06/25

WIC SERVICES GUIDEBOOK

STAFF TOOL FOR USE WITH WIC SERVICES WORKSHEETS

WIC NEBRASKA

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Guidelines for Using WIC Services Worksheets

The WIC Services Worksheets are paper copies designed to guide staff in recording information for WIC Certifications, Subsequent Nutrition Educations, and other appointments when Journey is unavailable. Use the worksheets for the participant's category to gather and document their information.

When the clinic is operating again, staff must enter information from the worksheets into Journey. The format of the worksheets closely follows the screens in Journey. **Once staff enter the information from the worksheets and scan them into Journey, destroy the paper copy following the agency's policy for disposing of participant information.**

When to use a paper worksheet:

- Hardware equipment failure
- Natural disasters
- Network problems
- Software problems
- Power outages
- Other times determined by staff

How to use the WIC Services Worksheets:

1. **Select** the Intake worksheet

2. **Write** the participant's FID at the top of each page in case the pages are separated. Record the date and staff name (completed by) at the bottom of each page.

3. **Complete the information** in each section.

    - Be sure to document the items in shaded boxes since they're required fields in Journey. i.e. proof of ID and residency

    - Although the Telephone field isn't required, it's important to document to contact the participant to make the next appointment.

4. **Participant Demographics including Race/Ethnicity** are required for new participants to be able to enter other information into the computer.

5. **Income:** Document income information when required (Certifications)

    - Adjunct Eligibility – Document the proof seen and self-declared income.

    - Income-based eligibility – document income details and proof seen.

6. **Select** the assessment worksheet for the participant's category.

7. **Anthro/Lab:** Record weight, measurements, hemoglobin, and dates collected.

    - Document relevant notes about the weights, measurements, or hemoglobin. For example, "Hgb. from MD on 03-12-2020."

    - Include any exempt or deferred reasons according to policy.

Guidelines for Using WIC Services Worksheets

8. **Health Information**:
   - Document medical health conditions and other health information depending on participant category. Interview questions for all worksheets are in the WIC Services Guidebook.

9. **Dietary & Health:** Listen and assess for nutrition risks. Document risks and make notes as needed.

10. **Assigned Risk Factors:** Document any additional risks identified using the Assessment Questions.

11. **Certification Signature:** Have the participant or authorized representative sign the assessment worksheet to acknowledge the Rights and Responsibilities.

    - For the R & R electronic signature in Journey, check No Signature Available box and select Other for Reason.

    - Obtain signatures for other forms as needed during the appointment (i.e. No Proof Forms).

    - Keep all worksheets and other forms together and store them in a secure location until the information is entered in Journey.

12. **Care Plan**:
    - **Referrals** - Document referrals provided, or follow-up as needed.

    - **Nutrition Education Topics** - Record nutrition education or breastfeeding topics discussed. Include notes about what was discussed and how the participant or caregiver feels about the topic for future follow up and goal setting.

    - **Maintain Goals** - Document the goal and what next steps to achieving the goal were shared by the participant.

    - **Notes** - Make any notes or comments.

13. **Issue Benefits/Prescribe Food:** Document any requested or needed food prescription changes and scan the Physician Authorization Form (PAF) if applicable.

14. **Issue Food Instruments**:
    - Document the months of issuance.

    - Electronic signature for food benefits: Check the No Signature Available box and select Remote Benefits Issuance for Reason.

15. **Next Appointment -** Document if the participant or caregiver requested a day and time for their next appointment to make it easier when calling to set up the next appointment.

16. **Enter the information from the worksheets then scan form(s) into Journey**. Verify all the information was entered and scans were successful. Destroy the worksheets according to agency policy.

INTAKE WORKSHEET
Required Items

FID:_____

PARTICIPANT DEMOGRAPHICS

Authorized Representative		
First Name:	Last Name:	DOB:
Sex: ☐ Female ☐ Male	Category: ☐ Breastfeeding ☐ Not Breastfeeding ☐Pregnant ☐ Miscarriage	
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander ☐ White (☐ Middle Eastern or North African)		
Hispanic/Latino: ☐ Yes ☐ No	VOC: Cert Start Date: Cert End Date:	Last Benefit Start Date: Last Benefit End Date:

Infant/Child 1		
First Name:	Last Name:	DOB:
Sex: ☐ Female ☐ Male	Category: ☐ Infant ☐Child	Hispanic/Latino: ☐ Yes ☐ No
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander ☐ White (☐ Middle Eastern or North African)		
☐ VOC Cert Start Date: Last Benefit Start Date: Cert End Date: Last Benefit End Date:		☐ Foster Entered Care: Change Family Date:

Infant/Child 2		
First Name:	Last Name:	DOB:
Sex: ☐ Female ☐ Male	Category: ☐ Infant ☐Child	Hispanic/Latino: ☐ Yes ☐ No
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander ☐ White (☐ Middle Eastern or North African)		
☐ VOC Cert Start Date: Last Benefit Start Date: Cert End Date: Last Benefit End Date:		☐ Foster Entered Care: Change Family Date:

Additional Authorized Representative		
First Name:	Last Name:	DOB:

Proxy	
First Name:	Last Name:

FAMILY DATA

Mother's Education Level:	Printouts Language:	☐ Needs Interpreter Preferred Spoken Language:
Referred to WIC By: ☐ Family/Friend ☐ Outreach Organization – Type: *_____ ☐ None ☐ Other – Specify: _____		

*See WIC Services Guidebook Appendix for drop-down options

DATE:_____ COMPLETED BY:_____

INTAKE WORKSHEET
Required Items AUTH REP: _____ FID:_____

IDENTITY

Authorized Representative	Physically Present ☐ Yes ☐ No – Reason: * Proof of Identity: * ☐ No Proof
Infant/Child 1	Physically Present ☐ Yes ☐ No – Reason: * Proof of Identity: * ☐ No Proof
Infant/Child 2	Physically Present ☐ Yes ☐ No – Reason: * Proof of Identity: * ☐ No Proof

CONTACT/ADDRESS

Primary Phone:	☐ Landline ☐ Cell/Mobile ☐ Allow Calls ☐ Allow Texts
Alternate Phone:	☐ Landline ☐ Cell/Mobile ☐ Allow Calls ☐ Allow Texts
Alternate Phone Owner: *	Email Address:
Proof of Residency: *	☐ No Proof

Physical Address		Mailing Address (if different than Physical)	
☐ Homeless ☐ Migrant ☐ Refugee		Address Line 1	
Address Line 1		Address Line 2	
Address Line 2		Apt/Suite	
Apt/Suite		P.O. Box	
City		City	
State		State	
ZIP Code		ZIP Code	
County		County	

INCOME

Household Size: ☐ No Proof

Income Determination

Sources*	Proof*	Amount	Period*	Note

Adjunct Eligibility

Participant	Proof*	MA (Title XIX)	MA ID	SNAP	TANF	599 CHIP
Authorized Representative		☐		☐	☐	☐
Infant/Child 1		☐		☐	☐	☐
Infant/Child 2		☐		☐	☐	☐

AFFIDAVIT SIGNATURE

I am unable to provide proof of (check all that apply): ☐ Identity ☐ Residency ☐ Income

The information I have given is true and accurate. X_____

*See WIC Services Guidebook Appendix for drop-down options

WIC NEBRASKA

DATE:_____ COMPLETED BY:_____

VOTER REGISTRATION

Are you registered to vote where you currently live?	☐ Yes ☐ No
Was a voter registration form completed today?	☐ Yes ☐ No

eWIC CARD

Card Needed: ☐ New[+] ☐ Replacement - Circle reason: Lost Stolen Damaged
eWIC Card Number:
☐ Card Given to Authorized Representative ☐ Mail Card ☐ Will pick up at clinic
[+]Provide instructions for PIN set up and WIC Shopper app ☐ No Card Provided

BENEFITS

Authorized Representative	Issued to Card: ☐ Yes	Number of Months:
	PAF Scanned: ☐ Yes ☐ N/A	
Infant/Child 1	Issued to Card: ☐ Yes	Number of Months:
	PAF Scanned: ☐ Yes ☐ N/A	
Infant/Child 2	Issued to Card: ☐ Yes	Number of Months:
	PAF Scanned: ☐ Yes ☐ N/A	

DAMAGED/LOST BENEFITS

Benefits Lost: (list specific items and amount/number of each)

Month	Item	Amount	Month	Item	Amount

Benefits Replaced ☐ Yes ☐ No If No, Reason:

APPOINTMENTS NEEDED

Authorized Representative	Type of Appointment:	☐ Remote ☐ Clinic Month Schedule:
Infant/Child 1	Type of Appointment:	☐ Remote ☐ Clinic Month Schedule:
Infant/Child 2	Type of Appointment:	☐ Remote ☐ Clinic Month Schedule:

*See WIC Services Guidebook Appendix for drop-down options

WIC NEBRASKA

DATE:_____ COMPLETED BY:_____

PREGNANT ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

PREGNANCY

Expected Delivery Date:	**OR** Last Menstrual Period Date:
Pre-Pregnancy Weight: lbs	BMI:
☐ Multifetal Gestation	# of Expected Babies:

ANTHROPOMETRICS

Current Height cm / in	Current Weight kg / lb	Date Taken:
If not accurate, why?	Measured by:	☐131 – Low Maternal Weight Gain ☐133 – High Maternal Weight Gain

Use Prenatal Weight Gain Grid to assess for Risk Codes 131 and 133.

BLOODWORK

Hgb Or Hct:	Bloodwork Date:	Collected by:
☐ Smoker Packs per day		
Reason not done: ☐Medical condition ☐Religious belief ☐Equipment failure	☐Not required by policy ☐Refusal ☐Illness	☐Will get from medical provider ☐ Participant not present ☐Couldn't get a value

Begin using Pregnant Interview

HEALTH/MEDICAL

Provider: ☐ No provider			Allow sharing: ☐ Yes ☐ No
Summary:			
Feeling nervous, anxious or on edge Score:	Not being able to stop or control worrying Score:	Feeling down, depressed or hopeless Score:	Little interest or pleasure in doing things Score:
Total Score: ☐ Mild ☐ Moderate ☐ Severe			Referral offered: ☐ Yes ☐ No ☐ N/A

WIC NEBRASKA

DATE: _____ COMPLETED BY:_____

PREGNANT ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

Previous pregnancies ☐1st	# of Live births
Pregnancies past 20 Weeks/5months	Last recorded Actual Delivery Date:
Past Pregnancy Complications:	
Current Feelings:	
Prenatal Care: ☐ No ☐ Yes Care began after 13th week ☐	
Medical Conditions: ☐None	
Medications: ☐None	
Oral Health:	

NUTRITION PRACTICES

Eating Habits/Mealtimes:
Desired Changes/Concerns:
Vitamin/Mineral intake in month prior to pregnancy (per week): <1 1 2 3 4 5 6 7
Taken Vitamin/Mineral intake in past month: ☐ Yes ☐ No ☐ Unknown
Herbs/Supplements: ☐ Yes ☐ No ☐ Unknown List here:
353 - Food Allergies:

WIC NEBRASKA

DATE: _____ COMPLETED BY:_____

PARTICIPANT NAME:_____ FID:_____

LIFESTYLE

Current Nicotine and Tobacco use: ☐ Yes ☐ No	904 Environmental Smoke Exposure: ☐ Yes ☐ No
Average daily cigarette use 3 months prior to pregnancy:	Currently:
Average weekly alcohol use 3 months prior to pregnancy:	☐ Non-Drinker Currently:
Current drug use: ☐ Yes ☐ No	
Physical Activity:	

BREASTFEEDING PREPARATIONS

Participant Comments:	
	☐ Interested in Breastfeeding
Previous BF Experience: ☐ Yes ☐ No	Length of time in weeks
Reason for stopping:	
BF Support	☐ Refer to BFPC
Changes/Concerns related to breasts:	
Currently Breastfeeding: ☐ Yes ☐ No	

SOCIAL ENVIRONMENTAL

Additional Needs:

ASSIGNED RISK FACTORS

Risk Codes:
High Risk: ☐ Yes ☐ No

WIC NEBRASKA

DATE: _____ COMPLETED BY:_____

PARTICIPANT NAME:_____ FID:_____

CERTIFICATION SIGNATURE

I have been advised and understand my rights and responsibilities for WIC and was offered the option to register to vote.

Participant Signature: _____

Reason for no signature: ☐ Remote Appointment

REFERRALS, EDUCATION, AND CARE PLAN

Referrals	Education Topics/Handouts	Goals

FOOD BENEFITS

Food Package	Milk Substitutes
☐ All Milk	☐ Lactose Free
☐ Milk and Cheese	☐ Soy
☐ Milk, Cheese, and Yogurt	☐ Whole Milk (PAF required)
Modifications (include reason): ☐ Physician Authorization Form (PAF) Attached	

eWIC CARD

Card Needed: ☐ New+ ☐ Replacement - Circle reason: Lost Stolen Damaged

eWIC Card Number:

☐ Card Given to Authorized Representative ☐ Mail Card ☐ Will pick up at clinic

+Provide instructions for PIN set up and WIC Shopper app ☐ No Card Provided

WRAP UP

Next Appointment Type:	Month:	☐ Remote ☐ In-Clinic
Next Appointment Preference - Day: M T W R F Time: AM PM		☐ No Preference

CHECKLIST Destroy paper copies when all boxes checked

☐ Data entered in MIS ☐ Documents scanned to MIS ☐ Benefits issued

☐ Card given/sent, or pickup arranged ☐ Next Appointment Scheduled

DATE: _____ COMPLETED BY:_____

INFANT ASSESSMENT WORKSHEET

Required Items PARTICIPANT NAME:_____FID:_____

ANTHROPOMETRICS

Birth Length cm / in	Birth Weight kg / lb oz	☐ Unknown Birth Measurements
Current Height cm / in	Current Weight kg / lb oz	Date Taken:
Weeks Gestation:	If not accurate, why?	Measured by:
Infants <6 months old assess for ☐ 135 – Slowed/Faltering Growth	Infants Birth to 2 Weeks: weight loss after birth, > 7% birth weight. **OR** Infants 2 weeks to 6 Months of Age: Any weight loss. Use two separate weight measurements taken at least eight weeks apart.	

BLOODWORK

Required at certification of infants ≥9 months old		
Hgb Or Hct	Bloodwork Date	Collected by:
Assign Risk 201 Low Hematocrit/Low Hemoglobin if: • infant is 6 months to < 12 months old AND Hgb is < 11.0 OR Hct < 33.0		
Reason not done: ☐ infant < 9 months old ☐Medical condition ☐Religious belief ☐Equipment failure	☐Not required by policy ☐Refusal ☐Illness	☐Will get from medical provider ☐ Participant not present ☐Couldn't get a value

Blood Lead Screening done in past 12 months: ☐ Yes ☐ No ☐Unknown If no or unknown, refer for testing at 1 year old	Result, if known: If ≥ 5 µg/dL assign Risk 211 Elevated Blood Lead

Begin using Infant Interview

BREASTFEEDING HISTORY

Start Date	Age (wks)	Description	BF Change Reason	Formula*	Foods*

*Indicate intake as Nothing, Rarely, or Regularly

INFANT ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

NUTRITION PRACTICES

Provider: ☐ No provider	Allow sharing: ☐ Yes ☐ No
Eating Habits/Mealtimes:	
Concerns/Challenges:	
Bottle feeding:	
Vitamins/Minerals:	
Herbs/Supplements:	
Other Concerns/Desired Changes:	
Medications:	

HEALTH/MEDICAL

Health Concerns:
Diagnosis:
Medications:

IMMUNIZATIONS and ORAL HEALTH

Immunizations

Record available:	☐ Yes ☐ No
DTaPs given:	☐ Yes ☐ No
Number of DTaPs given:	
If no records or unsure, provide referral	

Oral Health

Oral care:
Denal Visit: ☐ Yes ☐ No

DATE: _____ COMPLETED BY:_____

INFANT ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

LIFESTYLE

Activities:

904 Environmental Smoke Exposure: ☐ Yes ☐ No If yes, provide SU ed referrals

Additional Needs:

MOM'S WIC PARTICIPATION

Mom on WIC during pregnancy ☐ Yes ☐ No

If no, would she have been eligible? ☐ Yes ☐ No

If yes to either question, enter risk 701- Infant up to 6 months old of WIC mother or WIC eligible mother

If she would have been eligible, list nutrition risk codes that would have made mom eligible:

ASSIGNED RISK FACTORS

Risk Codes:

High Risk: ☐ Yes ☐ No

CERTIFICATION SIGNATURE

I have been advised and understand my rights and responsibilities for WIC and was offered the option to register to vote.

Participant Signature: _____

Reason for no signature: ☐ Remote Appointment

INFANT ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

REFERRALS, EDUCATION, AND CARE PLAN

Referrals	Education Topics/Handouts	Goals

FOOD PACKAGE

0-5 months	6-11 months	9-12 months
☐ Exclusive BF (No food package)	☐ Exclusive BF With complimentary foods	☐ Exclusive BF With complimentary foods & CVV
☐ BF In Range # of cans:		☐ BF In Range & CVV # of cans:
☐ Not BF/ BF Out Range		☐ Not BF/ BF Out Range & CVV
Modifications:		
		☐ PAF Required (Attach)

eWIC CARD

Card Needed: ☐ New+ ☐ Replacement - Circle reason: Lost Stolen Damaged

eWIC Card Number:

☐ Card Given to Authorized Representative ☐ Mail Card ☐ Will pick up at clinic

+Provide instructions for PIN set up and WIC Shopper app ☐ No Card Provided

WRAP UP

Next Appointment Type: Month: ☐ Remote ☐ In-Clinic

Next Appointment Preference - Day: M T W R F Time: AM PM ☐ No Preference

CHECKLIST

Destroy paper copies when all boxes checked

☐ Data entered in MIS ☐ Documents scanned to MIS ☐ Benefits issued

☐ Card given/sent, or pickup arranged ☐ Next Appointment Scheduled

DATE: _____ COMPLETED BY:_____

CHILD ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

ANTHROPOMETRICS

Birth Length+	Birth Weight+	Weeks Gestation+
Current Height cm / in	Current Weight kg / lb oz	Date Taken:
☐Recumbent ☐Standing	If not accurate, why?	Measured by:

+complete for Child <2 years old.

BLOODWORK

Hgb Or Hct	Bloodwork Date	Collected by:

Assign Risk 201 Low Hematocrit/Low Hemoglobin if:

- child is 1- <2 years old AND Hgb is < 11.0 OR Hct < 32.9
- child is 2- <5 years old AND Hgb is < 11.1 OR Hct < 33.0

Reason not done:

☐Medical condition	☐Not required by policy	☐Will get from medical provider
☐Religious belief	☐Refusal	☐ Participant not present
☐Equipment failure	☐Illness	☐Couldn't get a value

Blood Lead Screening done in past 12 months: ☐ Yes ☐ No ☐Unknown	Result, if known:
If no or unknown, provide referral	If ≥ 3.5 µg/dL assign Risk 211 Elevated Blood Lead

Begin using Child Interview

BREASTFEEDING HISTORY (complete for children < 2 years old)

Start Date	Age (wks)	Description	BF Change Reason	Formula	Foods

HEALTH/MEDICAL

Provider: ☐ No provider	Allow sharing: ☐ Yes ☐ No
Health Concerns:	
Diagnosis:	
Medications:	

DATE: _____ COMPLETED BY:_____

PARTICIPANT NAME:_____ FID:_____

IMMUNIZATIONS and ORAL HEALTH

Immunizations

Record available: ☐ Yes ☐ No

DTaPs given: ☐ Yes ☐ No

Number of DTaPs given:

If no records or unsure, provide referral

Oral Health

Oral care:

Denal Visit: ☐ Yes ☐ No If no, provide referral

LIFESTYLE

Activities:

Screen Time Hours:

904 Environmental Smoke Exposure: ☐ Yes ☐ No If yes, provide SU ed referrals

NUTRITION PRACTICES

Eating Habits/Mealtimes:

Desired Changes/Concerns:

Vitamins/Minerals:

Herbs/Supplements:

SOCIAL ENVIRONMENTAL

Additional Needs:

ASSIGNED RISK FACTORS

Risk Codes:

High Risk: ☐ Yes ☐ No

DATE: _____ COMPLETED BY:_____

CHILD ASSESSMENT WORKSHEET
Required Items PARTICIPANT NAME:_____FID:_____

CERTIFICATION SIGNATURE

I have been advised and understand my rights and responsibilities for WIC and was offered the option to register to vote.
Participant Signature: _____
Reason for no signature: ☐ Remote Appointment

REFERRALS, EDUCATION, AND CARE PLAN

Referrals	Education Topics/Handouts	Goals

FOOD PACKAGE

Food Package	Milk Substitutes
☐ All Milk	☐ Lactose Free
☐ Milk and Cheese	☐ Soy
☐ Milk, Cheese, and Yogurt	☐ 2% (one-year olds **ONLY**)
Modifications (include reason):	
☐ Physician Authorization Form (Attach)	

eWIC CARD

Card Needed: ☐ New+ ☐ Replacement - Circle reason: Lost Stolen Damaged

eWIC Card Number:

☐ Card Given to Authorized Representative ☐ Mail Card ☐ Will pick up at clinic

+Provide instructions for PIN set up and WIC Shopper app ☐ No Card Provided

WRAP UP

Next Appointment Type: Month: ☐ Remote ☐ In-Clinic

Next Appointment Preference - Day: M T W R F Time: AM PM ☐ No Preference

CHECKLIST Destroy paper copies when all boxes checked

☐ Data entered in MIS ☐ Documents scanned to MIS ☐ Benefits issued

☐ Card given/sent, or pickup arranged ☐ Next Appointment Scheduled

DATE: _____COMPLETED BY:_____

POSTPARTUM ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

PREGNANCY

Actual Delivery Date:	Weight gained during pregnancy: lbs
# of Expected Babies:	☐ Pregnancy Termination with No Live Birth (321c)
Infant(s) born from this pregnancy:	

ANTHROPOMETRICS

Current Height cm / in	Current Weight kg / lb	Date Taken:
If not accurate, why?	Measured by:	☐131 – Low Maternal Weight Gain ☐133 – High Maternal Weight Gain

Use Total gestational weight gain to assess for Risk Codes 131 and 133.

BLOODWORK

Hgb Or Hct:	Bloodwork Date:	Collected by:
☐ Smoker Packs per day:		
Reason not done: ☐Medical condition ☐Religious belief ☐Equipment failure	☐Not required by policy ☐Refusal ☐Illness	☐Will get from medical provider ☐ Participant not present ☐Couldn't get a value

Begin using Postpartum Interview

Provider: ☐ No provider			Allow sharing: ☐ Yes ☐ No
Summary:			
Feeling nervous, anxious or on edge Score:	Not being able to stop or control worrying Score:	Feeling down, depressed or hopeless Score:	Little interest or pleasure in doing things Score:
Total Score:	☐ Mild ☐ Moderate ☐ Severe		Referral offered: ☐ Yes ☐ No ☐ N/A

DATE: _____ COMPLETED BY: _____

POSTPARTUM ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

BREASTFEEDING SUPPORT ☐ Not breastfeeding, skip to Health/Medical

Participant Comments Complications/Concerns:
BF Plan:
BF Support: ☐ Refer to BFPC
Needs pump: ☐ Yes ☐ No

HEALTH/MEDICAL

Health Concerns and/or Medical Conditions: ☐None	
Medications: ☐None	
# of Previous pregnancies ☐1st	# of Live births
Pregnancies past 20 Weeks/5months	
Complications with this pregnancy: ☐None	
Oral Health:	

NUTRITION PRACTICES

Eating Habits/Mealtimes/Food prep & Storage:
Desired Changes/Concerns:
Takes Vitamin/Mineral or Herbs/Supplements: ☐ Yes ☐ No ☐ Unknown
353 - Food Allergies: ☐ Yes ☐ No List here:

DATE: _____ COMPLETED BY: _____

POSTPARTUM ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

LIFESTYLE

Current Nicotine and Tobacco use: ☐ Yes ☐ No	904 Environmental Smoke Exposure: ☐ Yes ☐ No	
Average daily cigarette use: 3 months prior to pregnancy:	Last 3 months of pregnancy:	Current cigarettes: /day
Average weekly alcohol use ☐ Non-Drinker 3 months prior to pregnancy:	Last 3 months of pregnancy:	Current drinks: /day /week
Current drug use: ☐ Yes ☐ No		
Physical Activity:		

SOCIAL ENVIRONMENTAL

Additional Needs:

ASSIGNED RISK FACTORS

Risk Codes:
High Risk: ☐ Yes ☐ No

CERTIFICATION SIGNATURE

I have been advised and understand my rights and responsibilities for WIC and was offered the option to register to vote.

Participant Signature: _____

Reason for no signature: ☐ Remote Appointment

DATE: _____ COMPLETED BY: _____

POSTPARTUM ASSESSMENT WORKSHEET

Required Items

PARTICIPANT NAME:_____ FID:_____

REFERRALS, EDUCATION, AND CARE PLAN

Referrals	Education Topics/Handouts	Goals

FOOD PACKAGE

Food Package	Milk Substitutes
☐ All Milk	☐ Lactose Free
☐ Milk and Cheese	☐ Soy
☐ Milk, Cheese, and Yogurt	☐ Whole Milk (Must have PAF)
Modifications (include reason):	
☐ Physician Authorization Form (Attach)	

eWIC CARD

Card Needed: ☐ New+ ☐ Replacement - Circle reason: Lost Stolen Damaged

eWIC Card Number:

☐ Card Given to Authorized Representative ☐ Mail Card ☐ Will pick up at clinic

+Provide instructions for PIN set up and WIC Shopper app ☐ No Card Provided

WRAP UP

Next Appointment Type: Month: ☐ Remote ☐ In-Clinic

Next Appointment Preference - Day: M T W R F Time: AM PM ☐ No Preference

CHECKLIST **Destroy paper copies when all boxes checked**

☐ Data entered in MIS ☐ Documents scanned to MIS ☐ Benefits issued

☐ Card given/sent, or pickup arranged ☐ Next Appointment Scheduled

DATE: _____ COMPLETED BY: _____

PREGNANT INTERVIEW

Required Questions in BOLD

Health Medical

What is the Name of your health care provider?

Do you give WIC permission to share your WIC information with this health care provider?

1.a. How is your pregnancy going?

Listen, ask, and assess for:

- Obtaining prenatal care
- Heartburn, constipation
- Previous pregnancies
- Nausea/vomiting

301- Hyperemesis Gravidarum: severe nausea and vomiting

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

Total score is determined by adding together the scores of each of the 4 items. Scores are rated as normal (0-2), mild (3-5), moderate (6-8), and severe (9-12).

1.b. Is this your first pregnancy?

(Not including current pregnancy)

_____# of previous pregnancies

_____# of live births

_____# of pregnancies past 20 weeks/5 months

____/____/____Date of last birth, abortion, miscarriage

*See appendix for dropdown options

+Record specific information on the worksheet

PREGNANT INTERVIEW

Required Questions in BOLD

1.c. With any past pregnancy did you have any complications?

303 - History of Gestational Diabetes	304 - History of Preeclampsia
311- History of Preterm Delivery	321a - History of Fetal or Neonatal death or 2 or more Spontaneous Abortions
337 - History of LGA Infant	345 - Hypertension and Prehypertension

1.e. How are you feeling this week?

How do you feel about your weight gain?

Listen, ask, and assess for:

- Nausea/Vomiting
- Discomfort

301-Hyperemesis Gravidarum	302 - Gestational Diabetes

1.f. Have you been to the doctor yet?

Care began after 13th week?

334 - Lack of or Inadequate Prenatal Care

1.g. Tell me about any medical problems or illnesses you have.

Has your doctor diagnosed any medical problems?

Listen, ask, and assess for:

- Medical conditions before pregnancy
- Health concerns
- Disability
- Illnesses

*See appendix for dropdown options

+Record specific information on the worksheet

PREGNANT INTERVIEW

Required Questions in BOLD

Medical Conditions

347-Cancer	354 - Celiac Disease
348 - Central Nervous System Disorders*	381- Dental Problems
362 - Developmental, Sensory or Motor Disabilities	343 – Diabetes
358 - Eating Disorders*	382- Fetal Alcohol Spectrum Disorders
336 - Fetal Growth Restriction (FGR)	353 - Food Allergies +
342 - Gastro-intestinal Disorders*	349 - Genetic and Congenital Disorders*
302 - Gestational Diabetes	339 – History of Birth with Nutrition Related Congenital Birth Defect
321a - History of Fetal or Neonatal death or 2 or more Spontaneous Abortions	337 - History of LGA Infant
303 - History of Gestational Diabetes	311a - History of Early term Delivery
301- Hyperemesis Gravidarum	311b - History of Preterm Delivery
356 - Hypoglycemia	345 - Hypertension and Prehypertension
351 – Inborn Errors of Metabolism*	352a - Infectious Diseases - Acute*
352b – Infectious Diseases – Chronic*	355 - Lactose Intolerance
361 – Mental Illness*	341- Nutrient Deficiency Diseases*
359 - Recent Major Surgery, Trauma, Burns+	901- Recipient of Abuse
346 - Renal Disease	344 - Thyroid Disorders
360 - Other Medical Conditions - severe enough to affect nutritional status*	

1.h. Are you currently taking any medications? +

Listen, ask, and assess for medications that compromise nutritional status

357 - Drug Nutrient Interactions

1.i. Do you ever have a hard time chewing or eating certain foods?

Listen, ask, and assess for:

- oral health care/referral
- tooth decay/tooth loss
- impaired ability to eat

381 Dental Problems

*See appendix for dropdown options

+Record specific information on the worksheet

PREGNANT INTERVIEW

Required Questions in BOLD

Nutrition Practices

2a. Tell me what you like to eat and drink.

Listen, ask, and assess for:

- Appetite, Timing of meals
- Meals, snacks, beverages
- Eating pattern, frequency
- Food likes/dislikes
- Food preparation
- Eating problems
- Pica

2.b. What would you like to change about your eating?

2.c. Is there anything you would like to eat more or less of?

2.d. In the month before you got pregnant with this baby, how many times a week did you take a multivitamin?

2.e. Have you taken any vitamins/minerals in the past month?

2.f. Do you take any herbs or dietary supplements now? +

427 Nutrition Practices

427a - Dietary Supplements with Potentially Harmful Consequences	427b - Consuming a Diet Very Low in Calories and/or Essential Nutrients
427c - Compulsively Ingesting Non-Food Items (Pica)	427d - Inadequate Vitamin/Mineral Supplementation
427e - Inappropriate Nutrition Practices for Women	

Other Nutrition Risks

401-Failure to Meet Dietary Guidelines for Americans	353 - Food Allergies +

*See appendix for dropdown options

+Record specific information on the worksheet

PREGNANT INTERVIEW

Required Questions in BOLD

Lifestyle

Current Nicotine and Tobacco Use

3.a. Do you currently use any of the following: cigarettes, hookahs/pipes, e-cigarettes, vaping devices, smokeless tobacco, or nicotine replacement therapies?

3.b. In the past seven days, have you been in an enclosed space (i.e. car home, workplace) while someone used tobacco products?

Cigarette Smoking

3.c. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day? (1 pack= 20 cigarettes)

3.d. How many cigarettes do you smoke on an average day now?

Past Alcohol Use

3.e. In the 3 months before you were pregnant, how many alcoholic drinks (beer, wine or liquor) did you have in an average week?

3.f. Have you consumed alcohol during this pregnancy?

Current Alcohol Use

3.g. How many alcoholic drinks (beer, wine or liquor) do you have in an average week now?

Current Drug Use

3.h. Are you misusing any prescription medications, using marijuana in any form or using any illegal substances?

Listen, ask, and assess for:

- Abuse of prescription medications
- Marijuana in any form
- Any illegal substances

372b Illegal Drug Use

3.i. What do you like to do for physical activity?

Listen, ask and assess for

- Physical activities
- Walking
- Playing with children
- Safe parks
- Access to fitness centers
- Activity frequency

*See appendix for dropdown options

+Record specific information on the worksheet

PREGNANT INTERVIEW

Required Questions in BOLD

BF Preparations

4.a. What have you heard about breastfeeding?

Listen, ask and assess for

- Interest in breastfeeding
- Myths or Concerns
- Support Systems

Is mom interested in breastfeeding?

4.b. Previous Experience?

4.c. If previously breastfed, how did it go?

Length of time (weeks)

Reason for stopping [+]

4.d. What does your family, friends or partner say about breastfeeding?

4.e. Tell me about the changes you have noticed or concerns you have about your breasts.

Listen, ask, assess for:

- Flat or inverted nipples
- Piercings
- Size, surgeries

4.f. We have trained moms who have breastfed before and can help you with breastfeeding. I will have one call you, if that is okay with you.

4.g. Are you exclusively breastfeeding an infant or partially breastfeeding multiples from a previous pregnancy?

338 – Pregnant Woman Currently Breastfeeding

4.h. How is breastfeeding going for you?

Listen, ask, and assess for:

- Successes
- Challenges
- Milk supply
- Teething/biting
- Baby preferring on breast
- Baby not interested
- Soreness/nipple care
- Breast leaking

602 - Breastfeeding Complications

602a - BF Complications - severe breast engorgement	602b - BF Complications - recurrent plugged ducts
602c - BF Complications - mastitis	602d - BF Complications - flat or inverted nipples causing latch problems
602e - BF complications - cracked, bleeding or severely sore nipples	602g - BF Complications - failure of milk to come in by 4 days post part um
602h - BF Complications - tandem nursing 2 siblings who are not twins	

*See appendix for dropdown options

+Record specific information on the worksheet

PREGNANT INTERVIEW

Required Questions in BOLD

Social Environment

5.a. What else can I help you with?

901- Recipient of Abuse
902 - Limited ability to make feeding decisions

*See appendix for dropdown options

+Record specific information on the worksheet

INFANT INTERVIEW

Required questions in bold

Breastfeeding History

Breastfeeding Description *

How old was your child when he/she completely stopped breastfeeding or being fed breast milk?
Age in Weeks or Date mm/dd/yyyy

What was your reason for stopping breastfeeding? *

How old was your child when he/she was first fed something other than breast milk?
Age in Weeks or Date mm/dd/yyyy

How old was your child when he/she was first fed something else on a regular basis?
Age in Weeks or Date mm/dd/yyyy

How old was your child when he/she was first fed formula?
Age in Weeks or Date mm/dd/yyyy

Nutrition Practices

What is the Name of your child's health care provider?

Do you give WIC permission to share your child's WIC information with this health care provider?

1.a. Tell me how it is feeding your child.

Listen, ask, and assess for:

- Hunger and satiety cues
- Number of wet/dirty diapers
- Appetite changes
- Vomiting
- Constipation or diarrhea
- Breastfeeding or formula

1.b. What concerns or challenges are you having?

Listen, ask, and assess for:

- Frequency
- Ounce/bottle and bottles/day
- Difficulty latching on/positioning
- Weak/ineffective suck
- Jaundice
- Breastfeeding support available
- Baby preferring one breast
- Baby not interested

603 - Breastfeeding Complications or Potential Complications

603a - BF complications - jaundice	603b - BF complications - weak or ineffective suck
603c - BF complications - difficulty latching onto mother's breast	603d - BF complications - inadequate stooling and/or <6 wet diapers a day

*See appendix for dropdown options

+Record specific information on the worksheet

INFANT INTERVIEW

Required questions in bold

1.c. If bottle feeding, listen, ask and assess for:

- Amount of breastmilk/formula
- Ounce/bottle and bottles/day
- Formula brand/type
- How is formula mixed
- Water source
- Contents other than formula
- Storage/handling

1.d. Does your baby take any vitamins, minerals, herbs, or dietary supplements?

1.e. What other questions or concerns do you have about feeding your baby? Or is there anything you would like to change?

Listen, ask, and assess for:

- Dietary progression
- Making baby food
- When to start solids & types of solids
- Introducing a cup
- Weaning breast/bottle

411- Nutrition Practices

411a - Primary Nutrient Source Inappropriate	411b - Improper Use of Bottles or Cups
411c - Inappropriate Complimentary Foods	411d - Feeding Practices that Disregard Developmental Stage of Infant
411e - Feeding Potentially Harmful Foods	411f- Dilution of Formula Inappropriate
411g - Infrequent Breastfeeding as Only Nutrition	411h – Consuming a diet very low in calories and/or essential nutrients
411i - Inappropriate Sanitation Practices in Handling Formula/Breast Milk	411j - Dietary Supplements with Potentially Harmful Consequences
411k - No Dietary Supplement of Vitamin D or Fluoride (when necessary)	

Other Nutrition Risks

353 - Food Allergies +	428 - Risk Associated w/Complimentary Feeding age 4-23 months

*See appendix for dropdown options

+Record specific information on the worksheet

INFANT INTERVIEW

Required questions in bold

Health/Medical

3.a. What concerns do you have about your baby's health?

3.b. Does your baby have any medical problems diagnosed by a doctor?

Medical Conditions

347-Cancer	354 - Celiac Disease
348 - Central Nervous System Disorders *	381- Dental Problems
362 - Developmental, Sensory or Motor Disabilities	343 - Diabetes
134 - Failure to Thrive	382 - Fetal Alcohol Syndrome
353 - Food Allergies +	342 - Gastro-intestinal Disorders*
349 - Genetic and Congenital Disorders *	345 - Hypertension and Prehypertension
356 - Hypoglycemia	351- Inborn Errors of Metabolism*
352 - Infectious Disease in past 6 months*	355 - Lactose Intolerance
341- Nutrient Deficiency Diseases Select from drop down	359 - Recent Major Surgery, Trauma, Burns+
901- Recipient of Abuse	346 - Renal Disease*
344 - Thyroid Disorders	360 - Other Medical Conditions - severe enough to affect nutritional status*

3c. Is your child currently on any medication?

Listen, ask, and assess for medications that compromise nutritional status

357 - Drug Nutrient Interactions+

*See appendix for dropdown options

+Record specific information on the worksheet

INFANT INTERVIEW

Required questions in bold

Immunizations

4.a. Can we look over your child's shot record today?

4.b. Have any DTaP shots been given?

4.c. # of DTaP immunizations

Oral Health

5.a. What questions do you have regarding caring for your baby's gums and teeth?

381 - Dental Problems

Lifestyle

6.a. How active is your child every day?

Listen, ask, and assess for:

- Strollers
- Play pens
- Infant seats
- Car seats

Listen, ask, and assess for planned physical activity times for:

- Crawling
- Rolling over
- Moving muscles (massage)
- Walking

6.b. In the past seven days, has your baby been in an enclosed space (i.e. car, home, childcare) while someone used tobacco products?

6.c. What else can I help you with?

Listen, ask and assess for

- Abuse/neglect
- Limited ability to make feeding decisions

901 – Recipient of Abuse
902 – Primary Caregiver with Limited Ability

Mom's WIC Participation

7.a. Was mother on WIC during her pregnancy?

7.b. If no, would she have been eligible?

701- Infant up to 6 mos old of WIC mother or WIC eligible mother

*See appendix for dropdown options

+Record specific information on the worksheet

CHILD INTERVIEW

Required questions in bold

Breastfeeding History (Children less than 2 years old)

Breastfeeding Description *

How old was your child when he/she completely stopped breastfeeding or being fed breast milk?
Age in Weeks or Date mm/dd/yyyy

What was your reason for stopping breastfeeding? *

How old was your child when he/she was first fed something other than breast milk?
Age in Weeks or Date mm/dd/yyyy

How old was your child when he/she was first fed something else on a regular basis?
Age in Weeks or Date mm/dd/yyyy

How old was your child when he/she was first fed formula?
Age in Weeks or Date mm/dd/yyyy

Health/Medical

What is the Name of your child's health care provider?

Do you give WIC permission to share your child's WIC information with this health care provider?

1.a. What concerns do you have about your child's health?

1.b. Does your child have any medical problems diagnosed by a doctor?

Medical Conditions

347-Cancer	354 - Celiac Disease
348 - Central Nervous System Disorders *	381- Dental Problems
362 - Developmental, Sensory or Motor Disabilities	343 - Diabetes
134 - Failure to Thrive	382 - Fetal Alcohol Syndrome
353 - Food Allergies +	342 - Gastro-intestinal Disorders*
349 - Genetic and Congenital Disorders *	345 - Hypertension and Prehypertension
356 - Hypoglycemia	351- Inborn Errors of Metabolism*
352a - Infectious Disease - Acute *	352b - Infectious Disease - Chronic *
355 - Lactose Intolerance	361 – Mental Illness *
341- Nutrient Deficiency Diseases*	359 - Recent Major Surgery, Trauma, Burns+
901- Recipient of Abuse	346 - Renal Disease*
151 – Small for Gestational Age	344 - Thyroid Disorders
360 - Other Medical Conditions - severe enough to affect nutritional status*	

*See appendix for dropdown options +Record specific information on the worksheet

CHILD INTERVIEW

Required questions in bold

1.c. Is your child currently on any medication?
Listen, ask, and assess for medications that compromise nutritional status

357 - Drug Nutrient Interactions +

Immunizations

2.a. Can we look over your child's shot record today?

2.b. Have any DTaP shots been given?

2.c. # of DTaP immunizations

Oral Health

3.a. How do you take care of your child's teeth?

3.b. Has your child seen a dentist?

If not, 381 - Dental Problems

Lifestyle

4.a. What types of activities does your child enjoy?

4.b. # of hours of TV watching/video playing per day

4.c. In the past seven days, has your child been in an enclosed space (i.e. car, home, childcare) while someone used tobacco products?

Nutrition Practices

5.a. Tell me about your child's eating and what he/she likes to drink.
Listen, ask, and assess for:

- Appetite
- Eating pattern
- Eating problems
- Beverages/containers
- Food preparation
- Food jags/refusal

5.b. What is mealtime like?
Listen, ask, and assess for:

- Environment, tone of mealtime

*See appendix for dropdown options +Record specific information on the worksheet

CHILD INTERVIEW

Required questions in bold

- When, where and with whom?

5.c. Is there anything you would like to see different about your child's eating?

5.d. Are there any foods you would like to see your child eat more/less of?

5.e. Does your child take any vitamins or minerals?

5.f. Does your child take any herbs or dietary supplements?

425 - Nutrition Practices

425a - Inappropriate Beverages as Primary Milk Source	425b - Feeding Sugar Sweetened Beverages
425c - Improper Use of Bottles, Cups or Pacifiers	425d - Feeding Practices that Disregard Developmental Stage of Child
425e - Feeding Foods Potentially Contaminated with Harmful Microorganisms	425f- Diet Very Low in Calories and/or Essential Nutrients
425g - Dietary Supplements with Potentially Harmful Consequences	425h - No Dietary Supplement of Vitamin D or Fluoride (when necessary)
425i - Eating of Non-Food Items (Pica)	

Other Nutrition Risks

428- Risk Associated w/Complementary Feeding Age 4-23 months	401 – Failure to Meet Dietary Guidelines for Americans
353 – Food Allergies +	

Social Environment

6.a. What else can I help you with?

Listen, ask and assess for

- 901 - Recipient of Abuse
- 902 - Limited ability to make appropriate feeding decisions or prepare foods

*See appendix for dropdown options +Record specific information on the worksheet

POSTPARTUM INTERVIEW

Required questions in BOLD

What is the name of your healthcare provider?

Do you give WIC permission to share your WIC information with this healthcare provider?

1.a. How is it being a new mom?

Listen, ask, and assess for

- Postpartum depression
- Struggles/successes
- Caregiver ability

361- Depression
902 - Limited ability to make feeding decisions

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

Total score is determined by adding together the scores of each of the 4 items.
Scores are rated as normal (0-2), mild (3-5), moderate (6-8), and severe (9-12).

Breastfeeding Support If not breastfeeding skip to Health/Medical

1.b. How is breastfeeding going for you?

Listen, ask, and assess for

- Successes, Challenges
- Milk supply
- Baby preferring one breast, baby not interested
- Soreness, nipple care

602 - Breastfeeding Complications

602a - BF Complications - severe breast engor gement	602b - BF Complications - recurrent plugged ducts
602c - BF Complications - mastitis	602d - BF Complicat ions - flat or inverted nipples causi ng latch problems
602e - BF complications - cracked, bleeding or severely sore nipples	602g - BF Complications - failure of milk to come In by 4 days post part um
602h - BF Complications - tandem nursing 2 siblings who are not twins	

*See appendix for dropdown options

+Record specific information on the worksheet

POSTPARTUM INTERVIEW

Required questions in BOLD

1.c. How long are you planning to breastfeed your infant?

Listen, ask, and assess for

- Returning to work/school
- Pumping/storage
- Continuation of BF
- Anticipated or current separation from infant

1.d. Are you currently employed or att ending school> 10 hours/week?

1.e. What type of support do you have for breastfeeding?

Listen, ask, and assess for

- Partner/spouse/other family/friends/peers
- Work/school environment
-

1.f. Do you need any help or assistance from the WIC program?

Listen, ask, and assess for

- BF equipment need, current use, type, experience using
- BFPC, CPA, Lactation specialist, additional referral

1. g. *If BFPC <u>has not</u> been assigned*. We have trained moms who have breastfed before and can help you with breastfeeding. I will have one call you, if that is okay with you.

Health/Medical

2.b. What concerns do you or your doctor have about your health?

Listen, ask, and assess for

- Medical conditions
- Family Planning

*See appendix for dropdown options

+Record specific information on the worksheet

POSTPARTUM INTERVIEW

Required questions in BOLD

2c. Any medical conditions, illnesses, or special needs?

Medical Conditions

347-Cancer	354 - Celiac Disease
348 - Central Nervous System Disorders*	381- Dental Problems
362 - Developmental, Sensory or Motor Disabilities	358 - Eating Disorders*
343 – Diabetes	382- Fetal Alcohol Spectrum Disorders
336 - Fetal Growth Restriction (FGR)	353 - Food Allergies +
342 - Gastro-intestinal Disorders*	349 - Genetic and Congenital Disorders*
302 - Gestational Diabetes	339 – History of Birth with Nutrition Related Congenital Birth Defect
321a - History of Fetal or Neonatal death or 2 or more Spontaneous Abortions	337 - History of LGA Infant
303 - History of Gestational Diabetes	311a - History of Early term Delivery
301- Hyperemesis Gravidarum	311b - History of Preterm Delivery
356 - Hypoglycemia	345 - Hypertension and Prehypertension
351 – Inborn Errors of Metabolism*	352 - Infectious Diseases in past Acute*
352b – Infectious Diseases – Chronic*	355 - Lactose Intolerance
361 – Mental Illness*	341- Nutrient Deficiency Diseases*
359 - Recent Major Surgery, Trauma, Burns +	901- Recipient of Abuse
346 - Renal Disease	344 - Thyroid Disorders
360 - Other Medical Conditions - severe enough to affect nutritional status*	

2.d. Are you currently taking any medications? +

Listen, ask, and assess for medications that compromise nutritional status

357 - Drug Nutrient Interactions

2.e. Was this your first pregnancy?

(Not including current pregnancy)

_____**# of previous pregnancies**

_____**# of live births**

_____**# of pregnancies past 20 weeks/5 months**

*See appendix for dropdown options

+Record specific information on the worksheet

POSTPARTUM INTERVIEW

Required questions in BOLD

2.f. Did you have any complications or special conditions with this pregnancy?

303 - History of Gestational Diabetes	304 - History of Preeclampsia
311- History of Preterm Delivery	321a - History of Fetal or Neonatal death or 2 or more Spontaneous Abortions
337 - History of LGA Infant	345 - Hypertension and Prehypertension
301-Hyperemesis Gravidarum	302 - Gestational Diabetes

2.g. Do you ever have a hard time chewing or eating certain foods?

Listen, ask, and assess for:

- oral health care/referral
- tooth decay/tooth loss
- impaired ability to eat

381 Dental Problems

Nutrition Practices

3.a. Tell me what you like to eat and drink.

Listen, ask, and assess for:

- Drink to Thirst
- Appetite, Timing of meals
- Meals, snacks, beverages
- Eating pattern, Frequency, food likes/dislikes
- Eating problems
- Pica

3.b. What would you like to change about your eating?

3.c. Is there anything you would like to eat more or less of?

3.d. Do you take any vitamins, minerals, herbs or dietary supplements?

427 Nutrition Practices

427a - Dietary Supplements with Potentially Harmful Consequences	427b - Consuming a Diet Very Low in Calories and/or Essential Nutrients
427c - Compulsively Ingesting Non-Food Items (Pica)	427d - Inadequate Vitamin/Mineral Supplementation
427e - Inappropriate Nutrition Practices for Women	

Other Nutrition Risks

401-Failure to Meet Dietary Guidelines for Americans	353 - Food Allergies +

*See appendix for dropdown options

+Record specific information on the worksheet

POSTPARTUM INTERVIEW

Required questions in BOLD

3.e. Do you have any problems with food preparation and/or storge?

Lifestyle

Current Nicotine and Tobacco Use

4.a. Do you currently use any of the following: cigarettes, hookahs/pipes, e-cigarettes, vaping devices, smokeless tobacco, or nicotine replacement therapies?

4.b. In the past seven days, have you been in an enclosed space (i.e. car home, workplace) while someone used tobacco products?

Cigarette Smoking

4.c. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day? (1 pack= 20 cigarettes)

4.d. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (1 pack= 20 cigarettes)

4.e. How many do you smoke on an average day now?

Past Alcohol Use

4.f. In the 3 months before you were pregnant, how many alcoholic drinks (beer, wine or liquor) did you have in an average week?

4.g. In the last 3 months of your pregnancy, how many alcoholic drinks (beer, wine or liquor) did you have in an average week?

Current Alcohol Use

4.h. Do you currently drink alcohol?

Current Drug Use

4.i. Are you misusing any prescription medications, using marijuana in any form or using any illegal substances?

Listen, ask, and assess for:

- Abuse of prescription medications
- Marijuana in any form
- Any illegal substances

372b Illegal Drug Use

*See appendix for dropdown options

+Record specific information on the worksheet

POSTPARTUM INTERVIEW

Required questions in BOLD

4.j. What do you like to do for physical activity?

Listen, ask and assess for

- Physical activities
- Walking
- Playing with children
- Safe parks
- Access to fitness centers
- Activity frequency

Social Environment

5.a. What else can I help you with?

901- Recipient of Abuse
902 - Limited ability to make feeding decisions

*See appendix for dropdown options

+Record specific information on the worksheet

Appendix - Dropdown Options

Breastfeeding

Breastfeeding Description	
Exclusively Breastfeeding (Excl BF)	Has been fed only human milk, vitamins, minerals, and/or medications. Infant receives no food package from WIC.
Primary Exclusive/No Formula Package (Prim Excl/No F Pkg)	Has been fed something other than human milk, vitamins, minerals, and/or medications on rare occasions, or has received a one-time feeding of infant formula, human milk fortifier, cow's milk, juice, sugar water, water, rehydration solution, baby food, or anything else. This description identifies an infant whose exclusive breastfeeding is interrupted because of special circumstances, such as acute illness, hospitalization or caregiver misinformation. Infant receives no food package from WIC.
Primarily Exclusive/complimentary Foods (Prim Excl/Comp)	Is fed any complementary foods in addition to only being fed human milk, vitamins, minerals, and/or medications. These complementary foods are provided on a routine or ongoing basis regardless of the amount. Infant receives age-appropriate food packages with no WIC formula.
Partially Breastfeeding (Part BF)	Is breastfeeding and receiving formula (WIC or non-WIC supplied formula). May also be fed complementary foods. Infant receives a WIC food package that includes formula and may include WIC foods.
No Longer Breastfeeding (No Longer BF)	Was breastfeeding at some point in time but has now discontinued.
Never Breastfed (Never BF)	Was never breastfed.
Breastfeeding Child (BF Child)	Greater than or equal to 12 months of age and continuing to breastfeed.

Appendix - Dropdown Options

Reason Ceased Breastfeeding	
Anatomical problem (cleft palate, surgery, etc.)	Mom wanted to eat usual/weight loss diet
Baby not gaining enough weight	Mom/baby didn't like breastfeeding
Baby not satisfied with breastmilk alone	Mom pregnant again
Baby sick/premature/jaundice	Nipples sore/cracked/bleeding
Breast problem/mastitis/engorgement/etc	No support from family/friends
HCP advised to stop breastfeeding	Oral contraceptive use
Latch-on or sucking problems	Other
Mom/baby decided time to wean	Return to work or school
Mom on contraindicated medication	Someone else needed/wanted to feed baby
Mom perceives not enough milk	Separation of mom and baby
Mom sick and unable to breastfeed	Too inconvenient/tiring/demanding

Contact/Address

Affidavit Reason - Residency	
Homeless	Landlord Refusal
Natural Disaster	Pandemic
Other	Fire/Flood
Transfer/VOC	Domestic Abuse Shelter

Alternate Phone Owner	
Boyfriend/Girlfriend	Spouse/Partner
Family	Friend
Neighbor	Co-Worker
Other	

Appendix - Dropdown Options

Proof of Residency	
Medicaid/Pandemic	Mail (Postmkd env or Card w/ current addr)
Utility or other bill showing service addr	Notice of Action – DHHS
Pay stub	Rental Agreement
Rent or Mortgage Receipts	Written statement from landlord
Other (In Notes/Scanned)	Address Confidentiality Program
Map – Rural Areas Only	Migrant Card/Migrant Health Card
Affidavit	

Family Data

Outreach Organization Types	
Breastfeeding Peer Counselor	Breastfeeding Support
Early Development Network	Food Resources
Head Start	Health Department
Public Health Nurse	NEP – Nutrition Education Program
Outreach Organization	Pharmacist
Other Programs	

Identity

Affidavit Reason - Identity	
Homeless	Natural Disaster
Pandemic	Other
Fire/Flood	Domestic Abuse Shelter

Reason Not Present	
Bed rest	Contagious illness
Infant under 1 month of age	Infant between 4 & 8 weeks of age
Serious illness/fragile condition	Transportation of medical equipment
VOC – Transfer	Disaster/Pandemic

Appendix - Dropdown Options

Proof of Identity	
Photo ID – Driver's, Gov't, School, Work, Military	WIC ID Card (Recert Only)
Medicaid Card	Medicaid/Pandemic
Voter Registration	Staff Saw Earlier
Text Message Opt In/Out	Birth Certificate
WIC Infant Enrollment ID Card	Social Security Card
Foster Papers	Custody/Guardianship Papers
Notice of Action	Verbal ID - Case Manager (Foster)
Staff Recognition (Recert Only)	Affidavit
Immunization Record NESIIS (Child & Infant	Paternity Papers
Birth Certificate Worksheet (Infant)	Voter Registration Card
Marriage License	Baptismal Certificate (Infant)
Refugee Card – I94	Other

Income

Adjunct Eligibility	
Medicaid Phone/Computer Verification	Medicaid Card Issued within 30 days
Infant Born to Medicaid Mom	Foster care Papers
Notice of Action	SNAP Phone/Computer Verification
Relicard Phone/Computer Verification	ADC Bank Statement

Affidavit Reason - Income	
Employer Refusal	Homeless
Natural Disaster	Pandemic
Zero Income	Other
Paid in Cash	Fire/Flood
Domestic Abuse Shelter	

Appendix - Dropdown Options

Income Determination - Sources	
Employment	Verbal Income for Adj Eligible
Child Support	Social Security/Disability
Unemployment Compensation	Tax Forms – Self Employed/Farmer
ADC	Foster Care
TANF – See Adjunctive	Alimony
Savings/Trust Accounts	Other
Lottery/Gambling Winnings	Zero Income

Income Determination - Proof	
Medicaid verification	Infant Born to Medicaid Mom
Pay Stub (paper or electronic)	Tax Forms/1040
Child Support/Alimony	Military LES
Foster Placement Papers/verification	Notice of Action – DHHS
SNAP verification	Social Security/Retirement/Pension
Disability	Unemployment Letter/Notice
Bank Statement – Saving/Checking	Self-Employment document other than tax forms
Written statement from employer	Other – document in Note column
Affidavit	

Income Determination - Period	
Weekly	Bi-weekly
Twice Monthly	Monthly
Annual	

Risk Codes

348 Central Nervous System Disorders	
Epilepsy	Cerebral palsy (CP)
Multiple sclerosis (MS)	Parkinson's disease
Neutral tube defects (NTDs), such as spina bifida	

Appendix - Dropdown Options

358 Eating Disorders	
Anorexia Nervosa (AN)	Binge-Eating Disorder (BED)
Bulimia Nervosa (BN)	

342 Gastrointestinal Disorders	
Post-bariatric surgery	Gastroesophageal reflux disease (GERD)
Pancreatitis	Inflammatory bowel disease, including ulcerative colitis or Crohn's disease
Short bowel syndrome	Peptic ulcer
Biliary tract disease	Liver disease

349 Genetic and Congenital Disorders	
Cleft lip or palate	Thalassemia major
Down's syndrome	Muscular dystrophy
Sickle Cell Anemia (not sickle cell trait)	

351 Inborn Errors of Metabolism	
Organic Acid Metabolism Disorders	Amino Acid Disorders
Lysosomal Storage Diseases	Fatty Acid Oxidation Disorders
Carbohydrate Disorders	Urea Cycle Disorders
Mitochondrial Disorders	Peroxisomal Disorders

352a Infectious Diseases - Acute	
Hepatitis E	Hepatitis A
Parasitic Infections	Meningitis (Bacterial/Viral)
Pneumonia	Listeriosis
Bronchitis (3 episodes in last 6 months)	

352b Infectious Diseases – Chronic	
HIV (Human Immunodeficiency Virus)	Hepatitis B
AIDS (Acquired Immunodeficiency Syndrome)	Hepatitis C
Hepatitis D	

Appendix - Dropdown Options

361 Mental Illness	
Personality Disorders Bipolar Disorders	Anxiety Disorders
Post-Traumatic Stress Disorder (PTSD)	Depression
Obsessive-Compulsive Disorder (OCD)	Schizophrenia
Attention-Deficit/Hyperactivity Disorder (ADHD)	

341 Nutrient Deficiency or Disease	
Protein Energy Malnutrition	Scurvy
Rickets	Beriberi
Hypocalcemia	Osteomalacia
Vitamin K Deficiency	Pellagra
Xerophthalmia	Iron Deficiency

360 Other Medical Conditions	
Juvenile Idiopathic Arthritis (JIA)	Cardiovascular Disease
Systemic Lupus Erythematosus (SLE)	Persistent Asthma (moderate or severe) requiring daily medication
Polycystic Ovary Syndrome (PCOS)	Cystic Fibrosis