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

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

INITIAL CONTACT DATE: DATE OF FIRST VISIT REQUESTING WIC SERVICES (Must change date if certifications are not consecutive)	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.	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)	[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?]				
*	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				
*	Dental Problems	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: / Referred To:

Enrolled In: / 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 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 births)		
Date last pregnancy ended (000000 = No Previous Pregnancy 01-12 (all four digits) = Month/Year)		
Diabetes – Postpartum visit (1=No, 2= Yes, most recent, 3=Yes, past and most recent, 4=Yes, first time)		
Hypertension – Postpartum visit (1=No, 2= Yes, most recent, 3=Yes, past and most recent, 4=Yes, first time)		
Multi / Prenatal Vitamin Consumption Prior to Pregnancy (0=less than once a week, 1-8=number per week, 9-Unknown)		
Cigarettes/Day – 3 mos prior to Pregnancy 00=no, 01-96=#cigs/day, 97=97 or more, 98=quantity unknown, 99=refused)		
Cigarettes/Day – Postpartum Visit (00=no, 01-96=#cigs/day, 97=97 or more, 98=unknown, 99=refused)		

Cigarettes/Day – Last 3 mos of Pregnancy 00=no, 01-96=#cigs/day, 97=97 or more, 98=quantity unknown, 99=refused)		
Household Smoking – Postpartum Visit (1=Yes, someone smokes, 2=No, no one smokes, 9=unknown)		
Drinks/week – 3 mos prior (00=No, 01=1 drink, 02-20=drinks, 21=21 or more, 98=quantity unknown, 99=refused)		
Drinks/week – Last 3 mos Postpartum (00=No, 01=1 drink, 02-20=drinks, 21=21 or more, 98=quantity unknown, 99=refused)		
Date breastfeeding began **(MM/DD/YYYY)**		
Date of last time of breastfeeding and/or pumping **(MM/DD/YYYY)**		
Fruit Intake. **D**=Daily **S**=Some Days **N**=Never		
Vegetable Intake. **D**=Daily **S**=Some Days **N**=Never		
Dairy Intake. **D**=Daily **S**=Some Days **N**=Never		
Daily Activity. **V**=Very Active **S**=Active Some of the Time **N**-Not Active		
Screen time. **Hours** = 00 through 24		

Comments:(Date/Sign/Title):_____

Proxy 1 _____ Proxy2 _____

WIC CERTIFICATION STATEMENT

RIGHTS AND OBLIGATIONS

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

NOTICE OF DISCLOSURE

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

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

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

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

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

Please initial below to indicate your preference:

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

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

Revised 6/12