Georgia Department of Public Health

GEORGIA WIC
EATHEALTHYGROWHEALTHYLIVEHEALTHY

GEORGIA WIC PROGRAM
ASSESSMENT/CERTIFICATION FORM
PRENATAL WOMAN

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

NAME LAST	FIRST	MIDDLE INITIAL	BIRTHDATE

ADDRESS	CITY	ZIP CODE

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

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

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

MEDICAL DATA DATE
(Enter date height and weight measurements were taken)

Height	Weight	Pregravid Weight	Pregravid BMI
in.	lbs.	lbs.	

Hematological Data Date:

Hematocrit/Hemoglobin (Value must be ≤ 90 days) HCT / .HGB

			YES	NO
Select appropriate risk criteria per State guidelines (See Risk Criteria Handbook for definitions)				
Low Hgb/Hct	[HR]	201		
Underweight (pregravid BMI < 18.5)	[HR]	101		
Overweight (pregravid BMI ≥ 25.0)	[HR?]	111		
Low Maternal Weight Gain	[HR]	131		
* **Gestational Weight Loss During Pregnancy**	[HR?]	132		
High Maternal Weight Gain		133		
* **Elevated Blood Lead Level** (Blood Lead Level ≥ 5 µg/dl)	[HR]	211		
* **Hyperemesis Gravidarum**	[HR]	301		
* **Gestational Diabtes**	[HR]	302		
* History of Gestational Diabetes		303		
* History of Preeclampsia		304		
* History of Preterm or Early Term Delivery (Enter delivery date(s) and weeks gestation:)		311		
* History of Low Birth Weight Infant(s) (Enter birth weight(s) and birth date(s):)		312		
* History of Fetal/Neonatal Death (Enter date(s) and weeks gestation:)	[HR?]	321		
Pregnancy at a Young Age (Age of EDC)		331		
* Short Interpregnancy Interval (Enter termination date of last pregnancy:)		332		
* High Parity and Young Age (Enter delivery dates of previous pregnancies:)		333		
* Lack of, or inadequate Prenatal Care [Prenatal care beginning after 1st Trimester (0-13 wks.)]		334		
* **Multi-Fetal Gestation**	[HR]	335		
* Fetal Growth Restriction		336		
* History of Birth of a Large for Gestational Age Infant (Enter birth weight(s):)		337		
Pregnant Woman Currently Breastfeeding		338		
* History of Birth with Nutrition Related Congenital or Birth 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 (#/day:)		371		
* Alcohol and Illegal Drug Use		372		
* Oral Health Conditions		381		
* Inappropriate Nutrition Practices		400		
Failure to Meet Dietary Guidelines		401		
Transfer of Certification		502		
* **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, 131, 132, 133, 211, 301, 302, 303, 304, 311, 312, 321, 331, 332, 333, 334, 335, 336, 337, 338, 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, 602, 904) **4=** (400, 401, 502, 801, 802, 901, 902, 903)				

***Additional Documentation Required**

FOOD PACKAGE: ***(Specify Tailoring Instructions)***	
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: 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)				
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)				
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 _____

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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