirm: I am a U.S. citizen. ■ I am a Maryland resident. ■ I am at least 16 years old. ■ I have not been convicted of buying or selling votes. ■ I have not been convicted of a felony, or if I have, I have completed serving a court-ordered sentence of imprisonment, including any term of parole or probation for the conviction. The information in this application is true to the best of my knowledge, information and belief.				
12	Signature (required)			Date	
	X				

Maryland State Board of Elections SBE 03-202-1 Rev 09/12 Internet VRA

LAST VOTER REGISTRATION INFORMATION (if applicable)

A	Name on Last Registration:		Last Name	Title (Jr., Sr., etc.)	First Name	Middle Name	Date of Birth
B	Address on Last Registration:		Street Number	Street Name	Apt. No.	City or Town	Zip Code
							State

After This Form Is Filled Out, You Must Sign And Mail It To Your County Board of Elections.
It Cannot Be Processed If It Is Faxed or E-mailed, Because It Requires An Original Signature.

MARYLAND VOTER REGISTRATION APPLICATION

WARNING

Giving false information to obtain voter registration is perjury and punishable by a fine of up to \$1,000, or by imprisonment for up to 5 years, or both.

PERSONAL RECORDS NOTICE/CONFIDENTIALITY

This form collects personal information for voter registration purposes. If you are not registered to vote and you refuse to provide this information, you will not be allowed to vote in Maryland. You may update your voter registration at any time at your County Board of Elections. Except for items specified as confidential, voter registration records are generally available for public inspection; they may also be shared with jury commissioners/clerks or other government agencies as provided by law. The law prohibits use of voter registration records for commercial solicitation purposes. If you decline to register to vote, that fact will remain confidential and will be used only for voter registration purposes.

If you register to vote, the identity of the office at which the application is submitted will remain confidential and will be used only for voter registration purposes.

QUESTIONS

Visit the State Board of Elections website at www.elections.state.md.us to verify your registration, find your polling place, and find out other important information. If you have any questions, call your County Board of Elections or the State Board of Elections at the numbers listed on the back of the application.

If you register to vote, the identity of the office at which the application is submitted will remain confidential and will be used only for voter registration purposes.

Large type Voter Registration Applications available upon request to your County Board of Elections or the State Board of Elections.

County Board of Elections

Allegany County

701 Kelly Road, Suite 213
Cumberland, MD 21502-2887
301-777-5931

Anne Arundel County

P.O. Box 490
Glen Burnie, MD 21060-0490
410-222-6600

Baltimore City

Charles L. Benton Bldg.
417 E. Fayette Street, Rm. 129
Baltimore, MD 21202-3432
410-396-5550

Baltimore County

106 Bloomsbury Avenue
Baltimore, MD 21228
410-887-5700

Calvert County

P.O. Box 798
Prince Frederick, MD 20678-0798
410-535-2214
DC Line 301-855-1376

Caroline County

Health & Public Services Bldg.
403 S. Seventh Street, Suite 247
Denton, MD 21629-1335
410-479-8145

Carroll County

300 S. Center Street, Rm. 212
Westminster, MD 21157-5248
410-386-2080

Cecil County

200 Chesapeake Blvd.
Suite 1900
Elkton, MD 21921-6395
410-996-5310

Charles County

P.O. Box 908
La Plata, MD 20646-0908
301-934-8972
301-870-3167

Dorchester County

501 Court Lane, Rm. 105
P.O. Box 414
Cambridge, MD 21613-0414
410-228-2560

Frederick County

Winchester Hall
12 E. Church Street
Frederick, MD 21701-5447
301-600-VOTE (8683)

Garrett County

Public Service Center
2008 Maryland Highway, Suite 1
Mountain Lake Park, MD 21550-6349
301-334-6985

Harford County

133 Industry Lane
Forest Hill, MD 21050-1621
410-638-3565

Howard County

9770 Patuxent Woods Drive, Suite 200
Columbia, MD 21046
410-313-5820

Kent County

135 Dixon Drive
Chestertown, MD 21620-1141
410-778-0038

Montgomery County

P.O. Box 4333
Rockville, MD 20849-4333
240-777-VOTE (8683)
TDD 800-735-2258

Prince George's County

16201 Trade Zone Ave., Suite 108
Upper Marlboro, MD 20774
301-430-8020

Queen Anne's County

P.O. Box 274
Centreville, MD 21617-0274
410-758-0832

St. Mary's County

P.O. Box 197
Leonardtown, MD 20650-0197
301-475-7844 ext. 1100

Somerset County

P.O. Box 96
Princess Anne, MD 21853-0096
410-651-0767

Talbot County

P.O. Box 353
Easton, MD 21601-0353
410-770-8099

Washington County

35 W. Washington Street
Room 101
Hagerstown, MD 21740-4833
240-313-2050

Wicomico County

P.O. Box 4091
Salisbury, MD 21803-4091
410-548-4830

Worcester County

100 Belt Street
Snow Hill, MD 21863-1300
410-632-1320

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:

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.26
Effective Date: October 1, 1996
Revised Date: October 1, 2006**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Nutrition and Health Information Requirement

Changed to Policy and Procedure 2.34.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.27
Effective Date: May 24, 2003
Revised Date: October 1, 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Immunization Record Screening (DTaP)

A. Policy

1. Local agency staff will, 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 will, 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 will advise the parent, legal guardian or designee of the apparent immunization status of the child.
4. Local agency staff will encourage the parent, legal guardian or designee to continue with the current schedule if the immunizations are current.
5. Local agency staff will 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 will 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 will 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 will 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 should 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 should enter whether or not a documented immunization record was brought to the clinic, the dates DTaP immunization (s) were received, and whether or not the parent or legal guardian will allow the immunization information to be shared, as directed in the clinic help screen..
4. Only the parent or legal guardian of an infant or child may sign the Rights and Responsibilities form regarding the release of immunization information. Designees (who are not the parent or legal guardian) may not sign in this area nor may foster parents since they are not the legal guardians of the foster children. In both instances, the signature area for release of immunization information should be left blank. If a designee (who is not a parent or legal guardian) or foster parent has brought the child's documented immunization record to the certification appointment, the record should show "Yes" in the "Documented Immunization Record" field and "No" in the "Signed Consent Release" field.
5. 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.

6. 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.
7. All children under age two will be provided with appropriate educational materials regarding immunizations. At a minimum, this information will contain a recommended immunization schedule. 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 will be documented in the participant’s record.
8. 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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.28
Effective Date: October 1, 2003
Revised Date: October 1, 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Blood Lead Screening Requirement

A. Policy

When completing the medical assessment of a child applicant, local agency staff shall ask the parent, caregiver, or designee if the child 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 parent, caregiver, or designee 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 parent, caregiver, or designee if the child has had a blood lead test. If the response is “no” or “don’t know,” staff shall:
 - Explain why children may need a blood test for lead;
 - 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.

- Providing additional written information from sources such as the Maryland Department of the Environment (MDE). This agency provides pamphlets about lead poisoning. To obtain these materials, access the MDE website at:

<http://www.mde.state.md.us/programs/Land/LeadPoisoningPrevention/Pages/Programs/LandPrograms/LeadCoordination/index.aspx>

3. If the 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 child's record.

Reference: WIC Policy Memo SFP 01-032

Revisions: October 2011 Updated MDE website
 October 2012 Updated MDE website

Policy and Procedure 2.29 has been removed.

Policy and Procedure 2.30 has been removed.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.31
Effective Date: October 1, 1990
Revised Date: May 1, 2016**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Assessment of Nutritional Risk

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 2.31Bas 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 certified before the infant, this risk criterion may be assigned to the infant” 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.

Maryland
WIC
Program

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.

1 Height or weight measurements. Examples include underweight, overweight, short stature, low maternal weight gain.

2 Hemoglobin or hematocrit test result.

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Alcohol Use or Any Illegal Drug Use

(3721) **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, with a 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**

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 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 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. Inadequate maternal nutrition may result in decreased nutrient content of the milk.

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**

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. Inadequate maternal nutrition may result in decreased nutrient content of the milk.

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.

Closely Spaced Pregnancies

(3321) **Categories: PG, BE/BP, WPP**

Defined as: Conception before 16 months postpartum.

Justification:

Pregnancy triggers a change to a new physiological state, resulting in a rapid depletion of maternal stores of certain nutrients, such as folate. Mothers with closely spaced pregnancies do not have sufficient time to replenish their stores. Breastfeeding places further demands on the mother. After birth, readjustments take place. It is undesirable for another pregnancy to occur before readjustment is complete.

A sharply elevated relative risk for low birth weight is associated with an interconceptional period of less than 6 months and may persist for 18 months when other risk criteria are present. Small for gestational age (SGA) infants are also more likely to be born to mothers with a short interval between pregnancies. 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 before.
 - Determine the time interval between the 2 pregnancies:
 - Obtain the date that the last pregnancy ended. For a pregnant woman, the date will be for the pregnancy preceding this current one. For a breastfeeding or postpartum woman, the date will be for the pregnancy that precedes her most recent one.
 - 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 the last pregnancy ended from the date of conception. The difference is the time interval between the 2 pregnancies.
 - Spontaneous abortions (miscarriages) which generally occur before the 20th week of gestation as well as fetal death which refers to pregnancy duration of 20 weeks or more may be used to apply this risk criterion.
 - Review collected information about dietary or lifestyle practices that may prevent the restoration of maternal nutrient stores.

Participant Focused Counseling:

- A pregnant woman with closely-spaced pregnancies can state the food and lifestyle choices she can make that promote a positive pregnancy outcome.
- A non-pregnant woman with a history of closely-spaced pregnancies can state the food, physical activity, and lifestyle choices she can make to promote optimal health, especially for a future pregnancy.

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, with a 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
- Including fish as recommended in the *Dietary Guidelines for Americans*, available from: <http://www.choosemyplate.gov/pregnancy-breastfeeding/eating-fish.html>
- 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/> 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: Venous blood lead level ≥ 10 ug/dl within the past 12 months.

A participant who has a venous blood lead level of 15 ug/dl or higher should have Nutrition Care counseling.

Justification:

- All participants: harmful effects on-
 - Health
 - Nutritional status
 - Learning
 - Behavior
- Pregnant women: harmful effect on developing fetus

Procedure:

When a participant has been diagnosed with lead poisoning:

- 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.

Failure to Thrive

(1341) **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 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.

Defined as weight or rate of weight gain significantly below that expected for children of the same sex and age, characterized by one or more of the following:

1. Weight for age decreasing across 2 major percentiles (5th, 10th, 25th, 50th, 75th, 90th and 95th) from a previously established growth pattern.
2. Weight for age consistently < 5th %ile on WHO growth chart (< 24 months) or CDC growth chart (>24 months).
3. Weight for length <80% of ideal weight. (Ideal weight may be estimated as the 50th %ile weight/height or BMI for chronological age; however, for some children such as those with developmental disabilities, the 10th %ile weight/height may be more appropriate.) Often but not always accompanied by normal linear growth.
4. A special formula may be appropriate if a child's growth pattern meets at least one of the criteria above. High calorie, nutrient dense foods should also be encouraged, either in addition to or instead of a special formula.

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, with a 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

(3021) **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 within 5 days, and a 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:

Pregnancy Weight Classification	BMI	Total Weight Gain (pounds) per week
Underweight	< 18.5	>1.3
Normal Weight	18.5 to 24.9	>1
Overweight	25 to 29.9	>0.7
Obese	≥ 30	>0.6
Multi-fetal Pregnancies	See Justification for more information	

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

Pregnancy Weight Classification	BMI	Total Weight Gain (pounds)
Underweight	< 18.5	>40
Normal Weight	18.5 to 24.9	>35
Overweight	25 to 29.9	>25
Obese	≥ 30	>20
Multi-fetal Pregnancies	See Justification for more information	

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 ≥ 9 pounds (≥ 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 ≥ 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

(3031) **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. A pregnant woman with a history of gestational diabetes should also 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 elevated, a history of GDM is also a risk factor for cardiovascular disorders. Most women with a history of GDM are insulin resistant.

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)

(3121) **Categories: PG, BE/BP, WPP**

Defined as: Birth of an infant weighing \leq 5 pounds, 8 ounces (\leq 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 \geq 30 is the most prevalent risk factor for preeclampsia.

Risk factors for preeclampsia include:

- Pre-pregnancy obesity BMI \geq 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 Delivery

(3111) **Categories: PG, BE/BP, WPP**

Defined as: Birth of an infant \leq 37 weeks gestation.

Justification:

Preterm birth causes at least 75 percent of neonatal deaths not due to congenital malformations. Known risk criteria include low socioeconomic status, nonwhite race, maternal age \leq 18 years or \geq 40 years, low pre-pregnancy weight, and preeclampsia.

Procedure:

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
- Review collected information about dietary or lifestyle practices that could lead to the birth of a premature infant.

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.

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, with a 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

(3452) **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 than 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 woman or child who has hypertension or prehypertension should have Nutrition Care counseling, with a 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 ≥ 9 pounds (≥ 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.

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 \leq 5 pounds, 8 ounces (\leq 2500 grams)
- **VLBW:** Infant born with a birth weight \leq 3 pounds, 5 ounces (\leq 1500 grams)

An infant identified with VLBW should have Nutrition Care counseling within 5 days, and a Nutrition Care follow-up in 1-3 months.

An infant identified with LBW should have Nutrition Care counseling and a 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 \leq 10.9 g/dl or hematocrit \leq 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, and a Nutrition Care follow-up in 3-6 months. A participant with hemoglobin <9 should have Nutrition Care counseling 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 Hb 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 $\leq 32.8\%$, 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

(1311) **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.

Medical Condition:	Explanation:
AIDS (3525)	Acquired Immune Deficiency (AIDS) is the final stage of HIV disease, which causes severe damage to the immune system. HIV infection is associated with the risk of malnutrition at all stages of infection. Breastfeeding is contraindicated if the mother has HIV infection or AIDS.
Anorexia nervosa (3582)	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, and a Nutrition Care follow-up in 3-6 months.
Asthma, moderate persistent or severe persistent (3601)	Asthma must be diagnosed as <i>moderate persistent</i> or <i>severe persistent</i> that requires the daily use of an inhaled anti-inflammatory agent or an oral corticosteroid. A participant diagnosed with both Asthma and Obesity or Asthma and Short Stature should have Nutrition Care counseling. A participant with uncomplicated Asthma may be counseled by the CPPA.
Bulimia (3581)	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.
Cancer (3471)	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.
Cardiorespiratory diseases (3604)	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.
Celiac disease (or Celiac Sprue; Gluten Enteropathy; Non-tropical Sprue) (3541)	Inflammatory condition of the small intestine precipitated by the ingestion of gluten, a protein in 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.

Cerebral palsy (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.
Cleft lip or palate (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. After 18 months of age and adequate corrections, a child with cleft lip or palate may be counseled by the CPPA.
Congenital Hyperthyroidism (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).
Congenital Hypothyroidism (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.
Crohn's disease (3423)	Weight loss, growth impairment, and malnutrition are prevalent. Nutrition care is essential.
Cystic fibrosis (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. Contact Cystic Fibrosis Center and/or Specialist RD before counseling and assigning food package
Developmental, Sensory, or Mental Disability (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. Consider contacting Specialist RD before counseling and assigning food package.
Diabetes Mellitus (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.
Down Syndrome (3497)	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.

Drug-nutrient interactions (3571)	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. Consider contacting Specialist RD before counseling and assigning food package.
Epilepsy (3481)	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.
Gall Bladder Disease (3421)	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.
Gastrointestinal anomalies (3493)	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.
Gastroesophageal Reflux Disease (GERD) (3429)	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.
Heart Disease (3603)	The <u>current condition or treatment for the condition must be severe enough to affect nutritional status</u> . The effect upon nutritional status varies according to the condition.
Hepatitis (3523)	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
HIV infection (3524)	HIV is a member of the retrovirus family. Since the virus primarily affects the cells of the immune system, immunodeficiency results (AIDS). HIV is associated with malnutrition at all stages of the

	infection.
Hyperthyroidism (3442)	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.
Hypothyroidism (3441)	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.
Inborn errors of metabolism (3511)	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; fructoaldolase 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
Juvenile Rheumatoid Arthritis (3606)	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.
Kidney disease (3461)	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
Liver disease (3422)	Liver disorders have far-reaching effects on nutritional status, including anorexia, nausea, vomiting, maldigestion, impaired fat and fat soluble vitamin absorption, and impaired protein synthesis. Nutrition care must balance promoting liver regeneration and preventing muscle wasting.
Lupus Erythematosus (3605)	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)

Multiple sclerosis (3482)	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.
Muscular dystrophy (3491)	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.
Neural tube defects (3483)	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.
Nutrient deficiency diseases (3411)	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.
Pancreatitis (3427)	Reduced secretion of pancreatic enzymes leads to malabsorption, and tissue necrosis can occur. A high carbohydrate, low-fat, low protein diet may be helpful.
Parasitic infections (3522)	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. The goals of nutrition counseling vary depending upon the infectious disease.
Parkinson's Disease (3484)	Some participants with Parkinson's disease required protein redistribution diets to increase efficacy of medication. Monitor weight for adequate maternal weight gain.
Peptic Ulcer (3425)	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.
Pneumonia (3528)	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.
Post bariatric surgery (3420)	Surgery to promote weight loss in morbid obesity presents risks for nutritional deficiencies, requiring daily nutritional supplements and eating nutritionally dense foods. . Contact with Specialist RD for current supplements and eating plan before counseling and assigning food package is suggested.
Postpartum thyroiditis (3445)	Postpartum thyroiditis can be either transient or permanent dysfunction occurring in the first year after delivery. Often resolution is spontaneous.

<p>Pre-diabetes (3631)</p>	<p>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.</p>
<p>Recent major surgery, trauma, or burns (3591)</p>	<p>Major surgery (including Cesarean sections), trauma, or burns <u>severe enough to compromise nutritional status</u>. Any occurrence within the past 2 months may be self-reported. Any occurrence more than 2 months previous must have the continued need for nutritional support diagnosed by a physician or health care professional working under the orders of a physician. Examples of major surgery include abdominal or heart surgery. Cesarean section is not usually treated as a high risk.</p>
<p>Short bowel syndrome (3426)</p>	<p>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.</p>
<p>Sickle cell anemia (not trait) (3496)</p>	<p>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 at MCV, since hemoglobin will always be low.</p>
<p>Thalassemia (3494)</p>	<p>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 tests are not required at MCV, since hemoglobin will always be low.</p>
<p>Tuberculosis (3527)</p>	<p>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.</p>
<p>Ulcerative colitis (3428)</p>	<p>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.</p>

Counseling for the following medical conditions may be provided by a CPPA

<p>Asthma, moderate persistent or severe persistent (3601)</p>	<p>Asthma must be diagnosed as <i>moderate persistent</i> or <i>severe persistent</i> that requires the daily use of an inhaled anti-inflammatory agent or an oral corticosteroid. A participant diagnosed with Asthma and Obesity or Asthma and Short Stature should be referred to the CPA for Nutrition Care Counseling.</p>
<p>Bronchiolitis (3 episodes in the last 6 months) (3526)</p>	<p>A lower respiratory tract infection that affects young children, usually under 24 months of age. Recurring episodes of Bronchiolitis may affect nutritional status during a critical growth period and lead to the development of asthma and other pulmonary diseases. The disease must be present within the past 6 months.</p>
<p>Cleft lip or palate (3492)</p>	<p>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. After 18 months of age and adequate corrections, a child with cleft lip or palate may be counseled by the CPPA.</p>
<p>Food Allergies (3531)</p>	<p>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. 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. 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. Consider contacting Specialist RD for participant with multiple complex food allergies before counseling or assigning food package.</p>
<p>Lactose intolerance (3551)</p>	<p>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 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.</p>

	Developmental lactase deficiency is relative lactase deficiency among pre-term infants <34 weeks gestation. May benefit from lactase supplemented feedings or lactose-reduced formula.
Meningitis (3521)	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.

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, with a 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.

Nutrition Practice – Child

(4251) **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.

INAPPROPRIATE FEEDING PRACTICE	JUSTIFICATION
Feeding inappropriate beverages as the primary milk source, such as: <ul style="list-style-type: none">• Reduced fat (2%), lowfat (1%), or fat free (skim) milk before 2 years of age.• Rice or soy-based beverages that are inadequately fortified.• Goat’s milk, sheep’s milk, or imitation or substitute milk inadequately fortified.	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.
Feeding any sugar containing beverages, such as Kool-Aid, punch, sodas, tea or sports drinks.	Excessive intake of nutrient-poor, high calorie foods by children between 13 and < 24 months of age can reduce the appetite for other foods, especially those high in iron. Fewer nutrients are available to support growth needs.
Using nursing bottles, cups, or pacifiers improperly, such as: <ul style="list-style-type: none">• Using a nursing bottle to feed any beverage other than breast milk or formula.• Putting the toddler to bed with the bottle.• Using a nursing bottle beyond 14 months of age.• Allowing unrestricted use of a bottle or cup.	Inappropriate use of nursing bottles, cups, or pacifiers increase the risk for tooth decay, earaches, and choking.
Using feeding practices that disregard the developmental stage of the child, such as: <ul style="list-style-type: none">• Not recognizing or disregarding the child’s cues for hunger and fullness.• 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.	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 diet. A dysfunctional relationship, characterized by a caregiver misinterpreting, ignoring, or overruling the innate capability of the child to regulate food intake based on hunger and satiety can result in poor dietary intake, poor growth, and future problems with

<ul style="list-style-type: none"> • 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. 	<p>regulation of food intake.</p>
<p>Feeding a diet very low in calories and/or essential nutrients, such as a vegan or macrobiotic or other highly restrictive diet.</p>	<p>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.</p>
<p>Pica practice (eating non-foods such as clay, dirt, or ashes).</p>	<p>Pica is the practice of eating nonfood items and is linked to lead poisoning, anemia, excess calories, small bowel obstruction, and parasitic infection. It may result in a nutrient deficiency.</p>
<p>Consuming foods that could be contaminated with harmful bacteria or toxins, such as:</p> <ul style="list-style-type: none"> • Feeding unpasteurized juice, milk, or cheese. • Feeding deli or processed meats or hotdogs without further cooking them. • Feeding local fish or seafood listed on the MDE advisory as DO NOT EAT. 	<p>Unpasteurized juice or dairy products and undercooked meats may contain pathogens that cause serious, potentially fatal foodborne illness.</p>
<p>Feeding dietary supplements that are inappropriate and/or excessive, such as:</p> <ul style="list-style-type: none"> • Giving any vitamin or mineral supplement (unless prescribed by health care provider). 	<p>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.</p>

<ul style="list-style-type: none"> • 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. 	
<p>Routinely not providing essential dietary supplements.</p> <ul style="list-style-type: none"> • 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. 	<p>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.</p>

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

(4111) **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.

INAPPROPRIATE FEEDING PRACTICE	JUSTIFICATION
<p>Infrequent breastfeeding of an exclusively breastfed infant. In a 24 hour period, infant is fed:</p> <ul style="list-style-type: none"> • Less than 8 times if < 2 months of age; or • Less than 6 times if ≥ 2 months of age but < 6 months of age. <p>Refer the infant to the breastfeeding specialist.</p>	<p>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.</p>
<p>Using a substitute for breast milk or FDA-approved iron-fortified formula as the primary nutrient source. Examples include:</p> <ul style="list-style-type: none"> • 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 	<p>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.</p>
<p>Over- or under-dilution of formula by:</p> <ul style="list-style-type: none"> • Not following manufacturer’s mixing instructions to stretch formula • Not following specific prescription instructions 	<p>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.</p>
<p>Using nursing bottles or cups inappropriately, such as:</p> <ul style="list-style-type: none"> • Using the bottle to feed fruit juice, fruit drinks, soda, gelatin water, chicken broth, corn syrup or sugar solutions, tea, or 	<p>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</p>

<p>diluted cereal or other solid foods.</p> <ul style="list-style-type: none"> • 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. 	<p>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.</p>
<p>Lack of sanitation in the preparation, handling, or storage of infant formula or expressed breast milk, such as:</p> <ul style="list-style-type: none"> • 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. • 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). • Fresh breast milk is added to frozen breast milk and then refrozen. • The infant is fed breast milk that has been previously frozen, thawed and then held in the refrigerator for over 24 hours before feeding, or thawed in a microwave. 	<p>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.</p>

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 4 months of age.
- Feeding juice or water before 6 months of age.

Before 4 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 4 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 vegan or macrobiotic diet.

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.
- 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.)

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.

<ul style="list-style-type: none"> • Not advancing the textures of foods (puree; mashed; chopped; tiny pieces of foods) according to the infant’s developmental readiness. 	
<p>Feeding foods that could be contaminated with harmful bacteria or toxins, such as:</p> <ul style="list-style-type: none"> • honey or unpasteurized fruit or vegetable juice • Undercooked meat, fish, 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 	<p>Honey in any form may contain spores of <i>Clostridium botulinum</i>, 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.</p>
<p>Feeding dietary supplements that are inappropriate and/or excessive, such as:</p> <ul style="list-style-type: none"> • 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. 	<p>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.</p>
<p>Not giving a dietary supplement recognized as essential by national public health policy, such as:</p> <ul style="list-style-type: none"> • 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 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D. 	<p>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 milligrams of fluoride daily.</p>

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 – Woman

(4271) **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.

INAPPROPRIATE NUTRITION PRACTICE	JUSTIFICATION
Severely limits intake of food sources of important nutrients, such as avoiding an entire food group like the Milk Group.	Highly restrictive diets prevent adequate intake of calories and nutrients and may lead to other adverse physiological effects.
Consumes plant foods only (vegan or macrobiotic diet).	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.
<ul style="list-style-type: none"> • Routinely fasts, limits meals to one a day, follows a very low calorie diet, or purges foods once eaten. • Follows a very low calorie diet or a low carbohydrate/high protein diet. 	Women consuming highly restrictive diets are at risk for nutrient deficiencies, especially during critical development periods such as pregnancy.
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.	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.
Currently or recently craves or consumes non-foods, such as clay, dry cornstarch, laundry starch, freezer frost, or baking soda.	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.
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	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.

<p>or vegetable juices, milk or other dairy products; soft, unaged cheeses like feta, blue-vein, or Mexican style cheeses.</p>	
<ul style="list-style-type: none"> • 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. 	<p>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.</p> <p>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.</p>

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 \geq 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 ≥ 95 th 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:

Noncariogenic Foods	Low Cariogenic Foods	High Cariogenic Foods
Cheese, cottage cheese, plain yogurt	Flavored milk	Breakfast bars, granola bars
Chicken, eggs, unflavored cow's milk	Fresh fruits	Cake, cookies, candies**
Popcorn, nuts and seeds*	Whole grain products	Doughnuts, pretzels, soda crackers
Seltzer, flavored club soda		Raisins and other dried fruit
Vegetables		Sweetened drinks, including fruit juice
		Sweetened dry cereal
*choking hazard for infants and toddlers		**Sticky candy and/or slowly eaten candy are extremely cariogenic

Adapted from: Faine, MP. Nutrition and oral health. In: Proceedings of Promoting Oral Health of Children with Neurodevelopmental Disabilities and Other Special Health Care Needs. May 4-5, 2001. Seattle, WA.

Overweight (Woman)

(1111) **Categories: PG, BE/BP, WPP**

Defined as:

1. **Pregnant Woman:** Pre-pregnancy Body Mass Index (BMI) $\geq 25.0^*$.
2. **Postpartum or Breastfeeding (less than 6 months postpartum) Woman:** Pre-pregnancy Body Mass Index (BMI) $\geq 25.0^*$.
3. **Breastfeeding (6 months or more postpartum) Woman:** Current Body Mass Index (BMI) $\geq 25.0^*$.

*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 \geq 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 \leq 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 \geq 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.

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

(3311) **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.

Prematurity

(1421) **Categories: IBE, IBP, IFF, C-1**

Defined as: An infant born at ≤ 37 completed weeks gestation.

An infant identified as premature should have Nutrition Care counseling.

Justification:

Premature infants may have physical problems that have nutritional implications, including immature sucking, swallowing, and immature digestion and absorption of carbohydrates and lipids. Premature infants have increased nutrient and calorie needs for rapid growth.

Procedure:

- Determine if the infant was born at 37 weeks gestation or earlier, using **Table GAA**.
- Review collected information for appropriateness of feeding practices.

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.

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.

- Discreetly 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 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 on line 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 intimate partner violence.
- Offer to provide information or make the necessary contact with a domestic violence support network.

Short Stature/At Risk of Short Stature

(1211) **Categories: IBE, IBP, IFF, C 1- 4**

Defined as:

- Length/age \leq 5th percentile, CDC/ WHO growth chart Birth to \leq 24 months, or
- Stature/Age \leq 10th percentile, CDC growth chart 2 to 5 years of age.

Explanation:

- CDC uses the cut off value of \leq 2.3 percentile length for age to define **short stature** in an infant or child from Birth to $<$ 24 months and \leq 5th percentile for a child 2 to 5 years.
- CDC uses \leq 5th percentile to define **at risk of short stature** in an infant or child from Birth to $<$ 24 months, and $>$ 5th percentile to \leq 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 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.

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 \leq 5th percentile, CDC/WHO growth chart Birth to \leq 24 months, **or**
- BMI/Age \leq 10th percentile, CDC growth chart 2 to 5 years of age.

Specifically:

Underweight: CDC, WHO, and WIC use a cut-off value of

- \leq 2.3 percentile weight for length in an infant Birth to \leq 24 months, **or**
- \leq 5th percentile BMI/Age for a child age 2 to 5 years.

At risk of underweight: WIC uses the cutoff value of

- $>$ 2.3 and \leq 5th percentile Wt/lgth for an infant/child Birth to \leq 24 months **and**
- $>$ 5 and \leq 10th 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 5th 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

Category	Hemoglobin or hematocrit value is less than or equal to:							
	Cigarettes per day							
	0 to 9		10 to 19		20 to 39		40+	
	Hgb	Hct	Hgb	Hct	Hgb	Hct	Hgb	Hct
Pregnant through 13 weeks	10.9	32.9	11.2	33.9	11.4	34.4	11.6	34.9
Pregnant 14 through 26 weeks	10.4	31.9	10.7	32.9	10.9	33.4	11.1	33.9
Pregnant 27 through 40 weeks	10.9	32.9	11.2	33.9	11.4	34.4	11.6	34.9
Breastfeeding or Postpartum 12 to < 15 years	11.7	35.6	12.0	36.6	12.2	37.1	12.4	37.6
Breastfeeding or Postpartum 15 to < 18 years	11.9	35.8	12.2	36.8	12.4	37.3	12.6	37.8
Breastfeeding or Postpartum 18 + years	11.9	35.6	12.2	36.6	12.4	37.1	12.6	37.6

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 W Weight Status of Pregnant, Breastfeeding, and Postpartum Women

Height is:		Underweight (BMI < 18.5)	Normal Weight (BMI 18.5-24.9)			Overweight (BMI 25.0-29.9)	Obese (BMI ≥ 30.0)		
Ft. &in.	In.	Weight (in pounds) is:							
4' 8"	56"	≤ 82 1/4	82 1/2	-	111 1/4	111 1/2	-	133 1/2	≥ 133 3/4
4' 8 1/2"	56-1/2"	≤ 83 3/4	84	-	113 1/4	113 1/2	-	135 3/4	≥ 136
4' 9"	57"	≤ 85 1/4	85 1/2	-	115 1/4	115 1/2	-	138 1/4	≥ 138 1/2
4' 9 1/2 "	57-1/2"	≤ 86 3/4	87	-	117 1/4	117 1/2	-	140 3/4	≥ 141
4'10"	58"	≤ 88 1/4	88 1/2	-	119 1/4	119 1/2	-	143 1/4	≥ 143 1/2
4' 10 1/2"	58-1/2"	≤ 89 3/4	90	-	121 1/4	121 1/2	-	145 3/4	≥ 146
4'11"	59"	≤ 91 1/4	91 1/2	-	123 1/2	123 3/4	-	148 1/4	≥ 148 1/2
4' 11 1/2"	59-1/2"	≤ 92 3/4	93	-	125 1/2	125 3/4	-	150 3/4	≥ 151
5' 0"	60"	≤ 94 1/4	94 1/2	-	127 3/4	128	-	153 1/4	≥ 153 1/2
5' 1/2"	60-1/2"	≤ 96	96 1/4	-	129 3/4	130	-	155 3/4	≥ 156
5' 1"	61"	≤ 97 1/2	97 3/4	-	132	132 1/4	-	158 1/2	≥ 158 3/4
5' 1-1/2"	61-1/2"	≤ 99 1/4	99 1/2	-	134	134 1/4	-	161	≥ 161 1/4
5' 2"	62"	≤ 100 3/4	101	-	136 1/4	136 1/2	-	163 1/4	≥ 163 3/4
5' 2-1/2"	62-1/2"	≤ 102 1/2	102 3/4	-	138 1/2	138 3/4	-	166 1/4	≥ 166 1/2
5' 3"	63"	≤ 104	104 1/4	-	140 3/4	141	-	169	≥ 169 1/4
5' 3-1/2"	63-1/2"	≤ 105 3/4	106	-	143	143 1/4	-	171 3/4	≥ 172
5' 4"	64"	≤ 107 1/4	107 1/2	-	145 1/4	145 1/2	-	174 1/4	≥ 174 1/2

Table W		Weight Status of Pregnant, Breastfeeding and Postpartum Women, continued							
Height is:		Underweight (BMI < 18.5)	Normal Weight (BMI 18.5-24.9)			Overweight (BMI 25.0-29.9)		Obese (BMI ≥ 30.0)	
Ft. & in.	In.	Weight (in pounds) is:							
5' 4-1/2"	64-1/2"	≤ 109	109 1/4	-	147 1/2	147 3/4	-	177	≥ 177 1/4
5' 5"	65"	≤ 110 3/4	111	-	149 3/4	150	-	179 3/4	≥ 180
5' 5-1/2"	65-1/2"	≤ 112 1/2	112 3/4	-	152	152 1/4	-	182 3/4	≥ 183
5' 6"	66"	≤ 114 1/4	114 1/2	-	154 1/2	154 3/4	-	185 1/2	≥ 185 3/4
5' 6-1/2"	66-1/2"	≤ 116	116 1/4	-	156 3/4	157	-	188 1/4	≥ 188 1/2
5' 7"	67"	≤ 117 3/4	118	-	159 1/4	159 1/2	-	191	≥ 191 1/4
5' 7-1/2"	67-1/2"	≤ 119 1/2	119 3/4	-	161 1/2	161 3/4	-	194	≥ 194 1/4
5' 8"	68"	≤ 121 1/4	121 1/2	-	164	164 1/4	-	196 3/4	≥ 197
5' 8-1/2"	68-1/2"	≤ 123	123 1/4	-	166 1/2	166 3/4	-	199 3/4	≥ 200
5' 9"	69"	≤ 124 3/4	125	-	168 3/4	169	-	202 3/4	≥ 203
5' 9-1/2"	69-1/2"	≤ 126 3/4	127	-	171 1/4	171 1/2	-	205 3/4	≥ 206
5' 10"	70"	≤ 128 1/2	128 3/4	-	173 3/4	174	-	208 1/2	≥ 208 3/4
5" 10-1/2"	70-1/2"	≤ 130 1/4	130 1/2	-	176 1/4	176 1/2	-	211 1/2	≥ 211 3/4
5' 11"	71"	≤ 132 1/4	132 1/2	-	178 3/4	179	-	214 3/4	≥ 215
5' 11-1/2"	71-1/2"	≤ 134	134 1/4	-	181 1/4	181 1/2	-	217 3/4	≥ 218
6' 0"	72"	≤ 136	136 1/4	-	183 3/4	184	-	220 3/4	≥ 221
6' -1/2"	72-1/2"	≤ 137 3/4	138	-	186 1/2	186 3/4	-	223 3/4	≥ 224
6' 1"	73"	≤ 139 3/4	140	-	189	189 1/4	-	227	≥ 227 1/4
6' 1-1/2"	73-1/2"	≤ 141 3/4	142	-	191 1/2	191 3/4	-	230	≥ 230 1/4

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

Completed Week of Gestation	Underweight pounds:	Normal Weight pounds:	Overweight/Obese pounds:	Completed Week of Gestation	Underweight pounds:	Normal Weight pounds:	Overweight/Obese pounds:
1	N/A	N/A	N/A	21	11 1/2	9 1/2	5 1/2
2	1/4	1/4	N/A	22	12 1/2	10 1/2	6
3	1/2	1/2	1/4	23	13 1/4	11 1/4	6 1/2
4	1	3/4	1/2	24	14	12	7
5	1 3/4	1 1/4	1/2	25	14 3/4	12 3/4	7 1/2
6	2	1 1/2	3/4	26	15 3/4	13 1/2	8
7	2 1/2	1 3/4	3/4	27	16 3/4	15	8 3/4
8	2 3/4	2	1	28	17 1/2	15 1/4	9
9	3 1/4	2 1/4	1	29	18 1/2	15 3/4	9 1/2
10	3 1/2	2 1/2	1 1/4	30	19 1/4	16 3/4	10
11	4	2 3/4	1 1/2	31	20	17 1/2	10 1/2
12	4 1/2	3	1 1/2	32	21	18 1/2	11
13	4 3/4	3 1/4	1 3/4	33	21 3/4	19	11 1/2
14	5 1/2	4 1/4	2 1/4	34	22 3/4	19 3/4	11 3/4
15	6 1/2	4 3/4	2 3/4	35	23 1/2	20 3/4	12 1/4
16	7 1/2	5 1/2	3 1/4	36	24 1/2	21 1/2	12 3/4
17	8	6 1/2	3 1/2	37	25	22 1/4	13 1/4
18	8 3/4	7 1/4	4	38	26 1/4	23	13 3/4
19	9 3/4	8	4 1/2	39	26 3/4	24	14 1/4
20	10 3/4	8 3/4	5	40	27 3/4	24 3/4	14 3/4

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:

$$\text{BMI} = \text{Weight} \div \text{Height} \div \text{Height} \times 703$$

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.

Fraction:	Decimal:
1/8	= .125
1/4 (2/8)	= .25
3/8	= .375
1/2 (4/8)	= .5
5/8	= .625
3/4 (6/8)	= .75
7/8	= .875

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	≤ 10 th percentile, BMI/Age
At Risk of Overweight	Infant or child whose biological parent has a self-reported BMI ≥ 30
Overweight	≥ 85 th to less than the 95 th percentile
Obese	≥ 95 th percentile

Table BMI.2:

Abbreviated Body Mass Index (BMI) Table (Self-reported by mother or father)*

Height	Height in inches	Weight (lbs) equal to BMI 30
4' 10"	58	143
4' 11"	59	148
5' 0"	60	153
5' 1"	61	158
5' 2"	62	164
5' 3"	63	169
5' 4"	64	174
5' 5"	65	180
5' 6"	66	186
5' 7"	67	191
5' 8"	68	197
5' 9"	69	203
5' 10"	70	209
5' 11"	71	215
5' 12"	72	221
6' 1"	73	227
6' 2"	74	233
6' 3"	75	240

**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 \geq 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 \leq 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

RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
Alcohol or Illegal Drug Use	PG = Any amount; BE/BP/WPP: ≥ 2 drinks/day All = drugs, any amount. CPA initial contact, then CPA follow up 3-6 months.	NC	NC	NC	NC					
BF Complications/potential	Woman: Use LIST 2, Infant: Use LIST 3 Initial BF contact within 5 days		BF	BF		BF	BF			
BF Infant of Woman at Nutritional Risk						BF NC	BF NC			
BF Mother of Infant at Nutritional Risk			BF NC	BF NC						
Closely Spaced Pregnancies	Conception before 16 months postpartum	X	X	X	X					
Complementary Feeding Process	Assign only if no other risk found. Documented complete nutrition assessment required. Applies 4 to 23 months					X	X	X	X	
Depression	CPA initial contact, then CPA follow up 3-6 months	NC	NC	NC	NC					
Elevated Blood Lead	≥ 10 mcg/dl last 12 months	X	X	X	X	X	X	X	X	X
Elevated Blood Lead	≥ 15 mcg/dl last 12 months	NC	NC	NC	NC	NC	NC	NC	NC	NC
Failure to Thrive	Initial CPA contact within 5 days CPA follow up 1-3 months					NC	NC	VC	NC	NC
Fetal Alcohol Syndrome	CPA initial contact, then CPA follow up 3-6 months					NC	NC	NC	NC	NC
Fetal Growth Restriction		X								
Foster Care	Entered into/transferred in last 6 months					M	M	M	M	M
Gestational Diabetes	Initial CPA contact within 5 days. CPA follow up 3 months.	NC								
High Maternal Weight Gain		X	X	X	X					
High Parity and Young Age	Age < 20 at date of conception w/3 prior pregnancies lasting ≥ 20 weeks	M	M	M	M					
High Weight for Length	≥ 97.9 percentile on Birth to 24 months growth chart. For <37 wks gestation, correct age using Table GAA before plotting growth chart.					X	X	X	X	

RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
History of Birth of a Large for Gestational Age Infant ≥ 9 pounds	PG = any pregnancy BE/BP/WPP = Any prior pregnancy	X	X	X	X					
History of Birth w/ Nutrition Related Congenital/ Birth Defect	Neural Tube Defect; Cleft Palate. PG = any pregnancy. BE/BP/WPP = Any prior pregnancy	X	X	X	X					
History of Gestational Diabetes	PG = any pregnancy. CPA follow up 3 months BE/BP/WPP = most recent pregnancy	NC	NC	NC	NC					
History of Low Birth Weight (≤ 5 lb 8 oz)	PG = any pregnancy BE/BP/WPP = Most recent pregnancy	X	X	X	X					
History of Preeclampsia	PG = any pregnancy BE/BP/WPP = Any prior pregnancy	X	X	X	X					
History of Preterm Delivery (≤ 37 weeks)	PG = any pregnancy BE/BP/WPP = Most recent pregnancy	X	X	X	X					
History of Spontaneous Abortion PG: 2 or more @ <20 wks; Fetal Death (≥ 20 wks)		X	X	X	X					
Homelessness		X	X	X	X	X	X	X	X	X
Hyperemesis Gravidarum	CPA follow up 1-3 months	NC								
Hypertension / Prehypertension (Woman)	Prehypertension = BP 130/80 – 139/89 mm Hg Hypertension = Systolic ≥ 140, Diastolic ≥ 90mmHg CPA initial contact, then CPA follow up 3-6 months	NC	NC	NC	NC					
Hypertension / Prehypertension Child Age 3+	Hypertension: > 95 th % for age, gender, height on ≥3 occasions Prehypertension = BP 90-95%									NC
Late to Prenatal Care	Prenatal care beginning after completed week 13 of gestation	X								
Large for Gestational Age	Birth weight ≥ 9 pounds					X	X	X		
Limited Ability of Caregiver to Make Feeding Decisions	Mother/caregiver ≤ 17 years, physical/mental disability, drug use	M	M	M	M	M	M	M	M	M
Low Birth Weight/ Very Low Birth Weight	LBW: Infant born ≤ 5 pounds, 8 ounces. CPA initial contact, then CPA follow up 3-6 months VLBW: Infant born ≤ 3 pounds, 5 ounces. Initial CPA contact within 5 days. CPA follow up 1-3 months.					NC	NC	NC	NC	NC

RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
Low Head Circumference	HC \leq 2.3% on Birth to 24 months growth chart					X	X	X	X	
Low Hemoglobin/Hematocrit: Infant/child \geq 9 months	Hgb \leq 10.9/Hct \leq 32.8. CPA initial contact, then CPA follow up 3-6 months Hgb $<$ 9: Initial CPA contact within 5 days					X	X	X	X	X
Low Hemoglobin/Hematocrit: Infant/child \geq 9 months	Hgb $<$ 10/Hct $<$ 30 Hgb $<$ 9: Initial CPA contact within 5 days					NC	NC	NC	NC	NC
Low Hemoglobin/Hematocrit: Woman	Use Table A	X	X	X	X					
Low Hemoglobin/Hematocrit	Use Table A Hgb $<$ 10/Hct $<$ 30%	NC	NC	MC	NC					
Low Maternal Weight Gain	Use Table IP (A women with underweight and low maternal weight gain = NC)*	X*								
Maternal Smoking	Any kind, any amount	X	X	X	X					
Maternal Weight Loss	Wt loss below pre-pregnancy wt through week 13; loss of \geq 2 lbs, weeks 14-40	X								
May Not Meet Dietary Guidelines	Only if no other risks. Document complete nutritional assessment.	X	X	X	X					X
Medical Condition, Nutrition Related:										
• AIDS		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Anorexia Nervosa	CPA initial contact, then CPA follow up 3-6 months	NC	NC	NC	NC					
• Asthma, moderate or severe persistent	With short stature or obesity	NC	NC	NC	NC	NC	NC	NC	NC	NC
• 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	X
•										
• Bronchiolitis						x	x	x	x	x
• Bulimia		NC	NC	NC	NC					
• Cancer		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Cardiorespiratory Diseases		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Celiac Disease		NC	NC	NC	NC	NC	NC	NC	NC	NC

RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
• Cerebral Palsy		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Cleft Lip or Palate						NC	NC	NC	NC	NC
• Cleft Lip or Palate	After 18 month of age and appropriate repairs					X	X	X	X	X
• Congenital Hyperthyroidism						NC	NC	NC		
• Congenital Hypothyroidism						NC	NC	NC		
• Crohn's Disease		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Cystic Fibrosis	Contact specialist RD	NC	NC	NC	NC	NC	NC	NC	NC	NC
•										
• Developmental, Sensory, or Motor Disability	Consider contacting specialist RD	NC	NC	NC	NC	NC	NC	NC	NC	NC
• Diabetes Mellitus	Hyperglycemia resulting from defects in insulin secretion, insulin action, or both	NC	NC	NC	NC	NC	NC	NC	NC	NC
• Down Syndrome		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Drug-nutrient Interactions		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Epilepsy		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Food Allergies	Milk/cheese, eggs, soy, nuts, peanuts, seafood, or wheat/other grains only. Diagnosed	X	X	X	X	X	X	X	X	X
• Gall Bladder Disease	Gallstones, bile duct obstruction	NC	NC	NC	NC	NC	NC	NC	NC	NC
• Gastrointestinal Anomalies		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Gastroesophageal Reflux Disease	(GERD)	NC	NC	NC	NC	NC	NC	NC	NC	NC
• Heart Disease		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Hepatitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
• HIV Infection		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Hyperthyroidism		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Hypothyroidism		NC	NC	NC	NC	NC	NC	NC	NC	NC

• Inborn Errors of Metabolism	Contact Metabolic Dietitian before assigning food package: Children's National Medical Center, Washington, D.C.: 1-202-476-6287 Johns Hopkins: 410-955-3071 University of Maryland Hospital: 410-328-3335	NC								
• Juvenile Rheumatoid Arthritis		NC								
• Lactose Intolerance		X	X	X	X	X	X	X	X	X
• Liver Disease		NC								
• Lupus Erythematosus		NC	NC	NC	NC					
• Meningitis		X	X	X	X	X	X	X	X	X
• Multiple Sclerosis		NC	NC	NC	NC					
• Muscular Dystrophy		NC								
• Neural Tube Defects (spina bifida)		NC								
• Nutrient Deficiency Diseases	Consider contacting specialist RD	NC								
• Pancreatitis		NC								
• Parasitic Infections		NC								
• Parkinson's Disease		NC	NC	NC	NC					
• Peptic Ulcer		NC								
• Pneumonia		NC								
• Post Bariatric Surgery	Contact specialist RD	NC	NC	NC	NC					
• Postpartum Thyroiditis			NC	NC	NC					
• Pre-Diabetes	Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT): hyperglycemia that does not meet diagnostic criteria for Diabetes	NC	NC	NC	NC					
• Recent Major Surgery, trauma, or burns	Caesarian section is not usually treated as a high risk.	NC								
• Renal Disease		NC								
• Short Bowel Syndrome		NC								

• Sickle Cell Anemia (not trait)		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Thalassemia Major		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Tuberculosis		NC	NC	NC	NC	NC	NC	NC	NC	NC
• Ulcerative Colitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
Migrant Farm Worker Status		X	X	X	X	X	X	X	X	X
Mother in WIC while Pregnant or Eligible with Priority 1 Risk	< 6 months of age only					X	X	X		
Multi-Fetal Gestation	Pregnant with twins, triplets, or more. CPA contact, then CPA follow up 3 months.	NC	NC	NC	NC					
Nutrition Practices, Child	Use LIST 4: some require manual entry								X	X
Nutrition Practices, Infant	Use LIST 3: some require manual entry					X	X	X		
Nutrition Practices, Woman	Use LIST 1: some require manual entry	X	X	X	X					
Obese	BMI/Age \geq 95 th % CDC growth chart Age 2 to 5									X
Oral Health Conditions		X	X	X	X	X	X	X	X	X
Overweight	Use Table W PG: Prepregnancy BMI \geq 25.0 Postpartum/BF < 6 months: Prepreg BMI \geq 25.0 Postpartum/BF \geq 6 months: Current BMI \geq 25.0	X	X	X	X					
Overweight/Risk of Overweight	Overweight: BMI/Age \geq 85 to < 95% CDD 2 to 5 yrs Risk Overweight: Infant/Child whose biological parent is obese					X	X	X	X	X
Possibility of Regression									X	X
Pregnancy at a Young Age	Age \leq 18 at date of conception	X	X	X	X					
Pregnant Woman Currently BF	Refer to BF specialist	M/ BF								
Prematurity	\leq 37 weeks gestation Use Table GAA					NC	NC	NC	NC	NC
Recipient of Abuse	Suspected child abuse/neglect must be reported	X	X	X	X	X	X	X	X	X
Short Stature/Risk of Short Stature	Length/Age \leq 5 %, WHO chart, Birth to 2 years Stature/Age \leq 10 th %, CDC chart, 2 to 5 years Use Table GAA if also premature					X	X	X	X	X

Small for Gestational Age (SGA)	Must be diagnosed. Small for gestational age plus low birth weight: CPA initial contact, then CPA follow up 3-6 months.					NC	NC	NC	NC	
Transfer		X	X	X	X	X	X	X	X	X
Underweight (Woman)	Pregnant: prepregnancy BMI < 18.5 Postpartum/BF woman (< 6 months postpartum): prepregnancy or current BMI < 18.5 Breastfeeding woman (≥ 6 months postpartum) Current BMI < 18.5	X	X	X	X					
Underweight (Woman) with Low Maternal Weight Gain	As above, with low maternal weight gain. CPA contact, then CPA follow up in 3 months	NC	NC	NC	NC					
Underweight/Risk of Underweight (Infant/Child)	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: > 2.3 to ≤ 5 % birth to 24 mo > 5 to ≤ 10 % 2 to 5 years	—	—	—	—	NC X	NC X	NC X	NC X	NC X

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.32
Effective Date: December 18, 1991
Revised Date: October 1, 2014**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Weight and Height Measurement Requirement

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 16th's will be converted to 8th's as per the chart below

Converting 16th's to 8th's

1/16	0/8		9/16	5/8
2/16	1/8		10/16	5/8
3/16	1/8		11/16	6/8
4/16	2/8		12/16	6/8
5/16	2/8		13/16	7/8
6/16	3/8		14/16	7/8
7/16	3/8		15/16	1 inch
8/16	4/8		16/16	1 inch

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

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.33
Effective Date: December 18, 1991
Revised Date: October 1, 2015**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Blood Test Requirement

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 training¹ 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
 - microcuvette²
 - 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.

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 AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.34
Effective Date: October 1, 1996
Revised Date: October 1, 2015**

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.

- 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.

Policy and Procedure 2.34A has been removed.

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.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.36
Effective Date: October 1, 2011
Revised Date: October 1, 2012**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Certification of Participants in Hospitals

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, and checks 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 WIC ID folder, unredeemed checks, 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), Competent Paraprofessional Authority (CPPA), or Breastfeeding Peer Counselor who has been trained as a 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 a 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 how to use the WIC checks shall also be explained to the participant. It is recommended that the "My WIC" participant instructional video be used for this purpose. (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. Local agencies shall monitor certifications performed in the hospital as part of their self-monitoring system. (Refer to Policy and Procedure 7.80.)
14. 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: 10/2012 Deleted references to WOW, Minor language change/clarification in B.6

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.37
Effective Date: October 1, 2012
Revised Date:**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Use of Volunteers in the WIC Program

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 WOW 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) Preparing ID folders for the day
 - b) Copying materials
 - c) Stuffing envelopes with appointment notices
 - 2) General
 - a) Sanitizing toys
 - b) Distributing/collecting health history forms or surveys
 - c) Assisting with check pickup by greeting participants/directing their flow

- d) Assisting with language interpretation
- e) 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 WOW 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.

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
WIC PROGRAM
POLICY AND PROCEDURE MANUAL**

**Policy and Procedure Number: 2.38
Effective Date: October 1, 2012
Revised Date: October 1, 2013**

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Extended Certification Periods/Mid-Certification Visits

A. Policy

WIC certification periods shall be extended for longer than six months for eligible infants, children, and breastfeeding women. During extended certification periods, local agencies shall continue to provide the nutrition services a participant would otherwise receive during a shorter certification period. The purpose of extended certification periods is to reduce the administrative burden on both WIC staff and participants by not requiring income eligibility determination and residency documentation for up to one year after certification/recertification. The time saved shall be used to increase the time spent with participants providing quality nutrition services, including nutrition assessment and education, breastfeeding promotion and support, food package tailoring, and referral services during the extended certification period.

B. Procedure

1. The certification/mid-certification periods for infants, children, and breastfeeding women shall be provided according to the following timeframes:
 - a. Any infant certified before six months of age shall be certified until the last day of the month in which the infant turns one year old, and shall be scheduled for a mid-certification visit approximately halfway through the certification.
 - b. Any infant certified from age six months to age one shall be certified for six months from the date of the certification, and shall not require a mid-certification visit.
 - c. Any child certified at age one year or over shall be certified for one year from the date of certification. All children shall be scheduled for a mid-certification visit approximately halfway through the certification/recertification.
 - d. All breastfeeding women shall be scheduled for a mid-certification visit approximately halfway through the certification/recertification.
2. WIC certifiers shall provide nutrition services during mid-certification visits for each participant category according to Attachment 2.38A.
3. Participants shall be present at mid-certification visits unless extraordinary circumstances exist. (Policy and Procedure 2.16).

4. A participant shall not be denied food benefits for failure to attend the scheduled mid-certification appointment. Therefore, local agencies shall stress (per Federal WIC Regulations 246.11(a)(2)) 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.

If the participant does not attend the mid-certification visit, the certifier shall attempt to schedule a follow up appointment in the following 30 days to complete the anthropometric and biochemical measurements. If the follow up cannot be scheduled, the certifier may print and complete the appropriate letter to the head of household to encourage a follow up visit or to have the health care provider complete anthropometric and biochemical data.

Attachments:

- 2.38A Provision of Nutrition Services During Mid-Certification Visits
- 2.38B Note for Designee/Proxy to give to Breastfeeding Woman Missing Mid-Certification Visit
- 2.38C Note for Designee/Proxy Attending Mid-Certification Visit Without Child to give to Head of Household
- 2.38D Note for Head of Household Attending Mid-Certification Visit Without Child

References:

1. 7CFR 246.7(g)(1)(iii-V)
2. USDA Guidance for Providing Quality WIC Nutrition Services during Extended Certification Periods (August 29, 2011)

Revisions:

- 10/13 Added paragraph to B.4. to give certifier the option to complete the form encouraging head of household to make a follow up appointment for the absent participant to complete anthropometric and biochemical data collection, or have the data submitted by the health care provider. Added attachments 2.38B, 2.38C, and 2.38D to provide notes for breastfeeding woman or head of household to make a follow up appointment to complete anthropometric and biochemical data collection, or contact healthcare provider to submit data.

Provision of Nutrition Services During Mid-Certification Visits

WIC certifiers shall provide nutrition services during 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 (questions for age 4 to 12 months): click the *New* checkbox. All new answers are required.
- 10) Assess risk factors.
- 11) Review growth chart.
- 12) Complete nutrition education based on risk factors and participant interest. Document nutrition education.
- 13) Make referrals as needed.

b. Child 1 to 2 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 (if applicable).
- 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: click the *New* checkbox. All new answers are required.
- 10) Assess risk factors.

- 11) Review growth chart.
- 12) Complete nutrition education based on risk factors and participant interest. Document nutrition education.
- 13) Make referrals as needed.

c. Child 2 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) 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.
- 8) Assess risk factors.
- 9) Review growth chart.
- 10) Complete nutrition education based on risk factors and participant interest. Document nutrition education.
- 11) Make referrals as needed.

d. 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
- 7) Complete nutrition education based on risk factors and participant interest.
Document nutrition education.
- 8) Make referrals as needed.

Note for Designee-Proxy to Give to Breastfeeding Woman Missing Mid-Certification Visit

Date: (auto-fill by WOW)

Dear (auto-fill by WOW),

We missed seeing you at your WIC appointment today. We hope you are doing well!

WIC's goal is to partner with you for healthy motherhood. **Please call to make an appointment within the next month**, so we can check your height and weight (and your hemoglobin if it was low at your certification) and discuss any health, nutrition, or breastfeeding concerns you might have.

We look forward to hearing from you.

WIC Local Agency: _____

WIC Clinic fax number: _____ phone number: _____

WIC certifier printed name: _____

WIC certifier signature: _____

Note for Designee/Proxy Attending Mid-Certification Visit Without Child to Give to Head of Household

Date: (auto-fill by WOW)

Dear Head of Household (auto-fill by WOW),

Today we began the nutrition assessment for your child or children named below:

We were unable to measure height, weight, and hemoglobin. This important information helps us partner with you and your health care providers to offer the best nutrition advice for the health and growth of your children.

Please call the WIC office to make an appointment for you or your designee to bring your children in for a free height and weight check up in about a month. At that time we can also do a hemoglobin test if it was low at certification.

Or – If your child has had height and weight measured by a health care provider within the past 60 days:

Please sign the consent form, then contact your health care provider to have the following information faxed to our office so we can complete the nutrition assessment.

Thank you for trusting WIC for health and nutrition support for your family.

Today's Date (auto-fill by WOW)

Dear Health Care Provider,

At WIC, our goal is to partner with caregivers and health care providers to provide the best possible nutrition counseling for the health and growth of young children. **Please complete the information below and fax it to our office so the records will be complete.**

Thank you for helping WIC to provide the best possible nutrition care for your patient.

WIC Local Agency: _____

WIC Clinic fax number: _____ phone number: _____

WIC certifier printed name: _____

WIC certifier signature: _____

.....
HEAD of HOUSEHOLD SIGNATURE

By signing, I authorize my health care provider to share this information with WIC.

I give permission, on behalf of myself and my children, to release the information, weights, and medical conditions contained on this form to the WIC staff, the breastfeeding support staff at the hospital where I receive services, my children's pediatrician(s), and my physician(s).

Head of Household Name (autofill by WOW) _____

Head of Household Signature _____

Date: _____

Child's Name _____

Length/Height ___ ft ___ inches _____ date (within 60 days of _____ [Auto-fill today's date])

Weight _____ lbs ___ ounces _____ date (within 60 days of _____ [Auto-fill today's date])

Hemoglobin _____ g/dl _____ date (within 60 days of _____ [Auto-fill today's date])

Health Care Provider signature: _____

Comments:

Note for Head of Household Attending Mid-Certification Visit Without Child

Date: (auto-fill by WOW)

Dear Head of Household (auto-fill by WOW),

Today we began the nutrition assessment for your child or children named below:

We were unable to measure height, weight, and hemoglobin. This important information helps us partner with you and your health care providers to offer the best nutrition advice for the health and growth of your children.

Please sign the consent form then contact your health care provider to have the following information faxed to our office so we can complete the nutrition assessment.

Thank you for trusting WIC for health and nutrition support for your family.

Today's Date (Auto-fill by WOW)

Dear Health Care Provider,

At WIC, our goal is to partner with caregivers and health care providers to provide the best possible nutrition counseling for the health and growth of young children. **Please complete the information below and fax it to our office so the records will be complete.** Thank you for helping WIC provide the best possible nutrition care for your patient.

WIC Local Agency: _____

WIC Clinic fax number: _____ phone number: _____

WIC certifier printed name: _____

WIC certifier signature: _____

.....
HEAD of HOUSEHOLD SIGNATURE

By signing, I authorize my health care provider to share this information with WIC.

I give permission, on behalf of myself and my children, to release the information, weights, and medical conditions contained on this form to the WIC staff, the breastfeeding support staff at the hospital where I receive services, my children's pediatrician(s), and my physician(s).

Head of Household Name (autofill by WOW) _____

Head of Household Signature _____

Date: _____

Child's Name _____

Length/Height ___ ft ___ inches _____ date (within 60 days of _____ [Auto-fill today's date])

Weight _____ lbs ___ ounces _____ date (within 60 days of _____ [Auto-fill today's date])

Hemoglobin _____ g/dl _____ date (within 60 days of _____ [Auto-fill today's date])

Health Care Provider signature: _____

Comments: