

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

CLINIC FAMILY NUMBER WIC ID NUMBER

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

*Additional Documentation Required

INCOME DETERMINATION (income must be documented)

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

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

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

UP: _____

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

Is the Client Income Eligible? YES () NO () UP _____

Check Here if Only One Income Reported ()

Staff Initials _____

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

UP: _____
Staff Initials _____

DATA NEEDED FOR PREGNANCY SURVEILLANCE

Marital Status (O=Married 1=Not Married 9=Unknown)		
Years of Education completed (e.g. 1 st grade = 01, 2yrs. College = 14, Unknown = 99)		
Month of gestation at time of first prenatal exam (0=0 Prenatal Care, 1=1 st . mo., 8=8 th or 9 th mo., 9=Unknown)		
Last weight prior to delivery (Round to the nearest pound)		
Parity (00= None 01-29 = Number of previous 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 breastfeeding began	(MM/DD/YYYY)	
Date of last time of breastfeeding and/or pumping	(MM/DD/YYYY)	
Fruit Intake.	D=Daily S=Some Days N=Never	
Vegetable Intake.	D=Daily S=Some Days N=Never	
Dairy Intake.	D=Daily S=Some Days N=Never	
Daily Activity.	V=Very Active S=Active Some of the Time N=Not Active	
Screen time.	Hours = 00 through 24	

Comments:(Date/Sign/Title): _____

Proxy 1 _____ Proxy2 _____

WIC CERTIFICATION STATEMENT

RIGHTS AND OBLIGATIONS

I have been advised of my rights and obligations for participation in 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 assess and evaluate the State's health system in terms of responsiveness to participants' 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

Name of WIC Official (please print)

UP:

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.