

**GEORGIA WIC PROGRAM
ASSESSMENT/CERTIFICATION FORM
POSTPARTUM BREASTFEEDING WOMAN**

CLINIC

FAMILY NUMBER

WIC ID NUMBER

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| NAME LAST | | FIRST | | MIDDLE INITIAL | | BIRTHDATE | |
| ADDRESS | | | | CITY | | ZIP CODE | |
| | | | | MIGRANT <input type="checkbox"/> YES <input type="checkbox"/> NO | | ENTER EDC DATE | |
| TELEPHONE () | | HISPANIC/LATINO <input type="checkbox"/> YES <input type="checkbox"/> NO | | RACE (check all that applies) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 | | | |
| COUNTY OF RESIDENCY <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | PROOF OF RESIDENCY UP: _____ | | PROOF OF I.D. UP: _____ | | FOSTER CARE <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| INITIAL CONTACT DATE: DATE OF FIRST VISIT REQUESTING WIC SERVICES <small>(Must change date if certifications are not consecutive)</small> | | | | Date: _____ Type: _____ | | Date: _____ Type: _____ | |
| WOMEN'S FEEDING METHOD: E= Exclusively Breastfeeding M= Mostly Breastfeeding S= Some Breastfeeding (Circle One) | | | | E M S | | E M S | |
| BREASTFEEDING AN INFANT LESS THAN 1 YEAR OF AGE (Enter Delivery Date: _____) (Birthweight: _____ lbs. _____ ozs.) (00= 0-6 days, 01= 7-13 days, 02= 14-20 days, 03= 21-27 days, etc.) | | | | Wks | | Wks | |
| Pregravid Weight: _____ lbs. | | Pregravid BMI: _____ | | BMI (Current) | | | |
| MEDICAL DATA DATE (Enter date height and weight measurement taken) | | | | | | | |
| | | | | Current Height / Weight | | ht. _____ wt. _____ | |
| | | | | Hematological Data Date: | | ht. _____ wt. _____ | |
| Hematocrit/Hemoglobin (Value must be ≤ 90 days) | | | | HCT | | HGB | |
| Select appropriate risk criteria per State guidelines (See Risk Criteria Handbook for definitions) | | | | YES | | NO | |
| Low Hgb/Hct [HR] 201 | | | | | | | |
| Underweight (< 6 mo. postpartum, based on pregravid or current wt., ≥ 6 mo. postpartum, based on current wt. < 185) [HR] 101 | | | | | | | |
| Overweight (< 6 mo. postpartum, based on pregravid wt., ≥ 6 mo. postpartum, based on current wt. ≥ 250) [HR?] 111 | | | | | | | |
| High Maternal Weight Gain (most recent pregnancy) [HR] 133 | | | | | | | |
| * Elevated Blood Lead Level (Blood Lead Level ≥ 10 µg/dl) [HR] 211 | | | | | | | |
| * History of Gestational Diabetes 303 | | | | | | | |
| * History of Preeclampsia 304 | | | | | | | |
| * Delivery of Preterm Infant(s) (most recent pregnancy) (enter weeks gestation: _____) 311 | | | | | | | |
| * Delivery of Low Birth Weight Infant(s) (most recent pregnancy) (Enter birth weight(s) and birth date(s): _____) 312 | | | | | | | |
| * Fetal/Neonatal Death (most recent pregnancy) (Enter date(s) of death and weeks gestation: _____) 321 | | | | | | | |
| Pregnancy at a Young Age (most recent pregnancy) [HR?] 331 | | | | | | | |
| * Closely Spaced Pregnancies (most recent pregnancy) (Enter termination dates of last (2) pregnancies: _____) 332 | | | | | | | |
| * High Parity and Young Age (Enter delivery date(s) of previous pregnancies: _____) 333 | | | | | | | |
| * Multi-Fetal Gestation (most recent pregnancy) [HR] 335 | | | | | | | |
| * History of Large for Gestational Age Infant (Birth weight(s): ≥ 9 lbs. enter birth weight(s): _____) 337 | | | | | | | |
| * Birth with Nutrition Related Congenital or Birth Defect(s) (most recent pregnancy) (specify defect(s): _____) 339 | | | | | | | |
| * Nutrition Related Medical Conditions (List code(s): _____) [HR?] 371 | | | | | | | |
| * Smoking (Any smoking of cigarettes, pipes or cigars) (Enter number of cigarettes or cigars smoked or number of times pipe smoked (# cig./day: _____) 372 | | | | | | | |
| * Alcohol and Drug Illegal Use 381 | | | | | | | |
| * Dental Problems 400 | | | | | | | |
| * Inappropriate Nutrition Practices 401 | | | | | | | |
| Other Dietary Risk (Failure to Meet Dietary Guidelines) 502 | | | | | | | |
| Transfer of Certification 601 | | | | | | | |
| * Breastfeeding Mother of an Infant(s) at Nutritional Risk (enter infants risk factors: _____) 602 | | | | | | | |
| * Breastfeeding Complications or Potential Complications [HR] 801 | | | | | | | |
| Homelessness 802 | | | | | | | |
| Migrancy 901 | | | | | | | |
| * Recipient of Abuse 902 | | | | | | | |
| * Woman with Limited Ability to make Feeding Decisions and/or Prepare Food 903 | | | | | | | |
| Foster Care 904 | | | | | | | |
| * Environmental Tobacco Smoke Exposure | | | | | | | |
| HIGH RISK (Yes or No) | | | | | | | |
| ELIGIBLE FOR WIC | | | | | | | |
| PRIORITY: 1= (201, 101, 111, 133, 211, 303, 304, 311, 312, 321, 331, 332, 333, 335, 337, 339, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 371, 372, 373, 381, 502, 601, 602, 904) 2= (502, 601) 4= (400, 401, 502, 601, 801, 802, 901, 902, 903) | | | | | | | |
| FOOD PACKAGE: (If unable to complete infant certification at this time, enter code AAA for infant food package and describe reason below.) | | | | WOMAN'S FOOD PACKAGE: | | | |
| | | | | INFANT'S FOOD PACKAGE: | | | |
| SERVICES: CH (A), Health Check (B), CMS (C), Women's Health (D), PCM (E), PRS (F), Immun (G), Lead Screen (H), Dental Health (I), STD (J), Private MD (K), SNAP (L), Medicaid (M), TANF (N), Mental Health (O), Head Start (P), NA/None (Q), Refused (R), Community Health Center (S), Children 1st (T), Other-Specify (U), Dietitian (V), Breastfeeding (W), Breastfeeding Peer Counselor (X) | | | | Enrolled In: _____ | | Enrolled In: _____ | |
| | | | | Referred To: _____ | | Referred To: _____ | |
| TODAY'S DATE | | | | | | | |
| SIGNATURE AND TITLE OF HEALTH PROFESSIONAL | | | | | | | |

*Additional Documentation Required

INCOME DETERMINATION (income must be documented)

| DATE | PHYSICAL PRESENCE | MEDICAID CURRENT Y/N/U | MEDICAID I.D. NUMBER VERIFY | TANF Y/N/U | SNAP Y/N/U | NO. IN FAMILY | GROSS INCOME (CURRENT/ANNUAL) |
|------|------------------------------|------------------------|-----------------------------|----------------------|----------------------|---------------|-------------------------------|
| | | | | COPY AND FILE | | | |
| | Y () N () * | Y () U () N () | | Y () U () N () | Y () U () N () | | C () A () UP () |
| | * N () R () D () W () | UP () | | UP () | UP () | | |

* See Procedures Manual (CT - Physical Presence) for a list of applicable reasons:
(MUST Document in Health Record)

Source of Income Code _____ Other _____
(Write in type)

UP: _____

No Proof () How is food, shelter, clothing and Medical Care obtained? _____

Is the Client Income Eligible? YES () NO () UP _____ Check Here if Only One Income Reported () Staff Initials _____

NOTE: The Income Calculation Form must be completed and filed in the Client's Medical Record if more than one income was calculated. UP: _____ Staff Initials _____

DATA NEEDED FOR PREGNANCY SURVEILLANCE

| | | |
|---|--|--|
| Marital Status (O=Married 1=Not Married 9=Unknown) | | |
| Years of Education completed (e.g. 1 st grade = 01, 2yrs. College = 14, Unknown = 99) | | |
| Month of gestation at time of first prenatal exam (0=0 Prenatal Care, 1=1 st . mo., 8=8 th or 9 th mo., 9=Unknown) | | |
| Last weight prior to delivery (Round to the nearest pound) | | |
| Parity (00= None 01-29 = Number of previous births) | | |
| Date last pregnancy ended (000000 = No Previous Pregnancy 01-12 (all four digits) = Month/Year) | | |
| Diabetes – Postpartum visit (1=No, 2= Yes, most recent, 3=Yes, past and most recent, 4=Yes, first time) | | |
| Hypertension – Postpartum visit (1=No, 2= Yes, most recent, 3=Yes, past and most recent, 4=Yes, first time) | | |
| Multi / Prenatal Vitamin Consumption Prior to Pregnancy (0=less than once a week, 1-8=number per week, 9-Unknown) | | |
| Cigarettes/Day – 3 mos prior to Pregnancy 00=no, 01-96=#cigs/day, 97=97 or more, 98=quantity unknown, 99=refused) | | |
| Cigarettes/Day – Postpartum Visit (00=no, 01-96=#cigs/day, 97=97 or more, 98=unknown, 99=refused) | | |
| Cigarettes/Day – Last 3 mos of Pregnancy 00=no, 01-96=#cigs/day, 97=97 or more, 98=quantity unknown, 99=refused) | | |
| Household Smoking – Postpartum Visit (1=Yes, someone smokes, 2=No, no one smokes, 9=unknown) | | |
| Drinks/week – 3 mos prior (00=No, 01=1 drink, 02-20=drinks, 21=21 or more, 98=quantity unknown, 99=refused) | | |
| Drinks/week – Last 3 mos Postpartum (00=No, 01=1 drink, 02-20=drinks, 21=21 or more, 98=quantity unknown, 99=refused) | | |
| Date breastfeeding began | (MM/DD/YYYY) | |
| Date of last time of breastfeeding and/or pumping | (MM/DD/YYYY) | |
| Fruit Intake. | D =Daily S =Some Days N =Never | |
| Vegetable Intake. | D =Daily S =Some Days N =Never | |
| Dairy Intake. | D =Daily S =Some Days N =Never | |
| Daily Activity. | V =Very Active S =Active Some of the Time N =Not Active | |
| Screen time. | Hours = 00 through 24 | |

Comments:(Date/Sign/Title): _____

Proxy 1 _____ Proxy2 _____

WIC CERTIFICATION STATEMENT

RIGHTS AND OBLIGATIONS

I have been advised of my rights and obligations for participation in Georgia's WIC. I certify that the information I will provide, or have provided, is correct to the best of my knowledge. The income information that I have provided is my total gross household income (all cash income before deductions). This certification form is being submitted in connection with the receipt of Federal assistance. Georgia's WIC 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 to Georgia's WIC, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

NOTICE OF DISCLOSURE

I understand that the chief state health officer for Georgia may authorize the disclosure of information about my participation in the WIC program for non-WIC purposes. This information will be used by Georgia WIC, its local WIC agencies and certain public organizations. These organizations include but are not limited to the Immunization Program, Pregnancy Risk Assessment Monitoring Systems (PRAMS), Epidemiology and other Maternal and Child Health Programs, Emergency Preparedness, Environmental Health and Medicaid. I understand that Georgia WIC, its local agencies and the public organizations can only use my information in the administration of their programs that serve persons eligible for WIC. The public organizations that receive my information must assure that it will not disclose my information to another organization or person without my permission.

I further understand that information about my participation in WIC may be used by the organizations that receive it only to:

1. Determine my eligibility for programs that the organization administers
2. Conduct outreach for such programs
3. Enhance the health, education, or well-being of WIC applicants and participants who are currently enrolled in those programs
4. Streamline administrative procedures to ease the burdens on WIC staff and participants
5. Assess the responsiveness of the state's health system to participants' health care needs and health care outcomes.

I have been advised that the decision to share my information is not a condition for eligibility for WIC, and if I decide not to share my information, this will not affect my application or participation in Georgia WIC.

Name of WIC Applicant/Participant/Guardian/
Caregiver/Spouse/Alternate Parent (please print)

Date

Name of WIC Official (please print)

Date

UP:

Signature of WIC Applicant/Participant/Guardian/
Caregiver/Spouse/Alternate Parent

Date

Signature of WIC Official

Date

Please initial below to indicate your preference:

___ In applying for WIC services, I **AUTHORIZE** DISCLOSURE of my WIC applicant or participant information for the purposes referenced above. I understand that my refusal to allow such disclosure does not affect my application for or participation in WIC or my eligibility for WIC services.

___ In applying for WIC services, I **DO NOT AUTHORIZE** DISCLOSURE of my WIC applicant or participant information for the purposes referenced above. I understand that my refusal to allow such disclosure does not affect my application for or participation in WIC or my eligibility for WIC services.

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