Georgia Department of Public Health

GEORGIA WIC PROGRAM
ASSESSMENT/CERTIFICATION FORM
POSTPARTUM BREASTFEEDING WOMEN

GEORGIA WIC
EATHEALTHYGROWHEALTHYLIVEHEALTHY

CLINIC ☐☐☐ Case ID ☐☐☐☐☐☐☐☐ Client ID ☐☐☐☐☐☐☐☐ WIC ID NUMBER ☐☐☐ ☐☐☐ ☐☐☐ ☐☐

NAME LAST	FIRST	MIDDLE INITIAL	BIRTHDATE

ADDRESS	CITY	ZIP CODE	MIGRANT ☐ YES ☐ NO

TELEPHONE	HISPANIC/LATINO	RACE (check all that applies)	ENTER EDC DATE
( )	☐ YES ☐ NO	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	

COUNTY OF RESIDENCY	PROOF OF RESIDENCY	PROOF OF I.D.	FOSTER CARE ☐ YES ☐ NO	FOSTER CARE ☐ YES ☐ NO
☐☐☐	UP:	UP:		

INITIAL CONTACT DATE: DATE OF FIRST VISIT REQUESTING WIC SERVICES (Must change date if certifications are not consecutive)	Date:	Type:	Date:	Type:
Infant's WIC ID Number:				

WOMEN'S FEEDING METHOD: **E**= Exclusively Breastfeeding **M**= Mostly Breastfeeding **S**= Some Breastfeeding (Circle One)	E M S	E M S
BREASTFEEDING AN INFANT LESS THAN 1 YEAR OF AGE (Enter Delivery Date:) (Birthweight: lbs. ozs.) (**00=** 0-6 days, **01=** 7-13 days, **02=** 14-20 days, **03=** 21-27 days, etc.)	Wks	Wks
Pregravid Weight: lbs.	Pregravid BMI:	Current BMI
MEDICAL DATA DATE (Enter date height and weight measurement taken)		
Current Height / Weight	ht. wt.	ht. wt.
Hematological Data Date:		
Hematocrit/Hemoglobin (Value must be ≤ 90 days)	HCT / HGB	HCT / HGB

Select appropriate risk criteria per State guidelines (See Risk Criteria Handbook for definitions)			**YES**	**NO**	**YES**	**NO**
	Low Hgb/Hct	[HR] 201				
	Underweight (< 6 mo. postpartum, based on pregravid or current wt., ≥ 6 mo. postpartum, based on current wt. < 185)	[HR] 101				
	Overweight (< 6 mo. postpartum, based on pregravid wt., ≥ 6 mo. postpartum, based on current wt. ≥ 250)	[HR?] 111				
	High Maternal Weight Gain (most recent pregnancy)	133				
*	**Elevated Blood Lead Level** (Blood Lead Level ≥ 5 µg/dl)	[HR] 211				
*	History of Gestational Diabetes	303				
*	History of Preeclampsia	304				
*	History of Preterm or Early Term Delivery (most recent pregnancy) (enter weeks gestation:)	311				
*	Delivery of Low Birth Weight Infant(s) (most recent pregnancy) (Enter birth weight(s) and birth date(s):)	312				
*	Fetal/Neonatal Death (most recent pregnancy) (Enter date(s) of death and weeks gestation:)	321				
	Pregnancy at a Young Age (most recent pregnancy)	[HR?] 331				
*	Short Interpregnancy Interval (most recent pregnancy) (Enter termination dates of last (2) pregnancies:)	332				
*	High Parity and Young Age (Enter delivery date(s) of previous pregnancies:)	333				
*	**Multi-Fetal Gestation** (most recent pregnancy)	[HR] 335				
*	History of Large for Gestational Age Infant (Birth weight(s): ≥ 9 lbs. enter birth weight(s):)	337				
*	Birth with Nutrition Related Congenital or Birth Defect(s) (most recent pregnancy) (specify defect(s):)	339				
*	**Nutrition Related Medical Conditions** (List code(s):)	[HR?]				
*	Smoking (Any smoking of cigarettes, pipes or cigars) (Enter number of cigarettes or cigars smoked or number of times pipe smoked (# cig./day:)	371				
*	Alcohol and Drug Illegal Use	372				
*	Oral Health Conditions	381				
*	Inappropriate Nutrition Practices	400				
	Failure to Meet Dietary Guidelines	401				
	Transfer of Certification	502				
*	Breastfeeding Mother of an Infant(s) at Nutritional Risk (enter infants risk factors:)	601				
*	**Breastfeeding Complications or Potential Complications**	[HR] 602				
	Homelessness	801				
	Migrancy	802				
*	Recipient of Abuse	901				
*	Woman with Limited Ability to make Feeding Decisions and/or Prepare Food	902				
	Foster Care	903				
*	Environmental Tobacco Smoke Exposure	904				
	HIGH RISK (Yes or No)					
	ELIGIBLE FOR WIC					
	PRIORITY: 1= (201, 101, 111,133, 211, 303, 304, 311, 312, 321, 331, 332, 333, 335, 337, 339, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 371, 372, 373, 381, 502, 601, 602, 904) **2=** (502, 601) **4=** (400, 401, 502, 601, 801, 802, 901, 902, 903)					

***Additional Documentation Required**

FOOD PACKAGE: (If unable to complete infant certification at this time, enter code AAA for infant food package and describe reason below.)	WOMAN'S FOOD PACKAGE:		
	INFANT'S FOOD PACKAGE:		
SERVICES: CH (A), Health Check (B), CMS (C), Women's Health (D), PCM (E), PRS (F), Immun (G), Lead Screen (H), Dental Health (I), STD (J), Private MD (K), SNAP (L), Medicaid (M), TANF (N), Mental Health (O), Head Start (P), NA/None (Q), Refused (R), Community Health Center (S), Children 1st (T), Other-Specify (U), Dietitian (V), Breastfeeding (W), Breastfeeding Peer Counselor (X)		Enrolled In:	Enrolled In:
		Referred To:	Referred To:
TODAY'S DATE			
SIGNATURE AND TITLE OF HEALTH PROFESSIONAL			

INCOME DETERMINATION (income must be documented)

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

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

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

UP: _____

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

_____ _____ Staff Initials

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

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

DATA NEEDED FOR PREGNANCY SURVEILLANCE

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

Comments: _____

Date/Sign/Title: _____

Proxy 1 _____ Proxy 2 _____

WIC CERTIFICATION STATEMENT

RIGHTS AND RESPONSIBILITIES

I have been advised of my rights and obligations for participation in the Georgia WIC Program. I certify that the information I will provide, or have provided, is correct to the best of my knowledge. The income information that I have provided is my total gross household income (all cash income before deductions). This certification form is being submitted in connection with the receipt of Federal assistance. The Georgia WIC Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying to the Georgia WIC Program, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

NOTICE OF DISCLOSURE

I understand that the chief state health officer for Georgia may allow information about my participation in Georgia WIC to be shared for non-WIC purposes to determine eligibility with other program services. I understand that this information may be used by Georgia WIC, shared with its local WIC agencies, or shared with other public organizations that serve persons eligible for WIC. Further, I understand that the recipients of this information will only use it to establish the eligibility for programs administered by other public organizations; to conduct outreach for programs administered by other public organizations; to enhance the health, education or well-being of Georgia WIC applicants and participants; to streamline administrative procedures to minimize burdens on program participants and staff; and, to health care needs and outcomes. The public organizations that receive my information cannot share my information with another organization or person without my permission.

I also understand that if I do not want my information shared, that decision will not affect my participation in Georgia WIC.

_____ Name of WIC Applicant/Participant/ Guardian/Caregiver/Spouse/Alternate Parent (please print)	_____ Date _____ UP:	_____ Name of WIC Official (please print)
_____ Signature of WIC Applicant/Participant/ Guardian/Caregiver/Spouse/Alternate Parent	_____ Date	_____ Signature of WIC Official

Please initial below to indicate your preference:

___ In applying for WIC services, I **AGREE** to allow my information to be shared for the purposes referenced above. I understand that if I do not want my information to be shared, this decision will not affect my participation in the Georgia WIC Program.

___ In applying for WIC services, I **DO NOT AGREE** to allow my information to be shared for the purposes referenced above. I understand that if I do not want my information to be shared, this decision will not affect my participation in the Georgia WIC Program.

Revised 7/2018