

ADDITIONAL INFORMATION #2

Need Interpreter Correspondence Preference English Spanish

Household Language 1 <input type="checkbox"/> Read <input type="checkbox"/> Spoken <input type="checkbox"/> Albanian <input type="checkbox"/> Chinese <input type="checkbox"/> Italian <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> English <input type="checkbox"/> Korean <input type="checkbox"/> Ukrainian <input type="checkbox"/> Baillie <input type="checkbox"/> Farsi <input type="checkbox"/> Romanian <input type="checkbox"/> Urdu <input type="checkbox"/> Bosnian <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Bulgarian <input type="checkbox"/> German <input type="checkbox"/> Sign <input type="checkbox"/> Other <input type="checkbox"/> Burmese <input type="checkbox"/> Hmong <input type="checkbox"/> Somali	Household Language 2 <input type="checkbox"/> Read <input type="checkbox"/> Spoken <input type="checkbox"/> Albanian <input type="checkbox"/> Chinese <input type="checkbox"/> Italian <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> English <input type="checkbox"/> Korean <input type="checkbox"/> Ukrainian <input type="checkbox"/> Braille <input type="checkbox"/> Farsi <input type="checkbox"/> Romanian <input type="checkbox"/> Urdu <input type="checkbox"/> Bosnian <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Bulgarian <input type="checkbox"/> German <input type="checkbox"/> Sign <input type="checkbox"/> Other <input type="checkbox"/> Burmese <input type="checkbox"/> Hmong <input type="checkbox"/> Somali
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EBT HOUSEHOLD REPRESENTATIVES

AUTHORIZED REPRESENTATIVE (REP.) - LAST NAME AUTHORIZED REPRESENTATIVE (REP.) - FIRST NAME

Marital Status <input type="checkbox"/> Declined <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Registered to Vote <input type="checkbox"/> Selected to register <input type="checkbox"/> Declined to register <input type="checkbox"/> Already registered	Educational Level <input type="checkbox"/> 1st grade <input type="checkbox"/> 7th grade <input type="checkbox"/> 1 year of college <input type="checkbox"/> 2nd grade <input type="checkbox"/> 8th grade <input type="checkbox"/> 2 years of college <input type="checkbox"/> 3rd grade <input type="checkbox"/> 9th grade <input type="checkbox"/> 3 years of college <input type="checkbox"/> 4th grade <input type="checkbox"/> 10th grade <input type="checkbox"/> 4 or 5 years of college <input type="checkbox"/> 5th grade <input type="checkbox"/> 11th grade <input type="checkbox"/> 1 year of graduate school <input type="checkbox"/> 6th grade <input type="checkbox"/> 12th grade or GED <input type="checkbox"/> 2 or more years of graduate school <input type="checkbox"/> Unknown
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AUTHORIZED REP. - LAST NAME	RELATIONSHIP <input type="checkbox"/> Self <input type="checkbox"/> Legal guardian <input type="checkbox"/> Mother/stepmother <input type="checkbox"/> Foster parent <input type="checkbox"/> Father/stepfather <input type="checkbox"/> Other <input type="checkbox"/> Family member	DATE OF BIRTH
AUTHORIZED REP. - FIRST NAME		PRIMARY CARDHOLDER <input type="checkbox"/> Yes <input type="checkbox"/> No
ALTERNATE REP. / PROXY 1 - LAST NAME	<input type="checkbox"/> Alt	RELATIONSHIP <input type="checkbox"/> Self <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Mother/Stepmother <input type="checkbox"/> Foster parent <input type="checkbox"/> Father/Stepfather <input type="checkbox"/> Other <input type="checkbox"/> Family member
AUTHORIZED REP. / PROXY 1 - FIRST NAME	<input type="checkbox"/> Proxy	DATE OF BIRTH
		PRIMARY CARDHOLDER <input type="checkbox"/> Yes <input type="checkbox"/> No
ALTERNATE REP. / PROXY 2 - LAST NAME	<input type="checkbox"/> Alt	RELATIONSHIP <input type="checkbox"/> Self <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Mother/Stepmother <input type="checkbox"/> Foster parent <input type="checkbox"/> Father/Stepfather <input type="checkbox"/> Other <input type="checkbox"/> Family member
AUTHORIZED REP. / PROXY 2 - FIRST NAME	<input type="checkbox"/> Proxy	DATE OF BIRTH
		PRIMARY CARDHOLDER <input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH INFORMATION

Unknown Birth Criteria Weeks in Gestation: _____

Birth Height: _____ (inches) _____ (8ths) Birth Facility: _____

Birth Weight: _____ (pounds) _____ (ounces) Hospital Home Birth Other _____

Mother's Birth Date (MM/DD/YY) _____ State ID Number: _____ Mother's Name: _____

Ever Breastfed:
 Yes No Unknown _____ Date Food Package III Verified: _____ Date Breastfeeding Ended: _____

Requires Food Package III Date Breastfeeding Verified: _____ Date Supplement Feeding Began: _____

Breastfeeding now Date Breastfeeding Began: _____ Date Solids Were Introduced: _____

Breastfeeding beyond one year

Breastfeeding Amount: <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Mostly breastfeeding <input type="checkbox"/> Some breastfeeding <input type="checkbox"/> Non-breastfeeding	Reason(s) Stopped Breastfeeding: <input type="checkbox"/> Breast problems <input type="checkbox"/> Infant medical conditions/issues <input type="checkbox"/> Lack support <input type="checkbox"/> Low milk supply <input type="checkbox"/> Mom met personal goal/personal preference <input type="checkbox"/> Returned to work or school	Household Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No	TV/Viewing (≥2 years old): <input type="checkbox"/> > 0 and < 1 hour/day <input type="checkbox"/> 1 hour/day <input type="checkbox"/> 2 hours/day <input type="checkbox"/> 3 hours/day <input type="checkbox"/> 4 hours/day <input type="checkbox"/> 5+ hours/day <input type="checkbox"/> None <input type="checkbox"/> Unknown
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Medical Conditions: Diabetes mellitus Hypertension or prehypertension

IMMUNIZATION

Immunization Status: Up to date Not up to date _____

HEIGHT/WEIGHT/BLOOD

Height/Weight
Measurement Date: _____ Age at Measurement: _____
Measurement Position: Standing Recumbent
Height: _____ (inches) _____ (eighths)
Weight: _____ (pounds) _____ (ounces) BMI: _____
WT% chart: _____

Possible Incorrect Measurement Reason:
 Greater than (>) scale max
 Hospital certification
 Participant disability
 Possible equipment error
 Uncooperative client

BLOOD
Measurement Date: _____
Age at Measurement: _____
Measurement Source: WIC clinic Outside of WIC clinic
Hgb (gm/dl): _____ Hct (%) _____
Lead (µg/dl): _____
Delayed Blood Work

Reason(s) Blood Work Was Not Collected:
 Skip until 15 to 18 months (child only)
 CPA determined Skip - WNL (child only)
 Religious beliefs
 Medical condition
 Participant refused
 Equipment malfunction
 Breastfeeding > 6 months (breastfeeding women only)

FOOD PRESCRIPTION

Food Package I (0-5 months)
 Food Package II (6-9 months) Infant food Infant cereal Other
 Food Package II (9-11 months) Infant food Infant cereal Fresh fruit and vegetable Other
 Food Package IV (12-59 months) All milk Milk Cheese Yogurt Other _____
 Food Package III _____
 Tailored Food Package _____

Cycle
 1
 2
 3

RISK FACTORS

- Infant**
- 103 Underweight or At Risk of Underweight
 - 114 Overweight or At Risk of Overweight
 - 115 High Weight-for-Length (Infants and Children < 24 months)
 - 121 Short Stature or At Risk of Short Stature
 - 134 Failure to Thrive
 - 135 Slowed/Faltering Growth Pattern
 - 141 Low Birth Weight and Very Low Birth Weight
 - 142 Preterm or Early Term Delivery
 - 151 Small for Gestational Age
 - 152 Low Head Circumference (Infants and Children ≤ 24 months)
 - 153 Large for Gestational Age
 - 201 Low Hematocrit/Low Hemoglobin
 - 211 Elevated Blood Lead Levels
 - 341 Nutrient Deficiency or Disease
 - 342 Gastrointestinal Disorders
 - 343 Diabetes Mellitus
 - 344 Thyroid Disorders
 - 345 Hypertension and Prehypertension
 - 346 Renal Disease
 - 347 Cancer
 - 348 Central Nervous System Disorders
 - 349 Genetic and Congenital Disorders
 - 351 Inborn Errors of Metabolism
 - 352a Infectious Diseases - Acute
 - 352b Infectious Diseases – Chronic
 - 353 Food Allergies
 - 354 Celiac Disease
 - 355 Lactose Intolerance
 - 356 Hypoglycemia
 - 357 Drug Nutrient Interactions
 - 359 Recent Major Surgery, Physical Trauma, Burns
 - 360 Other Medical Conditions
 - 362 Developmental, Sensory or Motor Interfering with the Ability to Eat
 - 381 Oral Health Conditions
 - 382 Fetal Alcohol Spectrum Disorders
 - 383 Neonatal Abstinence Syndrome
 - 411 Inappropriate Nutrition Practices for Infants
 - 428 Dietary Risk Associated with Complementary Feeding Practices (4-12 months)
 - 501 Possibility of Regression
 - 502 Transfer of Certification
 - 603 Breastfeeding Complications or Potential Complications (Infant)
 - 701 Infant Up to 6 Months Old of WIC Mother, or of a Woman Who Would Have Been Eligible During Pregnancy
 - 702 Breastfeeding Infant of Woman at Nutritional Risk
 - 801 Homelessness
 - 802 Migrancy
 - 901 Recipient of Abuse
 - 902 Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food
 - 903 Foster Care
 - 904 Environmental Tobacco Smoke (ETS) Exposure

[Note]
Risk Factors 103, 121, 134, 135, 141, 142, 201, and 211 are high risk and require a SOAP note.

RISK FACTORS**Child**

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|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> 103 Underweight or At Risk of Underweight | <input type="checkbox"/> 353 Food Allergies |
| <input type="checkbox"/> 113 Obese (Children 2-5 years) | <input type="checkbox"/> 354 Celiac Disease |
| <input type="checkbox"/> 114 Overweight or At Risk of Overweight | <input type="checkbox"/> 355 Lactose Intolerance |
| <input type="checkbox"/> 115 High Weight-for-Length | <input type="checkbox"/> 356 Hypoglycemia |
| <input type="checkbox"/> 121 Short Stature or At Risk of Short Stature | <input type="checkbox"/> 357 Drug Nutrient Interactions |
| <input type="checkbox"/> 134 Failure to Thrive | <input type="checkbox"/> 359 Recent Major Surgery, Physical Trauma, Burns |
| <input type="checkbox"/> 141 Low Birth Weight and Very Low Birth Weight (< 24 months) | <input type="checkbox"/> 360 Other Medical Conditions |
| <input type="checkbox"/> 142 Preterm or Early Term Delivery (< 24 months) | <input type="checkbox"/> 362 Developmental, Sensory or Motor Disabilities Interfering with Ability to Eat |
| <input type="checkbox"/> 151 Small for Gestational Age (< 24 months) | <input type="checkbox"/> 381 Oral Health Conditions |
| <input type="checkbox"/> 152 Low Head Circumference (Infants and Children ≤ 24 months) | <input type="checkbox"/> 382 Fetal Alcohol Spectrum Disorders |
| <input type="checkbox"/> 201 Low Hematocrit/Low Hemoglobin | <input type="checkbox"/> 401 Failure to Meet Dietary Guidelines for Americans (≥ 2 years) |
| <input type="checkbox"/> 211 Elevated Blood Lead Levels | <input type="checkbox"/> 425 Inappropriate Nutrition Practices for Children |
| <input type="checkbox"/> 341 Nutrient Deficiency or Disease | <input type="checkbox"/> 428 Dietary Risk Associated with Complementary Feeding Practices (12 - 23 months) |
| <input type="checkbox"/> 342 Gastrointestinal Disorders | <input type="checkbox"/> 501 Possibility of Regression |
| <input type="checkbox"/> 343 Diabetes Mellitus | <input type="checkbox"/> 502 Transfer of Certification |
| <input type="checkbox"/> 344 Thyroid Disorders | <input type="checkbox"/> 801 Homelessness |
| <input type="checkbox"/> 345 Hypertension and Pre-hypertension | <input type="checkbox"/> 802 Migrancy |
| <input type="checkbox"/> 346 Renal Disease | <input type="checkbox"/> 901 Recipient of Abuse |
| <input type="checkbox"/> 347 Cancer | <input type="checkbox"/> 902 Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food |
| <input type="checkbox"/> 348 Central Nervous System Disorders | <input type="checkbox"/> 903 Foster Care |
| <input type="checkbox"/> 349 Genetic and Congenital Disorders | <input type="checkbox"/> 904 Environmental Tobacco Smoke (ETS) Exposure |
| <input type="checkbox"/> 351 Inborn Errors of Metabolism | |
| <input type="checkbox"/> 352 a. Infectious Diseases – Acute | |
| <input type="checkbox"/> 352 b. Infectious Diseases – Chronic | |

[Note]

Risk Factors 103, 121, 134, 141, 142, 201, and 211 are high risk and require a SOAP note in MOWINS.

NUTRITION ASSESSMENT**NUTRITION EDUCATION****REFERRALS**

Contact Date: _____	Available Programs:	Other Program Enrollment Available:
	<input type="checkbox"/> Community services	<input type="checkbox"/> Community services
	<input type="checkbox"/> Federal/state program	<input type="checkbox"/> Federal/state program
	<input type="checkbox"/> Food assistance	<input type="checkbox"/> Food assistance
	<input type="checkbox"/> Lead screening	<input type="checkbox"/> Lead screening
	<input type="checkbox"/> Local health department	<input type="checkbox"/> Local health department
	<input type="checkbox"/> Mental/dental health services	<input type="checkbox"/> Substance abuse
	<input type="checkbox"/> Substance abuse	

APPOINTMENTS

Date: _____ What to Bring:
 Time: _____

NOTE