GEORGIA DEPARTMENT OF PUBLIC HEALTH / GEORGIA WIC

Nutrition Risk Criteria Handbook

FFY 2023

Effective September 2022

Georgia WIC Program
Office of Operations and Nutrition Services

GEORGIA DEPARTMENT OF PUBLIC HEALTH

This page was intentionally left blank.

FFY 2023 Risk Handbook Summary of Updates

Children: Orange

Page 88 – Risk 211 Elevated Blood Lead Level (Definition Change)

This page was intentionally left blank.

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

PRENATAL WOMEN

Data	Prenatal Women
Height	Required
Pre-Pregnancy Weight	Required
Current Weight	Required
Hematocrit or Hemoglobin	Required
Prenatal Weight Grid Plotted	Required
Evaluation of Inappropriate Nutrition Practices	Required
Risk Factor Assessment	Required

NUTRITION RISK CRITERIA
PREGNANT WOMEN

PREGNANT WOMEN			
CODE			PRIORITY
201	LOW HEMOGLOBIN/HEMATOCRIT **1st Trimester (0-13 wks.):** Non-Smokers Smokers **2nd Trimester (14-26 wks.):** Non-Smokers Smokers **3rd Trimester (27-40 wks.):** Non-Smokers Smokers High Risk: Hemoglobin OR hematocrit at treatment level (Appendix A-1)	Hemoglobin < 11.0 g/dl < 11.3 g/dl < 10.5 g/dl < 10.8 g/dl < 11.0 g/dl < 11.3 g/dl	Hematocrit < 33.0% < 34.0% < 32.0% < 33.0% < 33.0 % < 34.0%	I
101	UNDERWEIGHT Pre-pregnancy weight is equal to a Body Mass Index (BMI) of <18.5. Refer to Appendix B-1. High Risk: Pre-pregnancy BMI <18.5.			I
111	OVERWEIGHT Pre-pregnancy weight is equal to a Body Mass Index (BMI) of ≥25. Refer to Appendix B-1. High Risk: Pre-pregnancy BMI >29.9.			I
131	LOW MATERNAL WEIGHT GAIN Low weight gain at any point in pregnancy, such that a pregnant women's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective pre-pregnancy weight category. Refer to Appendix B-2. High Risk: Low Maternal Weight Gain.			I

PREGNANT WOMEN		
CODE		PRIORITY
133	HIGH MATERNAL WEIGHT GAIN High maternal weight gain at any point in pregnancy, such that a pregnant women's weight plots at any point above the top line of the appropriate weight gain range for her respective pre-pregnancy weight category.	I
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of $\geq$ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. High Risk: Blood lead level of $\geq$ 5 μg/deciliter within the past 12 months.	I
301	HYPEREMESIS GRAVIDARUM Severe and persistent nausea and vomiting during pregnancy which may cause more than 5% weight loss and fluid and electrolyte imbalances. This nutrition risk is based on a chronic condition, not single episodes. Hyperemesis Gravidarum is a clinical diagnosis, made after other causes of nausea and vomiting have been excluded. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hyperemesis gravidarum.	I

PREGNANT WOMEN		
CODE		PRIORITY
302	GESTATIONAL DIABETES Gestational diabetes mellitus (GDM) is defined as any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gestational diabetes.	I
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	I
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders. Document: Diagnosis and name of the physician that treated this condition in the participant's health record.	I
311	HISTORY OF PRETERM OR EARLY TERM DELIVERY **Preterm**: Any history of an infant born at < 37 weeks gestation Document: Delivery date(s) and weeks gestation in participant's health record.	I
	Early Term: Any history of an infant born ≥ 37 weeks and < 39 weeks gestation. Document: Delivery date(s) and weeks gestation in participant's health record.	

<table>
<tr><th colspan="3">PREGNANT WOMEN</th></tr>
<tr><th>CODE</th><th></th><th>PRIORITY</th></tr>
<tr><td>312</td><td>HISTORY OF LOW BIRTH WEIGHT INFANT(S)

Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb. 8 oz. (2500 g).

Document: Weight(s) and birth date(s) in the participant’s health record.</td><td>I</td></tr>
<tr><td>321</td><td>HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS

Any history of fetal or neonatal death or two (2) or more spontaneous abortions. This does not include elective abortions.

<table><tr><th>Term</th><th>Definition</th></tr><tr><td>Spontaneous Abortion (SAB)</td><td>The spontaneous termination of a gestation at < 20 weeks or of a fetus weighing < 500 grams.</td></tr><tr><td>Fetal Death</td><td>The spontaneous termination of a gestation at ≥ 20 weeks.</td></tr><tr><td>Neonatal Death</td><td>The death of an infant within 0-28 days of life.</td></tr></table>
Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician’s orders, or as self-reported by applicant/participant/caregiver.

Document: Date(s) of spontaneous abortions, fetal/neonatal death(s) in the participant’s health record; weeks gestation for spontaneous abortions, weeks gestation for fetal death(s); age, at death, of neonate(s).</td><td>I</td></tr>
<tr><td>331</td><td>PREGNANCY AT A YOUNG AGE

For current pregnancy, conception at less than or equal to 20 years of age.

Document: Age at conception in the participant’s health record.</td><td>I</td></tr>
<tr><td>332</td><td>SHORT INTERPREGNANCY INTERVAL

For current pregnancy, the participant’s EDC is less than 25 months after the live birth of the last pregnancy.

Document: Delivery date of last birth and EDC in the participant’s health record.</td><td>I</td></tr>
</table>

PREGNANT WOMEN		
CODE		PRIORITY
334	LACK OF, OR INADEQUATE PRENATAL CARE Prenatal care beginning after the 1st trimester (0-13 weeks) Document: Weeks gestation, in participant's health record, when prenatal care began. A pregnancy test is not prenatal care.	I
335	MULTI-FETAL GESTATION More than one (>1) fetus in a current pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Multi-fetal gestation.	I
336	FETAL GROWTH RESTRICTION Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation (IUGR), may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight <10th percentile for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Fetal Growth Restriction (FGR) must be diagnosed by a physician or a health professional acting under standing orders of a physician. Document: Diagnosis in participant's health record. High Risk: Fetal Growth Restriction.	I

PREGNANT WOMEN		
CODE		PRIORITY
337	HISTORY OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT Any history of giving birth to an infant weighing greater than or equal to 9lbs. (4000 grams). Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Birth weight(s) in the participant's health record.	I
338	PREGNANT WOMAN CURRENTLY BREASTFEEDING Pregnant woman who is currently breastfeeding. Note: Refer to or provide appropriate breastfeeding counseling, especially if at risk for not meeting her own nutrient needs, for a decrease in milk supply, or for premature labor.	I
339	HISTORY OF BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A prenatal woman with any history of giving birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect), excess vitamin A (cleft palate or lip). Document: Infant(s) congenital and/or birth defect(s) in participant's health record.	I

PREGNANT WOMEN	
CODE	PRIORITY
NUTRITION RELATED MEDICAL CONDITIONS 341 NUTRIENT DEFICIENCY OR DISEASE Any currently treated or untreated nutrient deficiency or disease. These include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Xerophthalmia, and Iron Deficiency. (See Appendix C) Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed nutrient deficiency disease.	I
342 GASTRO-INTESTINAL DISORDERS: Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as 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. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gastro-intestinal disorder.	I

PREGNANT WOMEN		
CODE		PRIORITY
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed diabetes mellitus.	I
344	THYROID DISORDERS Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hypothyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed thyroid disorder.	I
345	HYPERTENSION AND PREHYPERTENSION Hypertension is defined as high blood pressure which may eventually cause health problems and includes chronic hypertension during pregnancy, preeclampsia, eclampsia, chronic hypertension with superimposed preeclampsia, and gestational hypertension. Prehypertension is defined as being at high risk for developing hypertension, based on blood pressure levels. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypertension.	I

PREGNANT WOMEN		
CODE		PRIORITY
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but EXCLUDING urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self-reported by applicant/ participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed renal disease.	I
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Description of how the condition or treatment affects nutritional status and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed cancer.	I
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed central nervous system disorder.	I

PREGNANT WOMEN		
CODE		PRIORITY
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed genetic/congenital disorder.	I
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed inborn error of metabolism.	I

PREGNANT WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months and diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record.	I
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Presence of a chronic infectious disease must be diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record. High Risk: Diagnosed chronic infectious disease, as described above.	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed food allergy.	I

PREGNANT WOMEN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed Celiac Disease.	I
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	I
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypoglycemia.	I

PREGNANT WOMEN		
CODE		PRIORITY
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to an extent that nutritional status is compromised. Document: Drug/medication being used and respective nutrient interaction in the participant's health record. High Risk: Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	I
358	EATING DISORDERS Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: • Self-induced vomiting • Purgative abuse • Alternating periods of starvation • Use of drugs such as appetite suppressants, thyroid preparations or diuretics • Self-induced marked weight loss Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Symptoms or diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed eating disorder.	I

PREGNANT WOMEN		
CODE		PRIORITY
359	RECENT MAJOR SURGERY, TRAUMA OR BURNS Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. 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 provider working under the orders of a physician. Document: If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. High Risk: Major surgery, trauma or burns that has a continued need for nutritional support.	I
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, MUST be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, moderate, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed medical condition severe enough to compromise nutritional status.	I
361	DEPRESSION 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. Document: Diagnosis and name of physician, clinical psychologist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I

PREGNANT WOMEN		
CODE		PRIORITY
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. Document: Specific condition/ description of delays and how these interfere with the ability to eat and the name of the physician that is treating this condition. High Risk: Developmental, sensory or motor delay interfering with ability to eat.	I
371	NICOTINE AND TOBACCO USE Any use of products that contain nicotine and/or tobacco to include but not limited to cigarettes, pipes, cigars, electronic nicotine delivery systems (e-cigarettes, vaping devices), hookahs, smokeless tobacco (chewing tobacco, snuff, dissolvables), or nicotine replacement therapies (gums, patches). Document: Type and frequency of use of nicotine and/or tobacco products, on WIC Assessment/Certification Form (ex. Document daily/weekly use of # cigarettes, # puffs or cartridges of e-cigarette, # of patches, # of pinches of smokeless tobacco).	I
372	ALCOHOL AND SUBSTANCE USE • Any alcohol use • Any illegal substance use and/or abuse of prescription medications • Any marijuana use in any form Document: Enter the use of alcohol, illegal substance/ abuse of prescription medications and/or marijuana use on the WIC Assessment/Certification Form.	I

PREGNANT WOMEN	
CODE	PRIORITY
381 ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I
382 FETAL ALCOHOL SPECTRUM DISORDERS Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase that encompasses a range of possible diagnoses, including fetal alcohol syndrome (FAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopment disorder (ARNDD), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE). Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis in the participant's health record.	I
400 INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E) Document: Inappropriate Nutrition Practice(s) in the participant's health record.	IV
401 FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the Dietary Guidelines for Americans. (This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)	IV

PREGNANT WOMEN		
CODE		PRIORITY
502	TRANSFER OF CERTIFICATION Person with a valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid through the end of the current certification period, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or the certification period extends beyond the receiving agency's certification period for that category, and shall be accepted as proof of eligibility for Program benefits. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by the receiving State agency.	I
602	BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS A breastfeeding woman with any of the following complications or potential complications for breastfeeding. a) severe breast engorgement b) recurrent plugged ducts c) mastitis d) flat or inverted nipples e) cracked, bleeding or severely sore nipples f) age $\geq$ 40 years Document: Complications or potential complications in the participant's health record. High Risk: Refer to or provide the mother with appropriate breastfeeding counseling.	I
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedure Manual.	IV
802	MIGRANCY Migrancy as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	IV

PREGNANT WOMEN		
CODE		PRIORITY
901	RECIPIENT OF ABUSE Battering (abuse) 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. Battering refers to violent assaults on women.	IV
902	PRENATAL WOMAN WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples include, but are not limited to: • Documentation or self-report of misuse of alcohol, use of illegal substances, use of marijuana or misuse of prescription medications. • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant. • Intellectual disability diagnosed, documented, or reported by a physician of psychologist of someone working under a physician's orders, or as self-reported by the participant. • Physical disability to a degree which limits food preparation abilities. • ≤ 17 years of age. Document: The woman's specific limited abilities in the participant's health record.	IV
903	FOSTER CARE Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	IV
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as secondhand, passive, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems. Document: Type and location of Environmental Tobacco Smoke (ETS) Exposure in the participant's health record.	I

This page was intentionally left blank.

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

BREASTFEEDING WOMEN

Data	Breastfeeding and Non-Breastfeeding Woman Certified in Hospital Prior to Initial Discharge	Woman Certified in Clinic	Breastfeeding Woman Certified in Clinic ≥6 Months Postpartum
Height	Pre-pregnancy height from health record; self-reported if not available from record	Required	Required
Pre-Pregnancy Weight	Pre-pregnancy weight from health record; self-reported if not available from record	Required	Required
Current Weight	If available	Required	Required
Last Weight Before Delivery	Required	Required	Required
Hemoglobin or Hematocrit	Required (Apply 90-day rule when not available)	Required	Optional
Evaluation of Inappropriate Nutrition Practices	Required	Required	Required
Risk Factor Assessment	Required	Required	Required

NUTRITION RISK CRITERIA
BREASTFEEDING WOMEN

BREASTFEEDING WOMEN				
CODE				PRIORITY
201	LOW HEMOGLOBIN/HEMATOCRIT			I
		Hemoglobin	Hematocrit	
	12 to 15 years of Age:			
	Non-Smokers	< 11.8 g/dl	< 35.7%	
	Smokers	< 12.1 g/dl	< 36.7%	
	15 years of Age and Older:			
	Non-Smokers	< 12.0 g/dl	< 35.7%	
	Smokers	< 12.3 g/dl	< 36.7%	
	High Risk: Hemoglobin OR hematocrit at treatment level (Appendix A-1).			
101	UNDERWEIGHT			I
	< 6 months Postpartum: Pre-pregnancy or current weight is equal to a Body Mass Index (BMI) of <18.5. Refer to BMI Table, Appendix C-1.			
	≥ 6 months Postpartum: Current weight is equal to a Body Mass Index (BMI) of <18.5. Refer to Appendix B-1.			
	High Risk: Current BMI <18.5.			
111	OVERWEIGHT			I
	<6 months Postpartum: Pre-pregnancy weight is equal to a Body Mass Index (BMI) of ≥25. Refer to BMI Table, Appendix C-1.			
	≥ 6 months postpartum: Current weight is equal to a Body Mass Index (BMI) of ≥25. Refer to Appendix B-1.			
	High Risk: Current BMI >29.9.			

BREASTFEEDING WOMEN		
CODE		PRIORITY
133	HIGH MATERNAL WEIGHT GAIN Breastfeeding (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the recommended range based on Body Mass Index (BMI), as follows: Prepregnancy Weight Group / Definition (BMI) / Cut-off Value (Singleton) / Cut-off Value (Multi-Fetal) Underweight: < 18.5; >40 lbs.; * Normal Weight: 18.5 to 24.9; >35 lbs.; >54 lbs. Overweight: 25.0 to 29.9; >25 lbs.; >50 lbs. Obese: ≥ 30.0; >20 lbs.; >42 lbs. *There are no provisional guidelines for underweight woman with multiple fetuses. (Appendix B-2) Document: Pre-gravid weight and last weight before delivery.	I
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	I
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	I
311	HISTORY OF PRETERM OR EARLY TERM DELIVERY **Preterm**: Delivery of an infant at < 37 weeks gestation. Applies to most recent pregnancy only. Document: Delivery date and weeks gestation in participant's health record	I
	Early Term: Delivery of an infant at ≥ 37 weeks and < 39 weeks gestation. Applies to most recent pregnancy only. Document: Delivery date and weeks gestation in participant's health record.	
312	DELIVERY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb. 8 oz. (2500 g). Applies to most recent pregnancy only. Document: Weight(s) and birth date in the participant's health record.	I
321	HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS Most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living. This does not include elective abortions. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant caregiver. Document: Date(s) of spontaneous abortion(s) or fetal/neonatal death(s) in the participant's health record; weeks gestation for spontaneous abortion; weeks gestation for fetal death(s); age, at death, of neonate(s).	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
331	PREGNANCY AT A YOUNG AGE For most recent pregnancy, conception at less than or equal to 20 years of age. Document: Age at conception on the WIC Assessment/Certification Form.	I
332	SHORT INTERPREGNANCY INTERVAL Delivery date for most recent pregnancy occurred less than 25 months after the live birth of the previous pregnancy. Document: Delivery dates of last two pregnancies in the participant's health record.	I
335	MULTI FETAL GESTATION More than one (>1) fetus in the most recent pregnancy. High Risk: Multi-fetal gestation.	I
337	HISTORY OF A LARGE FOR GESTATIONAL AGE INFANT Most recent pregnancy, or history of giving birth to an infant with a birth weight of 9 pounds or more. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Birth weight(s) and date(s) of deliveries in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
339	BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A woman who gives birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect), excess vitamin A (cleft palate or lip). Applies to most recent pregnancy only. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Infant(s) congenital and/or birth defect(s) in participant's health record.	I
NUTRITION RELATED MEDICAL CONDITIONS		I
341	NUTRIENT DEFICIENCY OR DISEASE Any currently treated or untreated nutrient deficiency or disease. These include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Xerophthalmia, and Iron Deficiency. (See Appendix C) Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed nutrient deficiency disease.	

BREASTFEEDING WOMEN		
CODE		PRIORITY
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as 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. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gastro-intestinal disorder.	I
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed diabetes mellitus.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
344	THYROID DISORDERS Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hypothyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. • Postpartum Thyroiditis: Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed thyroid disorder.	I
345	HYPERTENSION AND PREHYPERTENSION Hypertension is defined as high blood pressure which may eventually cause health problems and includes chronic hypertension during pregnancy, preeclampsia, eclampsia, chronic hypertension with superimposed preeclampsia, and gestational hypertension. Prehypertension is defined as being at high risk for developing hypertension, based on blood pressure levels. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypertension.	I
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but EXCLUDING urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self-reported by applicant/ participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed renal disease.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Description of how the condition or treatment affects nutritional status and the name of the physician that is treating the condition in the participant's health record. High Risk: Diagnosed cancer.	I
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed central nervous system disorder.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed genetic/congenital disorder.	I
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed inborn error of metabolism.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months and diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record.	I
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Presence of a chronic infectious disease must be diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record. High Risk: Diagnosed chronic infectious disease, as described above.	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed food allergy.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed Celiac Disease.	I
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypoglycemia.	I
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to an extent that nutritional status is compromised. Document: Drug/medication being used and respective nutrient interaction in the participant's health record. High Risk: Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
358	EATING DISORDERS Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: • Self-induced vomiting • Purgative abuse • Alternating periods of starvation • Use of drugs such as appetite suppressants, thyroid preparations or diuretics • Self-induced marked weight loss Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Symptoms or diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed eating disorder.	I
359	RECENT MAJOR SURGERY, TRAUMA OR BURNS Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. 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 professional acting under the standing orders of a physician. Document: If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. High Risk: Major surgery, trauma or burns that has a continued need for nutritional support.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, MUST be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed medical condition severe enough to compromise nutritional status.	I
361	DEPRESSION 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. Document: Diagnosis and name of physician, clinical psychologist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. Document: Specific condition/description of the delay and how it interferes with the ability to eat and the name of the physician that is treating this condition in the participant's health record. High Risk: Developmental, sensory or motor delay interfering with ability to eat.	I
363	PRE-DIABETES Presence of pre-diabetes diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed pre-diabetes.	I
371	NICOTINE AND TOBACCO USE Any use of products that contain nicotine and/or tobacco to include but not limited to cigarettes, pipes, cigars, electronic nicotine delivery systems (e-cigarettes, vaping devices), hookahs, smokeless tobacco (chewing tobacco, snuff, dissolvables), or nicotine replacement therapies (gums, patches). Document: Type and frequency of use of nicotine and/or tobacco products, on WIC Assessment/Certification Form (ex. Document daily/weekly use of # cigarettes, # puffs or cartridges of e-cigarette, # of patches, # of pinches of smokeless tobacco).	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
372	ALCOHOL AND SUBSTANCE USE Alcohol use: • High Risk Drinking: Routine consumption of ≥8 drinks per week or ≥ 4 drinks on any day • Binge drinking: Routine consumption of ≥4 drinks within 2 hours Note: A serving or standard sized drink is: - 12 oz. beer - 5 oz. wine - 1 ½ fluid oz. 80 proof distilled spirits (e.g., gin, rum vodka, whiskey, cordials or liqueurs) Any illegal substance use and/or abuse of prescription medications. Any marijuana use in any form. Document: Alcohol Use (High Risk Drinking or Binge Drinking); Illegal substance and/or abuse of prescription medication and/or Marijuana use on WIC Assessment/Certification Form. See Appendix D for documentation codes.	I
381	ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I
382	FETAL ALCOHOL SPECTRUM DISORDERS Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase that encompasses a range of possible diagnoses, including fetal alcohol syndrome (FAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopment disorder (ARNDD), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE). Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E) Document: Inappropriate Nutrition Practice(s) in the participant's health record.	IV
401	FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. (This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)	IV
502	TRANSFER OF CERTIFICATION Person with a valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid through the end of the current certification period, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or the certification period extends beyond the receiving agency's certification period for that category, and shall be accepted as proof of eligibility for Program benefits. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by the receiving State agency.	I
601	BREASTFEEDING MOTHER OF AN INFANT AT NUTRITIONAL RISK A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk. Document: Infant's risks on mother's WIC Assessment/Certification Form.	I, II, IV

BREASTFEEDING WOMEN		
CODE		PRIORITY
602	BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS A breastfeeding woman with any of the following complications or potential complications for breastfeeding. a) severe breast engorgement b) recurrent plugged ducts c) mastitis d) flat or inverted nipples e) cracked, bleeding or severely sore nipples f) age $\geq$ 40 years g) failure of milk to come in by 4 days postpartum h) tandem nursing (nursing two siblings who are not twins) Document: Complications or potential complications in the participant's health record. High Risk: Refer to or provide the mother with appropriate breastfeeding counseling.	I
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	IV
802	MIGRANCY Migrancy as defined in the Special Population Section of the Georgia WIC Program Procedures Manual.	IV
901	RECIPIENT OF ABUSE Battering 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. Battering refers to violent assaults on women.	IV

BREASTFEEDING WOMEN		
CODE		PRIORITY
902	BREASTFEEDING WOMAN WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples include, but are not limited to: • Documentation or self-report of misuse of alcohol, use of illegal substances, use of marijuana or misuse of prescription medications. • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant. • Intellectual disability diagnosed, documented, or reported by a physician of psychologist of someone working under a physician's orders, or as self-reported by the participant. • Physical disability to a degree which limits food preparation abilities. • ≤ 17 years of age Document: The women's specific limited abilities in the participant's health record.	IV
903	FOSTER CARE Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	IV
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as secondhand, passive, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems. Document: Type and location of Environmental Tobacco Smoke (ETS) Exposure in the participant's health record.	I

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

POSTPARTUM NON-BREASTFEEDING WOMEN

Data	Woman Certified in Hospital Prior to Initial Discharge	Woman Certified in Clinic
Height	Pre-pregnancy height from health record; self-reported if not available from record	Required
Pre-Pregnancy Weight	Pre-pregnancy weight from health record; self-reported if not available from record	Required
Current Weight	If available	Required
Last Weight Before Delivery	Required	Required
Hemoglobin or Hematocrit	Required (Apply 90-day rule when not available)	Required
Evaluation of Inappropriate Nutrition Practices	Required	Required
Risk Factor Assessment	Required	Required

NUTRITION RISK CRITERIA
POSTPARTUM, NON- BREASTFEEDING WOMEN

POSTPARTUM NON-BREASTFEEDING WOMEN				
CODE				PRIORITY
201	LOW HEMOGLOBIN/HEMATOCRIT **12 to 15 years of Age:** Non-Smokers Smokers **15 years of Age and Older:** Non-Smokers Smokers High Risk: Hemoglobin OR hematocrit at treatment level (Appendix A-1)	<u>Hemoglobin</u> < 11.8 g/dl < 12.1 g/dl < 12.0 g/dl < 12.3 g/dl	<u>Hematocrit</u> < 35.7% < 36.7% < 35.7% < 36.7%	VI
101	UNDERWEIGHT Pre-pregnancy or current weight is equal to a Body Mass Index (BMI) of <18.5. Refer to Appendix B-1. High Risk: Pre-pregnancy or current BMI <18.5.			VI
111	OVERWEIGHT Pre-pregnancy weight is equal to a Body Mass Index (BMI) of <u>≥</u>25. Refer to Appendix B-1. High Risk: Pre-pregnancy BMI >29.9.			VI

POSTPARTUM NON-BREASTFEEDING WOMEN	
CODE	PRIORITY
133 HIGH MATERNAL WEIGHT GAIN Non-Breastfeeding (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the recommended range based on Body Mass Index (BMI), as follows: Prepregnancy Weight Group / Definition (BMI) / Cut-off Value (Singleton) / Cut-off Value (Multi-Fetal) Underweight / < 18.5 / >40 lbs. / * Normal Weight / 18.5 to 24.9 / >35 lbs. / >54 lbs. Overweight / 25.0 to 29.9 / >25 lbs. / >50 lbs. Obese / ≥ 30.0 / >20 lbs. / >42 lbs. *There are no provisional guidelines for underweight woman with multiple fetuses. (Appendix B-2) Document: Pre-gravid weight and last weight before delivery.	VI
211 ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	VI
303 HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	VI

<table>
<tr><th colspan="3">POSTPARTUM NON-BREASTFEEDING WOMEN</th></tr>
<tr><th>CODE</th><th></th><th>PRIORITY</th></tr>
<tr><td>304</td><td>HISTORY OF PREECLAMPSIA

History of diagnosed preeclampsia

Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician’s orders for any pregnancy.

Document: Diagnosis and name of the physician that is treating this condition in the participant’s health record.</td><td>VI</td></tr>
<tr><td rowspan="2">311</td><td>HISTORY OF PRETERM OR EARLY TERM DELIVERY

Preterm: Delivery of an infant born at < 37 weeks gestation. Applies to most recent pregnancy only.

Document: Delivery date and weeks gestation in participant’s health record.</td><td rowspan="2">VI</td></tr>
<tr><td>Early Term: Delivery of an infant born at ≥ 37 weeks and < 39 weeks. Applies to most recent pregnancy only.

Document: Delivery date and weeks gestation in participant’s health record.</td></tr>
<tr><td>312</td><td>DELIVERY OF LOW BIRTH WEIGHT INFANT(S)

Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb. 8 oz. (2500 gms). Applies to most recent pregnancy only.
Document: Weight(s) and birth date in the participant’s health record.</td><td>VI</td></tr>
<tr><td>321</td><td>HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS

Spontaneous abortion, fetal or neonatal loss in most recent pregnancy. This does not include elective abortions.

<table><tr><th>Term</th><th>Definition</th></tr><tr><td>Spontaneous Abortion (SAB)</td><td>The spontaneous termination of a gestation at < 20 weeks or of a fetus weighing < 500 grams.</td></tr><tr><td>Fetal Death</td><td>The spontaneous termination of a gestation at ≥ 20 weeks.</td></tr><tr><td>Neonatal Death</td><td>The death of an infant within 0-28 days of life.</td></tr></table>
Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician’s orders, or as self-reported by applicant/participant caregiver.

Document: Date(s) of spontaneous abortion, fetal/neonatal death(s) in the participant’s health record; weeks gestation of spontaneous abortion; weeks gestation for fetal death(s); age, at death, of neonate(s).</td><td>VI</td></tr>
</table>

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
331	PREGNANCY AT A YOUNG AGE For most recent pregnancy, conception at less than or equal to 20 years of age. Document: Age at conception on the WIC Assessment/Certification Form.	III
332	SHORT INTERPREGNANCY INTERVAL Delivery date for most recent pregnancy occurred less than 25 months after the live birth of the previous pregnancy. Document: Delivery dates of last two pregnancies in the participant's health record.	VI
335	MULTI FETAL GESTATION More than one (>1) fetus in the most recent pregnancy. High Risk: Multi-fetal gestation.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		Priority
337	HISTORY OF A LARGE FOR GESTATIONAL AGE INFANT Most recent pregnancy, or history of giving birth to an infant with a birth weight of 9 pounds or more. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Birth weight(s) and date(s) of deliveries in the participant's health record.	VI
339	BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A woman who gives birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect), excess vitamin A (cleft palate or lip). Applies to most recent pregnancy only. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Infant(s) congenital and/or birth defect(s) in the participant's health record.	VI
NUTRITION RELATED MEDICAL CONDITIONS		VI
341	NUTRIENT DEFICIENCY OR DISEASE Any currently treated or untreated nutrient deficiency or disease. These include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Xerophthalmia, and Iron Deficiency. (See Appendix C) Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed nutrient deficiency disease.	

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as 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. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gastro-intestinal disorder.	VI
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed diabetes mellitus.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
344	THYROID DISORDERS Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hypothyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. • Postpartum Thyroiditis: Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed thyroid disorder.	VI
345	HYPERTENSION AND PREHYPERTENSION Hypertension is defined as high blood pressure which may eventually cause health problems and includes chronic hypertension during pregnancy, preeclampsia, eclampsia, chronic hypertension with superimposed preeclampsia, and gestational hypertension. Prehypertension is defined as being at high risk for developing hypertension, based on blood pressure levels. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypertension.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but EXCLUDING urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed renal disease.	VI
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Description of how the condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed cancer.	VI
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of central nervous system disorder(s) diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed central nervous system disorder.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed genetic/congenital disorder.	VI
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethionninemia. Presence of inborn errors of metabolism diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed inborn error of metabolism.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months and diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record.	VI
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Presence of a chronic infectious disease must be diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record. High Risk: Diagnosed chronic infectious disease, as described above.	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition. High Risk: Diagnosed food allergy.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition. High Risk: Diagnosed Celiac Disease.	VI
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypoglycemia.	VI
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to an extent that nutritional status is compromised. Document: Drug/medication being used and respective nutrient interaction in the participant's health record. High Risk: Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	VI
358	EATING DISORDERS Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: • Self-induced vomiting • Purgative abuse • Alternating periods of starvation • Use of drugs such as appetite suppressants, thyroid preparations or diuretics • Self-induced marked weight loss Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Symptoms or diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed eating disorder.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
359	RECENT MAJOR SURGERY, TRAUMA OR BURNS Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. 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 provider working under the standing orders of a physician. Document: If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. High Risk: Major surgery, trauma or burns that has a continued need for nutritional support.	VI
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, MUST be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed medical condition severe enough to compromise nutritional status.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
361	DEPRESSION 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. Document: Diagnosis and name of physician, clinical psychologist or someone working under a doctor's orders that is treating this condition in the participant's health record.	VI
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, and other disabilities. Document: Specific condition/ description of delays and how these interfere with the ability to eat and the name of the physician that is treating this condition. High Risk: Developmental, sensory or motor delay interfering with ability to eat.	VI
363	PRE-DIABETES Presence of pre-diabetes diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed pre-diabetes.	VI
371	NICOTINE AND TOBACCO USE Any use of products that contain nicotine and/or tobacco to include but not limited to cigarettes, pipes, cigars, electronic nicotine delivery systems (e-cigarettes, vaping devices), hookahs, smokeless tobacco (chewing tobacco, snuff, dissolvables), or nicotine replacement therapies (gums, patches). Document: Type and frequency of use of nicotine and/or tobacco products, on WIC Assessment/Certification Form (ex. Document daily/weekly use of # cigarettes, # puffs or cartridges of e-cigarette, # of patches, # of pinches of smokeless tobacco).	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
372	ALCOHOL AND SUBSTANCE USE Alcohol use: • High Risk Drinking: Routine consumption of ≥8 drinks per week or ≥ 4 drinks on any day • Binge drinking: Routine consumption of ≥4 drinks within 2 hours Note: A serving or standard sized drink is: - 12 oz. beer - 5 oz. wine - 1 ½ fluid oz. 80 proof distilled spirits (e.g., gin, rum vodka, whiskey, cordials or liqueurs) Any illegal substance use and/or abuse of prescription medications Any marijuana use in any form Document: Alcohol Use (High Risk Drinking or Binge Drinking); Illegal substance and/or abuse of prescription medication and/or Marijuana use on WIC Assessment/Certification Form. See Appendix D for documentation codes.	VI
381	ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	VI
382	FETAL ALCOHOL SPECTRUM DISORDERS Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase that encompasses a range of possible diagnoses, including fetal alcohol syndrome (FAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopment disorder (ARNDD), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE). Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis in the participant's health record.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E) Document: Inappropriate Nutrition Practice(s) in the participant's health record.	VI
401	FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. (This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)	VI
502	TRANSFER OF CERTIFICATION Person with a valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid through the end of the current certification period, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or the certification period extends beyond the receiving agency's certification period for that category, and shall be accepted as proof of eligibility for Program benefits. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by the receiving State agency.	III
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	VI
802	MIGRANCY Migrancy as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
901	RECIPIENT OF ABUSE Battering 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. Battering refers to violent assaults on women.	VI
902	POSTPARTUM, NON-BREASTFEEDING WOMAN WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples include, but are not limited to: • Documentation or self-report of misuse of alcohol, use of illegal substances, use of marijuana or misuse of prescription medications. • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant. • Intellectual disability diagnosed, documented, or reported by a physician of psychologist of someone working under a physician's orders, or as self-reported by the participant. • Physical disability to a degree which limits food preparation abilities. • ≤ 17 years of age. Document: The women's specific limited abilities in the participant's health record.	IV
903	FOSTER CARE Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	IV
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as secondhand, passive, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems. Document: Type and location of Environmental Tobacco Smoke (ETS) Exposure in the participant's health record.	VI

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

INFANTS

Data	Documentation		
	Infant Certified in Hospital Prior to Initial Discharge	Infant 0-6 Months	Infant 6-12 Months
Length	Birth Data or other measurement	Required	Required
Weight	Birth Data or other measurement	Required	Required
Hematocrit or Hemoglobin	N/A	Optional	Required (9-12 months)
Weight for Age Plotted	Optional	Required	Required
Length for Age Plotted	Optional	Required	Required
Weight for Length Plotted	Optional	Required	Required
Evaluation of Inappropriate Nutrition Practices	Optional	Required	Required
Risk Factor Assessment	Required	Required	Required

NUTRITION RISK CRITERIA
INFANTS

INFANTS		
CODE		PRIORITY
201	LOW HEMOGLOBIN/HEMATOCRIT **6-11 month old:** Hemoglobin <11.0g/dl Hematocrit < 33.0% High Risk: Hemoglobin OR Hematocrit at treatment level (Appendix A-2)	I
103	UNDERWEIGHT or AT RISK OF UNDERWEIGHT Less than or equal to the 5th percentile weight-for-length as plotted on the CDC Birth to 24 months gender specific growth charts.* High Risk: Less than or equal to the 2nd percentile weight-for-length when manually plotted on the CDC Birth to 24 months gender specific growth charts.* Less than or equal to the 2.3rd percentile weight-for-length when electronically plotted on the CDC Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standards. For the Birth to < 24 months "underweight" definition, CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	I
115	HIGH WEIGHT- FOR-LENGTH Greater than or equal to the 98th percentile weight-for-length when manually plotted on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts.* Greater than or equal to the 97.7th percentile weight-for-length when plotted electronically on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts.* **Based on the 2006 World Health Organization (WHO) international growth standards. CDC labels the 97.7th percentile as the 98th percentile on the Birth to 24 months gender specific growth charts.*	I

INFANTS		
CODE		PRIORITY
121	SHORT STATURE OR AT RISK OF SHORT STATURE Less than or equal to the 5th percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts.* (if < 38 weeks gestation use adjusted age) High Risk: Less than or equal to the 2nd percentile length-for-age when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* Less than or equal to the 2.3rd percentile length-for-age when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standard. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	I
134	FAILURE TO THRIVE Presence of failure to thrive diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed failure to thrive.	I

INFANTS

CODE		PRIORITY
135	SLOWED/FALTERING GROWTH PATTERN (Infants ≤ 2 weeks of Age) Infants birth to 2 weeks of age with weight loss after birth of ≥ 7% birth weight.	I

Assign Risk When Birth Weight Is :	**And Weight Loss Is ≥ :**
4 lbs. 0 oz. – 4 lbs. 15 oz.	5 oz.
5 lbs. 0 oz. – 5 lbs. 12 oz.	6 oz.
5 lbs. 13 oz.– 6 lbs. 10 oz.	7 oz.
6 lbs. 11 oz. – 7 lbs. 8 oz.	8 oz.
7 lbs. 9 oz. – 8 lbs. 6 oz.	9 oz.
8 lbs. 7 oz. – 9 lbs. 5 oz.	10 oz.
9 lbs. 6 oz. – 10 lbs. 3 oz.	11 oz.
10 lbs. 4 oz. – 11 lbs. 2 oz.	12 oz.

SLOWED/FALTERING GROWTH PATTERN
(Infants 2 weeks of Age to 6 months of Age)

Infants 2 weeks of age to 6 months of age with any weight loss. Use two separate weight measurements taken at least eight weeks apart.

High Risk: Slowed/Faltering Growth Pattern.

141	LOW BIRTH WEIGHT Birth weight ≤ 5 lbs. 8 oz. (≤ 2500 g). Document: Birth weight in participant's health record. High Risk: Birth weight ≤ 5 lbs. 8 oz. (≤ 2500 g).	I

INFANTS		
CODE		PRIORITY
142	PRETERM OR EARLY TERM DELIVERY **Preterm**: Delivery of an infant born at < 37 weeks gestation. Document: Weeks gestation in participant's health record.	I
	Early Term: Delivery of an infant born ≥ 37 weeks and < 39 weeks gestation. Document: Weeks gestation in participant's health record.	
151	SMALL FOR GESTATIONAL AGE Infants diagnosed as small for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.	I
152	LOW HEAD CIRCUMFERENCE Less than 2nd percentile head circumference-for-age when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts* (if < 38 weeks gestation use adjusted age) Less than 2.3rd percentile head circumference-for-age when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts* (if < 38 weeks gestation use adjusted age). ** Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	I
153	LARGE FOR GESTATIONAL AGE Birth weight ≥ 9 lbs. or presence of large for gestational age diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or health care professional working under standing orders of a physician. Document: Weight(s) of infant in participant's health record.	I

INFANTS	
CODE	PRIORITY
211 ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in participant's health record. Must be within the past 12 months High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	I
NUTRITION RELATED MEDICAL CONDITIONS 341 NUTRIENT DEFICIENCY OR DISEASE Any currently treated or untreated nutrient deficiency or disease. These include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Xerophthalmia, and Iron Deficiency. (See Appendix C) Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed nutrient deficiency disease.	I

INFANTS		
CODE		PRIORITY
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as 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. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gastro-intestinal disorder.	I
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed diabetes mellitus.	I

INFANTS		
CODE		PRIORITY
344	THYROID DISORDERS Thyroid dysfunctions that occur in fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Congenital Hyperthyroidism: Excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation). • Congenital Hypothyroidism: Infants born with an under active thyroid gland and presumed to have had hypothyroidism in-utero. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed thyroid disorder.	I
345	HYPERTENSION AND PREHYPERTENSION Hypertension is defined as high blood pressure which may eventually cause health problems and includes chronic hypertension during pregnancy, preeclampsia, eclampsia, chronic hypertension with superimposed preeclampsia, and gestational hypertension. Prehypertension is defined as being at high risk for developing hypertension, based on blood pressure levels. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypertension.	I
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but EXCLUDING urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed renal disease.	I

INFANTS		
CODE		PRIORITY
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Description of how the condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed cancer.	I
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed central nervous system disorder.	I

INFANTS		
CODE		PRIORITY
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed genetic and congenital disorder.	I
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed inborn error of metabolism.	I

INFANTS		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months and diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record.	I
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Presence of a chronic infectious disease must be diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record. High Risk: Diagnosed chronic infectious disease, as described above.	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed food allergy.	I

INFANTS		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed Celiac Disease.	I
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	I

INFANTS		
CODE		PRIORITY
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypoglycemia.	I
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to an extent that nutritional status is compromised. Document: Drug/medication being used and respective nutrient interaction in the participant's health record. High Risk: Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	I
359	RECENT MAJOR SURGERY, TRAUMA, BURNS Major surgery, trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self-reported, by caregiver. Any occurrence more than 2 months previous MUST have the continued need for nutritional support diagnosed by a physician or health professional acting under standing orders of a physician. Document: If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affect nutritional status and include date. High Risk: Major surgery, trauma or burns that has a continued need for nutritional support.	I

INFANTS		
CODE		PRIORITY
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, MUST be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed medical condition severe enough to compromise nutritional status.	I
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. Presence of developmental, sensory or motor delay diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Specific condition/ description of delays and how these interfere with the ability to eat and the name of the physician that is treating this condition. High Risk: Developmental, sensory or motor delay interfering with ability to eat.	I

INFANTS		
CODE		PRIORITY
381	ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I
382	FETAL ALCOHOL SPECTRUM DISORDERS Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase that encompasses a range of possible diagnoses, including fetal alcohol syndrome (FAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopment disorder (ARNDD), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE). Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of physician treating the condition in the participant's health record. High Risk: Diagnosed fetal alcohol syndrome.	I
383	NEONATAL ABSTINENCE SYNDROME (infants ≤ 6 months of age) Neonatal Abstinence Syndrome (NAS) is a drug withdrawal syndrome that occurs among drug-exposed infants as a result of the mother's use of drugs during pregnancy. This condition must be present within the first 6 months of birth and diagnosed by a physician as self-reported by caregiver, or as reported or documented by a physician or a health professional working under a physician's orders. Document: Diagnosis and name of physician treating the condition in the participant's health record. High Risk: Diagnosed neonatal abstinence syndrome.	I

INFANTS		
CODE		PRIORITY
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E). Document: Inappropriate Nutrition Practice(s) in the participant's health record.	IV
428	DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES (Infants 4 to 12 months) An infant ≥ 4 months of age who has begun to or is expected to begin to do any of the following practices is considered to be <u>at risk</u> of inappropriate complementary feeding: 1) consume complementary foods and beverages, or 2) eat independently, or 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.* (This risk factor may be assigned <u>only</u> when an infant <u>≥</u> 4 months of age does not qualify for risk 400 or for any other risk factor.)	IV
502	TRANSFER OF CERTIFICATION Person with a valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid through the end of the current certification period, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or the certification period extends beyond the receiving agency's certification period for that category, and shall be accepted as proof of eligibility for Program benefits. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by the receiving State agency.	I

INFANTS		
CODE		PRIORITY
603	BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS Any of the following are considered complications or potential complications of breastfeeding: • Breastfed infant with jaundice • Breastfed infant with weak or ineffective suck • Breastfed infant with difficulty latching onto mother's breast • Breastfed infant with inadequate stooling for age (as determined by a physician or other health care provider) • Breastfed infant who wets diaper less than 6 times per day Document: Complications or potential complications in the participant's health record. High Risk: Refer to or provide the infant's mother with appropriate breastfeeding counseling.	I
701	INFANT UP TO 6 MONTHS OLD OF WIC MOTHER, OR OF A WOMAN WHO WOULD HAVE BEEN ELIGIBLE DURING PREGNANCY • An infant under 6 months of age whose mother was a WIC Program participant during pregnancy, OR • An infant whose mother's medical records document that the woman was at nutritional risk during pregnancy because of detrimental or abnormal nutrition conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions.	II
702	BREASTFEEDING INFANT OF A WOMAN AT NUTRITIONAL RISK A breastfed infant whose breastfeeding mother has been determined to be at nutritional risk. Document: Mother's risks on infant's WIC Assessment/Certification Form.	I, II, IV

INFANTS		
CODE		PRIORITY
801	HOMELESSNESS Homelessness as defined in the Special Population Section of the Georgia WIC Procedures Manual.	IV
802	MIGRANCY Migrancy as defined in the Special Population Section of the Georgia WIC Procedures Manual.	IV
901	RECIPIENT OF ABUSE Child abuse/neglect within past 6 months as self-reported by the caregiver, 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. Child abuse/neglect refers to any recent act, or failure to act, resulting in: • Imminent risk or serious harm • Serious physical or emotional harm • Sexual abuse or exploitation of an infant or child by a parent or caretaker. Georgia State law requires that medical and child service organization personnel, having reasonable cause to suspect child abuse, report these suspicions to the authority designated by the health district/organization.	IV

INFANTS		
CODE		PRIORITY
902	INFANT OF PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD Infant whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples include, but are not limited to: • Documentation or self-report of misuse of alcohol, use of illegal substances, use of marijuana or misuse of prescription medications. • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant. • Intellectual disability diagnosed, documented, or reported by a physician of psychologist of someone working under a physician's orders, or as self-reported by the participant. • Physical disability to a degree which limits food preparation abilities. • ≤ 17 years of age. Document: The primary caregiver's specific limited abilities in the participant's health record.	IV
903	FOSTER CARE Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	IV
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as secondhand, passive, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems. Document: Type and location of Environmental Tobacco Smoke (ETS) Exposure in the participant's health record.	I

This page was intentionally left blank.

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

CHILDREN

Data	Certification	Half-Certification
Length or Height	Required	Required
Weight	Required	Required
Hemoglobin or Hematocrit	Required	***
Weight/Age Plotted	Required	Required
Length or Height/Age Plotted	Required	Required
Weight/Length or BMI for Age Plotted	Required	Required
Evaluation of Inappropriate Nutrition Practices	Required	Required
Risk Factor Assessment	Required	Required

***Required when hemoglobin was low at most recent certification and for children less than 2 years old

NUTRITION RISK CRITERIA
CHILDREN

CHILDREN		
CODE		PRIORITY
201	LOW HEMOGLOBIN/HEMATOCRIT **12-23 months of age:** Hemoglobin < 11.0g/dl Hematocrit < 32.9% **24 months-5 years of age:** Hemoglobin < 11.1g/dl Hematocrit < 33.0% High Risk: Hemoglobin OR Hematocrit at treatment level (Appendix A-2)	III
103	UNDERWEIGHT or AT RISK OF UNDERWEIGHT (Children 12-24 Months of Age) Less than or equal to the 5th percentile weight-for-length as plotted on the CDC 12 to 24 months gender specific growth charts.* High Risk: Less than or equal to the 2nd percentile weight-for-length when manually plotted on the CDC Birth to 24 months gender specific growth charts.* Less than or equal to the 2.3rd percentile weight-for-length when electronically plotted on the CDC Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standards. For the Birth to < 24 months "underweight" definition, CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	III
	UNDERWEIGHT or AT RISK OF UNDERWEIGHT (Children 2-5 Years of Age) Less than or equal to the 10th percentile Body Mass Index (BMI) for age based on Centers for Disease Control and Prevention (CDC) age/sex specific growth charts. High Risk: Less than or equal to the 5th percentile Body Mass Index (BMI)-for-age as plotted on the 2000 CDC age/gender specific growth charts.	

CHILDREN		
CODE		PRIORITY
113	OBESE (Children 2-5 Years of Age) Greater than or equal to 95th percentile Body Mass Index (BMI) or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts. High Risk: Greater than or equal to 95th percentile BMI or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts.	III
114	OVERWEIGHT (Children 2-5 Years of Age) Greater than or equal to 85th and less than 95th percentile Body Mass Index (BMI)-for-age or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts.* * The cut off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk.	III
115	HIGH WEIGHT-FOR-LENGTH (Children 12-24 Months of Age) Greater than or equal to the 98th percentile weight-for-length when manually plotted on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts.* Greater than or equal to the 97.7 percentile weight-for-length when electronically plotted on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts.* **Based on the 2006 World Health Organization (WHO) international growth standards. CDC labels the 97.7th percentile as the 98th percentile on the Birth to 24 months gender specific growth charts.*	III

CHILDREN		
CODE		PRIORITY
121	SHORT STATURE OR AT RISK OF SHORT STATURE (Children 12-24 Months of Age) Less than or equal to the 5th percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts.* (if < 38 weeks gestation use adjusted age) High Risk: Less than or equal to the 2nd percentile length-for-age when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* Less than or equal to the 2.3rd percentile length-for-age when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	III
	SHORT STATURE OR AT RISK OF SHORT STATURE (Children 2-5 Years of Age) Less than or equal to the 10th percentile length or height for age based on CDC age/sex specific growth charts. High Risk: Less than or equal to the 5th percentile stature-for-age as plotted on the 2000 CDC age/gender specific growth charts.	
134	FAILURE TO THRIVE Presence of failure to thrive diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed failure to thrive.	III

CHILDREN		
CODE		PRIORITY
141	LOW BIRTH WEIGHT (Children < 24 months of age) Birth weight ≤ 5 lbs. 8 oz. (≤ 2500 g) Document: Birth weight of participant in health record.	III
142	PRETERM OR EARLY TERM DELIVERY (Children < 24 months of age) **Preterm**: Delivery of an infant born at < 37 weeks gestation. Document: Weeks gestation in participant's health record.	III
	Early Term: Born at ≥ 37 weeks and < 39 weeks gestation. Document: Weeks gestation in participant's health record.	
151	SMALL FOR GESTATIONAL AGE (Children 12-24 Months of Age) Children less than 24 months of age diagnosed as small for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.	III

CHILDREN	
CODE	PRIORITY
152 LOW HEAD CIRCUMFERENCE (Children 12-24 Months of Age) Less than 2nd percentile head circumference-for-age as when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts. (if < 38 weeks gestation use adjusted age) Less than 2.3rd percentile head circumference-for-age as when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts. (if < 38 weeks gestation use adjusted age) ** Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	III
211 ELEVATED BLOOD LEAD LEVELS Blood lead level of $\geq$ 3.5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in participant's health record. Must be within the past 12 months. High Risk: Blood lead level of $\geq$ 3.5 μg/deciliter within the past 12 months.	III
NUTRITION RELATED MEDICAL CONDITIONS 341 NUTRIENT DEFICIENCY OR DISEASE Any currently treated or untreated nutrient deficiency or disease. These include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Xerophthalmia, and Iron Deficiency. (See Appendix C) Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed nutrient deficiency disease.	III

CHILDREN		
CODE		PRIORITY
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as 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. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gastro-intestinal disorder.	III
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed diabetes mellitus.	III

CHILDREN		
CODE		PRIORITY
344	THYROID DISORDERS Thyroid dysfunctions that occur in fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hypothyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed thyroid disorder.	III
345	HYPERTENSION AND PREHYPERTENSION Hypertension is defined as high blood pressure which may eventually cause health problems and includes chronic hypertension during pregnancy, preeclampsia, eclampsia, chronic hypertension with superimposed preeclampsia, and gestational hypertension. Prehypertension is defined as being at high risk for developing hypertension, based on blood pressure levels. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypertension.	III
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but EXCLUDING urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition participant's health record. High Risk: Diagnosed renal disease.	III

CHILDREN		
CODE		PRIORITY
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Description of how the condition or treatment affects nutritional status and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed cancer.	III
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed central nervous system disorder.	III

CHILDREN		
CODE		PRIORITY
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed genetic and congenital disorder.	III
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed inborn error of metabolism.	III

CHILDREN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months and diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record.	III
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Presence of a chronic infectious disease must be diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: "See Medical Record" in the participant's health record. High Risk: Diagnosed chronic infectious disease, as described above.	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed food allergy.	III

CHILDREN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed Celiac Disease.	III
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	III

CHILDREN		
CODE		PRIORITY
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed hypoglycemia.	III
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to an extent that nutritional status is compromised. Document: Drug/medication being used and respective nutrient interaction in the participant's health record. High Risk: Use of drug and medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	III
359	RECENT MAJOR SURGERY, TRAUMA, BURNS Major surgery, trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self-reported by caregiver. Any occurrence more than 2 months previous MUST have the continued need for nutritional support diagnosed by a physician or health professional acting under standing orders of a physician. Document: If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. High Risk: Major surgery, trauma or burns that has a continued need for nutritional support.	III

CHILDREN		
CODE		PRIORITY
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, MUST be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed medical condition severe enough to compromise nutritional status.	III
361	DEPRESSION Presence of depression diagnosed by a physician or psychologist as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, psychologist or health care provider working under the orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in participant's health record.	III

CHILDREN		
CODE		PRIORITY
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. Presence of developmental, sensory or motor delay diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Specific condition/description of the delay and how it interferes with the ability to eat, and the name of the physician that is treating this condition in the participant's health record. High Risk: Developmental, sensory or motor delay interfering with ability to eat.	III
381	ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	III

CHILDREN		
CODE		PRIORITY
382	FETAL ALCOHOL SPECTRUM DISORDERS Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase that encompasses a range of possible diagnoses, including fetal alcohol syndrome (FAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopment disorder (ARNDD), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE). Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed fetal alcohol spectrum disorder.	III
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E) Document: Inappropriate Nutrition Practice(s) in the participant's health record.	V
401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS (Children 2-5 Years of Age) A child who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. (This risk factor may be assigned only when a child does not qualify for risk 400 or for any other risk factor.)	V

CHILDREN		
CODE		PRIORITY
428	DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES (Children 12-24 Months of Age) A child who has begun to or is expected to begin to do any of the following practices is considered to be <u>at risk</u> of inappropriate complementary feeding: 1) consume complementary foods and beverages, or 2) eat independently, or 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.* (This risk factor may be assigned <u>only</u> when a child does not qualify for risk 400 or for any other risk factor.)	V
502	TRANSFER OF CERTIFICATION Person with a valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid through the end of the current certification period, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or the certification period extends beyond the receiving agency's certification period for that category, and shall be accepted as proof of eligibility for Program benefits. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by the receiving State agency.	III
801	HOMELESSNESS Homelessness as defined in the Special Population Section of the Georgia WIC Procedures Manual.	V
802	MIGRANCY Migrancy as defined in the Special Population Section of the Georgia WIC Procedures Manual.	V

CHILDREN	
CODE	PRIORITY
901 RECIPIENT OF ABUSE Child abuse/neglect within past 6 months as self-reported by the caregiver, 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. Child abuse/neglect refers to any recent act, or failure to act, resulting in: • Imminent risk or serious harm • Serious physical or emotional harm • Sexual abuse or exploitation of an infant or child by a parent or caretaker. Georgia State law requires that medical and child service organization personnel, having reasonable cause to suspect child abuse, report these suspicions to the authority designated by the health district/organization.	V
902 CHILD OF PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD Child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples include, but are not limited to: • Documentation or self-report of misuse of alcohol, use of illegal substances, use of marijuana or misuse of prescription medications. • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant. • Intellectual disability diagnosed, documented, or reported by a physician of psychologist of someone working under a physician's orders, or as self-reported by the participant. • Physical disability to a degree which limits food preparation abilities. • ≤ 17 years of age. Document: The primary caregiver's specific limited abilities in the participant's health record.	V

CHILDREN		
CODE		PRIORITY
903	FOSTER CARE Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	V
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as secondhand, passive, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems. Document: Type and location of Environmental Tobacco Smoke (ETS) Exposure in the participant's health record.	III

This page was intentionally left blank.

TABLE OF APPENDICES
APPENDICES REFERENCED IN RISK CRITERIA SECTION

Women's Health
Recommended Guidelines for Iron Supplementation
Based on Treatment Values

	Hemoglobin Treatment Value		Hematocrit Treatment Value	
	Non-Smokers	Smokers	Non-Smokers	Smokers
Prenatal Woman 1st Trimester 3rd Trimester	<11.0 gm	<11.3 gm	<33.0%	<34.0%
Prenatal Woman 2nd Trimester	<10.5 gm	<10.8 gm	<32.0%	<33.0%
Non-Pregnant and/or Lactating Woman (<15 years of age)	<11.8 gm	<12.1 gm	<35.7%	<36.7%
Non-Pregnant and/or Lactating Woman (≥15 years of age)	<12.0 gm	<12.3 gm	<35.7%	<36.7%

PHYSICIAN REFERRAL:
- Hemoglobin less than 9.0 g/dL or hematocrit less than 27.0%
- Hemoglobin more than 15.0 g/dL or hematocrit more than 45.0% (2nd and 3rd trimester)
- If after 4 weeks the hemoglobin does not increase by 1 g/dL or hematocrit by 3%, despite compliance with iron supplementation regimen and the absence of acute illness

In 2006, the U.S. Preventive Services Task Force released a Recommendation Statement that states that the American College of Obstetricians and Gynecologists (ACOG) recommends screening and treatment based on low Hemoglobin results. ACOG does not recommend routine supplementation for pregnant women at this time.

References:

CDC/MMWR: April 3, 1998. Recommendations to Prevent and Control Iron Deficiency in the United States (*current April 20, 2015*)

Final Recommendation Statement: Iron Deficiency Anemia: Screening. U.S. Preventive Services Task Force. May 2006.
http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/iron-deficiency-anemia-screening

Child Health Recommended Guidelines
for Iron Supplementation
Based on Treatment Values

	Hemoglobin Treatment Value	Hematocrit Treatment Value	Treatment Regimen
Infant 6 through 11 months	<11.0	<33.0%	Dosage: 0.6 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 15 mg BID
Child 12 through 23 months	<11.0	<32.9%	Dosage: 0.6 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 15 mg BID
Child 2 through 5 years	<11.1	<33.0%	Dosage: 1.2 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 30mg BID

- Premature and low birth weight infants, infants of multiple births, and infants with suspected blood losses should be screened before 6 months of age, preferably at 6-8 weeks postnatal.
- Routine screening for iron deficiency anemia is not recommended in the first 6 months of life.
- Treatment of iron deficiency anemia is 3-6 mg per kilogram per day.
- Refer to the package insert of iron preparation to correctly calculate the appropriate dosage of elemental iron. Most pediatric chewable preparations (i.e., Feostat, 100 mg) contain 33 mg elemental iron per tablet as ferrous fumarate. Non-chewable preparations for older patients (i.e., Feosol, 300 mg) contain 60-65 mg per tablet or capsule elemental iron as ferrous sulfate.
- The doses for the liquid product referred to in the chart are based on the solution concentration of 15mg/0.6ml.

Sources: Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, April 3, 1998/Vol.47/No. RR-3 (current April 20, 2015).

Georgia Department of Public Health, Nurse Protocols for Registered Professional Nurses 2014, *Standard Nurse Protocol for Prevention and Treatment of Iron Deficiency with or without Anemia,* Child Health 8.73.

Body Mass Index (BMI) Calculation and Interpretation:

BMI is a number calculated from a person's weight and height. BMI is an inexpensive screening tool to identify weight problems and determine nutrition care plans for adults and children over the age of two. BMI alone should not be used to advise someone they have health problem. In WIC, a complete evaluation of diet, other nutritional problems, and current developmental stage will be used to counsel about the health risks of a BMI that is not within recommended ranges.

	Formula to Calculate BMI
Metric	Weight in kilograms divided by height in meters squared $WT(kg) / [HT(m)]^2$
American Standard	Weight in pounds/Height in inches squared and multiplying by a conversion factor of 703 $\{WT(lb.) / [HT(in)]^2\} \times 703$
	Round to two decimal points

For adults who are age 20 or older, BMI is interpreted using standard weight status categories that are the same for all ages and genders.

BMI	WIC Weight Status
Below 18.5	High Risk Underweight
18.5 – 24.9	Healthy Weight
25.0 – 29.9	Overweight
30.0 and Above	High Risk Overweight (Obese)

For children over age 2 (and teens), the interpretation of BMI is both age and gender specific. This interpretation requires the use of Growth Charts. Georgia WIC utilizes the Centers for Disease Control and Prevention WIC specific Growth Charts for Children, and selects risk based on Georgia WIC Risk Criteria. These growth charts can be obtained from the Georgia WIC District Resources page.

Percentile Range	WIC Weight Status
Less than or equal to the 5th percentile	High Risk Underweight
5th percentile to the 10th percentile	Underweight
10th percentile to the 85th percentile	Healthy Weight
85th to less than the 95th percentile	Overweight
Equal to or greater than the 95th percentile	Obese

Currently, the Institute of Medicine recommends that pregnant adolescents be evaluated using the BMI categories for weight gain ranges for adult women. They acknowledge that much more research needs to be done to determine whether special categories should be established. For WIC, we also assess breastfeeding and postpartum women based on the adult categories. There are complicating psychological, developmental and growth impacts with adolescents which necessitates ongoing critical thinking and evaluation as well as tailored education for positive outcomes for both the adolescent mom and infant.

References:
CDC - Healthy Weight – it's not a diet, it's a lifestyle!
http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/ March 18, 2015.

Weight Gain during Pregnancy: Reexamining the Guidelines.
http://iom.edu/~/media/Files/Report%20Files/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines/Report%20Brief%20-%20Weight%20Gain%20During%20Pregnancy.pdf

Definition of Weight Gain (Women)

Total Weight Gain Range (lbs.)

Singleton Pregnancy

Pre-pregnancy Weight Groups	Definition (BMI)	Low Maternal Weight Gain	Recommended Weight Gain	High Maternal Weight Gain
Underweight	< 18.5	<28	28-40	> 40
Normal Weight	18.5 to 24.9	<25	25-35	> 35
Overweight	25.0 to 29.9	<15	15-25	> 25
Obese	≥ 30.0	<11	11-20	> 20

Multi-Fetal Weight Gain

Pre-pregnancy Weight Groups	Definition (BMI)	Low Maternal Weight Gain	Recommended Weight Gain	High Maternal Weight Gain
Underweight	< 18.5	There was insufficient information for the IOM committee to develop provisional guidelines for underweight woman with multiple fetuses.	1.5lbs./week during 2nd and 3rd trimesters	There was insufficient information for the IOM committee to develop provisional guidelines for underweight woman with multiple fetuses.
Normal Weight	18.5 to 24.9	<37	37-54	> 54
Overweight	25.0 to 29.9	<31	31-50	> 50
Obese	≥ 30.0	<25	25-42	> 42

As you work with counseling morbidly obese pregnant participants, please be aware that American Congress of Obstetricians and Gynecologists, has opined that careful consideration of weight gain based on a holistic assessment of the mother and baby is necessary as these are only general recommendations. This does not impact the selection of the appropriate risk factors and growth charts for evaluation. It does mean that your counseling should be informed by a total evaluation of the participant's status including an awareness of what the participant is being told by their physician.

Reference: Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines. National Academy Press, Washington, D.C., 2009. http://www.iom.edu/en/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx Reviewed March 18, 2015.

Reference: American Congress of Obstetricians and Gynecologists: Committee Opinion: Weight Gain in Pregnancy. Number 548, January 2013. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Weight-Gain-During-Pregnancy accessed April 7, 2015.

Physical Signs Suggestive of Nutrient Deficiencies

Body Area	Normal Appearance	Signs Suggestive of Nutrient Deficiency(ies)	Nutrient Consideration(s)
Hair	shiny; firm; not easily plucked	lack of natural shine; dull; thin; loss of curl; color changes (flag sign); easily plucked	inadequate protein and calories
Eyes	bright; clear; shiny; no sores at corners of eyelids;	eye membranes pale;	anemia (inadequate iron, folacin, or vitamin B-12)
	membranes healthy pink and moist; no prominent blood vessels	Bitot's spots; red membranes; dryness of membranes; dull appearance of cornea (cornea xerosis); softening of cornea (keratomalacia);	inadequate Vitamin A
		redness and fissuring of eyelid corners	inadequate riboflavin, Vitamin B-6, and niacin
Lips	smooth; not chapped or swollen	redness or swelling of mouth or lips (cheilosis);	inadequate niacin and riboflavin
		bilateral cracks, white or pink lesions at corners of mouth (angular stomatitis) and/or scars	inadequate riboflavin, niacin, iron and Vitamin B-6
Gums	healthy, red; do not bleed; not swollen	spongy; bleeding; receding	inadequate ascorbic acid
Tongue	deep red; not swollen or smooth	scarlet; raw; edematous (glossitis)	inadequate niacin, riboflavin, folacin, iron, Vitamins B-6 and B-12
		purplish color (magenta);	inadequate riboflavin
		smooth; pale; slick; atrophied taste buds (papillae)	inadequate folacin, Vitamin B-12, iron and niacin
Face and Neck	skin color uniform, smooth, pink; healthy appearing; not swollen	diffuse depigmentation;	inadequate protein
		darkening of skin over cheeks and under eyes;	inadequate calories and niacin
		scaling of skin around nostrils (nasolabial seborrhea)	inadequate riboflavin, niacin, and Vitamin B-6
		swollen (moon) face;	inadequate protein
		front of neck swollen (thyroid enlargement);	inadequate protein; inadequate iodine
		swollen cheeks (bilateral parotid enlargement)	inadequate protein

Physical Signs Suggestive of Nutrient Deficiencies

Body Area	Normal Appearance	Signs Suggestive of Nutrient Deficiency(ies)	Nutrient Consideration(s)
Skin	no signs of swelling rashes, dark or light spots	dry and scaly (xerosis); sandpaper-like feel (follicular hyperkeratosis);	Inadequate Vitamin A or Essential fatty acids
		pinhead-size purplish skin hemorrhages (petechiae);	Inadequate Vitamin C
		excessive bruising;	Inadequate Vitamin K
		red, swollen pigmentation of areas exposed to sunlight (pellagrous dermatitis);	Inadequate niacin and Tryptophan
		extensive lightness and darkness of skin (flaky, pressure sores(decubiti)	Inadequate protein, Vitamin C, and zinc
Teeth	no cavities, no pain, bright	may be some missing or erupting abnormally; gray or black spots (fluorosis); cavities (caries) [signs are to be severe enough to interfere with mastication and/or other health implications]*	Inadequate Vitamin D and Vitamin A
Head / Neck	face not swollen	thyroid enlargement (front of neck); parotid enlargement (cheeks become swollen)	Inadequate iodine; inadequate protein
Nails	firm, pink	nails are spoon-shaped (koilonychia); brittle ridged nails, pale nail beds	Inadequate iron; Vitamin A toxicity
Muscular and Skeletal Systems	good muscle tone; some fat under skin; can walk or run without pain	muscles have "wasted" appearance; baby's skull bones are thin and soft (craniotabes); round swelling of front and side of head (frontal and parietal bossing); swelling of ends of bones (epiphyseal enlargement); small bumps on both sides of chest wall (on ribs); beading of ribs; baby's soft spot on head does not harden at proper time (persistently open anterior fontanelle); knock-knees or bow-legs; bleeding into muscle (musculoskeletal hemorrhages); person cannot get up or walk properly	Inadequate protein Inadequate thiamin Inadequate Vitamin D

Sources: 1. American Journal of Public Health, Supplement, November 1973, p. 19.

2. Georgia Dietetic Association Diet Manual, 1992.

This page is currently under review and is continued in 2018 by district request.

Alcohol and Cigarettes

Alcohol Equivalents:

One ounce of alcohol = 12 ounces of beer (light or regular);

12 ounces of wine cooler;

5 ounces of wine (light or regular);

1 1/2 ounces of liquor.

Key for Entering Ounces of Alcohol/Week:
On the WIC Assessment/Certification Form enter the amount of alcohol in ounces per week using the above equivalent chart.

Key:	00 ounces/week	= Does not drink
	01 ounces/week	= Greater than 0 and up to 1 1/2 ounce/week
	02-97 ounces week	= Number of drinks per week
	98	= Drinks, but the quantity is unknown
	99	= Unknown or refused to answer

High Risk Drinking: Routine consumption of $\geq$ 8 drinks per week or $\geq$ 4 drinks on any day.

Binge Drinking: Routine consumption of $\geq$ 4 drinks within 2 hours.

Key for Entering Number of Cigarettes/Cigars/Pipes Smoked:
On the WIC Assessment/Certification Form record the average number of cigarettes/cigars/pipes smoked per day. If the client reports smoking on average less than once per day, record the average number of cigarettes/cigars/pipes smoked *per week*. If the client reports smoking on average less than once per week, record the average number of cigarettes/cigars/pipes smoked *per month*. Please note that chewing tobacco, e-cigarettes or vaping is not included in this calculation.

Key:	00	= Does not smoke/average of less than 1/day
	01-96	= Average number of cigarettes/cigars/pipes smoked per day
	97	= Greater than/equal to 97 cigarettes/cigars/pipes smoked per day
	98	= Smokes but the quantity is unknown
	99	= Unknown or refused to answer

Note: The usual number of cigarettes in a pack is equal to 20. This number may vary.

Appendix E

Inappropriate Nutrition Practices for Women

Inappropriate Nutrition Practices for Women	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Potentially Harmful Dietary Supplements Consuming Dietary Supplements with potentially harmful consequences.	Examples of Dietary supplements which when ingested in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas.
Diet very low in calories or essential nutrients Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.	• Strict vegan diet; • Low-carbohydrate, high-protein diet; • Macrobiotic diet; and • Any other diet restricting calories and/or essential nutrients.
Routine ingestion of non-food items (pica) Compulsively ingesting non-food items (pica).	Non-food items: • Ashes; • Baking soda; • Burnt matches; • Carpet fibers; • Chalk; • Cigarettes; • Clay; • Dust; • Large quantities of ice • Paint chips; • Soil; and • Starch (laundry and cornstarch)
Inadequate supplementation of essential vitamin/minerals Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.	• Consumption of less than 27 mg of supplemental iron per day by pregnant woman. • Consumption of less than 150 µg of supplemental iodine per day by pregnant and breastfeeding woman. • Consumption of less than 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant women
Pregnant Women	
Ingestion of potentially contaminated foods Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.	Potentially harmful foods: • Raw fish or shellfish, including oysters, clams, mussels, and scallops; • Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole; • Raw or undercooked meat or poultry; • Hot dogs, luncheon meat (cold cuts), fermented and fry sausage and other deli-style meat or poultry unless reheated until steaming hot; • Refrigerated pâté or meat spreads; • Unpasteurized milk or foods containing unpasteurized milk; • Soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as “made with pasteurized milk”; • Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog; • Raw sprouts (alfalfa, clover, and radish); or • Unpasteurized fruit or vegetable juices.

Inappropriate Nutrition Practices for Children

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Inappropriate beverages as primary milk source Routinely feeding inappropriate beverages as the primary milk source.	Examples of inappropriate beverages as primary milk source: • Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk; and • Imitation or substitutes milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."
Routinely feeding sugar-containing fluids Routinely feeding a child any sugar-containing fluids.	Examples of sugar-containing fluids: • Soda/soft drinks; • Gelatin water; • Corn syrup solutions; and • Sweetened tea.
Improper use of nursing bottles, cups, or pacifiers Routinely using nursing bottle, cups, or pacifiers improperly.	• Using a bottle to feed: ➢ Fruit juice, or ➢ Diluted cereal or other solid foods. • Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime. • Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. • Using a bottle for feeding or drinking beyond 14 months of age. • Using a pacifier dipped in sweet agents such as sugar, honey, or syrups. • Allowing a child to carry around and drink, throughout the day, from covered or training cups.
Feeding practices that disregard development Routinely using feeding practices that disregard the developmental needs or stages of the child.	• Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's request for appropriate foods). • Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking. • Not supporting a child's need for growing independence with self-feeding (e.g.; solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). • Feeding a child with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily purees or liquid food when the child is read and capable of eating mashed, chopped, or appropriate finger food).

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Ingestion of potentially contaminated foods Feeding foods to a child that could be contaminated with harmful microorganisms.	Examples of potentially harmful foods for a child: • Unpasteurized fruit or vegetable juices. • Unpasteurized dairy products or soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as "made with pasteurized milk • Raw or undercooked meat, fish, poultry, or eggs • Raw sprouts (alfalfa, clover, and radish) • Hot dogs, luncheon meat (cold cuts), fermented and fry sausage and other deli-style meat or poultry unless reheated until steaming hot;
Diet very low in calories or essential nutrients Routinely feeding a diet very low in calories and/or essential nutrients.	Examples: • Vegan Diet; • Macrobiotic diet; and • Other diets very low in calories and/or essential nutrients.
Potentially harmful dietary supplements Feeding dietary supplements with potentially harmful consequences	Examples of dietary supplements which when feed in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas
Inadequate supplementation of essential vitamin/minerals Routinely not providing dietary supplements as recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.	• 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 contains less than 0.3 ppm fluoride. • Not providing 400 IU of vitamin D if a child consumes less than 1 liter (or 1 quart) of vitamin D fortified milk or formula.
Routine ingestion of non-food items (pica)	• Ashes; • Carpet fibers; • Cigarettes or cigarette butts; • Clay; • Dust; • Foam Rubber • Paint chips; • Soil; and • Starch (laundry and cornstarch)

Inappropriate Nutrition Practices for Infants

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Routinely using a human milk or formula substitute Routinely using a substitute(s) for human milk or FDA approved iron-fortified formula as the primary nutrient source during the first year of life.	Examples of substitutes: • Low iron formula without iron supplementation; • Cow's milk, goat milk, or sheep milk (whole, reduced-fat low-fat, skim) canned evaporated sweetened condensed milk; and imitation or substitute milks (such as rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."
Routinely using nursing bottles or cups improperly Routinely using nursing bottles or cups improperly	• Using a bottle to feed fruit juice • Adding any food (cereal or other solid foods) to the infant's bottle. • Feeding any sugar-containing fluids such as, soda/soft drinks; gelatin water; corn syrup solutions; and sweetened tea. • Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime. • Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. • Propping the bottle when feeding. • Allowing a child to carry around and drink, throughout the day, from covered or training cups.
Early introduction of solids or use of sweetening agents Routinely offering complementary foods* or other substances that are inappropriate in type or timing.	• Adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier; or • Introducing any food other than human milk or iron-fortified infant formula before 4 months of age. **Complementary foods are any foods or beverages other than human milk or infant formula.*
Feeding Practices that disregard development Routinely using feeding practices that disregard the developmental needs or stage of the infant.	• Inability to recognize, insensitivity to, or disregarding the infant's cues for hunger and satiety (e.g., forcing an infant to eat a certain type and/or amount of food or beverage or ignoring a hungry infant's hunger cues). • Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking. • Not supporting an infant's need for growing independence with self-feeding (e.g.; solely spoon-feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). • Feeding an infant with inappropriate textures based on his/her developmental stage (e.g., feeding primarily purees or liquid food when the child is read and capable of eating mashed, chopped, or appropriate finger food).

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Ingestion of potentially contaminated foods Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.	Examples of potentially harmful foods for an infant: • Unpasteurized fruit or vegetable juices. • Unpasteurized dairy products or soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican-style cheese such as queso blanco, queso fresco, or Panela unless labeled as "made with pasteurized milk; • Honey (added to liquids or solid food, used in cooking, as part of processed foods, on pacifier, etc.); • Raw or undercooked meat, fish, poultry, or eggs • Raw vegetable sprouts (alfalfa, clover, bean and radish) • Deli meats, hot dogs and processed meats (avoid unless heated until steaming hot). • Donor human milk acquired directly from individuals or the Internet.
Routinely feeding inappropriately prepared formula Routinely feeding inappropriately diluted formula	• Failure to follow manufacturer's dilution instructions (to include stretching formula for household economic reasons). • Failure to follow specific instructions accompanying a prescription.
Limiting nursing of the exclusively breastfed infant Routinely limiting the frequency of nursing of the exclusively breastfeed infant when human milk is the sole source of nutrients.	Examples of inappropriate frequency of nursing: • Scheduled feedings instead of demand feedings; • Less than 8 feedings in 24 hours if less than 2 months of age; and • Less than 6 feedings in 24 hours if between 2 and 6 months of age.
Diet very low in calories or essential nutrients Routinely feeding a diet very low in calories and/or essential nutrients	Examples: • Vegan Diet; • Macrobiotic diet; and • Other diets very low in calories and/or essential nutrients
Potentially Harmful Dietary Supplements. Feeding dietary supplements with potentially harmful consequences	Examples of Dietary supplements which when feed in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas
Inadequate Supplementation of Essential Vitamin/Minerals. Routinely not providing dietary supplements as recognized as essential by national public health policy when an Infant's diet alone cannot meet nutrient requirements.	• 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.

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Improper human milk or formula sanitation Routinely using inappropriate sanitation in preparation, handling, and storage of expressed human milk or formula.	Examples of inappropriate sanitation: • Limited or no access to a: o Safe water supply (documented by appropriate officials e.g., municipal or health department authorities); o Heat source for sterilization, and/or; Refrigerator or freezer for storage. • Failure to properly prepare, handle, and store bottles, storage containers or breast pumps properly; examples include: o Human Milk: - Thawing in a microwave - Refreezing - Adding freshly expressed unrefrigerated human milk to frozen human milk - Adding refrigerated human milk to frozen human milk in an amount that is greater than the amount of frozen human milk - Feeding thawed human milk more than 24 hours after it was thawed - Saving human milk from a used bottled for another feeding - Failure to clean breast pump per manufacturer's instruction - Feeding donor human milk acquired directly from individuals or the internet o Formula: - Storing at room temperature for more than 1 hour - Failure to store prepared formula per manufacturer's instructions - Using formula in a bottle one hour after the start of a feeding - Saving formula from a used bottle for another feeding - Failure to clean baby bottle properly

Instructions for Use of the Prenatal Weight Gain Grid

1. Record applicant/participant's name.

2. Use Body Mass Index table (Appendix C-1) to determine if the applicant is Normal Weight, Underweight, Overweight, or Obese using pregravid weight. Select for use the prenatal weight gain grid that corresponds to the prenatal woman's pregravid weight status. If she is pregnant with twins, use the "Twins" grid regardless of her weight status.

3. Enter height in inches without shoes.

4. Use Weight History chart.

5. Enter pregravid weight as indicated. Enter date and weight at each visit.

6. Plot today's weight using the following steps:

    a. Record the pregravid weight at the initial point of the selected weight curve, which is located on the left side of the grid at zero (0) point. From the chart or gestation calculator, determine the completed weeks of gestation.

    b. Using the gain (or loss) in weight from the pregravid weight baseline and the completed gestational weeks (this visit) place an X on the point at which these two (2) lines meet.

    c. If the patient does not know her pregravid weight, or if the weight she gives seems disproportionate to her current weight, place an X on the dotted line for the calculated completed gestational week. Let this be a beginning point to plot future weights. Indicate that this weight is an estimate by writing "estimate" vertically on the grid next to the X. Use the "Normal" weight curve unless it is very obvious that the prenatal woman was overweight or underweight prior to gestation. Document this observation in the health record.

    d. At the second and each subsequent visit, the weight gain for completed weeks of gestation should be plotted on the grid.

Measuring Length

Age:

Birth to 24 months

Material/Equipment:

An accurate length board has a firm, flat horizontal surface with a measuring tape in 1/8 inch increments, an immovable headpiece at a right angle to the tape, and a smoothly moveable footboard, perpendicular to the tape.

Two (2) people required (typically one of whom is the caretaker).

Procedure:

1. Check to be sure that moveable footboard slides easily and the headboard is at the zero (0) mark.

2. Remove headwear, shoes and bulky clothing. Instruct caretaker to apply gentle traction to ensure that the child's head is firmly against the headboard so that the eyes are pointing directly upward.

3. With the child positioned so that the shoulders, back and buttocks are flat along the center of the board, the measurer should hold the child's knees together, gently pushing them down against the board with one (1) hand to fully extend the child. With the other hand the measurer should slide the footboard to the child's feet until both heels touch the footboard. Toes should be pointing directly upward. Record length.

4. Recheck length measure after reassessing head and body placement.

5. Measure length in inches to the nearest 1/8-inch. Repeat the measurement until two (2) readings agree within 1/4 inch.

6. Record the length promptly.

Measuring Weight
(Infant Scale)

Age:

Infants and children to 24 months up to 40 pounds

Materials/Equipment:

Scales with beam balance and non-detachable weights or digital, with a maximum weight of 40 pounds, and weigh in pound and ounce increments. (*Italics* instructions are for beam balance.)

Scales must be calibrated yearly.

Procedure:

1. Check scales at zero (0) position. With weights at zero (0) position, indicator should point at zero (0). If not, use the adjustment screws to move adjustable zeroing weight until the beam is in zero (0) balance.

2. Remove shoes and clothes. Change to dry diaper if wet, or weigh without diaper.

3. Place infant/child in center of scale (may be done sitting or lying down). Record weight if digital scale.

4. Move the weight on the main beam away from the zero (0) position – left to right and right to left - until the indicator is centered and stationary. Record weight.

5 Remove the child from the scale, and repeat the measurements until two (2) readings agree within one (1) ounce for a digital scale and four (4) ounces for a beam balance scale. (Some newer models of digital scales have a “reweigh” function that does not require removing the child from the scale.)

6. Record the weight promptly.

Measuring Height

Age:

Children two (2) years of age and older

Adults

NOTE: Once measurements are started with child standing, all subsequent measurements must be done standing.

Material/Equipment:

An accurate stadiometer for stature measurements is designed for and dedicated to stature measurement. It can be wall mounted or portable. An appropriate stadiometer requires a vertical board with an attached metric rule and a horizontal headpiece (right angle headboard) that can be brought into contact with the most superior part of the head. The stadiometer should be able to read to 0.1 cm or 1/8 in.

Procedure:

1. Remove all bulky clothing, head and footwear.

2. Position the child/adult against the measuring device, instructing the child/adult to stand straight and tall.

3. Make sure the child/adult stands flat footed with feet slightly apart and knees extended; then check for three (3) contact points: (a) shoulders, (b) buttocks, and (c) the back of the heels.

4. Lower the moveable headboard until it firmly touches the crown of the head. The child/adult should be looking straight ahead, not upward or down at the floor.

5. Read the stature to the nearest 1/8-inch.

6. Repeat the adjustment of the headboard and re-measure until two (2) readings agree within 1/4 inch.

7. Record the height promptly.

Measuring Weight
(Standing)

Age:

Adults, and children 2 years of age or older
Materials/Equipment:

Standard electronic scale or platform beam scale with non-detachable weights that weighs in at least 1/4 pound or 100 gram increments. (*Italics* instructions are for platform beam scale.)

Scales must be calibrated yearly

Procedure:

1. Check scales at zero (0) position. *With weights in zero (0) position indicator should point at zero (0). If not, use adjustment screws to move the adjustable zeroing weight until the beam is in zero (0) balance.*

2. Should be wearing minimal indoor clothing. Remove shoes, heavy clothing, belts, and heavy jewelry. Be sure pockets are empty.

3. Have child/adult stand in the center of the platform, arms hanging naturally. The child/adult must be free standing.

1. Move the weight on the main beam away from the zero (0) position – left to right and right to left - until the indicator is centered and stationary. Record weight.

5. Make sure the child/adult is still not holding on, then record to the nearest 1/4 lb.

6. Have the child/adult step off scale and return weight to zero (0). Repeat until two (2) readings agree within one (1) ounce for digital or 1/4 pound (4 ounces) for platform beam.

7. Record the weight promptly.

Sources: Pennsylvania Department of Health, Division of Women, Infants and Children (WIC), Anthropometric Training Manual. June 2010. Accessed April 22, 2015 from http://www.nal.usda.gov/wicworks/Sharing_Center/PA/Anthro/lib/pdf/Anthropometric_Training_Manual.pdf

Instructions for Use of the Growth Charts

1. Select the appropriate chart for sex and age of the individual.

2. Record name and/or identifying number of the chart. Document birth date.

3. The child's age on the date on which measurements are taken must be determined before you start plotting the measurements. To figure out a child's age, follow this example:

	Year	Month	Day
Date of Measurement	2015	4	21
Date of Birth	- 2010	-8	-10
Child's Age	4 y	8	11

or 4 yrs. 8 mos.

As this example shows, you may have to borrow thirty (30) days from the month column and/or 12 months from the year column when subtracting the child's birth date from the date on which the measurements are taken.

4. Plot growth measurements by using the Interpolation Method.

   Plotting Interpolation Method:

   a. Birth - 24 Month Growth Chart - Calculate exact age (to nearest week) and plot measurement into the space at the point nearest to the age.
   b. 2 - 18 Years Growth Chart - Calculate exact age (to nearest month) and plot measurement into space at the point nearest to the age.

5. To plot the length or height for age and weight for age charts (Graph Ease Plotting Tool is best practice):

   a. Follow a vertical line at the appropriate age.

   b. Using a straight-edge line up as closely as possible to the measured length or height and weight and mark the point where the two (2) lines intersect.

   c. Write the date above the point.

6. To plot the length or height/weight chart (Graph Ease Plotting Tool is best practice):

    a. Follow a vertical line at the point of the correct length or height.

    b. Using a straight-edge, line up as closely as possible to the weight and mark the point where the two (2) lines intersect.

    c. Write the date on the point.

7. To plot Body Mass Index (BMI) for age (Graph Ease Plotting Tool is best practice):

    a. Follow a vertical line as near as possible to the appropriate age.

    b. Using a straight-edge, line up as closely as possibly the measured BMI and mark the point where the two (2) lines intersect.

8. To plot an infant's head circumference (Graph Ease Plotting Tool is best practice):

    a. Follow a vertical line as near as possible to the appropriate age.

    b. Using a straight-edge, line up as closely as possible the measured head circumference and mark the point where the two (2) lines intersect.

9. Calculating Gestation-Adjusted Age:

    a. Document the infant's gestational age in weeks. (Mother/caregiver can self-report, or referral information from the medical provider may be used.)

    b. Subtract the child's gestational age in weeks from 40 weeks (gestational age of term infant) to determine the adjustment for prematurity in weeks.

    c. Subtract the adjustment for prematurity in weeks from the child's chronological postnatal age in weeks to determine the child's gestation-adjusted age.

    d. For WIC nutrition risk determination, adjustment for gestational age should be calculated for all premature infants for the first 2 years of life.

    Example:
    Randy was born prematurely on March 19, 2001. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2001 clinic visit, his chronological postnatal age is 12 weeks. What is his gestation-adjusted age?

    30 = gestational age in weeks
    40 – 30 = 10 weeks adjustment for prematurity
    12 – 10 = 2 weeks gestation-adjusted age

    Measurements would be plotted on a growth chart as a 2-week-old infant.

10. Plotting for Prematurity:

    For all premature infants and children <24 months plot adjusted and actual age (Graph Ease Plotting Tool is best practice):

    Plot- (weight/age, Length/age, length/weight)

11. The formula for calculating BMI for age is:

    [weight (lb.) ÷ height (in.) ÷ height (in.) x 703]

    This can be calculated on a hand-held calculator or by computer systems in the district. Once calculated, BMI must be rounded to one decimal point. A reference for converting fractions to decimals and guidance for rounding to one decimal point follows.

Reference for Converting Fractions to Decimals:

1/8 = .125

2/8 or ¼ = .25

3/8 = .375

4/8 or ½ = .5

5/8 = .625

6/8 or ¾ = .75

7/8 = .875

Guidance for Rounding to One Decimal Point:

When calculating Body Mass Index (BMI) round the final answer to one decimal point. To do this you will round up to the next number if the second number past the decimal point is five or greater and you will round down if the second number past the decimal point is four or less.

Example:
If the final BMI calculation equals 17.158829, the BMI would be 17.2

If the final BMI calculation equals 17.14829, the BMI would be 17.1

Use and Interpretation of the Growth Charts

PLOTTING

1. Standing height and weight must be plotted on the 2-18 Years growth charts.
2. Recumbent length and weight must be plotted on the 0-24 Months growth charts.
3. When a measurement cannot be plotted, a notation to this effect must be noted in the health record or on the growth chart. This measurement may not be used as a risk criterion. See the following example:

   A 32 week premature female infant comes in for certification one month after delivery. The infant's weight at certification is 6# 4 oz. and the length is 18 inches. You will be unable to plot the adjusted weight/age and length/age. This means you are unable to use the length measure for the short stature risk criteria because it is based on the adjusted measure. You will be able to evaluate for weight for length.

INTERPRETATION

1. Pattern of growth can only be interpreted when two sets of measurements are plotted on the same growth grid. If one set of measurements are plotted on the 0-24 months growth charts and the next set of measurements on the 2-18 years growth charts, these measurements cannot be used to interpret the pattern of growth of the child.

Key for Entering Weeks Breastfed

The number of weeks breastfed must be manually entered when completing paper WIC Assessment/Certification Forms and paper Turnaround Documents for:

- Breastfeeding women: initial and six month certification visits
- Postpartum, non-breastfeeding women: certification visit
- Infants: initial certification and mid-certification nutrition assessments
- Children: initial certification and subsequent certification, until the answer is "No"

Length of time breastfed must be entered in weeks (two-digit). When the answer to the question "How long have you breastfed this infant?" OR "How long has this infant breastfed?" is given in days or months, use the following key to determine appropriate codes.

I. Codes to Enter When Breastfeeding is Given in Days

Convert Days to Weeks		
Fewer than 7 days	=	00 weeks
7 - 13 days	=	01 week
14 – 20 days	=	02 weeks
21 – 27 days	=	03 weeks
28 – 34 days	=	04 weeks
35 – 41 days	=	05 weeks
42 – 48 days	=	06 weeks

Source: Georgia WIC Branch ETAD Change Number 08-12b, 2008.

II. Codes to Enter When Breastfeeding is Given in Months

1 month	=	04 weeks	12 Months	=	52 weeks
2 months	=	08 weeks	13 Months	=	56 weeks
3 months	=	13 weeks	14 Months	=	61 weeks
4 Months	=	17 weeks	15 Months	=	65 weeks
5 Months	=	22 weeks	16 Months	=	69 weeks
6 Months	=	26 weeks	17 Months	=	74 weeks
7 Months	=	30 weeks	18 Months	=	78 weeks
8 Months	=	35 weeks	19 Months	=	82 weeks
9 Months	=	39 weeks	20 Months	=	87 weeks
10 Months	=	43 weeks	21 Months	=	91 weeks
11 Months	=	48 weeks	22 Months	=	96 weeks
			22.5 Months +	=	98 weeks or more

Source: Enhanced Pregnancy Nutrition Surveillance System User's Manual. Division of Nutrition, Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Public Health Service. February 2000.

Conversion Tables and Equivalents

I. TABLE OF EQUIVALENTS

3 teaspoon (tsp.)	=	1 Tablespoon (Tbsp.)
2 Tbsp.	=	1 ounce (oz.)
8 oz.	=	1 cup (c.)
16 Tbsp.	=	1 c.
2 c.	=	1 pint (pt.)
2 pts.	=	1 quart (qt.)
4 c.	=	1 qt.
4 qts.	=	1 gallon (gal.) = 128 oz.

II. METRIC SYSTEM

A. APPROXIMATE WEIGHTS/MEASURES

20 drops	=	1 milliliter (ml.)
1 ml.	=	1 gram (g.)
1 ml.	=	1 cubic centimeter (cc)
1 tsp.	=	5 ml. = 5 cc = 5 g.
1 Tbsp.	=	15 ml. = 15 cc = 15 g.
1 oz.., fluid	=	29.57 ml. = 30 cc
1 cup, fluid	=	240 ml.
1 oz.., weight	=	28.35 g. (approx. 30)
1 c., weight	=	240 g.
1 pound (lb.)	=	453.6 g.
2.2 lbs.	=	1 kilogram (kg.)
33 ½ oz.	=	1 liter (L.)
1.1 qts.	=	1000 ml = 1 liter

B. WEIGHTS

1 milligram	=	1000 micrograms (mcg)
1 gram (g)	=	1000 mg.
1 kilogram	=	1000 g.

C. CONVERSIONS

To convert ounces to grams multiply by 30.
To convert grams to ounces divide by 30.
To convert pounds to kilograms divide by 2.2.
To convert kilograms to pounds multiply by 2.2.
To convert inches to centimeters multiply by 2.54.

Failure to Thrive: Background, Treatment, and Implications for WIC Nutrition Services

Background

Failure to thrive (FTT) describes an inadequate growth pattern where growth is significantly lower than what is expected for age and sex (1, 2, 3, 4, 5). Typically a sign of undernutrition, the cause of FTT is often complex and includes many factors. FTT in infants and children can increase the risk of long-term growth and cognitive problems, among other concerns (4, 5).

Some of the indicators that a health care provider might use to diagnose FTT include the following:

- Weight-for-age repeatedly below the 2.3rd percentile for infants/children younger than 2 years or repeatedly below the 5th percentile for children 2 years and older (2, 3, 5)
- Weight-for-length repeatedly below the 2.3rd percentile for infants/children younger than 2 years or Body Mass Index (BMI) repeatedly below the 5th percentile for children 2 years and older (2, 3, 5)
- Stature-for-age consistently below the 2.3rd percentile for infants/children younger than 2 years or repeatedly below 5th percentile for children 2 years and older (3, 5)
- Weight less than 75% of median (“typical”) weight-for-age (3)
- Weight less than 80% of median weight-for-stature (3)
- Progressive fall-off in weight-for-age, weight-for-stature, and/or stature-for-age, that crosses down two major percentile lines (2, 3, 4)
- Rate of weight gain less than the 5th percentile based on World Health Organization velocity standards (3)

It is recommended that a combination of growth criteria be considered and that growth be assessed over time, rather than using a single measurement (4). It is useful to note that reduced weight-for-stature can be a strong indicator of recent undernutrition, while low weight-for-age can represent both current and long-term nutrition concerns. Stature takes a longer time to be impacted by malnutrition; therefore, reduced stature may indicate the cumulative effects of chronic malnutrition (5).

In the United States, FTT is diagnosed in about 5-10% of infants and children in outpatient settings and about 3-5% of those in hospitals. Highest rates are found among lower income rural and urban communities. Failure to thrive often manifests early in life; most infants and children with FTT are diagnosed before 18 months of age. (4)

Several stressors may interact with each other to eventually lead to FTT. Undernutrition, as a result of a variety of medical, nutritional or developmental issues, is a major cause and includes the infant/child not being offered adequate calories/nutrients, the infant/child not taking the offered foods/beverages, inadequate calorie/nutrient absorption, and/or excessive calorie expenditure. (4, 5)

The following table includes factors that can contribute to undernutrition and increase the risk for FTT in infants and children (2, 3, 4, 5):

Medical/Nutritional/Developmental	Behavioral/ Feeding Practices*	Environmental/ Psychosocial
<u>General conditions</u>: • Prematurity†, low birth weight‡, and small for gestational age • Exposure to substances in utero • Any chronic medical condition <u>Inadequate intake, which can be caused by</u>: • Neurological disorders • Developmental delays, including autism spectrum disorders • Dental problems including cleft lip, cleft palate, and dental caries • Enlarged tonsils or adenoids • Feeding problems including insufficient or ineffective breast milk transfer, weak suck, swallowing problems, and poor appetite • Gastrointestinal problems, including gastroesophageal reflux, frequent vomiting, and constipation • Chronic or frequent infections (These can lead to reduced intake, which can further compromise the immune system, thus contributing to additional infections and FTT.) • Lead poisoning (This can lead to anorexia, constipation, and abdominal pain. Reduced intake can then lead to calcium and iron deficiencies, further exacerbating the lead poisoning and FTT.)	• Infrequent feeding or not appropriately responding to hunger cues • Poor caregiver-infant/child interactions, especially when feeding • Inappropriate feeding based on infant/child's stage of development • Improper breastfeeding positioning or technique • Incorrect preparation of infant formula • Excessive fluids other than breastmilk/formula for infants • Once foods are started, not providing appropriate support (such as a high chair) while eating • For children, inconsistent timing of feeding or allowing to graze on food/beverages throughout day • Restrictive diet, including vegan, low-fat, or food allergy-related • Feeding in a chaotic household with multiple caregivers • Neglect or abuse	• Poverty, food insecurity, and homelessness • Caregiver's lack of knowledge about appropriate nutrition and feeding • Caregiver with limited ability to make appropriate feeding decisions/prepare food, including those with a mental health disorder, intellectual disability, or substance use disorder§ • Family stressors such as unemployment, separation, or incarceration • Inadequate access to appropriate foods, including culturally preferred foods

Medical/Nutritional/Developmental	Behavioral/ Feeding Practices*	Environmental/ Psychosocial
<u>Inadequate absorption, which can be caused by</u>: • Food allergies and lactose intolerance • Celiac disease • Gastrointestinal problems, including chronic diarrhea or vomiting and malformations • Protein-losing enteropathy • Pancreatic conditions, including cystic fibrosis • Inborn errors of metabolism <u>Excessive caloric expenditure, which can be caused by</u>: • Congenital heart disease or heart failure • Chronic pulmonary disease • Hyperthyroidism • Chronic or frequent infections • Inflammatory diseases, including asthma and inflammatory bowel diseases • Malignancy • Renal disease		

*See risk #411 *Inappropriate Nutrition Practices for Infants* and risk #425 *Inappropriate Nutrition Practices for Children* for more information about nutrition and feeding practices.
†See risk #142 *Preterm or Early Term Delivery* for more information about preterm delivery.
‡See risk #141 *Low Birth Weight and Very Low Birth Weight* for more information about low birth weight.
§See risk #902 *Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Appropriate Feeding Decisions and/or Prepare Food* for more information.

Failure to thrive in infants/children, especially when severe or prolonged, can have several harmful effects, including the following:

- Dehydration and nutrient deficiencies
- Compromised immune system and increased risk of infections (5)
- Increased susceptibility to lead poisoning (when calcium and iron deficiencies are
- present) (5)
- Long-term impaired cognitive development, including learning difficulties (4, 5)
- Long-term problems with socioemotional development (4, 5)
- Long-term lower than average weight and/or height (4)

Treatment:
The goal of FTT treatment is to achieve optimal growth while also addressing whatever factors may be contributing to the FTT. Catch-up growth (growth at a faster rate than normal for age) is usually necessary; according to the American Academy of Pediatrics, a typical catch-up rate is 2-3 times the average weight gain for age (2, 3, 5). As treatment progresses, the rate of catch-up growth is continually adjusted as needed until growth is deemed appropriate. Thus, growth must be measured frequently and assessed over time (5). It is also important to watch for relapse, as a history of FTT is associated with reoccurrence of FTT in the future (2).

During treatment, close follow-up by the health care provider and other health professionals is crucial. A multidisciplinary approach is often used, including collaboration among the family, pediatrician, dietitian, developmental therapist, and others.

Nutrition therapy is a core component of treatment, starting with nutrition assessment. A comprehensive assessment should take the following into account: feeding history, current intake, breastfeeding/formula-feeding, the caregiver-infant/child feeding relationship, feeding timing/environment, and nutrition knowledge/beliefs. Nutrition and breastfeeding counseling are individualized to the infant/child and typically focus on increasing consumption of calories, protein, and micronutrients (5). The health care provider may also suggest providing a multivitamin that includes the Recommended Dietary Allowance for all vitamins, iron, and zinc during the period of rapid growth, as well as additional iron or vitamin D if there are deficiencies (5).

If behavioral interventions are not effective, treatment providers may recommend nutritional/caloric supplements be given for a limited time to achieve catch-up growth. These include supplemental formula for breastfed infants, high calorie/concentrated formulas for infants, and high calorie beverage supplements for children. If treatment is not effective, hospitalization may be needed, though this is rare. This may occur if the infant/child has a severe safety or health risk, including having a serious infection, medical condition, malnourishment, or dehydration (2, 5).

Implications for WIC Nutrition Services
WIC staff can provide the following nutrition services to infants and children with failure to thrive:

- Learn about and reinforce the health care team's plan of care for treating the participant's FTT. Encourage caregivers to keep all health care appointments.
- Offer breastfeeding support to breastfeeding dyads. Refer to the WIC Designated Breastfeeding Expert, if available, or other professional breastfeeding support when needed.
- Offer participant-centered nutrition counseling based on a thorough assessment and on caregiver's concerns and interests. Suggestions to caregivers may include the following, based on the situation:
    - Increasing children's intake of calorically-dense food
    - Correctly preparing infant formula
    - Reducing volume of fluids consumed, if excessive, to appropriate amounts (other than breastmilk or formula for infants)
    - Allowing children to choose how much and which foods to eat (from what is offered)
    - Feeding children at consistent times and not allowing child to graze on foods and beverages throughout the day
    - Feeding in a supportive setting (such as a table or highchair) and in a distraction-free environment

- Provide individualized food packages, tailored to meet the increased nutritional needs of the infant/child.
- Reinforce the importance of following recommended vaccination schedules, as FTT is sometimes associated with a compromised immunize system.
- Offer individualized referrals based on the household's needs and interests, including referrals to financial assistance, food assistance, cooking classes, housing, transportation, childcare, adult education/career services, and substance use services. Consider referrals that promote a nurturing, responsive caregiver-infant/child relationship, including those to local home visiting programs, parenting programs, and early intervention services.

References

1. Larson-Nath C, Mavis A, Duesing L, Van Hoorn M, et al. Defining Pediatric failure to thrive in the developed world: validation of a semi-objective diagnosis tool. Clinical Pediatrics. 2019 [cited 2019 Jun 25];58(4): 446-452. Available from: https://www.ncbi.nlm.nih.gov/pubmed/30596256.

2. Homan GJ. Failure to thrive: a practical guide. American Family Physician. 2016 [cited 2019 Jun 25];94(4):296-300. Available from: https://www.ncbi.nlm.nih.gov/pubmed/27548594.

3. Larson-Nath C, Biank VF. Clinic review of failure to thrive in pediatric patients. Pediatric Annals. 2016 [cited 2019 Jun 25];45(2):e46-e49. Available from: https://www.ncbi.nlm.nih.gov/pubmed/26878182.

4. Ross E, Munoz FM, Edem B, Nan C, et al. Failure to thrive: Case definition & guidelines for data collection, analysis, and presentation of maternal immunization safety data. Brighton Collaboration Failure to Thrive Working Group. Vaccine. 2017 [cited 2020 Jul 24];35(48 Pt A), 6483–6491. Available from: https://doi.org/10.1016/j.vaccine.2017.01.051

5. American Academy of Pediatrics Committee on Nutrition. Failure to Thrive. In: Kleinman RE, Greer FR, eds. Pediatric Nutrition. 8th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2019.

Clarification

Self-reporting of a diagnosis by a health care provider should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.