# GEORGIA WIC PROGRAM
# ASSESSMENT/CERTIFICATION FORM
# POSTPARTUM / NON-BREASTFEEDING WOMAN

CLINIC ☐☐☐ FAMILY NUMBER ☐☐☐☐☐☐☐☐☐☐☐ 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: |
|---|---|---|
| NON-BREASTFEEDING, LESS THAN 6 MONTHS POSTPARTUM (Enter Delivery Date: ) (Birthweight: lbs. ozs.) EVER BREASTFED? ☐ YES ☐ NO | | Weeks Breastfed: |
| 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 |

| Select appropriate risk criteria per State guidelines (See Risk Criteria Handbook for definitions) | | | YES | NO |
|---|---|---|---|---|
| **Low Hgb/Hct** | [HR] | 201 | | |
| **Underweight** (pregravid or current BMI < 18.5) | [HR] | 101 | | |
| **Overweight** (pregravid BMI ≥ 25.0) | [HR?] | 111 | | |
| High Maternal Weight Gain (most recent pregnancy) | | 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 delivery 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 dates of previous pregnancies: ) | | 333 | | |
| * **Multi-Fetal Gestation** (most recent pregnancy) | [HR] | 335 | | |
| * History of Large for Gestational Age Infant (Birth weight ≥ 9lbs.) (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) | | 371 | | |
| * Alcohol and Illegal Drug Use | | 372 | | |
| * Dental Problems | | 381 | | |
| * Inappropriate Nutrition Practices | | 400 | | |
| Other Dietary Risk (Failure to Meet Dietary Guidelines) | | 401 | | |
| Transfer of Certification | | 502 | | |
| 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: 3= (**331, 502) **6=** (201, 101, 111, 133, 211, 303, 304, 311, 312, 321, 331, 332, 333, 335, 336, 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, 400, 401, 502, 801, 802, 901, 902, 903, 904) | | | | |
| **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 | | | | |

***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<br>COPY AND FILE | SNAP Y/N/U | NO. IN FAMILY | GROSS INCOME (CURRENT/ANNUAL) |
|---|---|---|---|---|---|---|---|
| | Y ( )<br>N ( ) *<br>* N ( ) R ( )<br>D ( ) W ( ) | Y ( ) U ( )<br>N ( )<br>UP (_____) | | Y ( ) U ( )<br>N ( )<br>UP (_____) | Y ( ) U ( )<br>N ( )<br>UP (_____) | | C ( )<br>A ( )<br>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=No 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 | |
| Vegetables 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 _____

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## 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.