IDAHO WIC PROGRAM POLICY MANUAL

October 2014

IDAHO DEPARTMENT OF HEALTH & WELFARE

CHAPTER 1: OVERVIEW AND ORGANIZATION

OVERVIEW

The Idaho WIC Program operates according to WIC program specific federal regulations as well as the Department of Health and Welfare operation guidelines. Sections in this chapter describe State agency and local agency responsibilities.

IN THIS CHAPTER

Section	A	State Agency Organization
Section	B	Local Agency Organization
Section	C	Applicant Records
Section	D	Supplies and Materials
Section	E	Nutrition Services and Administration
Section	F	Program Incentive Allowable/Unallowable Costs

SECTION A: STATE AGENCY ORGANIZATION

OVERVIEW

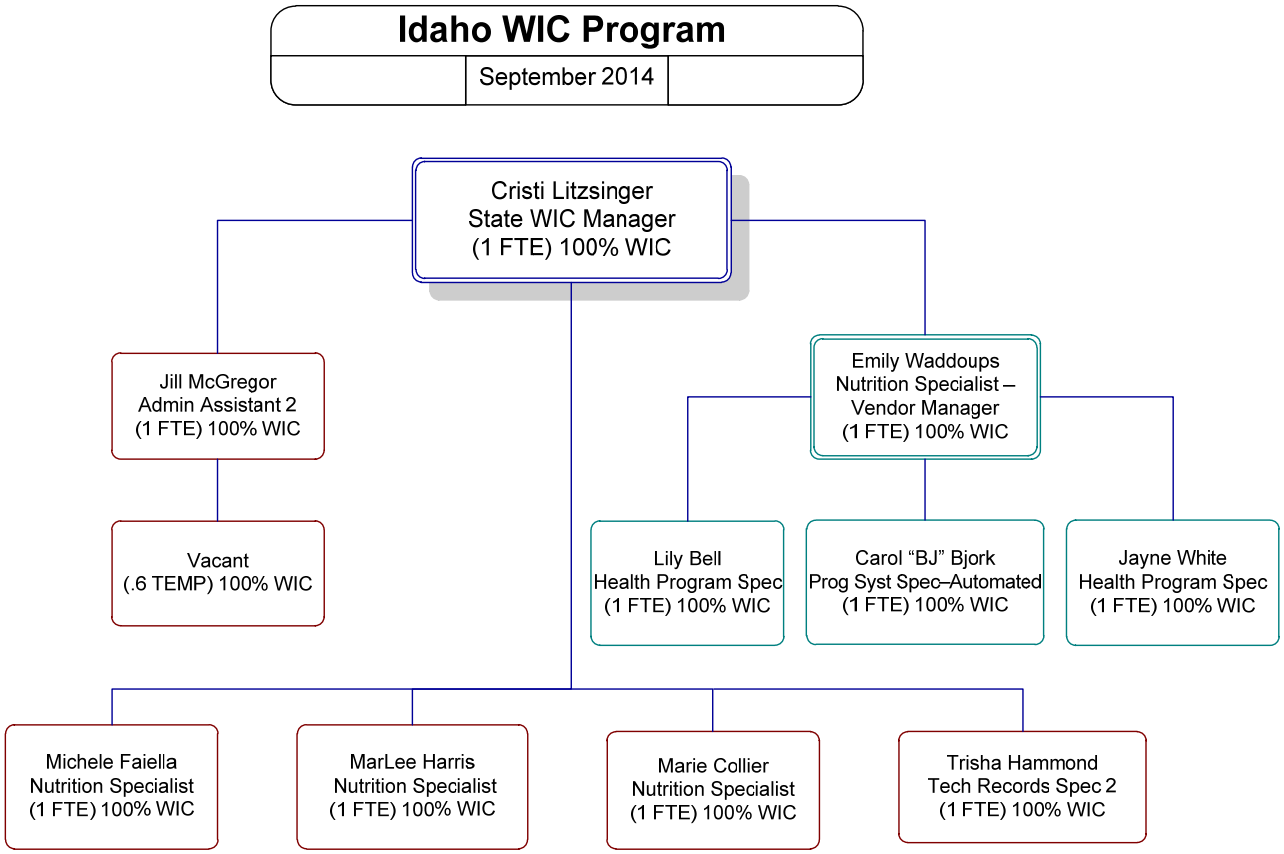
The Idaho WIC Program is organizationally located within the Idaho Department of Health and Welfare. The State agency is organizationally located in the Bureau of Clinical and Preventive Services within the Division of Public Health.

IN THIS SECTION

Organizational Chart
State Agency Primary Functional Responsibilities

ORGANIZATIONAL CHART

POLICY



STATE AGENCY PRIMARY FUNCTIONAL RESPONSIBILITIES

STATE AGENCY CONTACT AND MAILING INFORMATION

Idaho WIC Program
Idaho Department of Health and Welfare
Pete T. Cenarrusa Building
450 W. State Street – 1st Floor West
P.O. Box 83720
Boise, ID 83720-0036
208-334-5948 phone
1-866-347-5484 toll free
208-332-7362 fax

WISPr Help Desk
208-334-4905 phone
1-800-942-5811 toll free

STAFF MEMBER	PRIMARY RESPONSIBILITIES
Cristi Litzsinger, RD, LD State WIC Manager 334-5951 TOLL FREE: 1-866-347-5484 litzsinc@dhw.idaho.gov Back-up is Nutrition Specialist assigned to Acting Manager role	Federal grants management Contracts and budgets SFY budget review Program staffing and performance evaluation Program planning and evaluation Food cost containment WIC program operation changes/policy oversight Authorize and track funding for WISPr updates Caseload management Civil rights complaints/Fair Hearings Program representative to Hunger Task Force
Emily Waddoups, RD, LD Nutrition Specialist – Vendor Manager 334-5952 TOLL FREE: 1-866-347-5484 waddoupe@dhw.idaho.gov Back-up is Health Program Specialist - Vendor Coordinator	Direct supervision of Program System Specialist – Automated and Health Program Specialists Program lead for eWIC Assist Manager on vendor hearings, fraud investigations, and cost containment WIC Food grant management Budgets/monthly financial reporting Program contract monitor Financial audit lead Financial monitoring lead Management spreadsheets
Marie Collier, RD, LD Nutrition Specialist - Nutrition Education Coordinator 334-5953 TOLL FREE: 1-866-347-5484 collierm@dhw.idaho.gov Back-up is Clinic Operations Coordinator and Breastfeeding Coordinator	Nutrition education coordination VENA lead PCS lead State Nutrition Action Coalition representative Nutrition Education Plan lead Health Eating Active Living representative NEAT lead General nutrition questions Nutrition portion of MCH block grant Nutrition Risk CriteriaRD referrals/standards of care Nutrition Service Standards coordination Cultural competency lead Program outreach lead Western Region Nutrition Section Committee representative Nutrition services training coordination

STAFF MEMBER	PRIMARY RESPONSIBILITIES
Michele Faiella, MPH, RD, LD Nutrition Specialist – Clinic Operations Coordinator 334-5919 TOLL FREE: 1-866-347-5484 faiellam@dhw.idaho.gov Back-up is Nutrition Education Coordinator and Breastfeeding Coordinators	Coordination of clinic operations and policy changes Implementation of policy changes in WISPr Clinic procedures and caseload management Certification and eligibility Quarterly report coordination and oversight Infant formula, exempt infant formula, nutritionals Medicaid/WIC coordination Immunization linkage oversight Monitoring lead Data requests
MarLee Harris, RD, LD, CLC Nutrition Specialist – Breastfeeding Coordinator 334-4937 TOLL FREE: 1-866-347-5484 harrism@dhw.idaho.gov Back-up is Nutrition Education Coordinator and Clinic Operations Coordinator	Breastfeeding promotion and support Breastfeeding/Peer Counselor training Breastfeeding equipment, RFNS oversight Oversight of peer counseling program plan and budget Lead screening Training for State and local agency staff Annual civil rights training Immunization linkage Breastfeeding portion of MCH block grant
Lily Bell Health Program Specialist – Vendor Coordinator 334-4933 TOLL FREE: 1-866-347-5484 belll@dhw.idaho.gov Jayne White Health Program Specialist – Vendor 334-0605 whitej@dhw.idaho.gov Back-up for each other	Communication liaison to Western Region for vendor management Vendor agreements Store authorization and sanctions/termination Final Food Rule implementation Authorized Food List Vendor-related complaints/fraud Vendor monitoring Vendor inventory audits Vendor portion of State Plan Vendor training Vendor peer group analysis Price list surveys Compliance buy coordinator Process returned checks Infant formula rebate invoicing Authorized vendor tables in WISPr

STAFF MEMBER	PRIMARY RESPONSIBILITIES
Carol "BJ" Bjork Program System Specialist – Automated 334-5836 TOLL FREE: 1-866-347-5484 bjorkc@dhw.idaho.gov Back-up is Technical Records Specialist 2	Coordinate/conduct system training Review and edit documents for clarity and technical accuracy Liaison with WISPr developers and perform user acceptance training Analyze business requirement documents Design user interface components Develop and maintain system training guides WIC hardware specialist and technical support Disaster Recovery/Continuous Operations Plan WIC Help Desk support Maintain WISPr backlog Participant survey
Trisha Hammond Technical Records Specialist 2 WIC Help Desk 334-4905 TOLL FREE: 1-800-942-5811 hammondt@dhw.idaho.gov Back-up is Program System Specialist - Automated	WIC Help Desk computer and application support WIC hardware specialist and technical support Computer table changes Daily/monthly reconciliation reports, dual participation, unmatched redemptions, bank reports, report requests Computer supplies (check paper, toner) Security requests Dual participation and check audit research Check printer inventory Coordinate with DHW ITSD for connectivity troubleshooting Order check registers
Jill McGregor Administrative Assistant 2 334-5607 TOLL FREE: 1-866-347-5484 mcgregoj@dhw.idaho.gov Back-up is Technical Records Specialist 2	Office support Invoice/receipt processing Order supplies Preparation of correspondence Contract liaison for hotels, printing, graphic design Coordinate quarterly forms orders Policy manual updates Conference/meeting facility liaison Coordinate with WIC staff for website updates

SECTION B: LOCAL AGENCY ORGANIZATION

OVERVIEW

This section describes general descriptions of the minimum staffing requirements for local agencies. Local agencies may have additional positions.

IN THIS SECTION

Registered Dietitian
Project Dietitian
Registration Eligible
Breastfeeding Promotion Coordinator
Lactation Educator
Competent Professional Authority
Local Agency Roster
- Panhandle Health District
- Public Health – Idaho North Central District
- Southwest District Health
- Central District Health Department
- South Central Public Health District
- Southeastern Idaho Public Health
- Eastern Idaho Public Health District
- Nimiipuu Health
- Benewah Medical Center

REGISTERED DIETITIAN

POLICY

At a minimum, the local agency must employ at least one licensed, registered dietitian to manage the program and to provide high-risk counseling.

RESPONSIBILITIES

WIC Coordinator
Performs administrative supervisory and professional work necessary to the planning, implementation, and evaluation of local WIC program activities. Many of the duties of this role may be delegated to other staff; however, the ultimate responsibility for clinic operations falls on the WIC Coordinator.

Other Registered Dietitian
Performs professional work necessary for delivery of direct client services, primarily providing counseling and nutrition education for high-risk clients. Participates in supervision of clinic operations and program planning, and evaluation as assigned. Writes/oversees general nutrition education classes for Clinical Assistant.

PROJECT DIETITIAN

POLICY

The local agency will appoint a Project Dietitian with a bachelor of science degree in Nutrition who is a Registered Dietitian (RD) and Idaho Licensed Dietitian (LD).

RESPONSIBILITIES

- Oversee nutritional risk certification
- Oversee nutrition education
- Oversee high risk counseling components

REFERENCE

State policy

REGISTRATION ELIGIBLE

POLICY

An individual who possesses a bachelor's degree and can provide documented proof of eligibility to take the Commission on Dietetics Registration (CDR) examination may be hired to provide nutrition services to participants. High risk care plans must be co-signed by a RD and LD. Upon request, a local agency shall provide the State agency with certification of an employee's qualifications. Verification for a registration eligible individual must be in the form of *Current Verification Statement* from the Commission on Dietetic Registration (CDR) Verification of eligibility to take the RD exam.

If the registration eligible applicant does not pass the RD examination within six months of the date of completing a dietetic internship program, but remains eligible to test with the CDR, the local agency may use its own discretion on whether to continue the employment and pay scale agreed upon in the employment contract. However, the State agency recognizes a staff person who does not pass the RD examination within the first six months may only provide services within a Competent Professional Authority (CPA) scope of practice.

Local agencies are expected to follow the provisional licensure regulations for supervised practice established by the State of Idaho Board of Medicine.

REFERENCE

7 CFR 246.2 and 7 CFR 246.6 (b) (2)
California WIC Program Manual

BREASTFEEDING PROMOTION COORDINATOR

POLICY

Each local agency will appoint a Breastfeeding Promotion Coordinator. The local agency Breastfeeding Promotion Coordinator is a staff member who serves as a resource person and central contact for the coordination of breastfeeding promotion and support activities in the local agency. The local agency Breastfeeding Promotion Coordinator shall be given support from the local agency to ensure that the resources are available to perform the duties and responsibilities of this position.

RESPONSIBILITIES

Responsibilities are to include but are not limited to the following:

- Lead the implementation of a breastfeeding promotion and support plan for the local agency.
- Review breastfeeding data with local agency Coordinator on a regular basis to determine the effectiveness of the plan.
- Maintain current, accurate breastfeeding information resources such as posters, handouts, breastfeeding equipment, resource and referral information, etc. to optimally support breastfeeding in all clinics.
- Work with local agency Coordinator and staff to provide a baby- and breastfeeding-friendly clinic environment for all participants.
- Coordinate the planning and implementation of the breastfeeding promotion and support activities for the local WIC program under the direction of the WIC Coordinator.
- Participate in and conduct or coordinate ongoing training for WIC staff on breastfeeding promotion and support issues and information.
- Collaborate and interact with the local breastfeeding coalition/promotion council.
- Conduct and/or coordinate World Breastfeeding Week activities annually.
- Monitor breastfeeding classes, counseling, and charting.

REFERENCE

7 CFR 246.11(c) Establish Standards for Breastfeeding Promotion and Support

LACTATION EDUCATOR

POLICY

The local agency must employ a qualified person to serve as a Lactation Educator.

RESPONSIBILITIES

Provides breastfeeding training for WIC staff, and breastfeeding education and support for WIC participants via classes, individual counseling, and telephone support. Assists Breastfeeding Coordinator in the implementation of special projects, performing community breastfeeding/outreach activities, and conducting breastfeeding support services for WIC participants.

COMPETENT PROFESSIONAL AUTHORITY (CPA)

DEFINITION

An individual on the local agency staff who is trained and authorized by the Idaho WIC Program as competent to determine nutritional risk, assign priority, and prescribe appropriate food packages

POLICY

Local agencies shall have at least one Competent Professional Authority (CPA) to determine nutritional risk eligibility and prescribe an appropriate food package for each client.

PROFESSIONAL

The following health professionals are qualified as CPAs without completing the minimum paraprofessional competencies.

Registered Dietitian
Registered by the Commission on Dietetic Registration as a registered dietitian and licensed by the state of Idaho.

Nutritionist
Bachelor's or Master's degree in Nutritional Sciences, Community Nutrition, Clinical Nutrition, Dietetics, Public Health, or Home Economics with emphasis in Nutrition.

Registration Eligible
Bachelor's or master's degree in Nutritional Sciences, Community Nutrition, Clinical Nutrition, Dietetics, Public Health, or Home Economics with emphasis in Nutrition. Individual who has completed an approved dietetic internship and eligible to take the registration examination by the Commission on Dietetic Registration (CDR). Has provisional licensure with the State of Idaho Board of Medicine.

PARAPROFESSIONAL

Paraprofessional competency must be demonstrated after completing the Idaho WIC Program Paraprofessional Staff Training Program. Performance objectives which define specific tasks, skills, knowledge of WIC program policies and procedures, and basic nutrition must be mastered before being designated a CPA by the WIC Coordinator.

NOTE: The signature and title of the CPA are required on each certification and ineligibility document.

AGENCY 100: PANHANDLE HEALTH DISTRICT

Shelly Amos, RD, LD
WIC Coordinator
Panhandle Health District
8500 N. Atlas Rd., Hayden, ID 83835
(208) 415-5130 phone
(844) 415-5130 toll free
(208) 415-5131 fax
samos@phd1.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
101	HAYDEN 8500 N. Atlas Rd. 83835 415-5130 phone 844-415-5130 toll free 415-5131 fax	108	SANDPOINT 1020 W. Michigan Ave. 83864-1788 263-6963 fax
104	SAINT MARIES 137 N. 8th 83861 245-3692 fax	109	PRIEST RIVER 552 High St. (City Hall) 83856
107	KELLOGG 114 W. Riverside Ave. 83837-2351 783-4242 fax	110	BONNERS FERRY 7402 Caribou 83805-0893 267-3795 fax

AGENCY 200: PUBLIC HEALTH – IDAHO NORTH CENTRAL DISTRICT

Kara Jo Herndon, RD, LD
WIC Coordinator
Public Health – Idaho North Central District
215 10th St., Lewiston, ID 83501-1910
(208) 799-0390 phone
(208) 799-0349 fax
kherndon@phd2.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
201	LEWISTON 215 10th St. 83501-1910 799-0390 phone 799-0349 fax	204	OROFINO 105 115th St. P.O. Box 1239 83544 476-7850 phone 476-7494 fax
202	MOSCOW 333 E. Palouse River Dr. 83843-8916 882-7353 phone 882-3494 fax	206	KAMIAH 132 N. Hill St. P.O. Box 277 83536-0277 935-2124 phone 935-0223 fax
203	GRANGEVILLE 903 W. Main 83530 983-2842 phone 983-2845 fax		

AGENCY 300: SOUTHWEST DISTRICT HEALTH

Emily Geary, MS, RD, LD
WIC Coordinator
Southwest District Health
13307 Miami Ln., Caldwell, ID 83607
(208) 455-5333 phone
(208) 454-7722 fax
emily.geary@phd3.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
301	CANYON COUNTY 13307 Miami Ln., Caldwell 83607 455-5330 phone 454-7722 fax	308	GRAND VIEW 410 Roosevelt 83624 834-2550 phone
302	PAYETTE 1155 3rd Ave. N. 83661 642-9321 phone 642-5098 fax	311	HOMEDALE 132 E. Idaho St. 83628 337-4931 phone 337-4081 fax
303	COUNCIL Adams Co. Medical Clinic 205 Berkley St. 83612 (phone Payette or Weiser)	312	TEEN PARENT Parkview High School 609 15th Ave. N., Nampa 83687 498-0558 phone
304	EMMETT 1008 E. Locust St. 83617-2711 365-6371 phone 365-4729 fax	315	FARMWAY VILLAGE 222730 Farmway Rd., Caldwell 83607 454-7850
306	WEISER 46 W. Court 83672-1941 549-2370 phone 549-2371 fax	316	WILDER 218 Golden Gate Ave. 83676 318-4207
317	CANYON SPRING HIGH SCHOOL 516 N. 11th St., Caldwell 83607 455-3325 phone	318	VALLIVUE ACADEMY 6123 Timbre Dr., Caldwell 83607 455-1917 phone

AGENCY 400: CENTRAL DISTRICT HEALTH DEPARTMENT

Angela Spain, RD, LD
WIC Coordinator
Central District Health Department
707 N. Armstrong Pl., Boise, ID 83704
(208) 327-7488 phone
(208) 321-2243 fax
aspain@cdhd.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
401	BOISE 707 N. Armstrong Pl. 83704 327-7488 phone 321-2243 fax	405	IDAHO CITY (use Boise address and phone)
		406	GLENNS FERRY (use Boise address and phone)
402	MOUNTAIN HOME 520 E. 8th St. N. 83647-2199 587-4409 phone 587-3521 fax	408	CASCADE (use Boise address and phone)
		409	HORSESHOE BEND (use Boise address and phone)
404	MCCALL 703 N. 1st St. P.O. Box 1448 83638-1448 634-7194 phone 634-2174 fax	410	GARDEN VALLEY (use Boise address and phone)

AGENCY 500: SOUTH CENTRAL PUBLIC HEALTH DISTRICT

Tammy Walters, RD, LD
WIC Coordinator
South Central Public Health District
2311 Parke Ave., Unit 4, Suite 4, Burley, ID 83318-3412
(208) 678-8608 phone
(208) 678-7465 fax
twalters@phd5.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
501	TWIN FALLS 1020 Washington St. N. 83301-3156 737-5923 phone 734-9502 fax	505	GOODING 255 N. Canyon Dr. 83330-0494 934-4477 phone 934-8558 fax
502	BURLEY 2311 Parke Ave., Unit 4, Ste.4 83318-3412 678-8608 phone 678-7465 fax	506	JEROME 951 H Ave. E. 83338-3028 324-1323 phone 324-9554 fax
503	SHOSHONE (use Jerome address and phone)	507	BELLEVUE 117 Ash St. 83313 788-4335 phone 788-0098 fax

AGENCY 600: SOUTHEASTERN IDAHO PUBLIC HEALTH

Kathy Puckett, RD, LD
WIC Coordinator
Southeastern Idaho Public Health
1901 Alvin Ricken Dr., Pocatello, ID 83201
(208) 239-5263 phone
(208) 478-9297 fax
kpuckett@siph.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
601	POCATELLO 1901 Alvin Ricken Dr. 83201 239-5263 phone 478-9297 fax	605	MONTPELIER 455 Washington St., Ste. 2 83254-1544 847-3000 phone 847-2538 fax
602	BLACKFOOT 326 Poplar 83221-1726 785-2160 phone 785-6372 fax	606	MALAD 175 S. 300 E. 83252 766-4764 phone 766-2528 fax
604	PRESTON 42 W. 1st S. 83263-1205 852-0478 phone 852-2346 fax	607	SODA SPRINGS 55 E. 1st S. 83276 547-4375 phone 547-4398 fax
609	AMERICAN FALLS 590½ Gifford Ave. 83211-1314 226-5096 phone 226-7145 fax	613	TEEN CENTER (use Pocatello address and phone)
610	ABERDEEN (use American Falls address) 397-3764 phone	614	FORT HALL (use Pocatello address and phone)
611	ARCO 178 Sunset P.O. Box 806 83213-0806 527-3463 phone 527-3972 fax		

AGENCY 700: EASTERN IDAHO PUBLIC HEALTH DISTRICT

Angy Cook, RD, LD, IBCLC
WIC Coordinator
Eastern Idaho Public Health District
1250 Hollipark Dr., Idaho Falls, ID 83401
(208) 522-3823 or (208) 522-0310 phone
(208) 528-0857 fax
acook@phd7.idaho.gov

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
701	IDAHO FALLS 1250 Hollipark Dr. 83401 522-3823 or 522-0310 phone 533-3258 fax	706	DUBOIS (use Rigby address) 374-5216 phone 374-5609 fax
702	RIGBY 380 Community Ave. 83442 745-0346 phone 745-8151 fax	707	SALMON 801 Monroe St. 83467 756-2123 phone 756-6600 fax
703	ST. ANTHONY 45 S. 2nd W. 83445-0490 624-7585 phone 624-0954 fax	708	CHALLIS 1050 N. Clinic Rd. 83226 879-2504 phone 879-5679 fax
704	DRIGGS 139 Valley Centre Dr. 83422 354-2220 phone and fax	709	TERRETON (use Idaho Falls address) 663-4860 phone
705	REXBURG 314 N. 3rd E. 83440-0128 356-9594 or 356-3239 phone 356-4496 fax		

AGENCY 800: NIMIIPUU HEALTH

Julie Keller, MS, RD, LD, CDE
WIC Coordinator
Nimiipuu Tribal Health
111 Bever Grade, P.O. Drawer 367, Lapwai, ID 83540-0367
(208) 843-2271 phone
(208) 843-9406 fax
juliek@nimiipuu.org

Clinic Number	Address and Telephone	Clinic Number	Address and Telephone
881	NIMIIPUU HEALTH 111 Bever Grade P.O. Drawer 367 Lapwai, ID 83540-0367 Telephone: 843-2271 FAX: 843-9406	882	KAMIAH (use Lapwai address) 935-0733 phone

AGENCY 1100: BENEWAH MEDICAL CENTER

Carla Patterson, RD, LD, CDE
WIC Coordinator
Benewah Medical Center
427 N. 12th St., P.O. Box 388, Plummer, ID 83851
(208) 686-1931 phone
(208) 646-8052 fax
cpatterson@bmc.portland.ihs.gov

Clinic Number	Address and Telephone
1101	BENEWAH MEDICAL CENTER 427 N. 12th St. P.O. Box 388 Plummer, ID 83851 686-1931 phone 646-8052 fax

SECTION C: APPLICANT RECORDS

OVERVIEW

IN THIS SECTION

Confidentiality

CONFIDENTIALITY

POLICY

The use or disclosure of information regarding WIC applicants and participants is restricted to:

- Persons directly connected with the administration and enforcement of the WIC program.
- Representatives of the Department of Agriculture and the Comptroller General of the United States shall have access to all program records during normal business hours. Any reports or documents generated from records review that are released to the public may not include confidential applicant or participant information.
- Representatives of other Department of Health and Welfare programs, as agreed upon by the State agency, as part of service coordination and adjunctive income information.
- Specific vendors approved by the State agency to provide services if the participant or Responsible Adult signs a release of information, e.g., special formula direct shipment or breast pump related.

SUBPOENA

A subpoena is a request for information issued by a clerk of a court in response to an attorney representing a party. Responding to a subpoena will be according to District legal guidance and Federal WIC Regulation.

REQUESTS FOR INFORMATION

Participant information must not be released without a signed release of information. This includes telephone requests.

NOTE: Participant information may only be shared without written consent as defined by the WIC Participant Rights, Responsibilities and Consent:

”I authorize the WIC program to share the eligibility information (such as name, address, and birth date) for myself and my child(ren) with local, state, and federal WIC programs.

This information may also be shared with the Idaho Department of Health and Welfare Medicaid and SNAP Programs for the purpose of referral.”

RECORD RETENTION AND REMOVAL

All records pertaining to WIC operations at the State and local agency level must be retained for a minimum of four (4) years per Idaho WIC Program. Records include but are not limited to:

- Financial operations
- Food delivery systems
- Food instrument issuance and redemption
- Equipment inventory and purchases
- Certification
- Nutrition education
- Civil rights
- Fair Hearing proceedings

If any litigation, claim, negotiation, audit, or other action involving the records has been started before the end of the four-year period, the records must be kept until all issues are resolved or until the end of the four-year period, whichever is longer.

In the event that the State or local agency wishes to remove records past the minimum retention requirement, records are to be destroyed per individual agency policy (e.g., shredding, incineration, etc.). Confidentiality of WIC Program records is to be maintained throughout the process.

MAILING

Information containing a client name, identifying information, or medical information sent via mail or fax should be clearly marked as Confidential. This notice must appear on the outer envelope or lead page and is intended for the addressee only.

ELECTRONIC INFORMATION

Storing Electronic Information

The Idaho WIC program has adopted the use of electronic records. It is the responsibility of State and local agencies to ensure the reliability and integrity of the technology used. This will confirm the security and confidentiality of information documented and filed electronically. This includes safeguarding benefits in the event of a technology failure or disaster. Local agencies are encouraged to follow the policies and procedures established by their health district or tribal organization and consult their IT departments.

Sending Electronic Information

Use caution when sending participant information electronically. A disclaimer notice should be attached.

Example:
The information contained in this email may be privileged, confidential or otherwise protected from disclosure. All persons are advised that they may face penalties under state and federal law for sharing this information with unauthorized individuals. If you received this email in error, please reply to the sender that you have received this information in error. Also, please delete this email after replying to the sender.

REFERENCE

7 CFR 246.25 Records and Reports
7 CFR 246.26 Other Provisions

SECTION D: SUPPLIES AND MATERIALS

OVERVIEW

IN THIS SECTION

Forms and Materials Orders
Ordering WIC Check/CVV Supplies

FORMS AND MATERIALS ORDER

POLICY

Each central ordering clinic must appoint a Point of Contact (POC) responsible for ordering forms and materials from the State agency. This person will be the contact between the State agency and the local agency if any questions or problems with an order arise.

NOTE: The POC handles all forms/materials orders except check registers, check paper, and MICR toner for the check printers. For procedures on ordering these items, see Ordering WIC Check/CVV Supplies.

QUARTERLY ORDERING

The State agency will send an ordering and shipping schedule to each POC prior to the beginning of each federal fiscal year.

The State agency will send a Forms and Materials Order Sheet to the POC in each central ordering clinic every quarter. The POC will inventory the central clinic supply and contact outlying clinics to identify their needs. The POC may make copies of the sheet for distribution to each clinic and is responsible for compiling all orders and returning the completed local agency order sheet to the State agency. Items must be ordered in quantities noted on the order sheet. Packages will be divided at the local agency to accommodate individual clinic needs. Because forms and brochures are updated on a regular basis, each clinic should keep only a three-month supply in stock.

If a clinic runs out of a nutrition education, breastfeeding, or outreach item, copies may be obtained from a neighboring clinic within the local agency. If a photocopied, two-part or three-part form is needed, the State agency may be contacted for an electronic copy that will be reproduced at the local agency. Changes to State-developed forms are not permitted.

SHIPPING AND RECEIVING

Upon receipt of the full shipment, the POC will:

- Unpack the orders as soon as possible.
- Check to make sure the proper quantity of each item is received.
- Contact the State agency immediately if discrepancies are discovered.
- Divide packets and distribute items as needed to satellite clinics.

- Upon receipt of new or revised forms or materials, each clinic will dispose of the outdated item(s).

ORDERING WIC CHECK/CVV SUPPLIES

POLICY

SUPPLIES

To order:

- Check registers – contact the WIC Help Desk
- Check paper – contact the State agency
- MICR toner cartridges (for check printer) – contact the State agency

SHIPPING

Allow two weeks for delivery. If an emergency order of check paper is needed, it may be obtained from a neighboring clinic within the agency.

SECTION E: NUTRITION SERVICES AND ADMINISTRATION

OVERVIEW

IN THIS SECTION

Participant Survey
Local Agency Program Plan

PARTICIPANT SURVEY

POLICY

Periodically perform and document evaluations of nutrition education and breastfeeding promotion and support activities. The evaluations shall include an assessment of participants' views concerning the effectiveness of the nutrition education and breastfeeding promotion and support they received.

METHODS

Participants' views on nutrition education, breastfeeding promotion and support, WIC foods, and understanding of core WIC messages will be assessed periodically through one or more of the following methods:

- Questionnaire:

A State-developed questionnaire with instructions for distribution and collection will be sent out to local agencies. Local agencies that are being monitored by the State agency will be exempt that year from distributing the questionnaire.

- Focus Groups (State agency):

State agency may decide to conduct focus groups in lieu of questionnaires. All local agencies that would be impacted will be notified in advance.

- Focus Groups (Local Agencies):

Local agencies may conduct focus groups if desired.

RESULTS

Results from the annual assessment of participant views will be made available to all local agencies.

REFERENCE

7 CFR 246.11(c) State Agency Responsibilities
State policy

NUTRITION EDUCATION PLAN

POLICY

- Develop an annual Nutrition Education Plan consistent with the State's nutrition education component of operations and in accordance with guidelines described below.
- The State Agency and local agencies have common goals to promote optimal birth outcomes, maintain optimal anthropometry and hematology, promote and support breastfeeding, provide nutrition education to participants and staff, and to manage caseloads.
- The local agency Coordinator shall submit the nutrition education plan to the State agency by a date specified by the State agency.

LOCAL AGENCY CHARACTERISTICS

Each local agency has unique characteristics related to the population that it serves. This section at a minimum should include the following:

- The counties served by the local agency
- Population information
- Current economic status of the region served by the local agency
- Social factors
- WIC statistics (number of participants served, education level, marital status, etc.)
- Food insecurity
- Other information as determined by the local agency Coordinator

HEALTH AND NUTRITION INDICATORS

Health and Nutrition Indicators are how the health of the WIC community is measured. Each Health and Nutrition Indicator reflects a major health concern in WIC. The Health and Nutrition Indicators were selected on the basis of their impact on the WIC community, the availability of data to measure progress, and their importance as public health issues.
The Health and Nutrition Indicators are:

- Infants and Children
- Prevalence of Breastfeeding
- Low Hematology
- Underweight
- Overweight
- Baby Bottle Tooth Decay
- Baby Bottle Tooth Decay Risk Behaviors
- Women
- Low Hematology
- Underweight
- Overweight
- Low Birth Weight
- Premature Birth
- Prenatal Weight Gain
- Time of WIC Enrollment
- Begin Prenatal Care
- Self Reported Alcohol Use
- Self Reported Cigarette Use
- Self Reported Drug Use
- Severe Dental Problems
- Family

- Food Insecurity

REQUIRED ACTIONS

There are actions required by federal regulations and state contract that must be performed by local agencies. They are:

NUTRITION EDUCATION

Standard 1 – Quality nutrition education and counseling are provided to all participants or, when appropriate, their caregivers or proxies (collectively referred to as "participants").
FR §246.11(c)(6)

Standard 2 – Provision of an individual care plan for low-risk and high-risk participants.
FR §246.11(e)(5)

Standard 3 – Provide appropriate orientation and task-appropriate training on breastfeeding promotion and support.
FR §246.11(c)(7)(iii)

Standard 4 - Prepare a Local Agency Program Plan annually.
FR §246.11(d)(2)

BREASTFEEDING

Standard 1 – Implementation and evaluation of specific strategies that promote and support breastfeeding within the population served.
FR §246.11(c)(7)

Standard 2 – Local WIC agency will appoint a designated Breastfeeding Promotion Coordinator.
FR §246.11(c)(7)(ii)

Standard 3 – Provide appropriate orientation and task-appropriate training on breastfeeding promotion and support.
FR §246.11(c)(7)(iii)

Standard 4 – Implementation of a policy that encourages a positive clinic environment and that endorses breastfeeding as the preferred and normal way to feed infants.
FR §246.11(c)(7)(i)

Standard 5 – Quality breastfeeding education and support shall be offered to all pregnant WIC participants.
FR §246.11(c)(7), FR §246.11(e)(1)

Standard 6 – Breastfeeding women will be provided with support, information, and appropriate referrals throughout the postpartum period, particularly at critical times, to successfully establish and maintain breastfeeding for one year or longer if so desired.
FR §246.11(c)(7)(iv)

Standard 7 – All eligible women who meet the definition of breastfeeding are certified, to the extent that caseload management permits, and receive a food package consistent with their nutritional needs.
FR §246.11(e)(1), FR §246.10(b)(2)(iii)

OUTREACH/TARGETING

Standard 1 – Local agencies will conduct consistent targeted outreach to WIC-eligible populations.

FR §246.4(a)(7)(i)

Substance Abuse Screening and Referral

Standard 1 – Local agencies will ensure that quality information and updated referrals on drug and other harmful substance abuse are provided to all participants or, when appropriate, to their caregivers or proxies.
FR §246.11(a)(3), FR §246.7(a)

Caseload Management

Standard 1 – Maintain a quarterly average caseload level of 97-100% of the authorized participating caseload (including migrant clients) allocated by the State WIC Office. Authorized caseload is defined as the caseload number used to calculate funding and is based on the recent 12-month period's (July-June) actual participation. [WIC Contract Scope of Work, II.D]
Caseload is reviewed on a quarterly basis. If a Contractor is under-serving (serving less than 97%) of the authorized participating caseload, a corrective action plan is completed by the agency and the agency is encouraged to increase caseload. If the standard of 97% is not met on average for the year, a reduction in caseload funding is effective beginning the next fiscal year. [WIC Contract Scope of Work, II.E]
On a quarterly basis, if a Contractor is over-serving (serving more than 100%) of the authorized participating caseload, the State WIC Office will increase the Contractor's caseload and corresponding funding allocated to serve the caseload. Funding will be increased through the contract amendment process. The increased funding will cover both the quarter in which caseload exceeded 100% and future quarters in order to maintain the higher level caseload. [WIC Contract Scope of Work, II.F]

Standard 2 – Maintain a waiting list to ensure highest risk applicants are served first and within processing timeframes.

SECTION F: PROGRAM INCENTIVE ALLOWABLE/UNALLOWABLE COSTS

OVERVIEW

IN THIS SECTION

Program Incentive Items
Examples of Allowable and Unallowable Program Incentive Items
Reporting
Claims

PROGRAM INCENTIVE ITEMS

POLICY

Program incentive items can be allowable if they are considered to be reasonable and necessary costs that promote the specific program purposes of outreach, nutrition education, or breastfeeding promotion as defined below.

All program incentive items should be able to withstand review, audit, and public scrutiny for appropriate expenditure of public funds. Questions about a planned incentive can be directed to the State agency.

Ensure that funding is available for all required program functions, especially nutrition education, before considering the purchase of incentive items.

Local agencies are required to implement proportional allocation of costs for items that are shared between programs. For example, if WIC funds are used to purchase a television that will be used by other programs for viewing of other program messages, the appropriate percentage of cost must be shared among WIC and the other programs. The allocation should be based on an appropriate measurement directly related to the item or activity.

DEFINITIONS

Program incentive items – refers to a class of goods, usually of a nominal value, that are given to applicants, participants, potential participants, or persons closely associated with the WIC program (excluding staff) for purposes of outreach, nutrition education, or breastfeeding promotion. Other terms that may be used to describe these items include memorabilia, souvenirs, or promotional items.

Outreach – promotional efforts to encourage and increase participation in the WIC program.

Nutrition education – individual or group education sessions and the provision of information and educational materials designed to improve health status, achieve positive change in dietary habits, and emphasize relationships between nutrition and health, all in keeping with the individual's personal, cultural, and socioeconomic preferences.

Breastfeeding promotion – strategies, initiatives, and services to increase and support the initiation and continuation of breastfeeding among WIC participants.

Reasonable costs

- are consistent with the costs of similar items from other vendors.
- are in proportion to other program costs for the function that the costs serve.
- the quantity is justified per location (not every clinic office, rather per clinic/agency, for example).
- are a priority expenditure relative to other demands on available administrative resources.
- have a proven or reasonably expected positive outreach or nutrition education impact.

Necessary costs

- are incurred to carry out essential program functions.
- cannot be avoided without adversely impacting program operations.

Example: computers, monitors, or printers for a WIC staff workstation. Note: per WIC contract, all computers and printers, regardless of unit cost, and all equipment exceeding $2000 per unit must have a justification letter sent to the State WIC office prior to purchase.

GUIDELINES

Outreach items should:

- contain a WIC-specific message that targets the potentially eligible population.
- normally be seen in public.
- contain a WIC-approved nondiscrimination statement for publications or other printed material that include program information.
- have value as outreach devices that equal or outweigh other uses.
- include WIC contact information such as the State or local agency name, address, and/or telephone number.
- constitute (or show promise of) an innovative or proven way of encouraging WIC participation.
- be reasonable and necessary costs.

Nutrition education items should:

- be targeted to participants.
- contain a WIC-approved nondiscrimination statement for publications or other printed material that also include any program information.
- have a clear and useful connection to particular WIC nutrition education messages.
- either convey enough information to be considered educational or be utilized by participants to reinforce nutrition education contacts.
- have value as nutrition education aids that equal or outweigh other uses.
- be distributed to the audience for which the items were designed (e.g., easy flow cups distributed to mothers of infants who are learning or will be learning to drink from a cup during a relevant nutrition education contact).
- be reasonable and necessary costs.

Breastfeeding promotion and support items should:

- contain a WIC-approved nondiscrimination statement for publications or other printed material that also include any program information.
- have a clear and useful connection to promoting and supporting breastfeeding among current WIC participants.
- either convey information that encourages and supports breastfeeding in general, informs participants about the benefits of breastfeeding, or offers support and encouragement to women to initiate and continue breastfeeding.
- have value as breastfeeding promotion and support items that equal or outweigh other uses
- be distributed to the audience for which the items were designed.
- be reasonable and necessary costs.

EXAMPLES OF ALLOWABLE AND UNALLOWABLE PROGRAM INCENTIVE ITEMS

SOME ALLOWABLE ITEMS

- Outreach items (intended for WIC participants): T-shirts, buttons, diapers, bibs, toothbrushes, pens, cups or other items of nominal value with reasonable opportunity for public display that contain a WIC promotional message.
- Nutrition education – calendars that contain important nutrition education messages, refrigerator magnets picturing the food pyramid, easy flow cups that are provided to mothers of infants who are learning how to drink from a cup as reinforcement of a relevant nutrition education session.
- Breastfeeding promotion and support – T-shirts, buttons, or other items of nominal value with a breastfeeding promotion or support message.

SOME UNALLOWABLE ITEMS

- Celebratory items or items designed primarily as staff morale boosters, generally for the personal use of the staff, with minimal public display (example: fruit and veggies scrubs for staff, staff coffee mugs/water bottles with a nutrition message, staff T-shirts, pedometers).

- Items of nominal value which have no outreach, breastfeeding, or nutrition education message (such as container gardening products: pots, vegetable/fruit seeds or plants); any program incentive item intended for persons who are not participants, potential participants, their parents/guardians, or persons connected to the WIC program.

- Food items purchased for any reason other than demonstrated use of WIC foods in an educational environment.

- Items not of nominal value, such as diaper bags, infant slings, or ponchos (regardless of any nutrition education, outreach or breastfeeding promotion messages).

REPORTING

POLICY

- Items used for breastfeeding promotion need to be reported as a breastfeeding cost.
- Items used for nutrition education need to be reported as a nutrition education cost.
- Items used for general outreach items need to be reported as a general administration cost.

CLAIMS

If local agency is found to be in violation of the above policy, WIC money spent on unallowable items will be subject to repayment by the contracting agency. Federal money may not be the source of repayment. Payment or repayment plan must be agreed upon by the local agency and the State WIC Office and repayment must be received within 60 days of found violation.

REFERENCES

7 CFR Part 246.2
WRO Policy Memo 807-K/ASM 95-5 Allowability of Costs for Program Incentive Items
Utah WIC Program Policy and Procedure Manual

Arizona WIC Program Policy and Procedure Manual
Oregon WIC Program Policy and Procedure Manual

CHAPTER 2: ADMINISTRATION

OVERVIEW

IN THIS CHAPTER

Section A Customer Service

Section B Civil Rights and Nondiscrimination

Section C Complaints and Incidents

Section D Program Violation

Section E Fair Hearings

Section F Disaster Recovery

Section G Memorandum of Understanding (MOU)

SECTION A: CUSTOMER SERVICE

OVERVIEW

The goal of the Idaho WIC Program is to provide WIC services in a positive and helpful manner.

IN THIS SECTION

Clinic Environment
Telephone
Greeting Applicants and Participants
Evaluating Service Quality

CLINIC ENVIRONMENT

PRIVATE AND CONFIDENTIAL

Ensure that the clinic atmosphere/environment (including waiting room, bathrooms, counseling offices and reception area) conveys a warm, respectful, and professional atmosphere. The clinic environment should ensure:

- Private areas are available for participant counseling.
- Participants' charts are not identifiable by other participants or persons working outside the program.
- Clinic staff call participants to the front counter when they need to talk with them in the waiting area. Talk softly so other participants do not hear the conversation. Questions should not be called out across the waiting area.

PHYSICAL ARRANGEMENT

The clinic physical arrangement should strive for:

- Comfortable seating for all persons
- Comfortable temperature and appropriate lighting
- Cheerful posters and decorations on the wall
- Furniture arrangement that promotes a cooperative "working together" relationship rather than a dominate/subordinate relationship. When possible:
  - Have participant sit to one side of the desk.
  - Allow participants to sit down while they are signing papers and providing information to staff.
- Signs with positive messages rather than signs which are negative in intent, e.g., controlling signs about being late
- Being organized and non-cluttered

CHILD FRIENDLY

The clinic environment should strive to be child friendly by providing:

- Colorful, clean waiting rooms

- Waiting areas that are inviting places for children
- Toys, coloring books, and/or a child's entertainment center in the waiting area
- Items to amuse children in the counseling offices
- Decorations and distracting toys in the hematocrit/hemoglobin and anthropometric area

PROMPT SERVICE

Serve participants in a timely manner. They should not be kept waiting more than a few minutes. Tell a participant approximately how long the wait will be. If the wait is longer than expected, apologize to the participant and inform him/her how much longer the wait might be. Give participants complete and accurate information. Staff should take time to answer questions completely whether in person or on the phone.

REFERENCE

State policy

TELEPHONE

AVAILABILITY

- Be accessible by telephone.
- Have enough phone lines so callers rarely get a busy signal.
- Keep the use of an answering machine to a minimum.

TECHNIQUE

Good telephone techniques include:

- Asking if you may put the caller on hold and then wait for an answer.
- Telling the caller how long he or she will be on hold. Return to the phone call within that time. The wait should not be more than one minute.
- Taking a number and calling the person back if the wait is expected to be more than one minute.
- Thanking the person for calling. Do not reprimand a person who calls to cancel, even if it's at the last minute. Let participants know that WIC appreciates the call.

ANSWERING MACHINE

Use the answering machine when the clinic is closed or not in operation due to a staff meeting. Remember to turn the answering machine off as soon as the clinic reopens. The message on the machine should tell the caller:

- Office hours
- When to call back
- To leave a message, especially if calling to cancel an appointment
- If the caller leaves a message, ask the caller to:
  - Give his or her name
  - Indicate the reason for the call
  - Provide a contact phone number

Check messages regularly.
Return calls in a timely manner.
Update the machine message regularly.
Please do not use the answering machine just because the office is busy.

Reference

State policy

Greeting Applicants and Participants

Policy

Front office and reception staff should greet and acknowledge participants in a friendly manner. The first staff person to communicate with the participant sets the stage for positive relations. This can be the person who makes the appointment over the phone or the receptionist who interacts with the participant for the first time she comes in. All future interactions will be affected by this first contact. It's important that the first contact be positive. This is the first step in developing a caring, trusting relationship. If this is not established in the beginning, all future communication and teaching may be hindered.

Treat Participants in a Positive and a Respectful Manner

Participants should not be rushed through the system. There is a good balance between quick service and taking the time to meet the needs of participants. Greet participants when they arrive and acknowledge their children.

- Listen as well as tell. Listening shows respect.
- Tell participants how long they will be there.
- Tell participants if you are running later and give them the option to reschedule if it involves a significant wait. Apologize sincerely for any delays.
- Offer timely service and respect participants' time.
- Offer flexible appointments.
- Be understanding and don't judge. It's not possible to know what pressures the person may be dealing with, e.g., unemployment, inability to pay bills, divorce, domestic violence, taking care of a child with many medical problems, drug addiction, eviction notices, etc.
- Help participants carry belongings back to counseling rooms.
- Walk beside them and chat with participants while taking them back to get services instead of walking ahead of them.
- Don't interrupt.
- Be sure that behavior and dress are professional.
- Focus on people, not paper or computer.
- Know when to be flexible.

Reference

State policy

Evaluating Service Quality

Policy

Evaluate services yearly to ensure that clinics offer quality services. Develop a customer service questionnaire or use some other evaluation tool. Examples of questions follow.

Example:
For the most part, are you served within 15 minutes when you arrive on time? Yes No Comments
Have you been able to reach clinic staff by phone easily? Yes No Comments?
I have been treated fairly and kindly by the WIC staff. Yes No Comments Please explain
The WIC clinic uses answering machines: Too much Not enough Just the right amount

DEVELOP CUSTOMER SERVICE GOALS EACH YEAR

Examples:
The average waiting time for a voucher pick up appointment will be reduced to five minutes.
The percentage of clients who say on the questionnaire they have trouble getting through to the clinic by phone will be reduced to 10%.

SELF ASSESSMENT

Have staff check their attitudes by asking themselves which of the following statements reflect their beliefs.

Positive

I do all I can to help.
If I don't know the information needed, I will find out.
I serve participants as quickly as I can because they are important.
I like participants and co-workers.
I know participants and co-workers are trying their best.
I can give information, but participants and co-workers still have choices. I do not hold it against anyone if they don't take my advice.
Participants and co-workers know what is best for them.

Negative

I'm doing participants a favor by waiting on them.
I believe participants should just be thankful they are getting this free.
Participants should follow all our rules without questions.
WIC participants don't have anything to do anyway, so they can spend time at WIC.
I know more than participants and co-workers so I need to tell them what to do.
If we don't have strict rules, WIC participants will take advantage of us.
Participants don't even try.
Participants will never change.
WIC participants just take advantage of the system.
WIC participants are lazy, uneducated, cheaters.

REFERENCE

State policy

SECTION B: CIVIL RIGHTS

OVERVIEW

The Idaho WIC Program is committed to equal opportunity in the delivery of program services. In accordance with Federal law, U.S. Department of Agriculture, and the Idaho Department of Health and Welfare, the Idaho WIC Program prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

IN THIS SECTION

Civil Rights and Nondiscrimination
Reasonable Accommodation
Public Notification
Racial/Ethnic Data Collection
Staff Training
Compliance Reviews

CIVIL RIGHTS AND NONDISCRIMINATION

OVERVIEW

The Idaho WIC Program is committed to equal opportunity in the delivery of program services. In accordance with Federal law, U.S. Department of Agriculture, and the Idaho Department of Health and Welfare, the Idaho WIC Program prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

POLICY

The Idaho WIC Program is committed to equal opportunity in the delivery of program services. Program benefits are made available to all eligible persons without discrimination based on race, color, national origin, sex, age, or disability.

COMPLAINTS OF DISCRIMINATION

Any person (applicant, potential applicant, or participant) who feels he or she has been excluded from participation in or denied the benefits of services because of discrimination on the basis of race, color, national origin, sex, age or disability may file a complaint within 180 days of the alleged discriminatory action. This person shall have the right to present evidence and/or respond to adverse action.

Examples of discrimination:

- Exclusion of eligible person(s) from participation in the program on the basis of race, color, national origin, sex, age, or disability
- The inequitable allocation of program benefits to eligible person(s) on the basis of race, color, national origin, sex, age, or disability
- Issuance of program benefits (WIC checks/CVVs) in a place, time or manner that has the effect of denying or limiting benefits on the basis of race, color, national origin, sex, age, or disability

- Segregation of person(s) in clinic waiting areas or through the appointment system on the basis of race, color, national origin, sex, age, or disability
- Failure to apply the same eligibility criteria to all potential eligible person(s) seeking participation in the WIC program

LIMITED ENGLISH PROFICIENCY (LEP) PERSONS

Local agencies shall ensure meaningful access to WIC as needed to assist in the certification procedure and delivery of any WIC services for persons with Limited English Proficiency (LEP).

- Hiring bilingual or staff interpreters
- Contracting with an outside interpreter service
- Making formal arrangements for the use of voluntary community interpreter services
- Contracting for the use of telephone language interpreter services

Applicants and potential applicants must be informed of the right to request an interpreter at no charge to the applicant/potential applicant. A family member or friend is not considered an acceptable interpreter unless the applicant specifically requests that person be allowed to interpret.

The Participant Rights and Responsibilities should be read in the appropriate language to any applicant/potential applicant who cannot read.

TRANSLATED MATERIALS

Local agency written materials should be provided in languages other than English when needed. The State WIC Office will provide translated certification and nutrition education materials in non-English languages when necessary.
Non-English language materials available from the State WIC Office include: Spanish (all applicant and participant materials).
To determine the obligation to provide the translation of a document in languages other than English, local agencies will consider the following:

- frequency of the language need
- nature of the document
- number of pages in the document
- financial burden to translate
- availability of alternate means of providing information contained in the document to Limited English Proficiency (LEP) participants.

When document translation is not provided, alternate means will be used. This may include oral translation, taped translation, telephone translation, or interpretation.

REFERENCE

FNS Instruction 113-1 Civil Rights (Nov. 14, 2005)
7 CFR 246.8 Nondiscrimination (01/01/03)
All States Memo 98-90: Nondiscrimination Policy Statement (05/21/98)
IDHW-Policy Memorandum 04-05 (Replaces 01-1): Procedure for Civil Rights Complaints

Reasonable Accommodation

Overview

A reasonable accommodation is making adjustments for the disability of an applicant by structuring appointments or policies to enable an individual with a disability to have equal access to services. Reasonable accommodation includes modifying written materials, making facilities accessible, adjusting appointment schedules, providing sign language interpreters, and modifying appointment sites. Reasonable accommodation does not mean a local agency must make costly, disruptive changes or changes which fundamentally alter the nature or operation of WIC.

Policy

Local WIC agencies must have a procedure for making reasonable accommodations in a timely and cost-effective manner.

Requests for reasonable accommodation should be initiated by the individual needing the accommodation. Determining reasonable accommodation is a case-by-case process and depends on the circumstances of the particular situation. The State WIC Office is available for assistance in this area.

Individuals with Disabilities

An individual with a disability is any person who has a physical or mental impairment that substantially limits one or more of an individual's major life activities, having a record of such impairment, or being regarded as having such impairment (e.g., self-care, performing manual tasks, seeing, hearing, speaking, breathing, and working).

The local agencies will have a written procedure for serving WIC applicants and participants with physical disabilities if a facility is not accessible. Staff working in an office should be aware of the special accommodations available for that office.

Reference

FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
7 CFR 246.8 Nondiscrimination. (01/01/03)

Public Notification

Policy

Each local agency will take positive and specific actions to implement a public notification program throughout its jurisdiction which informs participants and applicants, particularly minority populations, of their program rights and responsibilities, their protection against discrimination, and the procedure for filing a complaint. This includes:

- Displaying the nondiscrimination poster, "And Justice For All," in prominent places such as a waiting room and other areas frequented by participants and applicants.
- Ensuring that appropriate staff, volunteers, or other translation resources are available to serve participants and applicants.
- Making available program regulations and guidelines to the public upon request.
- Providing participants and applicants access to civil rights information. This information includes procedures for filing complaints, program specifics, and Rights and Responsibilities of participants and applicants.

NOTE: An approved nondiscrimination statement must be included on all information printed or distributed with the WIC program listed or described on the material(s).

The nondiscrimination statement is required if the material:

- Describes eligibility requirements of the WIC program
- Identifies the benefits of WIC participation
- Describes participation of the WIC program
- Provides notice of conditions to continue eligibility
- Provides notice of ineligibility or disqualification

Use of Long Statement

The complete nondiscrimination statement must appear on all written materials and correspondence that identify or describe the WIC program eligibility and/or ineligibility. The following is the required statement:

> The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)
>
> If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
>
> Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).
>
> USDA is an equal opportunity provider and employer.

Short Statement

When space is limited, a shorter statement is suitable when written materials are one page or less or are too small to contain the long statement. This statement should be in print size no smaller than the text of the document. The following is the accepted short statement: USDA [WIC] is an equal opportunity provider and employer.

When providing information for the radio and television public service announcements, the nondiscrimination statement does not have to be read in its entirety. Rather, a statement such as "WIC is an equal opportunity provider and employer" is sufficient to meet the nondiscrimination requirement.

Exceptions

Nutrition education and breastfeeding promotion and support materials that strictly provide a nutrition message with no mention of WIC operations are not required to contain the nondiscrimination statement. If the nutrition education materials also contain information about WIC operations (e.g., clinic hours, authorized foods, rights and responsibilities), the nondiscrimination statement must be included. Outreach materials that are too small for the statement are exempt from the nondiscrimination statement requirement. Examples of these exceptions are pencils, pens, or small magnets.

POSTER

An approved nondiscrimination poster must be displayed in an obvious, easy to access, and readable location in each WIC office waiting room. More than one nondiscrimination poster may be displayed in the office. Posters are available from the State agency and may be ordered via the Quarterly Forms Order.

REFERENCE

All States Memorandum 06-21 (Jan. 11, 2006) Nondiscrimination Statement for WIC Materials
7 CFR 246.8 Nondiscrimination (01/01/03)
FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
All States Memorandum 98-90: Nondiscrimination Policy Statement (05/21/98)
USDA Nondiscrimination Statement Update (May 24, 2013)

RACIAL/ETHNIC DATA COLLECTION

OVERVIEW

Federal agencies, not State agencies, are required to compile information on multiple race combinations that represent one percent or more of the population served by the State agency. Therefore, the State WIC Office will be collecting this data, through local WIC agencies, for statistical reporting purposes only. This information will have no effect on determination of participant eligibility in the WIC program.

POLICY

Racial/ethnic information will be collected by local agencies for each WIC applicant at the time of certification.

PROCEDURE

WIC applicants will be asked to self-identify race and ethnicity to record in the WIC Information System Program (WISPr) or on the WIC Application Form. If the applicant does not self-identify race and ethnicity on the WIC Application Form, the WIC staff person must ask the participant to self-identify race and ethnicity, only after it has been explained that the collection of this information is for statistical reporting purposes and to monitor compliance with Federal civil rights laws. Participants should be informed that this information has no effect on the determination of their eligibility to participate in the WIC program.

NOTE: If the applicant declines to self-identify race and ethnicity, WIC staff should visually determine the race and ethnicity and enter the data into WISPr. This should be done as discreetly as possible so as not to offend the applicant. A brief notation must be documented in WISPr that race and/or ethnicity was determined visually.

REFERENCES

FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
7 CFR 246.8 Nondiscrimination (01/01/03)
All States Memorandum 04-34 (05/21/04) Final Policy on WIC Racial/Ethnic Data Collection

STAFF TRAINING

POLICY

State and local agencies are required to conduct annual civil rights training for all WIC staff.

TRAINING/DOCUMENTATION

All WIC staff members must complete Civil Rights training yearly. Documentation of Civil Rights training must be kept on file at the local agency. A copy of the sign-up sheet is to be submitted to the State agency with the quarterly report for the quarter in which the training was completed. Documentation will include, but is not limited to:

- Sign-in sheet for attendees
- Date of training for attendees
- Agenda/outline of topic(s) covered in training
  - Specific subject matter must include, but not be limited to:
    - Collection and use of data
    - Effective public notification systems
    - Complaint procedures
    - Compliance review techniques
    - Resolution of noncompliance
    - Requirements for reasonable accommodation of persons with disabilities
    - Conflict resolution and customer service

REFERENCE

FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
7 CFR 246.8 Nondiscrimination (01/01/03)
USDA Nondiscrimination Statement Update (May 24, 2013)

COMPLIANCE REVIEWS

PROCEDURE

As part of local agency monitoring, the State WIC Office will conduct a civil rights compliance review. The following items must be determined as a minimum:

- Location of the nondiscrimination poster
- The local agency conducts civil rights training for all staff. The local agency keeps documentation of such training.
- Racial/ethnic data collection occurs according to policy and procedure.
- The nondiscrimination statement is included on all printed materials for the public, per policy.
- All civil rights complaints are handled per policy.
- Review of waiting lists (if applicable) and ineligible applications for civil rights issues.
- The local agency has a policy on how to provide reasonable accommodation.
- The local agency has a policy on how to provide language assistance services for persons with limited English proficiency (LEP).
- The local agency has a policy on how to ensure that program information is available to all applicants/participants (e.g., bilingual staff, interpreter services, written materials in other language(s)).
- Accessibility of physical environment for persons with disabilities.
- Interview staff about civil rights complaint procedures (i.e., how to process a complaint).

REFERENCE

FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
7 CFR 246.8 Nondiscrimination (01/01/03)
7 CFR 246.19(b) State Responsibilities (01/01/03)

SECTION C: COMPLAINTS AND INCIDENTS

OVERVIEW

Any person has the right to file a complaint if the person feels he or she has been excluded from participation or denied appropriate services. A member of the public has the right to file a complaint if he or she believes a participant is not eligible to receive WIC services. A vendor or local agency staff person has the responsibility to make a formal report if he or she feels a participant has not adhered to WIC regulations or procedures.

Frequently, complaints involve misunderstandings rather than a true denial of participation in WIC or denial of services. The investigation of complaints can assist local agencies in providing better service to applicants and participants.

Complaints are considered one of three types: program, vendor, or civil rights, depending on the nature of the complaint.

IN THIS SECTION

Reporting Complaints and Incidents
Program Complaints and Incidents
Vendor Complaints and Incidents
Civil Rights Complaints
Complaint or Incident Report Form

REPORTING COMPLAINTS AND INCIDENTS

POLICY

Program: Any applicant or participant has the right to make a complaint if he/she feels they have been excluded from participation or denied appropriate services. A member of the public has the right to file a complaint if he or she believes a participant is not eligible to receive WIC services.

Vendor: A vendor or local agency staff person has the responsibility to make a formal report if he or she feels a participant has not adhered to the WIC Rights and Responsibilities.

Civil Rights: Any applicant, potential applicant, or participant has the right to file a complaint if they feel they have been excluded from participation or denied services based on race, color, national origin, sex, age, or disability.

No staff person shall intimidate, threaten, retaliate, or discriminate against a person who has made a complaint, testified, assisted, or participated in any manner during a complaint investigation.

TIMEFRAME

Complaints filed after the valid complaint period may not be investigated.
Program complaints must be filed within 90 days of the alleged action.
Vendor complaints must be filed within 90 days of the alleged action.

Civil rights complaints must be filed within 180 days of the alleged action.

NOTE: The State agency must be notified immediately if a civil rights complaint is received by the local agency. Refer to a specific topic in this section for details of the types of complaints mentioned above.

Who Can File

- Applicant or potential applicant
- Participant or Responsible Adult
- Member of the public
- Vendor
- Local agency staff person on behalf of self
- Representative chosen by the complainant
- Local agency staff person on behalf of the complainant

Complaints may be filed anonymously. When applicable, the complainant should be encouraged to provide his or her name to aid the investigation, and be reassured that their identity will be kept confidential to the extent possible.

Receiving Complaints

Local agency staff must accept all complaints. Staff should not attempt to determine if the complaint is valid; instead, staff must make sure the complaint is handled according to procedures.

Complaints may be filed in person, by telephone, or in writing. Complainants may write the complaint or request local agency staff to assist in writing the complaint.

- In-person complaints can be made at local agency offices and should be referred to the local agency Coordinator or other person designated by the Coordinator.

- Telephone complaints can be made by contacting the local agency Coordinator (or other designated person) or the State agency at (208)334-5948 or toll free at (866)347-5484.

- Written complaints from applicants, participants, or vendors should be reviewed by the local agency Coordinator and a copy forwarded to the State agency. If a resolution was reached at the local agency, the Coordinator must document this prior to sending a copy of the complaint.

NOTE: All civil rights complaints (whether in person, verbal or written) must be forwarded to the State agency and the State agency must forward the complaint to the USDA.

Resolution

Many times, complaints involve misunderstandings rather than true denial of participation or services.

Reference

FNS Instruction 113-1, Civil Rights (Nov. 14, 2005)
246.7(c)(2)(vi) Verification of income. (01/01/03)
246.8 Nondiscrimination (01/01/03)
State policy

PROGRAM COMPLAINTS AND INCIDENTS

POLICY

Any person has the right to make a complaint if they feel they have been excluded from participation or denied appropriate services. A member of the public may file a complaint if he or she believes a WIC participant is not eligible for WIC services. This type of complaint is investigated as potential fraud. It is desirable for program complaints to be handled by the local agency Coordinator. If the Coordinator is not available, the complaint should be referred to the person in charge. The State agency is available for consultation.

TIMEFRAME

The program complaint must be filed within 90 days of the alleged action. Complaints filed after the valid complaint period may not be investigated.

WHO CAN FILE

- Any applicant, potential applicant, participant, representative chosen by the complainant, or a WIC staff person on behalf of the complainant.
- Complaints may be filed anonymously.

HOW TO FILE

Complaints can be made in person, by telephone, or in writing. Complainants may write the complaint or local agency staff should document the complaint if received via telephone or requested to do so by the complainant.

A Complaint or Incident Report Form can be used to file complaints or report incidents. It is not necessary to complete a form for every complaint. Professional judgment should be used to determine if a written complaint form is warranted. A written record of complaints received should be kept by the local agency regardless of whether the complaint form was used. If requested by a participant, a written complaint is required. Forward a copy of all written complaints to the State agency. The copy should include any action(s) taken by the local agency.

RESOLUTION PROCEDURES

Many times, complaints involve misunderstandings rather than true denial of participation or services. Complaints will be investigated by the local agency Coordinator and forwarded to the State agency for action, if warranted. Complaints filed directly with the State agency will be investigated by the State agency.

DOCUMENTATION

A copy of all complaints and related documentation must be maintained in each local agency.
The State agency recommends the documentation be maintained in a central file. This allows for easier auditing for proper resolution procedures and maintains better confidentiality, possibly reducing the chances of retaliation.

NOTE: The local agency must have a local policy if it prefers to retain a copy in participant files.

REFERENCE

246.7(c)(2)(vi) Verification of Income (01/01/03)
State policy

VENDOR COMPLAINTS AND INCIDENTS

POLICY

Any participant has the right to make a complaint if the person feels he or she has been excluded from participation or denied appropriate services while at a vendor location. Vendors have the right to file an incident report if the vendor feels a participant has not followed correct procedures while cashing WIC checks/CVVs at the vendor's location.

Local agency staff must accept all incident reports. They should not attempt to determine if the complaint is valid; instead, staff must make sure the complaint is handled according to procedures.
No staff person shall intimidate, threaten, retaliate, or discriminate against a person who has made a complaint, testified, assisted, or participated in any manner during a complaint investigation.

TIMEFRAME

A vendor complaint or incident report must be filed within 90 days of the alleged action. Complaints filed after the valid complaint period may not be investigated.

WHO CAN FILE

- Any participant or representative chosen by the participant
- Any vendor
- Local agency staff person on behalf of the participant or vendor

HOW TO FILE

Complaints can be made in person, by telephone, or in writing. Local agency staff should document the complaint if received via telephone or requested to do so by the complainant.

A Complaint or Incident Report Form can be used to file complaints or report incidents. It is not necessary to complete a form for every complaint. Professional judgment should be used to determine if a written complaint form is warranted. If requested by a participant, a written complaint is required. Forward all written vendor complaints to the Vendor Coordinator at the State agency.

RESOLUTION PROCEDURES

Many times, complaints involve misunderstandings rather than true denial of appropriate services. If the complaint or incident report is determined to be valid, the Vendor Coordinator will work with the local agency coordinator and vendor to address and/or resolve the situation.

DOCUMENTATION

A copy of all vendor complaints and related documentation must be maintained in each local agency. The State agency recommends the documentation be maintained in a central file. This allows for easier auditing for proper resolution procedures and maintains better confidentiality, possibly reducing the chances of retaliation.

REFERENCE

State policy

CIVIL RIGHTS COMPLAINTS

POLICY

Any applicant, potential applicant, or participant alleging discrimination based on race, color, national origin, sex, age, or disability has the right to file a complaint within 180 days of the alleged discriminatory action.

WHO CAN FILE

A civil rights complaint can be filed by the person(s) alleging discrimination on the basis of race, color, national origin, sex, age, or disability, or a representative chosen by the complainant or a local agency staff person on behalf of the complainant.

HOW TO FILE

The complaint may be initiated at a local agency office, State WIC Office, USDA, or IDHW Office of Civil Rights.

All civil rights complaints, verbal or written, shall be accepted by the local agency. If a complaint is verbal, local agency staff will document the complaint using the Idaho WIC Program Complaint or Incident Report Form when the complaint is received by telephone or if requested to do so by the complainant.
Local agency WIC staff and State agency WIC staff must document and report all complaints according to the procedures outlined, regardless of whether or not a complainant requests the reporting or processing of such complaint. These complaints should then be reported as anonymous. Anonymous complaints will be handled as any other complaint.

NOTE: The State WIC Office must be notified immediately if a civil rights complaint is received by the local agency.

Idaho WIC Program
Dept. of Health and Welfare
450 West State Street, 1st Floor West
P.O. Box 83720
Boise, ID 83720-0036
Fax: (208) 332-7362

The State WIC Office will forward any civil rights complaint to USDA within 10 days.

Civil Rights Division (CRD)
3101 Park Center Drive, Suite 808
Alexandria, VA 22302

DOCUMENTATION

To protect the confidentiality of the complainant, documentation related to civil rights complaints will not be kept in a participant's chart. A copy of all civil rights complaints and related documentation must be maintained in a civil rights file in each local agency. A common file for the entire agency or one file per clinic location is acceptable. The State WIC Office will maintain a file documenting all civil rights complaints.

REFERENCE

FNS Instruction 113-1 Civil Rights (Nov. 14, 2005)
7 CFR 246.8 Nondiscrimination (01/01/03)
IDHW - Policy Memorandum 04-05 (replaces no. 01-1) Procedure for Civil rights complaint

COMPLAINT OR INCIDENT REPORT FORM

POLICY

A Complaint or Incident Report Form can be used to file complaints or report incidents. A copy of each completed form must be forwarded to the State agency.

The use of professional terminology and objective information is strongly recommended when a staff person completes the form. A confidential copy of the form may be provided to vendors and participants as part of the investigation.

COMPLETING THE FORM:

Front Side

- Date and Time
  When did it happen? Identify the date of the alleged action. This is important because there are time limits for filing different types of complaints.

- Location
  Describe the clinic or vendor location where the situation or incident occurred. It is virtually impossible to follow up a complaint without knowing where it happened. For example, specify the location of a grocery store.

- People Involved
  Identify the people involved by full name (best) or describe the person if the name is unknown. It is also helpful to include contact information (if known) to assist the investigator.

- Nature of the Complaint
  Describe what happened, including enough information to aid in the investigation and resolution of the complaint. It is also helpful to learn why the complainant feels this situation happened.

- Remedy Sought by Complainant
  Describe what the complainant believes would rectify the situation. Investigations will proceed more effectively if the investigator knows the desired outcome at the start.

- Identity of the Complainant
  Include as much information as possible so the investigator can contact the person, if necessary. Basic identity includes name, telephone number, mailing address, and relationship to the situation. The complainant relationship is important because it impacts how the complainant can be involved in the resolution.

Back Side

- If actions have been taken to resolve the complaint, describe the actions. This portion may be completed by the person who worked to resolve the complaint or the local agency coordinator.

- It is also acceptable for this portion to be left blank, if local agency staff have not taken action, usually because staff is aware of the complaint or incident and looking into further.

Alternate Form

Complaints can also be taken without using the form. At a minimum, the written complaint should include information described in Completing the Form. A written record of complaints received should be kept by the local agency regarding of whether the complaint form was used.

Anonymity

Complaints may be filed anonymously. When applicable, the complainant should be encouraged to provide his or her name to aid the investigation and be reassured that their identity will be kept confidential to the extent possible.

Reference

State policy

SECTION D: PROGRAM VIOLATION

OVERVIEW

Program violation means any intentional action by a participant, parent, caretaker of an infant or child participant, or proxy that violates Federal or State statutes, regulations, policies or procedures governing the WIC Program.

IN THIS SECTION

Employee Duty Restrictions
- Employees, Family or Friends as Participants
- Separation of Duties
- Conflict of Interest

Participant Violation and Disqualification
- Definitions
- Participant Disqualification for Program Fraud
- Infant/Child Disqualification
- Participant Rights and Responsibilities When Disqualified
- Exception for Disqualification
- Reapplication
- State and Local Agency Responsibilities
- Violations
- Repayment

Employee Investigation

EMPLOYEE DUTY RESTRICTIONS

POLICY

Staff duties should be assigned to minimize the potential for fraudulent activities and ensure integrity. Local agency Coordinators may write a local procedure specific to accommodating this requirement.

EMPLOYEES, FAMILY OR FRIENDS AS PARTICIPANTS

PURPOSE

Provide explanation and direction for managing situations when certification and benefits issuance may not be achievable for local agencies when employees, family or friends are participants.

POLICY

An employee who qualifies for program benefits should not determine eligibility for oneself, close friends, or immediate family members. Examples of family include parents, siblings, children, grandparents, in-laws, aunts, or any step-family members. Friends are defined as any close acquaintance or a person the staff member spends time with outside work, such as a babysitter or a best friend of that staff member's child. Likewise, staff must not provide WIC services, such as certifying and issuing checks/CVVs, to

oneself as a WIC participant, immediate family members or close friends. These tasks should be performed by another staff member.

In local agencies and clinics with more than one staff member, the following procedures should be performed to avoid a conflict of interest:

- Staff should be rotated at the clinic site and allow for:
  - Arrangements for the family member or friend to be certified and issued benefits by another staff member.
  - Rescheduling of family members or friends for a time when another staff member is available, when possible or appropriate.
- Suggest the family member or friend participates at a different WIC clinic or agency when it's possible or appropriate and doesn't cause hardship for the participant, responsible adult or caretaker.

In the event that local agencies operate small clinics or satellite clinics with only one staff member and it is not practical to accommodate the actions above, the local agency must implement procedures to increase supervisory oversight to ensure program integrity is maintained.
The clinic must be closely monitored to prevent program violations and fraud, and assure the procedures are being followed. All staff must disclose the name(s) and relationship(s) where a conflict of interest may arise. The local agency is responsible for keeping the Conflict of Interest forms updated.

The following actions must be performed based on the relationships disclosed by staff members. The local agency Coordinators must provide the State with a copy of the clinic procedures specific to meeting the requirements below:

- Review of participant files
- Review of the check register
  - Review signatures on check register and Rights, Responsibilities and Consent forms to see if they match
- Contact participants to verify appointments and check/CVV issuance

SEPARATION OF DUTIES

PURPOSE

Provide explanation of the requirement for separation of duties for certification and benefits issuance. Offer guidance for managing situations when separation of duties may not be achievable for local agencies.

POLICY

Separation of duties is a standard accountability and security practice taken by local agencies to separate certification from benefit issuance between more than one staff member, to the extent possible.
In a local agency clinic with more than one staff member, there will be separate certification procedures, check/CVV issuance functions, and check/CVV accountability procedures to ensure the entire cycle of issuance does not rest with one person.

In the event that local agencies operate small clinics or satellite clinics with only one WIC staff member, the local agency must implement procedures to ensure program integrity is maintained, such as:

- Anytime another staff member is available at the clinic, eligibility determination and check issuance should be separated.
- Non-WIC staff members may be trained to issue checks in order to separate duties.
- Staff of the satellite clinic should be rotated on a routine basis with other clinic staff members.

- Batch print checks by one staff member at the main site, but issue benefits by another staff person at the remote site, when possible or appropriate.

If it is not practical to accommodate these actions described above, then increased supervisory oversight must be implemented. The clinic must be closely monitored to prevent program violations and fraud. The following procedures must be performed on a routine basis, and local agency Coordinators must provide the State with a copy of the clinic procedures specific to meeting the requirements below:

- Random review of participant files
- Random review of the check registers
  - Review signatures on check register and Rights, Responsibilities and Consent forms to see if they match.
- Randomly contact participants to verify appointments and check issuance.

NOTE: If the clinic routinely meets the separation of duties requirement and staff does not certify or issue benefits to family, friends or themselves, but due to unusual circumstances there is only one staff member available, the agency must ensure tha day's check issuance is monitored appropriately. This means a review of the participant's chart, the check register, and contact with that participant will be completed and documented to verify procedures were followed.

Conflict of Interest

All State and local agency staff must sign a Conflict of Interest Form regarding the above mentioned scenarios as well as disclose the relationship between themselves and WIC authorized vendors. These relationships include staff, immediate family members, or close friends who have any financial interest in any Idaho WIC authorized vendor.

- Staff must not show any favoritism by oral or written communication, posters, handouts, or media presentations towards any Idaho WIC authorized vendor.
- Staff will not endorse or discourage the use of any Idaho WIC authorized vendor to WIC participants.
- Staff will not receive any gratuities including cash, food, or food coupons not available to the public from an Idaho WIC authorized vendor.

Staff who falls under any of these scenarios must sign a Conflict of Interest Form which is to be kept by their supervisor and available for review.

Reference

All States Memorandum 99-94 (7/8/99) Separation of Duties in WIC Clinic Operations
7 CFR 246.4 (a)(26)(i-iii) State Plan Requirements
Alaska WIC Polict
Washington State WIC Policy and Procedure Manual

Participant Violation and Disqualification

Definitions

Abuse: To cause harm or threaten harm with words.

Fraud: An intentional misrepresentation of the truth to deceive others for the purpose of acquiring something of value, such as money or WIC benefits. Anything calculated to deceive, whether by a single act or combination, or by the suppression of truth, or by suggestion of what is false, whether it is by a direct lie, silence, look, or gesture. An example of fraud is selling a WIC Food check or CVV, which deceives the WIC program to acquire money.

Participant Violation: Intentional activities or actions of WIC participants or their authorized representatives or proxies to obtain benefits to which they are not entitled and/or to misuse benefits they receive.

PARTICIPANT DISQUALIFICATION FOR PROGRAM FRAUD

Idaho WIC Program participants shall receive written warning or be disqualified when documentation verifies that participant fraud has occurred. Serious violations of program integrity, such as selling WIC food checks/CVVs, will result in disqualification without any warning.

The State WIC agency reserves the right to disqualify participants for other actions not listed herein if the participant violates program policies and regulations.

Participant violation activities and actions include, but are not limited to:

- Making false or misleading statements or intentionally misrepresenting, concealing, or withholding facts to obtain WIC program benefits
- Exchanging WIC food checks/CVVs or supplemental foods for cash, credit, non-food items, or unauthorized food items
- Exchanging WIC food checks/CVVs for more than the specified amount of supplemental foods listed on the WIC food check/CVV
- Physically harming or threatening to harm WIC clinic staff or vendor staff or property belonging to the WIC clinic or vendor
- Participating in more than one WIC clinic or participating in the WIC Program and in Commodities Supplemental Food Program (CSFP) at the same time (dual participation)
- Theft of WIC food checks/CVVs
- Redeeming more than the number of WIC food checks/CVVs for which the participant is eligible
- Altering the WIC food check/CVV
- Redeeming WIC food checks/CVVs at an unauthorized food vendor
- Misuse of program benefits and/or equipment in direct conflict with policy

INFANT/CHILD DISQUALIFICATION

When the participant being disqualified is an infant or a child, the Responsible Adult is the one to be disqualified. The infant or child can continue to receive benefits and participate during disqualification if another Responsible Adult or proxy is designated. If the Responsible Adult represents multiple infants and/or children, all infants and children can remain on the program under the preceding conditions.

PARTICIPANT RIGHTS AND RESPONSIBILITIES WHEN DISQUALIFIED

Participants have the right to appeal any denial, claim or disqualification at a fair hearing. Participants shall be provided, within a minimum of 15 calendar days, written notice prior to disqualification.

EXCEPTION FOR DISQUALIFICATION

The State WIC Agency may decide not to impose a mandatory disqualification if, within thirty (30) days of receipt of the notice of repayment, full restitution is made or a repayment schedule is agreed upon.

REAPPLICATION

A participant that has been disqualified may reapply for the WIC Program at the end of a disqualification period or the full repayment of a claim. However, they must meet all current eligibility criteria before certification.

STATE AND LOCAL AGENCY RESPONSIBILITIES

STATE RESPONSIBILITIES	LOCAL AGENCY RESPONSIBILITIES
The State agency will verify information regarding alleged participant abuse or fraud and retain the documentation in which a repayment or disqualification occurred. This will include: • Name of participant • Reason for and amount of claim • Dates that certified letters were sent • Date and disposition of a requested Fair Hearing • Date and repayment schedule of a restitution agreement • Date and amounts of restitution collected (including in-kind services) • Date that further collection actions ceased due to a cost-benefit analysis When an investigation has verified fraud or abuse, the State agency will send a certified letter to the participant regarding the sanction and, if appropriate, the amount of repayment. A copy of the certified letter will be sent to the local agency. The State agency will determine the amount of funds improperly received by the participant. The State agency will use the total purchase price of the WIC food check(s)/CVV(s). The State agency will inform the participant of the right to appeal a claim or a program disqualification. The State agency will provide an informal dispute resolution meeting and/or a Fair Hearing. The State agency will collect repayments prior to providing benefits.	The local agency will document all allegations of program abuse or fraud on the Idaho WIC Complaint or Incident Report form and/or in the computer. In all cases where program abuse or fraud is alleged against a participant, the local agency shall submit a Complaint or Incident Report form and accompanying documentation to the State agency. The local agencies shall consult with the State agency prior to taking any action regarding participant abuse or fraud. If there is a sanction action, the local agency will advise the participant of the program requirement(s) they violated. (What they did wrong and the correct procedure.) The local agency will provide program benefits to participants who appeal disqualification within 15 calendar days of the written notification of disqualification until the appeal is decided, the participant becomes categorically ineligible, or the certification period expires, whichever occurs first. If the violation is one that warrants a warning letter, the local agency Coordinator will create the letter and either mail the letter or have the participant read and sign the letter at the next WIC appointment.

VIOLATIONS

Three (3) documented violations, beyond the warning letter(s), of any combination of the violations listed below will result in a one (1) year disqualification period. The three (3) documented violations must be committed within a 12-month period.

If there are less than three (3) combinations of violations with different sanctions, the participant shall receive the maximum sanction.

VIOLATIONS	NUMBER OF OFFENSES	SANCTIONS
Using WIC food checks/CVVs before "First Day to Use" or after "Last Day to Use"	1 2	Verbal warning Warning letter
Failing to sign WIC food checks/ CVVs at time of purchase	1 2	Verbal warning Warning letter
Cashing WIC food checks/CVVs reported lost or stolen	1 2 3	Warning letter 30 day disqualification 1 year disqualification
Allowing an unauthorized person to use WIC food checks/CVVs or WIC ID folder	1 2 3	Warning letter 30 day disqualification and repayment 1 year disqualification and repayment
Using WIC food checks/CVVs to buy unauthorized food costing $99.99 or less	1 2 3	Warning letter 30 day disqualification and repayment 1 year disqualification and repayment
Creating a public nuisance, threatening harm, or disrupting normal activities at the local agency or at the vendor (store)	1 2 3	Warning letter 30 day disqualification 1 year disqualification
Altering WIC food checks/CVVs' date, quantity, or type of food	1 2 3	60 day disqualification and repayment 90 day disqualification and repayment 1 year disqualification and repayment
False statement or misrepresentation of income, name, residence, family size, medical data, pregnancy, or date of birth to obtain WIC benefits	1 2	90 day disqualification and repayment 1 year disqualification and repayment If unintentional, warning letter
Exchanging WIC food checks/CVVs for credit or non-food items	1	1 year disqualification and repayment
Attempting to sell WIC food checks/CVVs	1	1 year disqualification
Selling WIC food checks/CVVs	1	1 year disqualification and repayment
Attempting to sell or give away supplemental food that was purchased with WIC food checks/CVVs	1 2	90 day disqualification 1 year disqualification If unintentional, warning letter
Selling or giving away supplemental food that was purchased with WIC food checks/CVVs	1 2	90 day disqualification and repayment 1 year disqualification and repayment
Using WIC food check(s)/CVV(s) at unauthorized vendor (store)	1 2 3	Warning letter 90 day disqualification and repayment 1 year disqualification and repayment
Using WIC food checks/CVVs to buy unauthorized food equaling $100 or more	1	1 year disqualification and repayment If unintentional then warning letter.
Theft of WIC food check(s)/CVV(s)	1	1 year disqualification, repayment, and reported to law enforcement

VIOLATIONS	NUMBER OF OFFENSES	SANCTIONS
Physically abusing WIC or vendor staff/property	1	1 year disqualification and reported to law enforcement
Dual participation—using benefits from two WIC programs/agencies in the same month, includes CSFP.	1	1 year disqualification and repayment of the dual benefits.
Intentional dual participation	1	1 year disqualification from all programs and repayment of all benefits
Assessed claim for $100 or more. A claim is the amount of a repayment.	1	1 year disqualification and repayment If unintentional, warning letter.
Assessed second or subsequent claim for any amount	1	1 year disqualification and repayment

REPAYMENT

The State agency will be responsible for all documentation of the participant's violation and repayment. The designated Department of Health and Welfare personnel will track claims, record funds received, send the participant or Responsible Adult or caretaker a receipt of payment received and monitor remaining balances due. The State agency will notify the participant when the claim is paid in full. All actions and determinations, including a determination that it is not cost effective to pursue further collection actions, must be documented in the case file.

The State agency may pursue repayment through a state collection agency or another collection agency, including the federal government.

Terms of Repayment

- The term of repayment schedule will be no longer than twelve (12) months and no less than $10.00 per month.
- Repayment must be made via check or money order payable to the "Idaho WIC Program." No cash will be accepted.
- Repayment must include with the check or money order a clear identification of the participant's name, client ID number, family ID number, and reason for repayment.
- A letter outlining the program violation along with payment envelopes will be sent via certified mail to the WIC participant or Responsible Adult or caretaker who committed the violation.
- A copy of the signed Participant Rights and Responsibilities form will accompany the letter. The State agency will contact the local agency WIC Coordinator to obtain a copy from the participant file and to inform them of the actions being taken.
- If, at any time, the State agency determines that the participant, Responsible Adult, or caretaker of child or infant WIC participants is at least two (2) payments behind, the participant or Responsible Adult, or caretaker will be disqualified from the program. The number of months of disqualification will be determined as a pro-rated portion of the original penalty based on the percentage of months of unpaid restitution.

EMPLOYEE INVESTIGATION

Employees who are participants are also subject to participant program violation policies. All employee fraud cases involving benefits are investigated by the local agency, the State agenct, law enforcement, and/or the Department of Health and Welfare Fraud Investigation Unit.

Employee program violations include, but are not limited to:

- Disregard for confidentiality of program information
- Physically harming or threatening to harm other WIC clinic staff or vendor staff, or property belonging to other WIC clinic staff or vendor staff
- Falsely obtaining benefits for self or others
- Theft of program supplies/equipment
- Failure to report knowledge of any of the above situations

NOTE: Employee fraud case investigations must be documented and such documentation is kept for a minimum of ten years.

REFERENCE

7 CFR 246.7 (l) Dual Participation
7 CFT 246.7 (j) Notification of Participants Rights and Responsibilities
7 CFR 246.9 Fair Hearings
7 CFR 246.12 (u) Participant Violations and Sanctions (Referral for Prosecution)
7 CFR 246.23 (c) Claims against Participants

SECTION E: FAIR HEARINGS

OVERVIEW

The purpose of this section is to help clinic staff answer questions from WIC participants about the fair hearing procedure. In Idaho, the WIC program is required to follow the hearing procedures set forth by the Department of Health and Welfare and Federal regulations.

IN THIS SECTION

Notification of Right to Fair Hearing

NOTIFICATION OF RIGHT TO FAIR HEARING

POLICY

The following situations require the notification of the right to a fair hearing:

- The participant is denied participation at time of certification
- The participant is suspended/disqualified mid-certification
- The WIC program makes a claim against a WIC participant for repayment of the cash value of improperly issued benefits

Notification is not required at the expiration of a certification period.

NOTICE REQUIREMENTS

At the time of a claim against an individual for improperly issued benefits, participation denial, suspension or disqualification, the local agency must inform the individual in writing of:

- The right to a fair hearing
- The method used to request a hearing
- The fact that positions or arguments on behalf of the individual may be presented personally or by a representative such as a relative, friend, or legal counsel

TIMEFRAME

A request for a hearing must be made within 60 days from the date the State WIC office or local agency mailed or gave notice of adverse action to deny or terminate benefits.

The person requesting the fair hearing will receive written notification at least 10 days prior to the conduct of the hearing.

The results of the hearing will be provided within 45 days of the request for fair hearing.

WHO CAN REQUEST

Any applicant or participant aggrieved by any action of the Idaho WIC Program which results in the individual's denial of participation, suspension, disqualification, or termination from the program, may request a hearing.

The right to make such a request will not be interfered with in any way.

The request can be made by the applicant or participant or some other person acting on the applicant or participant's behalf, such as a legal counsel, friend, or household member.

HOW TO REQUEST

A request for a hearing is any clear expression by the individual, individual's parent, caretaker, or other representative that they want to present their case to a higher authority.

The hearing request may be made orally or in writing. If orally, local agency may write the request for the individual.

The Fair Hearing Request Form must be provided to anyone who requests it. A copy of the completed request from should be given to the individual making the request

CONTINUATION OF BENEFITS

Except for participants whose certification period has expired, participants who appeal the termination of benefits within the 15 days of this action shall continue to receive program benefits until the hearing officer reaches a decision or the certification period expires, whichever occurs first.

Participants whose certification period has expired or who have become categorically ineligible during the appeal process will not receive program benefits while awaiting the hearing decision.

Applicants who are denied benefits at initial certification or expiration of their certification may appeal the denial, but will not receive benefits while awaiting the hearing decision.

WIC Program funds may not be used to pay for retroactive benefits.

PROCEDURE

All requests for a fair hearing must be sent to the State WIC Office as soon as a local WIC office receives the request. Attach a copy of the letter of ineligibility or claim for repayment.

The State WIC Office will notify the Department of Health and Welfare, who will maintain responsibility for appointing the Hearing Officer and conducting the hearing according to Department procedures.

DENIAL OR DISMISSAL OF REQUEST

The State WIC Office will not deny or dismiss a request unless the following have occurred and/or upon legal counsel provided by the Department.

- Request is received after the 60-day time limit.
- Request is withdrawn, in writing, by the applicant or authorized representative.
- Appellant or representative fails, without good cause, to appear at the scheduled hearing.

- Appellant has been denied participation by a previous hearing and cannot provide evidence that circumstances relevant to program eligibility have changed.

REFERENCE

7 CFR 246.9 Fair hearing procedures for participants
State of Idaho, Department of Health and Welfare Administrative Rules, 16.05.03 Contested cases and declaratory rulings

SECTION F: DISASTER RECOVERY

OVERVIEW

This section describes the division of responsibility for service continuation in the event of a natural disaster, computer system failure, or other emergency situation.

IN THIS SECTION

Local Agency Responsibilities
State Agency Responsibilities
Checks/CVVs Printed by State Agency
Contaminated Water

LOCAL AGENCY RESPONSIBILITIES

POLICY

The following procedures will vary depending on the circumstances of the disaster or emergency.

1. Clinic staff should notify the local agency Coordinator as soon as possible of the emergency situation.

2. The Coordinator should notify the State WIC Office of the emergency situation.

INFORMATION NEEDED BY STATE AGENCY

- Nature of the disaster or emergency
- Number of clinics affected
- Number of participants involved
- Water supply/safety problems (check with Environmental Health officer)
- The next scheduled clinic day
- Number of potential vendors involved

CHECK/CVV ISSUANCE

State agency will work with the local Coordinator regarding printing and issuance of checks/CVVs.

Options:
1. Checks/CVVs can be printed at another nearby site.
2. State agency can print checks/CVVs and mail them to a clinic or to the participant.

Clinics are responsible for check register documentation.

Issue one month of checks/CVVs only.

Participant Education

Certain areas within the state are at high risk for floods, fire, road problems, snowstorms, etc. Education classes should be provided for participants living in these areas. Information is not limited to, but should include: what to do about inaccessible stores, what to do with checks/CVVs that aren't cashed, and what to do about contaminated water.

Formula

The State WIC Office will work with the local agency Coordinator to determine formula needs (e.g., Ready to Feed (RTF) formula).

Vendors

State Vendor Coordinator will determine vendor procedures during the disaster and will work with the vendors as needed.

Reference

State policy

State Agency Responsibilities

Policy

The following procedure will vary depending on the circumstances of the disaster or emergency.

State WIC Program Manager will coordinate disaster or emergency response. The State agency will document all disaster or emergency operations.

Document Information from Clinic:

- Nature of the disaster or emergency
- Number of clinics affected
- Number of participants involved
- Water supply problems
- Next scheduled clinic day
- Number of potential vendors involved
- Changes made to assist participant

Vendor Relations

The State agency will work with vendors during the disaster to accommodate needs of participant and check issues. The Vendor Coordinator will take the lead in this effort.

- Researching alternative stores
- Notifying vendors of procedures
- Sending checks/CVVs to the State agency instead of the bank
- Issuing credit slips

Red Cross

If needed, the State agency will contact the Red Cross during a disaster or emergency to deliver formula, supplies, etc.

CHECK/CVV ISSUANCE

The State agency will print checksCVVs if they cannot be printed in an outlying clinic or closer to participants in need. State agency will work with local Coordinator to determine location of check/CVV printing.

FORMULA

The State agency, in conjunction with the local agency Coordinator, will be responsible for:

- Assessing clinic formula needs (type and amount)
- Ordering more formula samples from the company, if needed
- Arranging for mailing/shipment of formula samples
- Working with Vendor Coordinator on vendor supplies
- Working with Coordinator to assess need for RTU formula
- Working with formula companies as needed
- Arranging for shipment of formula, if needed

BREASTFEEDING

The State Breastfeeding Coordinator will work with breastfeeding mother/infant separation concerns and issues involving breast pumps.

REFERENCE

State policy

CHECKS/CVVS PRINTED BY STATE AGENCY

POLICY

1. Clinic notifies State agency which participants need to have checks/CVVs printed.
2. Screen print Clinic Appointment screen for participants needing checks/CVVs.
3. A current food package is set up on CF screen for participants.
4. Checks/CVVs are printed and mailed to another clinic or to the participant.
5. Copy of Client Appointment Screen sent to Coordinator, with documentation of any changes made.

If no appointments were entered on AC, clinic must fax participant's name, ID #, along with the appointment date and time to the State agency. Appointment information will be added to AC screen by the State agency and used to print checks/CVVs.

1. If checks/CVVs need to be mailed, an address report for labels may be requested.
2. Clinic is responsible for documentation on check register.

REFERENCE

State policy

CONTAMINATED WATER

POLICY

If contaminated water warnings last for several weeks, RTF formulas may need to replace powdered or concentrated formulas.

The State agency should:

1. Find out how many participants and which vendors are involved.
2. Determine if RTF formula is available in other clinics.
3. Contact involved vendors with approximate amount of formula needed.
4. If needed, enter RTF price for vendors on Food Vendor Price Table so check/CVV can be printed.

REFERENCE

State policy

SECTION G: MEMORANDUM OF UNDERSTANDING (MOU)

OVERVIEW

In general, a Memorandum of Understanding (MOU) is a written document between two or more parties in which they agree to perform certain complementary functions in service of a common goal.

Federal WIC regulations and USDA policy require MOUs or agreements in order to disclose client information to other public health or welfare programs for the purpose of eligibility for program services (State agency function). MOUs may also be developed for other purposes, e.g., delineation of responsibilities or activities to be conducted (local agency function).

IN THIS SECTION

Memorandum of Understanding (MOU)

MEMORANDUM OF UNDERSTANDING (MOU)

POLICY

State and local WIC agencies must develop MOUs with other agencies/programs to ensure coordination of services and confidentiality (e.g., Medicaid, SNAP, Immunizations, Head Start). Participant information must not be released without a signed release of information. This includes telephone requests. Confidential participant information includes any information about an applicant or participant, whether it is obtained from the applicant or participant, another source, or generated as a result of WIC application, certification, or participation, that individually identifies an applicant or participant and/or family member(s).

At minimum, MOUs should include:

- Parties to the Agreement
  - The WIC Program needs to be specified as a party to the agreement.
- Background
  - Provide specific details of what participant information is being shared and why.
- Purpose
  - Summarize the specific use of the participant information being shared for non-WIC purposes.
  - The responsibilities of each party involved.
  - Define the sole purpose of the participant information being used and agree the information will not be shared with a third party or utilized for any other purpose.
- Terms of the Agreement
  - The duration of the agreement (for example, one year)
- Signatures with dates from both parties

See sample MOU in the Forms and Arrachments chapter of this manual.

PROCEDURE

State and local WIC agencies must have MOUs in place prior to sharing confidential information with any program (within or outside of the agency) in which services are coordinated and/or participant information is shared, MOUs will be kept updated. Once the duration of the agreement expires, renewal is required as long as information continues to be shared.

Examples of agencies where MOUs must be in place include:

- Medicaid
- SNAP
- Immunization program
- Head Start
- Family planning
- County extension offices

Agencies sharing patient information with multiple programs within their health district have the option to create one MOU as long as it specifies all of the individual programs within the district sharing information.

When participant information is released in an MOU agreement, in addition to the MOU, local agencies must have a separate consent form signed by participants to notify them their information will be shared with another party. Participants must be allowed the option to refuse the release of information and be notified that signing of the form is not a condition of eligibility and refusing to sign the form will not affect the applicant's or participant's eligibility or participation in the WIC Program.

State and local WIC agencies must keep MOUs available to be reviewed during site monitoring. Local WIC agencies will be asked to submit a list of current MOUs prior to site monitoring.

REFERENCE

7 CFR 246.26 (d)(i)
7 CFR 246.26 (d)(2)
7 CFR 246.26 (d)(4)
7 CFR 246.26 (h)(1)

CHAPTER 3: CASELOAD MANAGEMENT

OVERVIEW

IN THIS CHAPTER

Section A Caseload Management

Section B Waiting Lists

Section C Outreach

SECTION A: CASELOAD MANAGEMENT

OVERVIEW

The WIC Program is funded by the federal government to serve eligible pregnant, breastfeeding and postpartum women, infants, and children up to age five. In times when funding does not allow for all eligible participants to be served by the WIC Program, the State WIC Office may choose to implement a caseload management policy.

IN THIS SECTION

Caseload Management
Priority System: Sub-Priorities

CASELOAD MANAGEMENT

OVERVIEW

Caseload management assures that applicants are categorized into appropriate priorities so that benefits can be provided to those in most need and not provided for those in lesser need at times when demand exceeds funding resources.

POLICY

Caseload Management must be made as equitable as possible on a statewide basis to ensure participants have equal access to the WIC Program throughout the state. Therefore, when a state level decision is made to implement caseload management, all local agencies must follow the same procedure for enrolling applicants.

The State WIC Office will determine which priority/sub-priority will receive benefits during caseload management. This decision will be based on current caseload numbers, available funds, and federal guidance.

Local agencies will be notified in writing of the need for caseload management for specific priority/sub-priority groups and the date to implement caseload management.

PRIORITY SYSTEM: SUB-PRIORITIES

OVERVIEW

The WIC priority/sub-priority system was designed to ensure that persons at the greatest nutritional risk are first to receive program benefits when a state is unable to serve all participants because of limited caseload (statewide caseload management has been implemented at the direction of the State agency).

The order of priorities recognizes the fact that the earlier in a child's development intervention takes place, the greater the impact on the child's health. For this reason, pregnant women are served first and younger children are served before older children within each priority. The priorities also reflect the

importance of serving participants with a current medical nutrition risk before participants with a poor diet who may develop a medical nutrition risk later.

DEFINITION

A sub-priority is any priority other than Priority I within a category (for example: pregnant women found to be a Priority IV based on Nutrition Risk Criteria would be a sub-priority of category P). Sub-priority designation shall be used when statewide caseload management is implemented and only a part of a priority can be served.

POLICY

Determining the order of serving participants using the priority and sub-priority system:

- Participants with a valid Verification of Certification (VOC) card will be served first regardless of their priority.
- A Competent Professional Authority (CPA) shall assign the highest priority to each participant based on their category (P, BF, N, I, or C) and nutritional risk.
- All participants in the higher priority shall be served before participants in lower priorities. Sub-priority designation shall be initiated by the State WIC Office. Determination will be based on statewide caseload numbers.
- Participants who are being recertified have no priority over other applicants during caseload management.
- Federally, there are seven priorities. Priority I is the highest need (highest priority) and VII is the lowest priority. Idaho WIC serves 6 priorities (Priority I is the highest priority need and Priority VI is the lowest priority need).

PROCEDURE

In the event that caseload management is initiated by the State WIC Office, all applicants from the date of caseload management implementation must be prescreened to determine priority/sub-priority.

Prescreening takes place when a person first inquires about participation in WIC. Depending on the sub-priority level that has been determined to be used by the State agency, local agencies may need to further prescreen applicants. Local agencies may partially screen to the point where eligibility is determined for the purpose of certification or placement on a waiting list.

Prescreening may involve determining the following:

- Residency of local agency service area
- Applicant category (i.e., pregnant woman, breastfeeding woman <1 year postpartum, postpartum woman, infant, or child under age 5)
- Income eligibility

Probable priorities may be determined with information obtained through interviews with applicants, through referral from a physician, and/or by anthropometric or biochemical data either brought in by applicant (must have been taken within past 60 days and written on prescription from a healthcare provider) or through local agency prescreening for anthropometric and biochemical data.

The six priorities are:

PRIORITY I MEDICAL

Pregnant women, breastfeeding women, and infants with medical nutritional risks based on information gathered during the prescreening assessment.

Sub-prioritized in this order:

1. Pregnant women
2. Breastfeeding women
3. Infants

PRIORITY II INFANT OF WIC MOM

Infants under the age of 6 months (who are not Priority I) of women who participated in WIC during pregnancy, or who would have been eligible to participate in WIC during pregnancy due to medical or dietary risk. There shall be no sub-priorities. Serve in order of application to the program.

PRIORITY III MEDICAL

Children with medical nutritional risks based on information gathered during the prescreening assessment.

Sub-prioritized in this order:

1. All children with physician prescriptions for WIC-eligible nutritionals are served first, regardless of age
2. 1-year-old children
3. Two-year-old children
4. Three-year-old children
5. Four-year-old children

NOTE: This means children needing WIC-eligible nutritionals are served to age 5 years even before younger Priority III children. After Priority I, all other children shall be sub-prioritized by age, with younger children being served first.

PRIORITY IV NUTRITIONAL

Homelessness, migrancy, or pregnant women, breastfeeding women, and infants with nutritional risk based on information gathered during the nutrition assessment.

Sub-prioritized in this order:

1. Pregnant women
2. Breastfeeding women
3. Infants

PRIORITY V NUTRITIONAL

Homelessness, migrancy, and children with nutritional risk based on information gathered during the nutrition assessment.

Sub-prioritized in this order:

Sub-prioritized by age, with youngest served first

PRIORITY VI MEDICAL AND NUTRITIONAL

Homelessness, migrancy, and postpartum women (up to six months postpartum) with nutritional risk based on information gathered during the nutrition assessment.

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
Priority I – Medical	Pregnant Women	**Biochemical** 201—Low Hemoglobin, Low Hematocrit **Anthropometric** 101—Underweight Woman 111—Overweight Woman 131—Low Maternal Weight Gain 132—Maternal Weight Loss During Pregnancy 133—High Maternal Weight Gain **Medical** 301—Hyperemesis Gravidarum 302—Gestational Diabetes 303—Hx of Gestational Diabetes 304---Hx of Preeclampsia 311—Hx Preterm Delivery (≤ 37 wks) 312—Hx Low Birth Weight 321—Hx Fetal or Neonatal Loss 331—Pregnancy -Young Age (< 18 Yr) 332—Closely Spaced Pregnancy 334—Lack of or Inadequate Prenatal Care 335—Multifetal Gestation 336—Fetal Growth Restriction 337—Hx Birth LGA Infant 338—Pregnant and Breastfeeding 339—Hx Birth -Congenital Defect 341—Nutrient Deficiency Diseases 342—Gastrointestinal Disorder 343—Diabetes 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 352—Infectious Diseases 353—Food Allergy 354---Celiac Disease 355—Lactose Intolerance 356—Hypoglycemia 357—Drug Nutrient Interactions 358—Eating Disorders 359—Recent Major Surgery, Trauma, Burns 360—Other Medical Conditions 361—Depression 362—Developmental, Sensory, Or Motor Delays 371—Maternal Smoking 372—Alcohol or Illegal Drug Use 381—Oral Health Conditions 501—Possibility of Regression 904—Exposure to Environmental Tobacco Smoke

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
	Breastfeeding Women	**Biochemical** 201—Low Hemoglobin, Low Hematocrit **Anthropometric** 101—Underweight Woman 111—Overweight Woman 133—High Maternal Weight Gain **Medical** 303—Hx Gestational Diabetes 304---Hx of Preeclampsia 311—Hx Preterm Delivery (≤ 37 wks) 312—Hx Low Birth Weight 321—Hx Fetal or Neonatal Loss 331—Pregnancy Young Age (< 18 yrs) 332—Closely Spaced Pregnancy 335—Multifetal Gestation 337—Hx Birth LGA Infant 339—Hx Birth - Congenital Defect 341—Nutrient Deficiency Diseases 342—Gastrointestinal Disorder 343—Diabetes 344—Thyroid Disorders 345—Hypertension and Prehypertension 346—Renal Disease 347—Cancer 348—Central Nervous System Disorders 349—Genetic and Congenital Disorders 351—Inborn Error of Metabolism 352—Infectious Diseases 353—Food Allergy 354—Celiac Disease 355—Lactose Intolerance 356—Hypoglycemia 357—Drug Nutrient Interactions 358—Eating Disorders 359—Recent Major Surgery, Trauma, Burns 360—Other Medical Conditions 361—Depression 362—Developmental, Sensory, or Motor Delays 363—-Pre-Diabetes 371—Maternal Smoking 372—Alcohol or Illegal Drug Use 381—Oral Health Conditions 601—BF Mom of Infant at Nutritional Risk 602—BF Complication - Woman 904—Exposure to Environmental Tobacco Smoke
	Infants	**Biochemical** 201—Low Hemoglobin, Low Hematocrit **Anthropometric** 103—Underweight or At Risk for Underweight 115—High Weight-For-Length

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
		121—Short Stature or At Risk for Short Stature 135—Inadequate Growth 141—Low Birth Weight **Medical** 142—Prematurity 153—Large for Gestational Age 341—Nutrient Deficiency Diseases 342—Gastrointestinal Disorder 343—Diabetes 344—Thyroid Disorders 345—Hypertension and Prehypertension 346—Renal Disease 347—Cancer 348—Central Nervous System Disorders 349—Genetic and Congenital Disorders 351—Inborn Error of Metabolism 352—Infectious Diseases 353—Food Allergy 354—Celiac Disease 355—Lactose Intolerance 356—Hypoglycemia 357—Drug Nutrient Interactions 359—Recent Major Surgery, Trauma, Burns 360—Other Medical Conditions 362—Developmental, Sensory, or Motor Delays 381—Oral Health Conditions 382—Fetal Alcohol Syndrome 501—Possibility of Regression 603—BF Complication - Infant 702—BF Infant of Mom at Nutritional Risk 904—Exposure to Environmental Tobacco Smoke
Priority II	Infant of WIC Mom	701—Born to WIC Mom or Born to a Potential WIC Mom
Priority III – Medical	Infants, Children requiring medical formula/supplement	**Medical** 341—Nutrient Deficiency Diseases 342—Gastrointestinal Disorder 343—Diabetes 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 352—Infectious Diseases 353—Food Allergy 354—Celiac Disease 355—Lactose Intolerance 356—Hypoglycemia 357—Drug Nutrient Interactions 359—Recent Major Surgery, Trauma, Burns

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
		360—Other Medical Conditions 362—Developmental, Sensory, or Motor Delays 381—Oral Health Conditions 382—Fetal Alcohol Syndrome
	All other children sub-prioritized by age; younger children being served first (i.e., 1 year, 2 year, 3 year, 4 year)	**Biochemical** 201—Low Hemoglobin, Low Hematocrit **Anthropometric** 103—Underweight or At Risk for Underweight 113—Obese 114—Overweight 115—High Weight-For-Length 121—Short Stature or At Risk for Short Stature 135—Inadequate Growth 141—Low Birth Weight **Medical** 341—Nutrient Deficiency Diseases 342—Gastrointestinal Disorder 343—Diabetes 344—Thyroid Disorders 345—Hypertension and Prehypertension 346—Renal Disease 347—Cancer 348—Central Nervous System Disorders 349—Genetic and Congenital 351—Inborn Error of Metabolism 352—Infectious Diseases 353—Food Allergy 354—Celiac Disease 355—Lactose Intolerance 356—Hypoglycemia 357—Drug Nutrient Interactions 359—Recent Major Surgery, Trauma, Burns 360—Other Medical Conditions 362—Developmental, Sensory, or Motor Delays 381—Oral Health Conditions 382—Fetal Alcohol Syndrome 501—Possibility of Regression 904—Exposure to Environmental Tobacco Smoke
Priority IV – Nutritional	Pregnant Women	401—Failure to Meet Dietary Guidelines 427—Inappropriate Nutrition Practices Women 502—Transfer of Certification (VOC)
	Breastfeeding Women	401—Failure to Meet Dietary Guidelines 427—Inappropriate Nutrition Practices - Women 502—Transfer of Certification (VOC) 601—BF Mom of Infant at Nutritional Risk 801—Homelessness 802—Migrancy 902—Feeding Skills Limitations

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
	Infants	411—Inappropriate Nutrition Practices - Infant 428—Dietary Risk Associated with Complementary Feeding Practices (4-12 mos) 502—Transfer of Certification (VOC) 702—BF Infant of Mom at Nutritional Risk 801—Homelessness 802—Migrancy 902—Feeding Skills Limitations 903—Foster Care
Priority V – Nutritional	Sub-prioritized by age, with youngest children served first	401—Failure to Meet Dietary Guidelines (≥ 2) 425—Inappropriate Nutrition Practices - Child 428—Dietary Risk Associated with Complementary Feeding Practices (12-23 mos) 502—Transfer of Certification (VOC) 801—Homelessness 802—Migrancy 902—Feeding Skills Limitations 903—Foster Care
Priority VI – Medical and Nutritional	No sub-prioritization. Serve in order of application to the program.	**Biochemical** 201—Low Hemoglobin, Low Hematocrit **Anthropometric** 101—Underweight Woman 111—Overweight Woman 133—High Maternal Weight Gain **Medical** 303—Hx Gestational Diabetes 304—Hx of Preeclampsia 311—Hx Preterm Delivery (≤ 37 wks) 312—Hx Low Birth Weight 321—Hx Fetal or Neonatal Loss 331—Pregnancy -Young Age (<18 yrs) 332—Closely Spaced Pregnancy 335—Multifetal Gestation 337—Hx Birth LGA Infant 339—Hx Birth -Congenital Defect 341—Nutrient Deficiency Diseases 342—Gastrointestinal Disorder 343—Diabetes 344—Thyroid Disorders 345—Hypertension and Prehypertension 346—Renal Disease 347—Cancer 348—Central Nervous System Disorders 349—Genetic and Congenital Disorders 351—Inborn Error of Metabolism 352—Infectious Diseases 353—Food Allergy 354—Celiac Disease 355—Lactose Intolerance 356—Hypoglycemia

Priority	Sub-Priority (in order of WIC service)	Nutrition Risk Criteria
		357—Drug Nutrient Interactions 358—Eating Disorders 359—Recent Major Surgery, Trauma, Burns 360—Other Medical Conditions 361—Depression 362—Developmental, Sensory, or Motor Delays 363—Pre-Diabetes 371—Maternal Smoking 372—Alcohol or Illegal Drug Use 381—Oral Health Conditions 401—Failure to Meet Dietary Guidelines 427—Inappropriate Nutrition Practices - Women 501—Possibility of Regression 502—Transfer of Certification (VOC) 801—Homelessness 802—Migrancy 902—Feeding Skills Limitations 904—Exposure to Environmental Tobacco Smoke

SECTION B: WAITING LISTS

OVERVIEW

IN THIS SECTION

Policy/Procedure for Waiting Lists

POLICY/PROCEDURE FOR WAITING LISTS

POLICY

The only time a local agency shall have a waiting list is during authorized caseload management per State WIC Office.

When the State WIC Office notifies local agencies for the need to implement caseload management, a waiting list of applicants to be enrolled, including recertifications, must be initiated and maintained. The purpose of the waiting list is to ensure that higher priority applicants are enrolled before lower priorities.

The priority/sub-priority system must be used to schedule certification appointments, to organize the waiting list, to put applicants on the waiting list, or to pull applicants off the waiting list to enroll onto the program during caseload management.

PRIORITIES

Local agencies will maintain a waiting list in accordance with the priority/sub-priority ranking system. Individuals in each priority who the local agency is currently unable to serve, but reasonably expects to serve in the future (6 months), will be placed on a waiting list as well as any other applicant who requests placement on a waiting list. Applicants will be recorded on the waiting list according to their potential priority and in the order in which they apply for services.

CONTENT OF WAITING LISTS

The waiting list will include, at a minimum, the following information:

- Name of applicant
- Mailing address and telephone number of applicant
- Category of applicant (i.e., pregnant woman, breastfeeding woman, postpartum woman, infant, or child)
- Date and notification of placement on the waiting list
- Date and time of appointment for screening (if performed by local agency)
- Potential priority

PROCEDURES FOR MAINTAINING THE WAITING LIST ELIGIBLE TRANSFERS

New Applicant, Certification, Recertification:

- Screen the applicant for residency and income eligibility.
- Depending on the level of caseload management operation as directed by the State agency, screen the applicant for anthropometric, biochemical, and physical/medical status.
- If medical data (height, weight, hemoglobin/hematocrit values, medical condition) are available, the presence of an anthropometric, biochemical or medical risk can be assessed, which would place the applicant in a higher priority than if only a dietary inadequacy were present.
- If the applicant applies for the program without the medical information necessary to determine an anthropometric, biochemical, or medical risk, the local agency must assess through screening.
- Place applicant on a waiting list according to her/his potential priority in chronological order on application and/or in WISPr.
- Inform the applicant, either verbally or in writing, that he/she has been placed on the waiting list. This must be done within 20 days of the applicant's request for program benefits.

Transferring Participants:

- Participants with a valid Verification of Certification (VOC) card will be served first regardless of their priority.
- In the rare event that a transferring participant with a current VOC card applies for continuing services and the agency is not enrolling additional persons because they are currently operating under a strict caseload management policy directed by the State agency, the participant will be placed on a waiting list and enrolled ahead of all other persons on the waiting list regardless of priority.

If more than one transferring participant with a current VOC card must be placed on a waiting list, she/he will be placed in order of priority.

Enrolling from Waiting List

When an opening occurs, the local agency will contact applicants from the waiting list to schedule a certification appointment.

- Contact applicants by telephone or letter, starting with those individuals on the VOC waiting list. If no applicant has VOC status, contact applicants beginning with the highest priority.
- After all VOC transfers and applicants with the highest priority have been contacted, proceed to the next highest priority.

Example: The local agency would begin contacting anyone on the waiting list with a Priority III status. After all Priority III status applicants have been contacted for a certification appointment, the local agency would precede to the Priority IV applicants, then to Priority V, etc.

If an applicant fails to keep the scheduled certification appointment, she/he will be removed from the waiting list.

Current Participants Who Come Up For Recertification

A current participant whose priority is lower than applicants on waiting lists will *not* be recertified at the end of the current certification period in order to make space available for higher priority applicants. The participant will then be placed on the waiting list for his/her priority ranking, if the local agency reasonably expects to serve that priority in the future.

Example: Statewide, WIC is only serving Priority V participants up to age 4 years.

Scenario: A 4-year-old comes up for recertification. Upon screening, it is determined that this child has low hemoglobin. Therefore, this child is now a Priority III and would be served.

Scenario: A 4-year-old comes up for recertification. Upon screening, it is determined that this child has inadequate diet. Therefore, this child is a Priority V and would be placed on the waiting list should the expectation be that WIC would be likely to serve this participant within the next six months.

A current participant whose priority is the same as other applicants on the waiting list will not be recertified ahead of those applicants within the same priority. Rather, at the end of the current certification period, the participant will be served depending on priority or placed on the waiting list at the bottom of the priority category for which he/she is potentially eligible.

REFERENCE

Policy Memo 803-2, Revision 1 (1988) WIC Program Certification: Nutritional Risk/Participant Priority System
Policy Memo 803-6, Revision 1 (1988) WIC Program-Certification: Waiting Lists
Policy Memo 803-G (1993) Revision Verification of Certification
Policy Memo 803-S (1993) Priority Restrictions

SECTION C: OUTREACH

OVERVIEW

Outreach activities are those promotional efforts designed to encourage and/or increase participation in the WIC Program.

The purposes of outreach are to:

- Improve the health of pregnant women and children.
- Increase public awareness of the benefits of the WIC Program.
- Inform potentially eligible persons about the WIC Program in order to encourage and promote their participation in the program.
- Inform health and social service agencies of the WIC Program's qualifications for participation and encourage referrals.
- Ensure cooperation between WIC and other related services and programs so that WIC benefits and other related services a participant may be receiving are coordinated to provide more comprehensive service.
- Promote a positive image of the WIC Program

IN THIS SECTION

General Outreach
Public Notification
Network Building
Benefits Targeting
Outreach Material
Outreach Log

GENERAL OUTREACH

POLICY

Establish and maintain networks/relationships with agencies and organizations serving potentially eligible persons and publicize the availability of program benefits.

STATE RESPONSIBILITIES

Make outreach materials available to local agencies and other relevant programs and organizations on a request basis.

- Outreach materials may be ordered by local WIC agencies quarterly using the Quarterly Order Form
- Supply outreach materials in appropriate languages
- Monitor local agency compliance
- Provide technical assistance to local agencies as needed

Local Agency Responsibilities

Local agencies must contact the State WIC Office for approval prior to implementation of outreach materals containing the Idaho WIC Program logo a minimum of 60 days prior to release of materials. If outreach materials are developed using non-WIC funds, the logo of the funding organization may be used (such as a health district logo) in place of the Idaho WIC Program logo. Outreach materials not containing the Idaho WIC Program logo must still be submitted to the State WIC Office prior to implementation to ensure all outreach materials meet policy standards.

Public Notification

Policy

At least once annually, notify the public of WIC services by publishing the availability of program benefits in relevant newspapers.

This may be done by both the State agency and local agencies. Local agencies may provide the State agency with a list of local media contacts for assistance in distribution.

Procedure

Develop a news release that includes the following information:

- WIC agency contact information
- A brief description of the WIC program
- A brief description of who is eligible and services provided
- Include the following non-discrimination statement: “The WIC Program is an equal opportunity provider and employer.”

Network Building

Policy

At least annually, local agencies must contact organizations and community groups serving or associated with potentially eligible individuals and provide information about WIC services, income guidelines, and eligibility requirements.

Procedure

At a minimum, contact and inform the following organizations and community groups about WIC:

- Regional Idaho Department of Health & Welfare offices, including Medicaid, SNAP, CHIP, TANF (cash assistance), Foster Care, and Child Protective Services
- Migrant farm worker organizations
- Health and medical organizations
- Hospitals and clinics, including migrant health clinics
- Social services agencies and offices
- Homeless facilities and institutions
- Head Start programs

Examples of other organizations that may be contacted include:

- American Indian tribal organizations
- Community action groups
- Neighborhood councils

- Schools and daycares
- Civic organizations
- Churches and religious organizations

Develop and maintain a list of specific agencies and organizations that will be contacted on a regular basis (i.e., at least annually). Review and update list annually.

- List must include name of organizations and locations and may include contact name, mailing address, and other information relevant to agency.
- List is to be kept on file and will be reviewed by the State agency as part of monitoring procedures.

All contacts must be documented on the Quarterly Outreach Log and submitted to the State agency. The Outreach Log is found in the electronic Quarterly Report Form sent to local agency Coordinators.

BENEFITS TARGETING

POLICY

Each local agency will develop and implement a benefits targeting plan. This plan will be submitted for review and approval by the State WIC Office as part of the Nutrition Education Plan (NEP).

TARGETING PLAN

The benefits targeting plan must include:

A list or description of strategies the local agency will use to inform each of the following groups about the availability of program benefits:

- Employed families
- Pregnant women in the early months of pregnancy
- Highest-risk (Priorities I-III) individuals and families including:
  - High risk postpartum women (e.g., teenagers)
  - Children in foster care/protective services
  - Priority I infants
  - Incarcerated pregnant women
- Institutionalized persons (see Chapter 4, Section A - Persons Living in a Shelter Home or other Institution)
- Migrant families
- Rural families
- Homeless individuals and families

A description of how the local agency will monitor progress of implementing plan and evaluate impact of plan.

Contacts must be documented on the Quarterly Report Form's Outreach Log and submitted to the State agency.

REFERENCE

7 CFR 246.4(a)(5)(i-ii),(6),(7),(18) and (19) Outreach Policies and Procedures
7 CFR 246.4(a)(5)(i),(6),(7),(18),(19),(20), and (21) Benefits Targeting

OUTREACH MATERIAL

POLICY

The USDA's nondiscrimination statement must be included on all publications, outreach materials, handouts, referral materials, leaflets, and brochures that identify or describe the WIC Program.

If the material is too small to permit the full statement to be included, the material will, at a minimum, include the statement in print size no smaller than the text that, "This institution is an equal opportunity provider and employer."

NONDISCRIMINATION STATEMENT

"The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/ complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer."

Use of Statement on Written Materials

- Must be printed on all new materials
- Not required on items such as cups, button, magnets, and pens that identify the WIC Program due space limitations on such items

Use of Statement for Radio and Television
The nondiscrimination does not have to be read in its entirety on these announcements.

Public Service Announcement
It is sufficient to include an abbreviated version of the nondiscrimination statement to meet the nondiscrimination requirement: "The WIC Program is an equal opportunity provider."

STATE WIC LOGO USE

The Idaho WIC Program logo shall remain intact and must not be altered or recreated in any way. The size may be adjusted to fit the existing space. The logo must be used to promote the WIC Program and materials encompassing the logo must meet program policy requirements. For consistency across the State, the local agencies are not authorized to create agency specific WIC Program logos.

REFERENCE

All States Memorandum 06-21 (Jan. 11, 2006) *Nondiscrimination Statement for WIC Materials*
State WIC Policy

OUTREACH LOG

POLICY

A completed Outreach Log must be submitted quarterly to the State agency.

PROCEDURE

The Outreach Log is found in the electronic Quarterly Report Form sent to local agency Coordinators. Local agency Coordinators may submit this via hard copy or may email the log.

REFERENCE

State policy

CHAPTER 4: ELIGIBILITY AND CERTIFICATION

OVERVIEW

IN THIS CHAPTER

Section A Eligibility

Section B Certification

Section C Mid-certification

Section D Ineligible

SECTION A: ELIGIBILITY

OVERVIEW

IN THIS SECTION

Eligibility Criteria
Priority Levels
Adoption and Wet Nurses
Foster Children
Immigrants and Foreign Students
Joint Custody
Migrancy
Persons Living in an Institution
Verification of Certification
    Acceptance of VOC Cards or Documents
    Waiting Lists
    Procedure – Verification of Certification
Issuing a Verification of Certification Document (VOC)

ELIGIBILITY CRITERIA

POLICY

To be certified as eligible to receive WIC program benefits in Idaho, an applicant must be categorically eligible, live within the health service area, meet income guidelines, and have a nutritional need.

CATEGORICALLY ELIGIBLE

Applicants must be in one of five categories:

- Pregnant woman (P)
- Breastfeeding woman up to one year postpartum (B)
- Postpartum woman not breastfeeding less than six months postpartum (N)
- Infant up to 1 year of age (I)
- Child 1 to 5 years of age (C)

RESPONSIBLE ADULT

The Responsible Adult is usually the parent (or caretaker) who makes the initial contact to apply for WIC services and attends the certification appointment to apply for WIC for herself or for children. It is acceptable for either parent to be the Responsible Adult for infant and child participants.

Generally, the Responsible Adult should be the parent or caretaker who will most often attend appointments on behalf of the infant or child participant.

An Authorized Signer may be designated at the request of the Responsible Adult to lessen participation barriers (e.g., work schedules, sickness, ease of shopping).

It is permissible to designate a proxy to attend appointments for the Responsible Adult and/or Authorized Signer during the certification period if circumstances indicate doing so will lessen participation barriers (e.g., a change in work schedule).

RESIDENCY

All participants must reside within the state where they receive WIC benefits.

Applicants must live within the boundaries of the public health district or tribal services to receive benefits from that program.

Agreements between state agencies may be established for those participants living outside the boundaries of Idaho who use Idaho health care because of long distances to their own state health care services. Contact the State agency.

INCOME ELIGIBLE

An applicant's income must be verified to be within the limits of total gross household income level/family size as defined in the Income Eligibility Guidelines, or automatically income eligible based on eligibility for Medicaid, TANF, SNAP or CHIP.

NUTRITIONAL RISK

Nutrition Risk Criteria are specifically defined per category, and are assessed by a medical assessment (height, weight, hemoglobin or hematocrit, and pertinent medical information) and a nutrition assessment.

ANTHROPOMETRIC SCREENING

Requirements

Measurement of weight and height (or length) is required at certification for assessing nutritional risk.

Measurements from another source (e.g., physician's office) may be used if the measurement was taken within 60 days of the certification and is reflective of the current category.

Exceptions (document in participant file):

- An applicant who has a medical condition or disability which makes obtaining the measurement at certification impossible
- An applicant who has a disability that prevents his/her presence at certification
- Difficult child struggling with certifier during procedure

Measuring Weight

- Staff are to perform weight measurements according to the techniques described in the Paraprofessional Training Manual.

Measuring Height

- Staff are to perform height measurements according to the techniques described in the Paraprofessional Training Manual.

INFANTS

- Infants are weighed without clothing and diaper; infants are weighed using an infant scale.
- Infants are measured using a recumbent length board.
- Premature infants less than 40 weeks adjusted age will be assessed by an RD for rate of weight and height gain (chart may be routed if an RD is not available during certification appointment) and won't be plotted on a premature or regular infant grid. Estimated "in utero" rates of growth are weight gain of 15 g/kg/day and length gain of .05-1.0 cm/week. The RD may document the assessment in the Participant Care Plan or RD Referral follow-up notes.
- Infants at or beyond 40 weeks adjusted age will be plotted on the regular growth chart.

CHILDREN

- Children are measured in minimal indoor clothing (without coat/hats/boots, in light shirt/pants without shoes).
- Child weight is measured using either an infant scale or an adult scale. Which scale to use is determined by the size of the child and up to the discretion of the Competent Professional Authority (CPA) and Responsible Adult.
- Child length is measured using a recumbent length board if the child is less than 24 months of age.
- Child height is measured using a wall stature board if the child is more than 24 months of age, unless the child is too small to use a stature board. If recumbent length is measured, the length must be plotted on the correct growth chart.

WOMEN

- Women are measured in minimal indoor clothing (without coat/hats/boots, in light shirt/pants without shoes).
- Women are weighed using an adult scale (floor model).
- Women are measured using a wall mounted stature board.

CALIBRATION OF EQUIPMENT

Calibration means to standardize a measuring instrument by determining its deviation from a known standard. Each piece of anthropometric equipment should be evaluated at least quarterly to make sure it is calibrated and in working order.

The WIC Coordinator must maintain a written record of equipment calibration and staff training for use of equipment. The Idaho WIC Paraprofessional Training Manual should be used to train staff. Some equipment is self-calibrating.

HEMATOLOGICAL SCREENING

A hemoglobin or hematocrit test is required at certification for assessing nutritional risk.

Test results from another source (e.g., physician's office) may be used if the measurement was taken within 60 days of the certification and is reflective of the current category.

Exceptions:

- Infants less than 9 months of age
- Children 2 years and older only need one test per year if the test was within normal limits at the previous certification.
- Breastfeeding women only require one postpartum test.

Exceptions (document in participant file):

- An applicant who has a medical condition or disability which makes obtaining the test measurement at certification impossible
- An applicant who has a disability that prevents his/her presence at certification
- An applicant who has cultural, personal, or religious beliefs that conflict with drawing blood
- Difficult child struggling with certifier during procedure

Staff are to perform the hemoglobin/hematocrit test according to the manufacturer's specifications for the machine used and in accordance with CLIA and OSHA recommendations.

REFERENCE

7 CFR 246.7(e)(1) Determination of Nutritional Risk
WRO Policy Memorandum 803-AP, Nutrition Risk Criteria (March 30, 2001)
WRO Policy Memorandum 803-Z, Bloodwork Requirements for Children and the Allowability of Additional Blood Tests During Certification Periods (August 1994)
WRO Policy Memorandum 803-AO, Policy Memos Related to Bloodwork Requirements (January 2001)
Nutritional Screening of Children: A Manual for Screening and Follow-up, US Department Health and Human Services Administration, Bureau of Community Health Services, Publication No. HAS 81-5114, 1981
Lohman, TG et al, editors. Anthropometric Standardization Reference Manual. Human Kinetics Books, 1988, pp.4-8.
Simko MD et al. Nutrition Assessment: A Comprehensive Guide for Planning Intervention. Aspen Publications, 1984, pp. 72-80.
All States Memorandum, 803-M, *Bloodwork Protocols*, July 27, 1992.

PRIORITY LEVELS

CLARIFICATION

According to the category and nutritional risk criteria identified by a CPA, a priority level is assigned to each participant. The priority level establishes the need for WIC services and prioritizes the applicants for WIC services.

- A breastfeeding mother and her breastfed infant must be placed in the same priority level and should be the highest for which either qualifies.

PRIORITY I

- Pregnant women (P), breastfeeding women (B), or infants (I) who are at risk based on medical assessment

PRIORITY II

Infants up to 6 months of age born to a WIC mother, or born to a mother who was at nutritional risk during her pregnancy, but was not enrolled in WIC during the pregnancy.

- A breastfeeding (B) mother of a fully breastfed Priority II infant will also be assigned Priority II.

PRIORITY III

- Children (ages 1 to 5) who are at risk based on medical assessment
- Postpartum women (N) who were less than 16 years old at conception

PRIORITY IV

- Pregnant women (P), breastfeeding women (B), or infants (I) who are at risk based on nutritional risks only
- Postpartum, non-breastfeeding women (N) who have two or more nutritional risks based on medical risk only, excluding nutritional risks

PRIORITY V

- Children (ages 1 to 5) with nutritional risk only

PRIORITY VI

- Postpartum women (N) who have one identified risk; may include nutritional-related risk criteria or transfer criteria code (79)

ADOPTION AND WET NURSES

POLICY

A breastfeeding woman does not have to be the birth mother of the infant to be certified as a breastfeeding woman. Wet nurses and nursing adoptive mothers are eligible if they meet eligibility criteria. However, both the birth mother and adoptive mother of the same infant cannot be certified as breastfeeding women. The birth mother would only qualify as a postpartum woman. This applies if the relationship is known to exist.

ADOPTED CHILD

When a family adopts a child, the family size and income of the entire family is used to determine income eligibility. Typically, the adopted child will have been a foster child in the home for some time prior to adoption.

When a child is adopted, it may be necessary to sever all ties with the previous identity, including issuing a new WIC participant ID and Social Security number. Contact the WIC Help Desk for guidance. The appropriate procedure is determined on a case-by-case basis.

REFERENCE

FNS Instruction 803-R WIC Eligibility of Wet Nurses (6-25-93)
FNS Instruction 803-AC Non-Birth Mothers Certified as Breastfeeding Women (10-16-95)

FOSTER CHILDREN

POLICY

An infant or child in foster care is certified according to standard procedures. A foster child living with a foster family but remaining the legal responsibility of the Department of Health and Welfare (DHW) or tribal authority, is considered a family of one. Children in foster care should have automatic income eligibility because they are enrolled in Medicaid. The payments made by DHW or tribal authority to the foster family caring for the child are the household income for the child. Participant records should be maintained to protect the confidentiality of the parent(s) and the foster family.

Local agency Coordinators may develop local procedures as needed (e.g., a procedure for maintaining the participant file).

Child in Temporary Care

This refers to an infant or child in temporary care of friends or relatives, but not in the legal custody of the Idaho Department of Health and Welfare, tribal authority, or other welfare entity (e.g., as in the case of families of military personnel if the absent parent(s) is serving in the military, the caregiver of the child participant is not available to care for the child). For more information, see Section B, Household Size.

Reference

FNS Instruction 803-3, Revision 1: Income Eligibility: Definition of Family and Economic Unit (4-1-88)
FNS Instruction 800-1: Confidentiality - Release of Information to Applicants and Participants (3-30-90)
WRO Policy Memorandum 803-AI: Strengthening Integrity in the WIC Certification Process (3-10-99)

Immigrants and Foreign Students

Policy

U.S. citizenship is not required to receive WIC services in Idaho. Legal and illegal immigrants can apply for and receive WIC services.

Foreign students may participate in WIC without incurring public charge.

The Immigration and Naturalization Service (INS) issued a statement clarifying participation in WIC does not constitute public charge and INS should not request WIC benefits be repaid by a person of alien status.

Confidentiality requirements do not allow WIC staff to report any information about WIC participation to INS or anyone else without written consent from the participant.

Reference

WRO All States Memorandum 98-66 (3/27/98) *Impact of Participation in the WIC Population on Alien Status (Immigrants and Foreign Students)*

Joint Custody

Policy

When parents have joint custody and maintain separate households, either parent may apply on behalf of the child, provided the parent has custody of the child at least 50% of the time. The other parent cannot apply for the same child but may apply for other children or for herself if she becomes pregnant.

The benefits for the child will be provided by the local agency to one Responsible Adult, usually the parent who makes the initial contact with the WIC office. It is the responsibility of the two parents to mutually agree on sharing the child's supplemental foods. The other parent can be a proxy if the Responsible Adult requests it.

Joint custody can be complicated, particularly if the parents reside in two separate local agency service areas and custody determination changes.

For example:
Becky's parents have joint custody and each parent has 50% custody. The mother applied for WIC and Becky has been certified eligible. Becky is included when determining household size of the mother and

any child support payments the mother receives are counted as income. The two parents must decide how to share the foods.

If Becky's father has remarried, he or his wife may apply for WIC benefits for other children in his new household, but not Becky. He can count Becky as part of his household size. He cannot deduct the child support he pays to Becky's mother when determining income eligibility.

REFERENCE

FNS Instruction 803-3, Revision 1 Income Eligibility: Definition of Family and Economic Unit (4-1-88)

MIGRANCY

POLICY

Categorically eligible women, infants, and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purpose of such employment a temporary abode.

A temporary abode is established when the worker's job location requires him or her to leave the place of regular residence periodically (not permanently) for one or more days. A car, van, or camper may be considered a temporary abode when used for temporary residence.

Agriculture means farming in all its branches, including logging.

This applies to migrant worker families in which all members are relocated and families in which only one member is relocated.

INCOME DETERMINATION

Migrancy income determination is valid for one year.

REFERENCE

FNS Instruction 803-14 (1988) WIC Program Certification: Eligibility of Special Populations
WRO Policy Memo 803-X (1994) Loggers as Migrant Farm Workers

PERSONS LIVING IN AN INSTITUTION

POLICY

If an applicant is living in an institution, such as a mother and children temporarily living in a shelter home, she is still eligible to apply for WIC if the following conditions are met:

- WIC foods given to the participant must not be transferred to the institution's own general inventory. The foods must be available to and used by the WIC participant only.
- Food purchased with WIC checks/CVVs cannot be combined and used in group feeding.
- The institution cannot restrict the use of the supplemental food by the WIC participant or restrict participation in any WIC services.

The family size and income determination does not include the other residents of the institution. The WIC family is considered an independent economic unit from the institution.

Eligibility of Shelter Homes and Other Institutions

To the extent practical, local WIC agencies shall determine whether a homeless facility or institution complies with the conditions listed above. A full certification period may be given to an applicant without establishing the institution's compliance, but food package benefits (except infant formula) are to be suspended in subsequent certification periods if compliance has not been assured.

- Each local agency is encouraged to maintain a master list of eligible institutions so staff may make referrals if an institution is found to be out of compliance.
- Local agencies should periodically contact the institution to ensure continued compliance with the conditions outlined above, as deemed necessary.

Reference

7CFR 246.7(n) Certifications of persons in homeless facilities and institutions
ASM 803-13, WIC Program-Certification Eligibility of Persons Affiliated with Institutions, 11-27-87.

Verification of Certification

Overview

Verification of Certification (VOC) documents are intended to facilitate the transfer of currently eligible WIC participants between states and from those participants who have been participating in the program at another local agency within Idaho who fall under the status of homeless or migrant worker. An individual who has a current certification date does not have to go through the certification process until the certification period expires. A VOC document represents proof of nutritional risk.

Policy

Local agencies shall accept valid Verification of Certification (VOC) information and documentation from out-of-state WIC participants and certification documentation from all persons who have been participating in the WIC program in another local agency within Idaho.

Local agencies shall provide VOC information for each participating family member for whom there is an intention to relocate out-of-state during a certification period. Additionally, local agencies shall provide VOC information to out-of-state WIC agencies who request confirmation of a relocated WIC participant's certification.

Definitions

In-state Transfer: A participant transferring from one local agency to another local agency within the state of Idaho.

Out-of-state Transfer: A participant transferring into Idaho from another state, and a participant transferring out of Idaho to another state.

Acceptance of VOC Cards or Documents

VOC documents must be accepted as long as they have the minimum required information:

- Participant name
- Date the certification expires

- Name and address of certifying local agency

In the event that the VOC document is missing any of the above required pieces of information, the local agency may contact the previous agency for information missing from the VOC document. *A separate signed release of information is not necessary when one WIC agency contacts another WIC agency.* Information may be taken over the phone, via fax or letter from another state or local agency in order to not create a barrier to service.

Any individual who presents a valid VOC card or document must be served for the length of certification noted on the VOC document, regardless of whether he or she meets Idaho's eligibility criteria. However, the transferring participant must be categorically eligible.

Example: If the transferring participant was last certified as Breastfeeding, but has since stopped breastfeeding and her infant is greater than six months of age, the woman is not eligible as a transfer since she no longer meets the category requirement.

Example: A child whose VOC card indicates a certification period that expires after the end of the month of the child's fifth birthday is not eligible as a transfer since she/he is no longer categorically eligible.

Example: Individuals who present a VOC card or document with an expired certification date must reapply as new applicants.

WAITING LISTS

In the event that the state of Idaho WIC Program is operating under a strict caseload management policy and is not enrolling any applicants, participants with a current VOC card or document shall be placed on the list ahead of all other waiting applicants, regardless of priority ranking. If more than one transferring participant with a current VOC card or document must be placed on the waiting list, they shall be placed in order of priority rank.

PROCEDURE – TRANSFER OF CERTIFICATION (VOC)

For all transfers:

- Verify the identity and residence of the participant.
- Have the participant or Responsible Adult review and sign the Participant Rights, Responsibilities and Consent form. Participant information may be entered directly into WISPr or the application may be used.
- Educate the participant/Responsible Adult about WIC in Idaho. Issue checks/CVVs and WIC Identification Folder and explain how to use checks/CVVs, if necessary.
- Provide nutrition education and make referrals as needed.

If the participant is transferring from another clinic within the state:

- Check the certification end date. If the certification has expired, process as a new applicant. If the certification has not expired, provide the next available appointment in order to prevent a break in services.

If the participant is transferring from another state:

- If the certification period has not expired and the VOC card or document contains all of the required information, provide the next available appointment in order to prevent a break in services. Required elements:

    - Participant's name
    - Date that the current certification expires
    - Name and address of the certifying local agency

- Check the date the income eligibility was determined. A migrant worker should have income reassessed if the date is more than one year.

ISSUING A VERIFICATION OF CERTIFICATION DOCUMENT (VOC)

VOC ISSUANCE

Verification of Certification (VOC) documents will be issued to:

- A participant who indicates he/she will be moving out of Idaho during the current certification period
- A participant in a family with a migrant worker
- A participant in a homeless situation

VOC documents should be issued to migrant and homeless participants at certification, regardless of whether they will be moving or not.

Completed VOC documents shall, at a minimum, include:

- The participant's name
- The date the certification was performed
- The date income eligibility was last determined
- The period for which the last WIC checks/CVVs were issued
- The nutritional risk(s) of the participant
- The date the certification expires
- The signature and printed or typed name of the certifying local agency staff
- The name and address of the certifying local agency
- The VOC ID Number. This number is derived from the following information: State, Participant ID, Date, Time.

MAILING OF VOC CARD

Participants may request a VOC card after they have already moved out of state. Upon receipt of a verbal or written request, the local agency shall forward a completed VOC document to either the participant's new local agency or the participant. The order of preference regarding where VOC cards are to be mailed is as follows:

1. To the participant's new local agency, if known
2. Directly to the participant

If the request to mail a VOC card is received by mail, by fax, or verbally by phone, the local agency shall take reasonable steps to confirm the identity of the individual making the request. The local agency must document in the participant chart the address to which the VOC will be mailed or the agency where the VOC is to be faxed.

Replace the card if needed and make a note in the participant's chart describing the circumstances and solution.

ISSUING DUPLICATE VOC CARD

Local agencies shall provide participants with a duplicate VOC document *only* if the original VOC document is returned to the local agency. A comment needs to be written in the participant's chart explaining the reason for a duplicate issuance of the VOC card.

If a participant has lost his/her VOC document and applies for program benefits at a new out-of-state agency as a transfer, the participant's new out-of-state agency may contact the participant's prior local agency to verify the participant's identity and to request certification information. The prior local agency shall accommodate the new local agency's request by printing and forwarding a new VOC document by mail or fax to the new out-of-state agency.

NOTE: A VOC document shall not be printed and mailed to a participant who has lost a VOC which was issued in person or mailed. In the case of a lost VOC, it may only be faxed or mailed to an out-of-state local WIC agency.

REFERENCE

FNS Instruction 803-11, Rev. 1 (1988) *Verification of Certification Document*
FNS Instruction 803-G, Rev. (1993) *Verification of Certification*
7 CFR 246.7(k) and 7 CFR 246.25(a)

SECTION B: CERTIFICATION

OVERVIEW

IN THIS SECTION

Processing Applicants
Certifying Schedule
Certifying Pregnant Women
Certifying Breastfeeding Women up to One Year
Certifying Infants
Certifying Children
Documentation Required at Certification
- Category
- Identification
- Residency
- Proof of Pregnancy
- Income

Assessing Income Eligibility
- Determine Household Size
- Automatic (Adjunct) Income Eligibility
- Traditional Income Eligibility

Required Documentation Not Available
Certification Procedures
Required Referrals
Required Screening

PROCESSING APPLICANTS

POLICY

When there are funds available to provide program benefits, the local agency will:

- Accept applicants
- Arrive at eligibility determinations
- Notify the applicants of the eligibility status
- Provide nutrition education and referral
- Issue WIC checks/CVVs to eligible applicants

TIMEFRAMES FOR PROCESSING APPLICATIONS

All of the above actions will be accomplished within the following timeframes:
Pregnant women and members of migrant workers and their family members who soon plan to leave the service area of the local agency must be notified of their eligibility or ineligibility within 10 working days of the date of the first request for program benefits.

All other applicants shall be notified of their eligibility or ineligibility within 20 working days of the date of the first request for program benefits.

The processing timeframes begin when an applicant visits the local agency to make an oral or written request for program benefits. At the time of the request, an applicant who is present may be certified and the staff person should verify income, residence, identification, and complete the certification in WISPr. If an application is used, instruct the applicant to complete an Application form. Fill in the date applied for WIC services and the appointment date (upper left-hand corner). If the applicant does not complete a certification appointment at that time, when the applicant returns for the certification appointment the staff person should verifiy income, residence, identification, and complete the certification in WISPr.

When a WIC participant's certification period ends, he/she must re-apply to WIC. Prior participation in WIC does not imply priority is given to those applicants. Each certification period is new.

Referral Data

Certification of nutritional risk may be based on medical data (height, weight, hematocrit or hemoglobin) from another health care provider that is less than 60 days old. The interval for the return certification will be based on the date when the medical data was taken and entered in WISPr. Pregnant women are exceptions to this rule; their return certification date is calculated six weeks (42 days) beyond the EDC.

Appointment Coordination and Scheduling

When possible, appointments should be scheduled to coincide with other clinic appointments and transportation availability. Appointments should not knowingly require a person to take time off of work.

Pregnant Women Who Miss First Appointment

The local agency shall attempt to contact (by phone call or by mail) each pregnant woman who misses her first appointment to apply for WIC in order to reschedule the appointment. At the time of the initial contact, the local agency shall request an address and telephone number where the pregnant woman may be contacted.

A record of this attempt must be kept.

Reference

7 CFR 246.7 (f) Processing Standards
7 CFR 246.7 (b)(6) Program Referral and Access

Certifying Schedule

Certification Period Length

- **Pregnant women** are certified for the duration of their pregnancy and for up to six weeks postpartum (after delivery).
- **Breastfeeding women** may be certified up to one year ending on the breastfeeding infant's 1st birthday.
- **Postpartum women** are certified for up to six months postpartum (after delivery).
- **Infants (under age 1)** are certified up until age 1 or for a six-month period.
- **Children (ages 1 to 5)** are certified at intervals of approximately six months, ending with the last day of the month in which the child's 5th birthday occurs

CERTIFYING PREGNANT WOMEN

POLICY

Pregnant women are certified for the duration of their pregnancy and for up to six weeks postpartum (after delivery).

Proof of pregnancy is required for program participation if a woman is not visibly pregnant. Local agencies should issue benefits to applicants who claim to be pregnant and allow reasonable time (not to exceed 60 days) for the applicant to provide the required proof of pregnancy, provided all other eligibility criteria are met. Required proof for a woman whose pregnancy is not visibly noticeable may include an EDC written by a medical care provider or a copy of an ultrasound with an EDC.

PREGNANT WOMAN WHO DELIVERS OR WHOSE PREGNANCY ENDS

A woman who is certified during pregnancy has a certification period that lasts until six weeks after the pregnancy ends. Regardless of the reason the pregnancy ended (i.e. miscarriage, abortion, delivery of still birth, delivery of live birth), a woman added as pregnant can continue to receive WIC benefits and services based on the pregnancy certification for up to six weeks postpartum. There is no time limit on pregnancies that end without a live birth. Example: If a woman had a miscarriage and has proof of that pregnancy, it does not matter how long she was pregnant (days, weeks,..).

To continue receiving WIC more than six weeks after the pregnancy ends, standard postpartum certification eligibility requirements apply.

Breastfeeding women may have their eligibility assessed any time up to one year postpartum.

REFERENCE

7 CFR 246.2 Definition of Postpartum Woman
7 CFR 246.7(g)(1) Certification Periods
7 CFR 246.7(c)(2)(ii) Eligibility Criteria and Basic Certification Procedures
ASM 95-148 (WRO Policy Memorandum 803-AB) Categorical Eligibility and Postpartum WIC Benefits for Women Whose Pregnancy Terminated
WRO Policy Memorandum 803-K (June 1992) *Proof of Pregnancy*

CERTIFYING BREASTFEEDING WOMEN UP TO ONE YEAR

POLICY

- Breastfeeding women who are less than six months postpartum will be certified up to one year, ending with the breastfeeding infant's 1st birthday.
- Breastfeeding women over six months postpartum will be certified for up to six months, also ending with the breastfeeding infant's 1st birthday.
- Breastfeeding women over six months postpartum whose infant receives >50% formula package will no longer be eligible to receive a food package; however, she will still be eligible to participate on the program.

Nutrition/breastfeeding education must be provided to the postpartum woman within three months after the initial certification, at the infant's 5-7 month health screen, and within three months after the infant's health screen. This schedule for providing nutrition/breastfeeding education may vary based on the mother's postpartum certification date.

Local agencies will develop a plan for implementing postpartum breastfeeding education to ensure that nutrition education occurs twice every six months.

PROCEDURE

Breastfeeding woman *less than six months postpartum*: The computer will automatically set the end date at the breastfeeding infant's 1st birthday.

Breastfeeding woman *over six months postpartum*: The computer will automatically set the end date at the breastfeeding infant's 1st birthday.

Breastfeeding woman who *stops nursing*: See Section C.

CERTIFYING INFANTS

POLICY

Infants who are less than 6 months old will be certified up to 1 year of age. Infants over 6 months of age will be certified for a six-month period.

Infants must have a health screening between 5 and 7 months of age and a hemoglobin test done sometime between 9 and 12 months.

An infant under 6 months of age may be determined to be at nutritional risk if the infant's mother was a WIC program participant during pregnancy.

In addition, an infant may be determined to be at nutritional risk if the mother's medical history shows that she was at nutritional risk during pregnancy because of detrimental or abnormal medical conditions detectable by biochemical or anthropometric measurements or other documented nutritionally-related medical conditions.

CERTIFYING CHILDREN

POLICY

Children (ages 1 to 5) are certified at intervals of approximately six months, ending with the last day of the month in which the child's 5th birthday occurs.

DOCUMENTATION REQUIRED AT CERTIFICATION

POLICY

Applicants must provide documentation that they meet the eligibility criteria for WIC. Staff must verify that the applicant provided each of these proof documents.

The purpose of this policy is to strengthen the integrity of the WIC certification process, prevent dual participation, and make sure WIC services are provided only to those applicants who are truly eligible.

If the applicant fails to provide this documentation at the certification appointment, a 30-day temporary certification period is available.

Providing documentation should be implemented in a manner that does not constitute a barrier to any applicant, particularly a person who is mobile, such as a homeless person, a person in the military, or a migrant.

A participant may use electronic forms or display an image on a moble device to provide the documents approved by the Idaho WIC Program. The proof needs to be legible and contain all of the information a certifier may need to establish proof of identity, income, residency, or proof of pregnancy. Staff should look for credible sources of electronic documents such as the institution's contact information, letterhead, or logo.

CATEGORY

The applicant must provide proof he or she belongs to a category served by the WIC Program. This is determined by identification and proof of pregnancy.

IDENTIFICATION

Acceptable proof of identity includes:

- Social Security card
- Driver's license
- Birth certificate
- Crib card
- Government-issued identification
- Immunization record
- WIC Identification Folder

Visual identification is permissible at subsequent certifications once initial proof of identity has been established. For women participants with authorized proxies, this includes checking the identification of the proxies. For children and infants, this includes checking the identity of the parent, guardian or proxy.

RESIDENCE WITHIN HEALTH SERVICE AREA

Applicants must present proof of residence in the health service area. This means establishing the physical location or address where an applicant routinely lives or spends the night.

There is no requirement for length of residency.

Acceptable proof of residency includes:

- Business letter or other postmarked mail addressed to applicant at the physical residence (not a post office box)
- Driver's license or passport
- Paycheck stub with address
- Car registration
- Current utility bill (water, electric, gas, cable TV, sewer, trash)
- Rent or mortgage receipt
- State or local document which is obtained through proof of residency

NOTE: Proof of residency must show the address where the applicant currently lives.

PROOF OF PREGNANCY

A woman whose pregnancy is not visibly noticeable must provide documented proof of her pregnancy. An EDC written on a prescription pad or a copy of an ultrasound with an EDC is adequate proof.

INCOME

Income is defined as ***total gross household income***, before deductions for income taxes, employee Social Security taxes, insurance premiums, bonds, etc. The determination of the amount of a household's gross income shall not be reduced for any reason (e.g., financial hardship, medical bills, child support).

Income eligibility is determined by comparing the household/economic unit's total ***gross*** household income against the Income Eligibility Guidelines. Income guidelines are updated yearly and become effective on July 1. If the household income is equal to or less than these guidelines, the applicant is income eligible.

Use ***net income*** to determine income eligibility for self-employed persons. Net income is determined by subtracting the operating expenses from the gross income.

ASSESSING INCOME ELIGIBILITY

DETERMINE HOUSEHOLD SIZE

Household/Economic Unit Size

Staff shall determine the number of persons living in the household/economic unit. A household is an economic unit composed of one person or group of persons, related or non-related, who usually live together and share economic resources and consumption of goods or services to support the household. The terms "household," "economic unit," and "family" may be used interchangeably.

It is possible for two households to reside under the same roof. A woman living with another person or group of persons, for example, who pays for her own living expenses can be her own household.

Pregnant Women

A pregnant woman is counted as a household/economic unit of two. A woman expecting a multiple birth (more than one fetus) may be counted as three or more if she provides written confirmation of the number of fetuses from a medical care provider. This option should only be used if the woman is not income eligible when she is counted as two, but would be income eligible if the multiple fetuses were counted. Exception: If the applicant indicates that cultural, personal, or religious beliefs conflict with increasing the household size, do not count the fetus.

Split custody: When custody of a child is split, the child shall be considered a member of the household in which he or she lives a majority of the time (50% or more). A parent paying child support may *not* claim the child as a member of his or her household unless the child lives with that parent 50% of the time.

Joint custody: In joint custody, the child lives with each parent 50% of the time. Consider the child a member of the family that applies for WIC services first. The child may only be counted as participating in one household.

Foster child: A foster child for whom an agency has legal responsibility is counted as a family of one. Payments made by the agency for the care of the child count as the only income for the child (see Section A, Foster Children).

Adopted child: Count the adopted child as part of the family household who adopted the child.

Absent military personnel: Military personnel serving overseas or assigned to a military base and temporarily absent from the household should be counted in the household/economic unit. Income received by these military personnel s*hould be counted as income*.

Child in temporary care of family or friends: This refers to an infant or child in temporary care of friends or relatives, but not in the legal custody of the Idaho Department of Health and Welfare or other welfare entity (e.g., as in the case of families of military personnel if the absent parent is serving in the military, the caregiver of the child participant is not available to care for the child). Staff should use either of the following options, depending on individual family circumstances:

- Count the absent parents and children in the household size as would have been the case prior to the parents' departure. Use of this option depends on whether staff is able to reasonably determine income from documentation provided by the friends or relatives who are caring for the child(ren).
- If the first option is not feasible, consider the child(ren) to be part of the temporary caretaker's household.

Residents of an Institution

A group of residents of a homeless facility or an institution shall not be considered as one household. An individual or group of individuals (e.g., a woman and two children) who reside in a homeless facility or an institution are counted as a separate household.

AUTOMATIC (ADJUNCT) INCOME ELIGIBILITY

Assess automatic (adjunct) eligibility on the basis of eligibility to receive Medicaid (MA), SNAP, Child Health Insurance Program (CHIP), or Temporary Assistance for Needy Families in Idaho (TANF).

NOTE: Automatic eligibility is determined by verifying participation in or pending status approval for participation in any one of the above-mentioned programs.

By law, persons and/or certain family members certified as eligible for some assistance programs at the time of WIC application are automatically income eligible for WIC. These applicants are not subject to the income guidelines used in Traditional Income Eligibility. Because these programs generally document income, their use for WIC income eligibility determination helps strengthen the integrity of the WIC income eligibility determination process without undue burden to WIC.

An applicant is automatically income eligible for WIC if documentation shows that the individual is one of the following:

- Certified as fully eligible to receive benefits from Medicaid (MA), SNAP, Child Health Insurance Program (CHIP) or Temporary Assistance for Needy Families (TANF).
- Determined to be presumptively eligible for the above-mentioned programs pending completion of that program's eligibility process.
- A member of a household containing:
  - a TANF recipient
  - a pregnant woman or infant currently on Medicaid
- An infant born to a woman with current proof of participation in Medicaid is deemed income eligible for their first year of life.

Category	Medicaid	TANF	Food Stamps
Pregnant woman	Self and household members	Self and household members	Self

Postpartum woman (Breastfeeding and Non-Breastfeeding)	Self and infant	Self and household members	Self
Infant	Self and household members	Self and household members	Self
Child	Self	Self and household members	Self

Proof of automatic income eligibility based on eligibility in Medicaid (MA), SNAP, Child Health Insurance Program (CHIP) and/or Temporary Assistance for Needy Families (TANF) must be confirmed at the time of application. Self-declaration is not sufficient. Documentation must accurately represent current eligibility for participation in such a program.

Documentation may include:

- Computer system match
- Notice of eligibility letter or card showing current eligibility dates
- Online or telephone access to adjunct programs which indicate current status

Quest cards by themselves are not adequate because they do not include the period of eligibility. They are acceptable if they can be scanned on a machine to show the eligibility period.

NOTE: WIC staff must obtain a verbal report of income for households where applicants are automatically income eligible. If the verbally reported income exceeds the upper limit for the household size but there is proof the applicant is automatically eligible, enter the verbally reported household income.

Traditional Income Eligibility

If an applicant is not automatically income eligible or staff is unable to substantiate automatic income eligibility with the information provided, Traditional Income Eligibility screening is required. In order to apply the guidelines, household size and total income must be determined.

- Income eligibility determination is based on gross income received 30 days prior to application for WIC services.
- Annual income is used if household income fluctuates due to seasonal work, periodic layoffs, or self employment.
- Net income is used for self-employed people.

Local agencies should request that applicants bring income documents which cover the period for the previous 30 days to the certification appointment. The local agency may choose to use income documentation which covers more than 30 days if this better reflects the applicant's income at the time he/she is applying for WIC services (includes periods of unemployment such as layoffs, maternity leave or seasonal work). Do not include future income or changes in income that may happen in the future (see Source of Income Chart below).

If the applicant does not bring income documents to the certification appointment, a verbal income may be taken and recorded at the time of certification. The applicant has 30 days to provide the income documentation.

Only one income determination is required in a certification period. Once an applicant is certified as "income eligible" he/she remains so for the duration of the certification period. If a participant shares a change in income mid-certification and this information is not solicited by staff, an income reassessment should be made. Reassessment of income mid-certification is not required if sufficient time does not exist to effect the change. Sufficient time means 90 days prior to the expiration of the certification period.

NOTE: A participant's certification period is to end on December 15. He/she comes to a WIC appointment on September 1 and states he/she may be over income due to a job change. An income reassessment must be done since it is more than 90 days until the certification ends.

If an applicant reports zero income or has no proof of income, the applicant must sign a No Proof Form declaring this (see Zero Income in this section).

Local agency staff will need to compare income to the published Income Eligibility Guidelines (IEGs) in the following ways:

1. If a household has only one income source, or if all sources have the same frequency, do not use conversion factors. Compare the income, or the sum of the separate incomes, to the published IEGs for the appropriate frequency and household size to make the WIC income eligibility determination.
2. If a households reports incomes sources at more than one frequency, perform the following calculations:
    a. Annualize all income by multiplying weekly income by 52, income received every two weeks by 26, income received twice a month by 24, and income received monthly by 12.
    b. Do not round the values resulting from each conversion.
    c. Add together all the unrounded, converted values.
    d. Compare the total to the published IEGs (annual income for the appropriate household size) to make the final income eligibility determination.

The following chart describes how to handle different combinations of the above.

If the pay frequency is:	AND the amount is:	DO this:	To Annualize:^
Monthly	Always the **same** and **different** (income eligible)	Compare to the Income Guidelines	Multiply one check by 12.
	Different and over income ~	*Add 3 checks together and divide by 3, then compare.	Add 3 checks together and multiply by 4.
Every 2 weeks	Always the **same**	Compare to the Income Guidelines	Multiply check by 26.
	Different	*Add 2 checks together and divide by 2, then compare.	Add 2 checks together and multiply by 13.
Twice each month	Always the **same**	Compare to the Income Guidelines	Multiply check by 24.
	Different	*Add 2 checks together and divide by 2, then compare.	Add 2 checks together and multiply by 12.
Weekly	Always the **same**	Compare to the Income Guidelines	Multiply one check by 52.
	Different	*Add 4 checks together and divide by 4, then compare.	Add 4 checks together and multiply by 13.
Combination of incomes with **same** frequency		Calculate separately as described above and add together, then compare.	
Combination of incomes with **different** frequency			Calculate separately as described above and add together.

~ If the participant is determined over income with the 1 month of income and is paid a different amount each month, ask the participant to return with 3 months of income to better determine their income situation.

*Note: In most cases this will work, but further inquiry about income amounts may be necessary. Need to assess if this income is the most reflective of the normal situation. Seek assistance from your supervisor, Coordinator, or the State agency if you have questions.
^ All income does not need to be annualized. Use if all income frequency is different or it better reflects the participant's situation.

Source of Income	Examples of Acceptable Proof of Income
Salary, wages, tips, commissions, bonuses	Current pay stub(s) with information about pay timeframe (e.g., weekly, bi-weekly, monthly) Signed statement from employer indicating gross cash earnings for a specified period
Net income from self-employment	Income tax return for the most recent calendar year Accounting records for the self-employed
Regular cash contributions from persons not living in the household	Letter from person contributing resources to the household
Child support payments or alimony	Divorce decree Award letter Copy of check received
Cash assistance payment(s)	Decision letter Quest card
Social Security benefits	Check stub Award letter from Social Security stating current amount of earnings Bank statement
Foster care	Foster child placement letter Foster parent award letter
Student financial assistance, such as grants and scholarships. Certain grants and loans will not be counted as income.	Award letter Scholarship letter
Unemployment compensation	Unemployment letter or notice
Active military payments	Recent Leave and Earnings Statement Pay stubs, vouchers, allotments or bank statements confirming the amount of deposit
Net rental income	Income tax return for the most recent calendar year
Dividends or interest on savings or bonds, income from estates, trusts or investments	Income tax return for the most recent calendar year Bank or account statements
Private pensions or annuities	Income tax return for the most recent calendar year
Government civilian employee or military retirement or pensions or veteran's payments	Annual statement that shows monthly amount of retirement income
Other cash income such as withdrawals from savings, investments, trust accounts and other resources that are readily available to the household	Bank account statements indicating regular draws on the account(s)

INCOME INCLUSIONS

Income includes the following:

a. Money received for services, including wages, salaries, commissions and fees
b. Net income from farm and non-farm self-employment (see Self Employed in this section)

c. Social Security benefits, including payments for disabled individuals
d. Dividends or interest on savings, bonds, estates, trusts, or net rental income
e. Public assistance or welfare payments
f. Unemployment compensation
g. Government civilian employee or military retirement, pensions, or veterans payments
h. Private pensions or annuities
i. Alimony or child support payments
j. Regular contributions from persons not living in the household
k. Net royalties
l. Student financial assistance (loans or grants) intended to pay for room, board, or dependent care expenses
m. Other cash income which includes, but is not limited to, cash amounts received or withdrawn from any source, including savings, investments, trust accounts, and other resources which are readily available to the family
n. Military cash allowances for uniforms and food
o. Insurance settlement, unless providing reimbursement for lost property or expenses
p. Lump sum payments that represent *new* income such as gifts, inheritance, lottery or sweepstake winnings, worker's compensation for lost income and severance pay (see Income Exclusions in this section for more detail)
q. Reenlistment bonuses (if received as a lump sum, take the bonus and divide by 12 to add to the monthly amount)

INCOME EXCLUSIONS

Income does not include the following:

a. Child Care: Any child care payments from the following:

- Title IV-A Child Care Program
- Idaho Child Care Program (child care assistance paid to low income working parents)
- At-Risk Child Care Programs
- Child Care Development Block Grant

b. Compensation

- Payments made under the Disaster Relief Act of 1974, as amended by the Disaster Relief and Emergency Assistance Amendments of 1989
- Payment received due to the Agent Orange Compensation Exclusion Act
- Payment received from Wartime Relocation of Civilians under the Civil Liberties Act of 1988 (Japanese Internment Camps)
- Payment received from National Flood Insurance Program per Public Law 109-64

c. Elderly

- Payments received under the Old Age Assistance Claims Settlement Act, except for per capita shares in excess of $2000.00
- Payments received under the Judgment Award Authorization Act

d. Food Assistance: The value of assistance to children or their families from the following programs:

- School Lunch Program
- Summer Food Service Program
- Child and Adult Care Food Program
- Special Milk Program
- School Breakfast Program

- SNAP Program
- Food Distribution Program (e.g., on Indian Reservations)
- Food Bank Programs

e. Housing

- Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Payments received under the Cranston-Gonzales National Affordable Housing Act, unless the household's income equals or exceeds 80% of the median income of the area
- Payments received under the Housing and Community Development Act of 1987, unless the household's income increases at any time higher than 50% of the median income of the area
- Payments of allowances received from the Home Energy Assistance Act of 1980
- (See Military)

f. Job Training: Payments received under the Job Training Partnership Act from the following programs:

- Adult and Youth Training Programs
- Summer Youth Employment and Training Programs
- Dislocated Worker Programs
- Programs for Native Americans
- Migrant Seasonal Workers Programs
- Veterans Employment Programs
- Job Corps

g. Lump Sum Payments

- Earned Income Credit (EIC), a tax credit for families who work and have children
- Lump sum payments that represent reimbursements including those received from insurance companies for loss or damage of property and payments of medical bills resulting from an accident or injury. If the lump sum payment cannot be easily placed into one category (reimbursement or new money), determine what portion of the payment is reimbursed and what portion is considered new income. Do not count the reimbursement amount as income. Do count the amount which is new money as income.
- Federal tax refunds.

h. Military

- Mandatory salary reduction amount for military service personnel which is used to fund the Veteran's Educational Assistance Act of 1984 (G.I. Bill) as amended
- Military housing allowances (Basic Allowance for Housing-BAH; Family Separation Housing Allowance-FSH)
- In-kind housing or other in-kind benefits (e.g., military on-base housing, medical services)
- Family Subsistence Supplemental Allowance (FSSA)
- Outside Continental United States Cost of Living Allowance (OCONUS COLA)
- Pay and allowance continuation for wounded, ill, and injured (PAC)
- Deployment Extension Incentive Pay (DEIP)/ Deployment Extension Stabilization Program (DESP) payments only while deployed. Payments from this program are considered income once the service member returns to a base in the United States.
- Combat pay
- For an exhaustive list of military income exclusions, please visit the following website: www.fns.usda.gov/snap/rules/Memo/2005/011405.htm#2

i. Native Americans: Payments to the Confederated Tribes and Bands of the following Native American Tribes:

- Yakima Indian Nation
- Apache Tribe of the Mescalero Reservation
- Grand River Bank of Ottawa Indians
- Passamaquoddy Tribe
- Penosbscot Nation
- Sac and Fox Indians (claims agreement)
- Navajo and Hopi Tribes (relocation assistance)
- Turtle Mountain Band of Chippewas (Arizona)
- Blackfeet Tribe (Montana)
- Gros Ventre Tribe (Montana)
- Assiniboine Tribes (Montana)
- Papago Tribe (Arizona)
- Red Lake Bank of Chippewas
- Saginaw Chippewa Indian Tribe (Michigan)
- Chippewas Tribe (Mississippi)

Income derived from certain submarginal land of the United States which is held in trust for certain Native American tribes

j. Payments received under the Alaska Native Claim Settlement Act

k. Student Financial Assistance: Student loans and grants used for tuition, student fees, the costs for rental or purchase of any required equipment, materials or supplies, books, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis. Following are examples of student loans and grants that are not counted as income:
   - Pell Grant
   - Supplemental Educational Opportunity Grant
   - State Student Incentive Grants
   - Stafford Loans
   - PLUS
   - Supplemental Loans for Students
   - College Work Study
   - Byrd Honor Scholarships

l. Short-term, Non-secured Loans: Excludes loans to which the applicant does not have constant or unlimited access to monies.

m. Vocational Education: Payments received under the Carl D. Perkins Vocational Education Act and the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1990

n. Volunteers

   - Any payment to volunteers under Title I (VISTA and others) and Title II (Retired Senior Volunteer Program, foster grandparents, Senior Companions Program, and others)
   - Payment to volunteers under Section 8 of the Small Business Act (SCORE and ACE)

CASH INCOME

If an applicant reports cash income payments, he or she should still provide documentation from the employer, if possible.

Request the applicant to have employer provide a written document which acknowledges the employment and rate of pay and number of hours worked. If unable to obtain, ask applicant to write a statement which describes the compensation in terms of hourly rate and number of hours worked.

INCOME CONFIRMATION FROM EMPLOYERS

To confirm income means directly contacting the source of income (e.g., employer) to determine if the documentation provided by the applicant is accurate and complete.

Staff may confirm income reported by applicants or participants when there is reason to suspect the applicant or participant is intentionally misrepresenting income. The reason for making such inquiry must be documented in the applicant/participant file. Reasons may include, but are not limited to:

- Applicant is paid in cash
- Contradictory information is given by applicant or participant
- Complaint made by another individual
- Information WIC staff may have about the financial situation of the applicant or participant

MIGRANT WORKERS

Migrant workers' income is valid for one year. A migrant worker is an individual whose principle employment is in agriculture on a seasonal basis, who has been employed within the last 24 months, and who establishes, for the purpose of such employment, a temporary abode. Agriculture means farming in all of its branches, including logging.

This applies to migrant worker families in which all members are relocated and to families in which only one member is relocated.

SELF-EMPLOYED

Net income is used to make income eligibility determinations for self-employed applicants or household members. Net income is calculated by subtracting the self-employment operating expenses from the gross receipts during the past twelve (12) months.

If the applicant is unable to provide the operating expenses and gross receipts for the past twelve (12) months, net income from the preceding year's Federal income tax return may be used only as a basis for the income determination. In such cases, the applicant is required to adjust the net income from the previous year as necessary to better reflect actual income over the past year. If using an income tax statement, the net income is listed on the 1040 U.S. Individual Income Tax Return under Farm Income.

Farm Income: Gross receipts include:

- Value of all products sold
- Rent received from farm land, equipment, or buildings
- Receipts from the sale of items such as wood, sand, gravel, etc.

Operating expenses include:

- Cost of feed, fertilizer, seed and other farming supplies
- Wages paid to migrant workers
- Depreciation (must be documented on income tax return)
- Rent paid for farm land, equipment or buildings
- Interest on farm mortgages
- Cost of farm building repairs
- Farm taxes

Non Farm Income: Gross receipts include, but are not limited to:

- Value of goods sold or services rendered by the business

NOTE: The value of services and merchandise which are consumed by the household are not considered operating expenses. If using an income tax statement, the net income is listed on the 1040 U.S. Individual Income Tax Return under Business Income or Loss.

STUDENT APPLICANTS

If a student applicant is found to be income eligible using the Traditional Income Eligibility status, continue with the certification. If the student applicant is found to be over income, subtract school-related expenses described above. Calculate the student's income over a semester or quarter and convert to monthly income for determination of eligibility.

TEENAGE APPLICANTS

A teenage applicant is someone who is less than 18 years old at the time of WIC application.

For teenage applicants residing at home with parent(s), determine if the total household income is within income eligibility limits. If the teenage applicant is supported by her parents, the parent's income should be included in the household income.

ZERO INCOME

If an applicant reports zero income, ask additional questions to determine if there is any financial assistance or other support for living expenses.

If there is financial support provided by others, consider this information for income eligibility determination.

If the income is zero, the applicant must complete a No Proof Form which declares that he/she has no income. A copy of this form should be kept with the applicant record.

REFERENCE

Idaho Administrative Code – Department of Health and Welfare: IDAPA 16.03.01 Eligibility for Health Care Assistance for Families and Children; Section 530 Newborn Child Deemed Eligible for Medicaid, 2014.
ASM, 00-48, Publication of New WIC Income Poverty Income Guidelines, 3/30/00.
7 CFR 246.7(2)(D) Verification (of Income) and Exclusions
7 CFR 246.7(h) Actions affecting participation in mid-certification
FNS Instruction 803-3, Revision 1: WIC Program Certification: Income Eligibility 05/98.
FNS Instruction 803-14: WIC Program Certification: Eligibility of Special Populations, 1988
FNS Instruction 803-L: Lump Sum Payments as Income, 1992.
FNS Instruction 803-Q: Child Care Payments Excluded from Income Consideration in WIC, 2/19/93.
FNS Instruction 803-X: Loggers as Migrant Farm Workers, 1994
FNS Instruction 803-AI [All States Memo 99-54 (1999)]: Strengthening Integrity in the WIC Certification Process
FNS Instruction 803-AS, Rev. 2: Treatment of Family Subsistence Supplemental Allowance in WIC Income Eligibility Determination
FNS Instruction 803-AV: WIC Income Eligibility Determinations for Households Affected by Privatization of On-Base Military Housing, April 2002
FNS Instruction 803-AX: Family Size and Income Determination for Military Families, March 2003
FNS Instruction 803-AY: Exclusion of the Earned Income Tax Credit (EITC) from Income Eligibility Determinations for the WIC Program, August 2003
WIC Policy Memorandum 2010-02: Implementation of Public Law 111-80; Exclusion of Combat Pay from WIC Income Eligiblity Determination

Required Documentation Not Available

Policy

Forgot to Bring Required Written Documentation:

If the applicant forgets to bring the required written proof of identity, pregnancy, residence, or income but verbally provides information that appears to make him or her eligible, a temporary, one-month certification may be granted. A woman who is visibly pregnant is not required to provide written proof of the pregnancy. The applicant has 30 days to provide any missing documentation. If he or she fails to provide the written proof after 30 days, the certification must be terminated. Refer to Ineligible at Mid-certification in Section D of this chapter.

Cannot Provide Required Documentation:

In some situations, the applicant may not be able to provide the required proof for identity, residence or income (for example: homeless, migrant workers, military). The applicant must explain why he or she is not able to provide proof and a No Proof Form must be completed.

Reference

Policy Memo 803-AI (1999) Strengthening Integrity in the WIC Certification Process

Certification Procedures

Policy

Certification procedures are outlined in greater detail in the Idaho WIC Program Paraprofessional Training Manual.

New Applicant

New applicants physically present may be entered directly into WISPr. The applcation is not required and use of the form is at the discretion of the local agency.

- WIC Participant Rights, Responsibilities and Consent
    - Required for all agencies
    - One per family
- Application for WIC
    - Optional per agency
    - One per family

Physical Presence Required at Certification Appointment

A local agency shall ensure that WIC applicants and/or participants are physically present at all certification appointments, with limited exemptions. In the case of infants and/or children, a parent or caretaker shall also be present.

Exemptions:

Infants under 8 weeks of age who cannot be present at certification for a reason determined culturally appropriate by the local agency and for whom all necessary certification information is provided may be exempt from the physical presence requirement.

Local agency staff shall require the parent and/or caretaker to bring the infant to the next appointment after the infant reaches 8 weeks of age unless the infant has been present at the WIC agency or been determined to fall within one of the other exemption reasons as stated below.

Participant(s) may be exempt from the physical presence requirement for WIC certification if being physically present would pose an unreasonable barrier to current participation under the following circumstances:

A participant or parent/caretaker of a participant who is a qualified individual with a disability as defined by the Americans with Disabilities Act. Examples are:

- a medical condition that necessitates the use of medical equipment that is not easily transportable
- a medical condition that requires confinement to bed rest
- a serious illness that may be exacerbated by coming into the WIC site
  a serious illness that is highly contagious (e.g., tuberculosis)

The infant or child applicant is under the care of one or more working parents or primary caretakers whose working status presents a barrier to bringing the infant or child into the WIC office. In two-parent/caretaker families, both parents/caretakers must be working and it must present a barrier to participation for the infant/child if neither person were able to leave work and bring the infant/child to the certification appointment.

NOTE: All applicants/participants with disabilities are not automatically exempt from physical presence at certification. Only those persons with a disability that creates a current barrier to the physical presence requirement may have a basis for exemption. All exemptions must be documented by a medical care provider. Documentation must include date, diagnosis, and reason for inability to come into the WIC site.

Determine Eligibility

Determining if applicant is eligible based upon category, residence in health service area, and income is done first. This process does not require using a CPA. It can be done by any trained WIC staff person.

If the applicant does not meet one or more of the above eligibility requirements, give him/her a Letter of Ineligibility at this time.

If the applicant is eligible, complete the eligibility documentation within WISPr and continue with the certification by conducting the health screening and determining nutritional risk.

Eligible Applicant Certification Procedures

An applicant who has met the eligibility requirements (for category, residence, and income) now has a nutrition assessment to complete the fourth component of eligibility.

Conduct a health screening by collecting nutrition-related information:

- Height and weight
- Blood test
- Nutrition assessment

Determine the nutritional risk of the participant. Document the findings in the chart and computer. If the applicant does not have at least one nutritional risk criteria, give him or her a Letter of Ineligibility at this time.

If the applicant has one or more nutritional risk criteria, print and sign the Certification Record/Care Plan. The person is now eligible for WIC services.

Educate the participant about WIC, including a review of Participant Rights and Responsibilities.

Issue checks/CVVs and WIC Identification Folder and explain how to use the checks/CVVs.

Provide nutrition education, make referrals, and schedule follow-up as needed.

If migrant or homeless, issue a VOC document.

REFERENCE

7CFR 246.7(p)(1)(2)
WRO Policy Memorandum 803-BA, Implementation of the Certification and General Administration Provisions of P.L. 108-265

REQUIRED REFERRALS

POLICY

WIC benefits include providing applicants and participants with written and verbal referral information. Required referrals at certification, as applicable, include:

- Medicaid (MA)/Child Health Insurance Program (CHIP)
- Food Stamps
- Immunization (IM)
- Temporary Assistance for Needy Families – TANF/TAFI/Cash Assistance (TA)
- Drug and Other Harmful Substance Abuse (SA)
- Others, as needed

DOCUMENTATION

All referrals should be documented on the Verification of Certification screen and on the Certification/Care Plan form. Each referral type has a two-digit code.

MEDICAID, SNAP, CHIP

At certification, each participant or Responsible Adult must be provided referral information about Medicaid and SNAP, and caretakers of children must receive information about CHIP.

IMMUNIZATION

At initial certification and all subsequent certification visits for children under the age of two, screen the infant/child's immunization status using a documented record. A documented record is a record (computerized or paper) in which actual vaccination dates are recorded. This includes a parent's hand-held immunization record (from the provider), an immunization registry, an automated data system, or a participant's paper chart (paper copy).

At minimum, screen the infant/child's immunization status by counting the number of doses of DTaP (diphtheria, and tetanus toxoids and acellular pertussis) vaccine they have received in relation to their age, according to the following table:

By 3 months of age	1 dose of DTaP

By 5 months of age	2 doses of DTaP
By 7 months of age	3 doses of DTaP
By 19 months of age	4 doses of DTaP

If the infant/child is not current on the above listed minimum screening protocols: 1) provide information on the recommended immunization schedule appropriate to the current age of the infant/child, 2) provide referral for immunization services, ideally to the child's usual source of medical care, and 3) encourage the parent/caretaker to bring the immunization record to the next certification.

NOTE: It is not the intent of this policy to replace more comprehensive immunization screening, assessment, and referral activities that may already be in place at the local agency level, but to clarify the minimum required by WIC regulation. Local agencies are encouraged to coordinate efforts with local agency Immunization programs and per Local Agency WIC/Immunization contract. Coordination of screening and referral for immunizations may be facilitated through a formal agreement that outlines the responsibilities of the State Immunization program and the WIC program. WIC offices in district health departments must maintain a copy of the immunization history for each WIC child, as specified in the current WIC/Immunization Linkage contract.

Drug and Other Harmful Substance Abuse

Drug and other harmful substance abuse screening, education, and referral are integrated into the certification process for pregnant women and into nutrition education activities for pregnant, postpartum, and breastfeeding women, and to parents or caretakers of infants and children participating in the program.

Required Screening

Policy

Screening and Referral at Certification

All potentially eligible pregnant women will be screened for drug and other harmful substance abuse at certification by completing the nutrition assessment process for pregnant women. Screening is completed so that appropriate referrals can be made.

If a potentially eligible pregnant woman has concerns about her drug use or harmful substance abuse or if the nutrition assessment process identifies a potential problem with drugs or other harmful substance abuse, a referral must be made.

Local agencies must maintain a current list of local substance abuse counseling and treatment services. This must be printed and updated on at least an annual basis. The referral information may be included in a comprehensive written list of important local community resources that is used as a handout for participants.

Education

Local agencies must provide drug and other harmful substance abuse information to all pregnant, postpartum, and breastfeeding women, and to parents or caretakers of infants and children participating in the program. This information may be provided through handouts or information included in participant newsletters.

REFERENCE

7CFR 246.7 (a) Integration with health services
7CFR 246.7 (b) Program referral and access
7CFR 246.7 (o) Drug and other harmful substance abuse screening
7CFR 246.11 (a)(3) General nutrition education
ASM 01-56 (WRO Policy Memo 803-AT) Immunization Screening and Referral in WIC

SECTION C: MID-CERTIFICATION

OVERVIEW

IN THIS SECTION

Category Changes in Women

CATEGORY CHANGES IN WOMEN

POLICY

PREGNANT WOMAN WITH EDC CHANGE

If the EDC changes by less than two weeks, no changes need to be made to the computer system.

If the EDC changes by two weeks or more, staff should adjust the dates on the computer system.

PREGNANT WOMAN WHO DELIVERS OR WHOSE PREGNANCY ENDS

Women who miscarry are treated the same as non-breastfeeding postpartum women.

Non-breastfeeding women who were not on WIC during pregnancy may be certified any time up to six months after the pregnancy end, even if the baby died or is no longer with the mother. There must be written documentation that a pregnancy existed.

BREASTFEEDING WOMAN WHO NEEDS A BREAST PUMP (MANUAL OR ELECTRIC)

Women and infants who require a breast pump to support breastfeeding must both be certified eligible to participate in WIC to receive a manual pump or rented electric pump.

If the woman is not enrolled in WIC, she cannot receive a WIC breast pump until she and her infant have been certified.

If the woman is certified as a pregnant woman and she has recently delivered but has not yet had her postpartum WIC eligibility determined, she may receive a breast pump prior to being certified as a breastfeeding woman. Both mother and baby should be scheduled for certification within six weeks of the delivery.

BREASTFEEDING WOMAN WHO BECOMES PREGNANT

A breastfeeding woman who is fully breastfeeding and **receiving Food Package 7** may remain as category B until she is one year postpartum and no longer categorically eligible as a breastfeeding woman. At that time, she should be certified as a pregnant woman.

A breastfeeding woman who is **not receiving a Food Package 7** should be certified as a pregnant woman. Staff should remember to use Nutrition Risk Criteria 338, Pregnant and Breastfeeding, and other criteria as applicable.

Breastfeeding Woman Who Stops Nursing

A breastfeeding woman who stops breastfeeding is in one of three situations described below.

A. A breastfeeding and nutrition assessment must be conducted to determine the appropriate food package to issue her and her infant. If she is greater than six months postpartum and her infant receives >50% formula package, she will no longer be eligible to receive a food package. However, she will still be eligible to participate on the program and receive appropriate nutrition/breastfeeding education and health referrals.

B. If she is less than six months postpartum and was eligible based solely on her infant, she must have a breastfeeding and nutrition assessment completed to establish if she is still eligible to receive WIC benefits.

C. If she is less than six months postpartum and qualified because of her own risks, she may be kept on WIC with a new breastfeeding and nutrition assessment completed. Any Nutrition Risk Criteria which apply only to breastfeeding women should be removed.

Non-breastfeeding Postpartum Woman Who Resumes Breastfeeding

A non-breastfeeding woman who notifies staff she has resumed breastfeeding is in one of two situations described below.

- If she previously qualified as a breastfeeding woman and the timeframe is still within that original certification period, she may be kept on WIC <u>with a new breastfeeding and nutrition assessment completed</u>. Any Nutrition Risk Criteria which apply only to non-breastfeeding postpartum women should be removed.
- If she has not previously qualified as a breastfeeding woman, she must have a breastfeeding and nutrition assessment completed to establish if she is still eligible to receive WIC benefits.

It is acceptable to make the changes when she notifies staff of the change or to make another appointment. It is preferred to do it when she notifies staff, but not always possible.

SECTION D: INELIGIBLE

OVERVIEW

IN THIS SECTION

Notice of Certification Ending
Ineligible at Certification
Ineligible at Mid-Certification

NOTICE OF CERTIFICATION ENDING

POLICY

Participants shall be advised in writing that the certification is ending at least 15 days before the certification expires. The notice must include information about why the participant is no longer eligible and the right to request a Fair Hearing.

A participant is no longer eligible for the following reasons:

- Moved out of service area
- Over Income
- Voluntary withdrawal
- Deceased
- Disqualified
- Error
- Dual participation in WIC
- Program misuse
- Not serving priority
- Client receiving benefits from CSFP
- Categorically ineligible

REFERENCE

7CFR 247.7 (j)(8) Notification of Participant Rights and Responsibilities
7CFR 246.7 (g) Certification Periods

INELIGIBLE AT CERTIFICATION

LETTER OF INELIGIBILITY

Ask the Applicant/Responsible Adult to sign a copy of a Letter of Ineligibility and give him/her a copy of the letter. File the letter in case a Fair Hearing is requested or a discrimination complaint is filed.

DOCUMENTATION

A copy of the Letter of Ineligibility, the Application (if applicable), and other certification documentation must be kept on file (electronic or hard copy) for four years. If this is a new applicant, it may be kept in a designated place, such as an Ineligible Applicant file.

INELIGIBLE AT MID-CERTIFICATION

POLICY

A participant who becomes ineligible at any time during a certification period **shall be advised in writing at least 15 days before termination from the program.**

EXPLANATION

The agency must explain to the participant why he or she is not eligible.

LETTER

Ask the Responsible Adult to sign a copy of the Letter of Ineligibility and give him/her a copy of the letter. File the letter in case a Fair Hearing is requested or a discrimination complaint is filed.

DOCUMENTATION

A copy of the Letter of Ineligibility, the Application (if applicable), and other certification documentation must be kept on file (electronic or hard copy) for four years. If this is a new applicant, it may be kept in a designated place, such as an Ineligible Applicant file.

REFERENCE

7CFR, Sub part C, 246.7 Certification of participants
E-mail from Tricia Barnes (06/29/99)
WRO Policy Memo 803-R: WIC Eligibility of Wet Nurses (issued as All States Memo 93-119, 06/25/93)
All States Memorandum Participation Reporting, WIC Program (11/30/88)
WRO Policy Memo 803-AB: Categorical Eligibility and Postpartum WIC Benefits for Women Whose Pregnancy Terminated (issued as All States Memo 95-148, 09/21/95)
WRO Policy Memo 803-AC: Non-Birth Mothers Certified as Breastfeeding Women (issued as All States Memo 96-06, 10/06/95)

CHAPTER 5: NUTRITION EDUCATION

OVERVIEW

The WIC nutrition assessment is the first step in providing quality nutrition services. The Value Enhanced Nutrition Assessment (VENA) process allows staff and participants to use their limited time to identify individual needs and concerns, and provides a positive approach based on desired health outcomes rather than on deficiencies. VENA provides the foundation for targeted and relevant nutrition education that guides and supports families in making healthier eating and lifestyle choices. (More detail about the VENA process is located in the Idaho WIC Program Paraprofessional Training Manual.)

Nutrition education is a benefit available at no cost to all participants. Nutrition education is defined as "individual and group sessions and the provision of materials that are designed to improve health status and achieve positive change in dietary and physical activity habits, and that emphasize the relationship between nutrition, physical activity, and health, all in keeping with the personal and cultural preferences of the individual," as stated in the Child and Nutrition and WIC Reauthorization Act of 2004. Nutrition education should be easily understood and relevant to the participant and integrated into all areas of WIC. Individual care plans shall be developed for participants based on an individual's need for a care plan or for a participant who requests an individual plan.

IN THIS CHAPTER

Section A General Requirements

Section B Delivery of Nutrition Education

Section C Participant Survey

Section D Nutrition Education Topic Codes

SECTION A: GENERAL REQUIREMENTS

OVERVIEW

IN THIS SECTION

Availability of Nutrition Education
Low Risk Contact
High Risk Contact
Drugs and Other Harmful Substances
Documentation of Contacts
Refusal of Nutrition Education

AVAILABILITY OF NUTRITION EDUCATION

POLICY

Nutrition education must be available to all participants through either individual or group sessions appropriate to the individual participant's nutritional risks, needs, and interests. A minimum of two nutrition education contacts must be made available during each six-month certification period for all adult participants, the parents or caretakers of infant and child participants, and the child participants themselves, when possible. Nutrition education shall be thoroughly integrated into participant health care plans, the delivery of supplemental foods, and other program operations.

GOALS

Nutrition education shall be designed to achieve the following broad goals:

- Stress the relationship between proper nutrition and good health with special emphasis on the nutritional needs of pregnant, postpartum, and breastfeeding women, infants, and children under five years of age
- Assist the individual who is at nutritional risk in achieving a positive change in food habits, resulting in improved nutritional status and in the prevention of nutrition-related problems through optimal use of the WIC supplemental foods and other nutritious foods
- Facilitate creating a partnership with the participant in goal setting
- Provide a positive approach toward achieving desired health outcomes (rather than focusing on deficiencies)

MINIMUM CRITERIA

Nutrition education contacts based on nutritional risks are defined in two categories:

- Low risk nutrition education contacts
- High risk nutrition education contacts

Referral standards for participant risk status are based on Nutritional Risk Criteria and priority level. Roles and qualifications of staff providing nutrition education are identified in the guidelines below.

All contacts must:

- Facilitate continuing to build rapport with the participant
- Have a practical relationship to the nutritional risks, needs, and interests of the participant
- Use effective communication and be designed for easy understanding by participants
- Meet the different cultural, language, educational, economical, and environmental needs of the participant
- Include information on how to select food for both the participant and the family
- Create a partnership with the participant in goal setting

REFERENCE

7 CFR 246.11 Nutrition Education

LOW RISK CONTACT

POLICY

A participant who does not require high risk nutrition education by a registered dietitian can receive nutrition education from a trained paraprofessional. Nutrition education can address participants' nutritional needs specific to category of eligibility.

REFERENCE

State Policy

HIGH RISK CONTACT

POLICY

A high risk participant is one whose health is in jeopardy mostly due to nutritional status. Every high risk participant must receive at least one contact with the registered dietitian during a six-month certification period. The registered dietitian uses critical thinking skills to develop an individual high risk nutrition care plan. The registered dietitian considers all relevant information gathered during the assessment process, nutrition problems identified, previous goals, the participant's viewpoint, and the desired health outcome.

The purpose of the individual care plan is to give direction and enhance the continuity of care provided by the registered dietitian and support staff. The plan must be realistic and tailored to the individual risks, needs, goals, and interests of the participant.

Participants requiring nutrition counseling by a registered dietitian are identified in the Referral Guidelines for Nutrition Counseling.

DOCUMENTATION

Documentation must include a well developed care plan based on an assessment of the participant's risks and needs, the changes expected, and the strategies to be used to achieve those changes directed toward a desired health outcome. Such a plan includes the following components:

- Date of contact
- Assessment including results from nutrition, socioeconomic and cultural assessments, the participant's knowledge, interests, and attitude toward nutritional risk.
- Intervention and nutrition education provided, including client goal(s), education materials discussed
- Progress evaluation criteria to determine effectiveness of nutrition education
- Referrals
- Plan for follow-up, including topics to be discussed and repeat biochemical or anthropological measurements
- Name or initials and credentials of the registered dietitian

DRUGS AND OTHER HARMFUL SUBSTANCES

POLICY

Information on drugs and other harmful substances must be provided to all pregnant, postpartum, and breastfeeding women and to parents or caretakers of infants and children in the WIC Program at certification and as needed.

Health messages related to use of drugs and other harmful substances may be provided through pamphlets, participant newsletters, educational displays in the clinic, and posters or videos in waiting areas.

REFERENCE

7 CFR 246.7(n) Drug and Harmful Substance Abuse Screening

DOCUMENTATION OF CONTACTS

POLICY

All nutrition education provided to participants should be entered into the Idaho WIC Information System Program (WISPr), either in the Participant Care Plan or Nutrition Education screen. If this is not possible, documentation must be written in the participant chart until it can be entered into WISPr. If nutrition education is not provided because a participant refused or was not able to attend, this information should also be entered into WISPr or the participant chart until it can be entered into WISPr.

CERTIFICATION CONTACTS

Documentation must include:

- Date of contact or refusal/inability to attend or participate
- Topic of nutrition education provided
- Education materials discussed
- Client goal, if set
- Plans for follow-up, if needed

- Referrals, if given
- Name and title of staff member providing the nutrition education

The above information is captured on the Care Plan portion of the Certification Form.

INDIVIDUAL CONTACTS

Documentation must include:

- Date of contact or refusal/inability to attend or participate
- Topic of nutrition education provided
- Name and title of staff member providing the nutrition education, if written in the chart

GROUP CONTACT

Documentation must include:

- Date of contact or refusal/inability or attend or participate
- Class topic or title
- The average group education length should be 15 to 30 minutes total (including check/CVV issuance and appointment scheduling).

BREASTFEEDING CONTACTS

Refer to local agency breastfeeding education and support plan as included annually in the Nutrition Education Plan and Evaluation.

FORMAT OF DOCUMENTATION

Documentation should be accomplished in a manner that is readily understandable by all staff. Narrative notes, Subjective Objective Assessment Plan (SOAP) notes, or a combination of the two can be used. A description of these methods is found in the Idaho WIC Program Paraprofessional Training Manual, Unit 1 - Basic Skills.

Group education can be documented in several ways:

- Checklist
- Progress notes
- Calendar pages
- Card file system

Class outlines, including handouts, must be kept on file along with a schedule of when classes were presented.

REFUSAL OF NUTRITION EDUCATION

POLICY

Documentation is required for participants who refuse or are unable to attend/participate in nutrition education. Refusal or inability to attend should be documented in the participant's chart. The purpose of recording this information is to plan further education efforts and to monitor services. Every effort should be made to reschedule participants who were unable to attend or participate in nutrition education.

REFERENCE

WRO Policy Memo 803-AW; Participant Orientation (1/31/03)
State policy

SECTION B: DELIVERY OF NUTRITION EDUCATION

OVERVIEW

Nutrition education is any type of learning experience that desires to help an individual adopt dietary behaviors that enhance health and well being. "... nutrition education 'works,' in that it is a significant factor in improving dietary practices when behavioral change is set as the goal and the educational strategies employed are designed with that as a purpose." (Adapted from Volume 27, Number 6, November-December 1995 Journal of Nutrition Education Special Issue *The Effectiveness of Nutrition Education and Implications for Nutrition Education Policy, Programs, and Research: A Review of Research*.)

Education that is participant centered, motivational, and "how to" is most likely to produce behavioral change. Nutrition education should include communication between local agency staff and participants. Communication is not telling or informing the participant, but recognizing that the participant has an active role in deciding to accept or ignore, misunderstand, or reject the nutrition message. Communication is defined as interaction between WIC staff and participants, such as establishing rapport, discussions about nutrition information provided through classes, individual counseling, newsletters, handouts, displays and exhibits, or audiovisuals.

In order to enhance communication with non-English-speaking participants, the FNS regional office recommends the local agency hire at least one bilingual staff person when more than 5% of the caseload or 100 non-English speaking people are served. The local agency should also hire at least one part-time interpreter when over 5% of caseload or 100 people are served in any individual clinic. Interpreter expenses are allowable nutrition education costs.

The three most common strategies for providing nutrition education are:

- Individual counseling
- Group education
- Displays or exhibits

All three strategies are considered acceptable nutrition education contacts when they meet the criteria specified.

Online education is an acceptable option for a second nutrition education contact if the participant is eligible. Local agencies will be responsible to meet policy requirements when choosing to offer online education.

IN THIS SECTION

Individual Counseling
Group Education for Adults
Group Education for Children
Online Nutrition Education
Other Methods
Learning Environment
Displays and Exhibits
General Visual Aids
Newsletters
Handouts, Booklets and Brochures
Audiovisuals
Evaluation of Nutrition Education

INDIVIDUAL COUNSELING

DESCRIPTION

Successful individual counseling is dependent upon establishing rapport and developing a solid relationship with the participant. The primary role of clinic staff is to help the participant gain useful knowledge about diet or health behavior, and improve behavior change and decision-making skills through goal setting. In all individual nutrition education sessions, the nutrition education intervention must be tailored to the participant's individual needs, interests, and concerns and be relevant to the participant's literacy level and cognitive development as well as be culturally sensitive.

A telephone call is considered an acceptable method of individual counseling in two instances:

- When the call is initiated by the registered dietitian.
- If the participant phones, the call must relate to identified nutritional risks and the appropriate nutrition counselor must respond to the question.

GROUP EDUCATION FOR ADULTS

DESCRIPTION

A wide variety of group experiences can be used to provide nutrition education. Group nutrition education can be a very effective education strategy. It brings together participants with similar needs and facilitates learning through idea exchange.

In planning group education sessions, it is essential that class outlines (lesson plans) are developed and used for each class topic. A class outline must include a title, learning objectives including the behavioral change desired, a timeline, a description of activities, an evaluation component, and the date of development. Each class should have an introduction section which includes an icebreaker. This allows the participants to create a sense of camaraderie. All lesson plans should be kept on file and be available for review during monitoring visits. A suggested class size would be eight participants.

Group education proceeds smoothly when taught by trained staff. One option is to present classes to the staff first and clarify all learning objectives prior to having the class presented to participants. A roster of staff who have received training to conduct each class should also be kept on file.

A variety of different types of group nutrition education experiences can be used in the WIC Program. A brief description of such group experiences is provided.

FACILITATED GROUP DISCUSSIONS

Facilitated group discussions are an interactive form of education where participants decide the topic to discuss and share their knowledge and experience with the group. The discussion is facilitated by a trained staff member who encourages, supports, and promotes the group discussion. Discussion should be designed to either help participants with a problem (e.g., shopping on a limited budget) or to introduce a positive health behavior (e.g., delaying the infant's introduction to solid foods). For further information on facilitated group discussion, contact the Nutrition Education Coordinator at the State agency.

DISCUSSION/SUPPORT GROUPS

Discussion groups are similar to facilitated group discussions except the topic is decided ahead of time and a short, five-minute presentation precedes the discussion by the group.

Support groups can usually function as discussion groups as well. Support groups must help participants with nutrition-related problems (e.g., how to relieve engorgement) or introduce positive health behaviors (e.g., combining working and breastfeeding) to be considered a nutrition education contact.

LECTURE CLASSES

Lecture style classes are less effective methods of group nutrition education. Lectures disseminate information from the group leader with little or no time allocated for discussion or interaction. They are not encouraged, but are acceptable occasionally if a guest speaker is sponsored. Even then, discussion is required for the class to be considered a nutrition education contact.

GROUP EDUCATION FOR CHILDREN

Classes designed specifically for the WIC preschooler (3 to 5 years old) have been enthusiastically received by both participants and parents/caretakers. A wide variety of resources is available to use in the planning and development of children's classes.

Some key points to remember when working with this age group:

- Preschoolers have short attention spans, so class should be 15 minutes or less.
- Lessons should include objects to touch, taste, or smell. Preschoolers learn best from "hands-on" projects.
- Classes should include movement. Preschoolers will not sit for very long.
- Several short projects should be planned rather than one long one.
- Videos, filmstrips, and slide shows should be under 10 minutes long.
- Any visual aids should be large, simple, and easy to identify.

If space permits, children's groups could be scheduled simultaneously with nutrition education for adult participants or the parents/caretakers. The removal of children from adult sessions will help minimize distractions, interruptions, and noise, producing a more conducive atmosphere for adult learning. Ideally, the local agency staff should be assigned to run children's groups. Parents/caretakers may prefer to remain within sight of their children. Participation should be limited to 10 children or less.

ONLINE NUTRITION EDUCATION

Online modules may be used to provide the second nutrition education contact for low risk participants with nutrition risk(s) relevant to the online modules available. Online modules provide an alternative form of education that is self-paced and flexible while still providing effective nutrition education. WIC staff should determine if the participant is eligible for online nutrition education. If the participant is eligible, staff may offer individual, group or online session to complete their second nutrition education.

Participants eligible for online nutrition education include the Responsible Adult or caregiver of a low risk infant or child and low risk pregnant women with nutrition risk(s) relevant to the online modules being offered.

To participate in online education, the participant would be required to have internet and computer access. Acceptable access options may include:

- A home computer with internet access
- A computer in another location with internet access, such as a
  - Library
  - Friend's or relative's home
- WIC clinic kiosks with internet connectivity for participants to access online (if available in the clinic)

- Mobile devices such as smart phones or tablets (may require Wi-Fi or personal data use)

If a participant chooses online education, staff need to:

- Explain to the participant, Responsible Adult, or caretaker of the infant or child how to complete online modules
- Recommend specific modules relevant to the participant's nutrition needs
- Provide a completion date
- Instruct the participant how to provide proof of completion
  - Bring in a copy of their certificate or email to the local WIC clinic
- Provide information for contacting help
- How to receive their checks
- Schedule a follow-up appointment

A follow-up online education appointment should be documented in WISPr to include:

- Collection of documentation
- Review what the participant learned
  - The class topic
  - When the class was taken
- An opportunity to establish a goal(s) based on what they learned.

Local Agency Requirements for Offering Online Education

Local agencies that provide online education for low risk participants to complete their second nutrition education contact must have procedures documented. Written procedures must be approved by the State agency a minimum of 60 days prior to implementation and reviewed biannially.

At minimum, the procedures should include:

- A plan to train staff on the content of each online class available for participants at your agency. This may include staff reviewing each class and completing training about the nutrition risks relevant for each class.
- Criteria for staff to determine participant eligibility for online education. This includes a way to verify participants have the necessary access to complete the education within the certification period.
- Procedures for participants to provide proof of class completion in order to obtain benefits and establish what proof will be accepted for class completion.
- How benefits will be issued to the participant.
- How the appointment will be identified in the participant's record.
- Identification of local agency staff who will assist with proof of class completion, reviewing content or answering participant questions about classes, and discussion about goal setting.
- Where documentation will occur in the participant's chart within WISPr.

Reference

Oregon WIC Program and Policy Manual

Other Methods

Food Demonstrations

Food demonstrations should focus on only one food or theme, using foods and utensils commonly available to participants. Sound principles of proper sanitation, food handling, and storage should be

incorporated into the demonstration. Taste testing and recipes should be provided. Food purchases are legitimate nutrition education expenditures.

Nutrition Games

Retention of information improves when individuals are provided with the opportunity to “practice” what they have learned. Using games for providing nutrition education is an effective method for enabling such practice and active participation. Some common, readily identifiable television game shows can be easily adapted to convey nutrition and health-related information. “Game shows” can also be an effective strategy for stimulating greater participant interest in other nutrition education programs provided by the local agency.

Puppet Shows

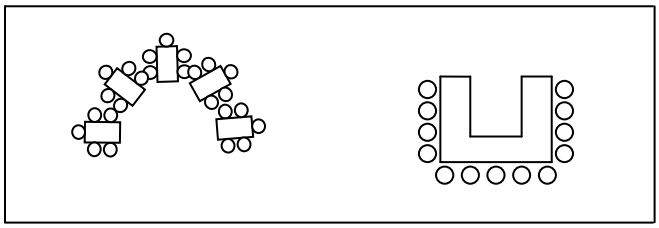
Both preschoolers and their parents/caretakers can learn nutrition messages from short puppet shows. Puppet shows allow for involvement by more than one staff member, and are less threatening for staff learning to conduct nutrition education classes. Puppet shows should be no longer than 15 minutes and simple enough for the preschooler to understand.

Learning Environment

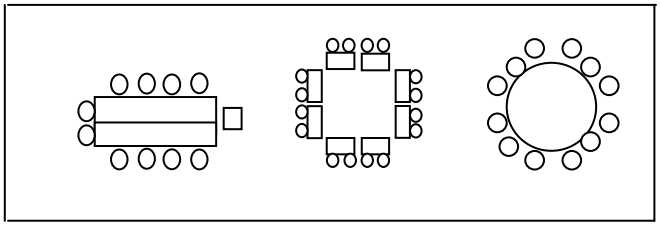
Description

Participants should be seated in a way to encourage greater interaction. If the environment can not be adapted, be assertive in asking participants to sit close together. It is possible in almost any situation to arrange a way to pair up participants in order to have more inactive learning. Look at the following illustrations for ideas on how to set up a learning environment. (From *101 Ways to Make Training Active,* Silberman, 1995, Jossey-Bass Inc.)

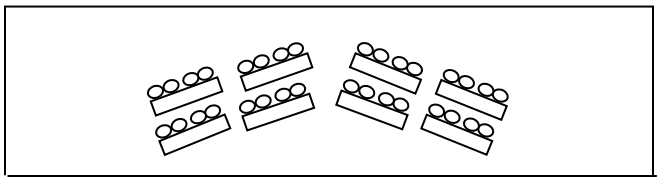
U-Shaped



Circle



V-SHAPED



LENGTH OF GROUP CONTACT

The average group education length should be 15 to 30 minutes total (including check/CVV issuance and appointment scheduling).

DISPLAYS AND EXHIBITS

DESCRIPTION

A display is a small amount of visual aid material set up in either the entrance hall or waiting room area of the local agency or satellite clinic. An exhibit is similar to a display, but much more elaborate and on a much larger scale. The main purpose of a display or exhibit is to inform participants of new ideas and information in an understandable and interesting way.

MINIMUM CRITERIA

The following standards should be followed whenever developing and organizing displays or exhibits:

- All displays and exhibits must be carefully planned to meet the needs of the participants who will view the display or exhibit.
- Only one topic should be covered in a display or exhibit. Since the average time spent at an exhibit is 7 minutes (less time for a display), the number of new ideas participants are expected to absorb must be kept to a minimum.
- The display or exhibit should not be crowded with too many visual aids.
- The materials should be arranged in a progressive fashion, with ideas and information becoming more complex as the participant moves along the display or exhibit.
- Simply having participants view a display or exhibit does not constitute a nutrition education contact. Displays and exhibits are appropriate nutrition education contacts if the following requirements are met:
    - Participants must complete a brief written or verbal evaluation after viewing the display or exhibit. The evaluation may be incorporated into the exhibit by using a flip chart or a question-and-answer board.
    - Results of the evaluation must be available to the participants.
    - A staff person must be available at the display or exhibit or immediately after the participant views it to address questions. This can be the person who is issuing food vouchers, as long as the staff person has received training on the contents of the display or exhibit.

NOTE: Displays are a good way of addressing non-nutritional interests such as child development, immunizations, toy safety, etc. However, these can not be counted as a nutrition education contact. Using displays for non-nutritional topics saves class time for nutrition-specific education.

General Visual Aids

Description

Common visual aids used in the WIC Program include handouts, newsletters, posters, flip charts, and audiovisuals. Their use is intended solely to aid in the presentation of information and to facilitate participant learning. Visual aids cannot teach by themselves. Simply giving out a handout, distributing a newsletter, or having participants view a video without discussion does not constitute an acceptable nutrition education contact.

Visual aids are considered appropriate components of nutrition education contacts if used as part of individual counseling, a class, or an exhibit.

Newsletters

Description

Newsletters can help communicate information on clinic schedules, changes in the list of WIC foods, new clinic sites and hours, or changes in local agency WIC staff. Newsletters can also be used to convey nutrition or health information to participants. Simply distributing a newsletter to participants is not an acceptable nutrition education contact.

Criteria

To be considered nutrition education, the contents of the newsletter must relate to an individual participant's nutritional risks. It must be reviewed with the participant, and the participant must complete a brief written or verbal evaluation (including possibly setting a goal) which is then documented into the participant's chart.

Planning

The local agency and staff members should meet to plan newsletter themes for the entire year when possible. Themes can be planned around the seasons, holidays, designated health days or months (e.g., National Nutrition Month), or a special nutrition or health topic.

Size

In general, newsletters should range from 5" x 8½" to 8½" x 11".

Reading Level

The newsletter should be at the sixth grade level or less.

TYPE OF LETTERING

The size of the letters should be easily readable, 12 point font or larger. Key points should be emphasized with underlining or neat free-hand lettering. Do not use all capital letters or italics.

ILLUSTRATIONS

All illustrations should relate to the information presented in the newsletter. A wide variety of clipart books and computer software packages are available for professional looking illustrations. These can be purchased at art supply and computer retail stores, respectively.

REPRODUCTION

Before reproduction, verify that all information is easily understood. If possible, print on bright colored paper or use different colored ink for a more eye-catching product. When distributing the newsletter, make sure it was printed clearly.

TRAINING STAFF

All staff who will be using the newsletter with participants should receive training on the content of the newsletter. It is important to anticipate the types of questions participants may ask and train staff on appropriate answers to questions.

NOTE: All nutrition education information that also provides information about the WIC Program or WIC benefits produced at the state or local level must include the USDA non-discrimination statement as stated in Chapter 2.

HANDOUTS, BOOKLETS AND BROCHURES

DESCRIPTION

Handouts and booklets can best assist in promoting attitude and behavior change when used in group or individual counseling sessions. They should be discussed and reviewed with participants. Handouts serve to re-emphasize information or clarify concepts. They can also be an outline or guide during an education session. Ideally, only one (not more than two) handouts should be discussed with a participant, in any given education session.

CRITERIA

Handouts should be evaluated prior to use. They should contain up-to-date information, be simple to understand, easy to read, clear, and culturally appropriate. The reading level of the handout should be sixth grade level or lower. If there are concerns, please contact the Nutrition Education Coordinator at the State agency.

AUDIOVISUALS

DESCRIPTION

Video cassettes and DVDs are useful tools for nutrition education. Prior to using any audiovisual product, it is important to preview and evaluate it to make sure its content is appropriate for the social, educational, cultural backgrounds, and nutritional needs of your audience. A list of audiovisual materials should be maintained and updated periodically.

Most audiovisuals are not 100% appropriate and may contain errors, outdated scenes, or confusing or biased information. This does not mean the audiovisual should be discarded. Point out these problems to the group prior to the showing. It is important to check equipment to assure it is in good working order prior to each use.

As with other aids, audiovisuals are not intended to provide the sole educational message. Showing an audiovisual without discussion does not constitute a nutrition education contact. Ideally, the audiovisual should consume less than one-third of the scheduled time, with remaining time devoted to discussion or topic-related activities.

Key points to remember for enhancing the educational experience:

- Check equipment to assure it is in good working order prior to use.
- Always provide a brief introduction prior to the viewing.
- Use a lead-in or teaser to encourage viewing, for instance, “I noticed one mother in the film has a very creative way to breastfeed in public. See if you can spot this woman.”
- Stay in the room with the group, even if you have seen the audiovisual several times before. This way, it will feel like a shared experience.
- Allow sufficient time for discussion and activities after the showing. Review key points, provide additional information, and address participant questions. You should also try to assess the group’s reaction to the audiovisual.

EVALUATION OF NUTRITION EDUCATION

POLICY

Evaluation is critical in the nutrition education process. Evaluation provides information regarding the services participants receive. Whenever possible after a nutritional education contact, consider the following:

- Were only one or two topics discussed?
- Were topics tailored to the participant’s nutrition risks, needs, and interests?
- If goals were set, was the participant actively involved? Were the goals set by the participant?
- If handouts were used, were the parts that related to the participant emphasized?
- Did the participant have a chance to express her viewpoint and ask questions?

SECTION C: PARTICIPANT SURVEY

OVERVIEW

Policy: Federal Regulation 246.11 (c)(5) Nutrition Education

IN THIS SECTION

Participant Survey

PARTICIPANT SURVEY

POLICY

Perform and document evaluations of nutrition education and breastfeeding promotion and support activities. The evaluations shall include an assessment of participants' views concerning the effectiveness of the nutrition education and breastfeeding promotion and support they received.

METHODS

Participants' views on nutrition education, breastfeeding promotion and support, WIC foods, and understanding of core WIC messages will be assessed through one or more of the following methods:

Questionnaire
A State-developed questionnaire with instructions for distribution and collection will be sent to local agencies. Local agencies will be exempt from distributing the questionnaire if they are being monitored by the State Office that year.

Focus Groups (State Office)
The State Office may decide to conduct focus groups in lieu of questionnaires. All local agencies that will be impacted will be notified in advance.

Focus Groups (Local Agencies)
Local agencies may conduct focus groups, if desired.

RESULTS

Results from the periodic assessment of participant views will be made available to all local agencies.

REFERENCE

7 CFR 246.11(c)(5) State Agency Responsibilities

SECTION D: NUTRITION EDUCATION TOPICS

POLICY

The Idaho WIC computer system requires documentation of the nutrition education topics used. The nutrition education topics below may be used for nutrition education only if the interactive education session emphasizes the relationship between nutrition, physical activity, and health. Nutrition education needs to support the participant who is at nutritional risk in achieving positive changes in their dietary and physical activity habits resulting in improved nutritional status and the prevention of nutrition education-related problems.

IN THIS SECTION

Nutrition Education Topics

NUTRITION EDUCATION TOPICS

Nutrition Education Topics:	
Adjust Feeding to Meet Developmental/Sensory Needs	Food Preparation/Recipes
Breastfeeding Management	Food Safety (Selection, Storage, Choking)
Breastfeeding Milk Supply	Formula Preparation/Storage
Breastfeeding Nutrition	Growing Food
Breastfeeding Positioning/Attachment	Healthy Balanced Eating (Specific to Category)
Breastfeeding Return to Work or School	Heartburn Management
Lactation Consult:	High Iron Foods – Pica
Breastfeeding Equipment Request	Increase Nutrient/Calorie Dense Foods
Breastfeeding Supply Follow-up	Introducing Solids
Infant Concerns	Introducing Table Foods
Medical Issue, MD Referral Required	Lactose Foods
Multiple Births	Nausea/Vomiting Management
Budgeting/Shopping for Food	Physical Activity (Related to Nutrition)
Dental Concern Nutrition Management	Planning Meals/Snacks
Diabetes Nutrition	Portions
Drug Nutrient Interaction Management	Salt/Sodium DASH
Fiber	Supplements
Food Allergy/Sensitivity	Weaning

CHAPTER 6: BREASTFEEDING PROMOTION AND SUPPORT

OVERVIEW

Human milk is the healthy and normal food for infants from birth to one year and beyond.

"Breastfeeding and human milk are the normative standards for infant feeding and nutrition. …breastfeeding and the use of human milk confer unique nutritional and nonnutritional benefits to the infant and the mother and, in turn, optimize infant, child, and adult health as well as child growth and development."

American Academy of Pediatrics
Breastfeeding and the Use of Human Milk
February 2012

IN THIS CHAPTER

Section A General Requirements

Section B Breastfeeding Equipment and Inventory

SECTION A: GENERAL REQUIREMENTS

OVERVIEW

The Idaho WIC Program is committed to promoting and supporting breastfeeding. Information and support systems are key to establishing and maintaining breastfeeding for the first year of life and beyond.

IN THIS SECTION

Benefits of Breastfeeding
Breastfeeding Friendly Environment
Prenatal Promotion and Support
Postpartum Support for Women and Infants
Supplemental Formula Use During Breastfeeding
Local Agency Breastfeeding Promotion Coordinator
Peer Counselors
Peer Counselor Training

BENEFITS OF BREASTFEEDING

BACKGROUND

The advantages of breastfeeding range from biochemical, immunological, and endocrinologic to psychosocial, developmental, and economical. Human milk contains the ideal balance of nutrients, enzymes, immunoglobulin, anti-infective agents, anti-allergic substances, hormones, and growth factors. Breastfeeding provides a time of intense maternal-infant interaction and facilitates the physiologic return to the pre-pregnant state. It has numerous possible health benefits for the breastfeeding woman, including improved bone remineralization postpartum with reduction in hip fractures in the postmenopausal period and a reduction in risk of ovarian cancer and premenopausal breast cancer.

AMERICAN ACADEMY OF PEDIATRICS (AAP)

The American Academy of Pediatrics in its policy statement *Breastfeeding and the Use of Human Milk* states “recently published research and systematic reviews have reinforced the conclusion that breastfeeding and human milk are the reference normative standards for infant feeding and nutrition... The AAP reaffirms its recommendation of exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant. (AAP, 2012)

NATIONAL WIC ASSOCIATION (NWA)

“NWA supports human milk as the best infant nutrition for the first year of life and beyond with the introduction of solid foods at the appropriate age. NWA challenges all WIC staff to actively promote breastfeeding as the norm for infant feeding. **Infants** fed human milk receive multiple health, nutritional,

environmental and economic benefits compared to infants fed artificial baby milk (formula). **Human** milk helps infants grow and mature properly…" (NWA, 2004)

IDAHO WIC'S ROLE

The Idaho WIC Program breastfeeding promotion and support efforts during the prenatal and postpartum periods include:

- Individual counseling
- Telephone support
- Nutritious foods
- Peer counselors
- Support groups
- Educational classes
- Breastfeeding educational materials
- Referrals to physicians and community support systems

Policies and guidelines included in this chapter provide the foundation for breastfeeding promotion and support in the Idaho WIC Program.

BREASTFEEDING FRIENDLY ENVIRONMENT

POLICY

The local agency will ensure that clinic environments endorse breastfeeding as the preferred method of infant feeding by meeting the criteria listed below.

REQUIRED CRITERIA

- Materials: All print and audio-visual materials, posters, office supplies, equipment, and office furniture will be free of formula product names and pictures.

- Bottle feeding equipment and formula: All formula and bottle feeding equipment will be stored out of view of WIC participants and staff.

- Acceptance of formula by staff: Staff will not accept formula from formula manufacturer representatives for personal use.

RECOMMENDED CRITERIA

Advertise Breastfeeding

- Display or use breastfeeding posters, handouts, bulletin boards, breastfeeding pins, memo pads and pens with breastfeeding messages.
- Have staff wear T-shirts with breastfeeding messages.
- Include positive breastfeeding messages where possible, like WIC newsletters, handouts, recipe cards, calendars, bumper stickers, health department newsletters, etc.
- Put breastfeeding messages in visible and key locations like the receptionist area, waiting area, on scales where pregnant women weigh themselves, and on bathroom doors—anywhere participants are likely to read a message.
- Display signs or exhibits that welcome breastfeeding in the clinic, show breastfeeding women overcoming common barriers to breastfeeding like embarrassment and employment and list the many benefits of breastfeeding.

Supportive Environment

- Discuss breastfeeding early and often with participants.
- Create private areas for breastfeeding women to breastfeed while waiting at the clinic.
- Advertise breastfeeding classes and invite family members and support people to attend.
- Offer advice and encouragement rather than formula when a breastfeeding woman doubts her ability to breastfeed.
- Show breastfeeding videos in waiting areas.

REFERENCE

7 CFR 246.11(c)(7)(i) Nutrition Education, State Agency Responsibilities

PRENATAL PROMOTION AND SUPPORT

POLICY

The purpose of this policy is to promote the nutritional well-being of infants and to support and encourage women in choosing the most nutritious feeding method for their infants.

All pregnant participants shall be encouraged to breastfeed unless contraindicated for health reasons.

Each local agency must have a written plan ensuring that breastfeeding is encouraged during the prenatal period and breastfeeding education is provided to all pregnant participants (unless it is contraindicated for health reasons).

All local agency staff must be trained on how to support and promote breastfeeding with pregnant participants.

REQUIRED EDUCATION AND SUPPORT

Prenatal breastfeeding education must include all of the following:

- Assisting pregnant participants in identifying any personal barriers to breastfeeding.
- Providing education focused on overcoming barriers of breastfeeding.
- Communicating to participants the benefits of breastfeeding for both infants and their mothers and families.
- Helping women make informed decisions by including information about the risks of using breast milk substitutes (unless breastfeeding is contraindicated for health reasons). Examples of the risks associated with use of breast milk substitutes include:
    - Increased illnesses and infections
    - Increased risk of food allergies
    - Increased risk of diabetes and SIDS
- Providing information on “Getting Started” with breastfeeding. Topics to include at a minimum:
    - Positioning and attachment
    - Signs that baby is getting enough
    - Maintaining milk supply
    - Resources to call for help and/or support

- Offering the following information describing WIC benefits for breastfeeding women:
    - Breastfeeding women are at a higher priority level than non-breastfeeding postpartum women. When local agencies lack funds to serve all qualified individuals, breastfeeding participants are more likely to be served than non-breastfeeding postpartum women.
    - Breastfeeding women may receive WIC benefits for up to one year postpartum, while non-breastfeeding postpartum women are eligible for only six months postpartum.
    - The WIC Program offers a greater variety and quantity of foods to breastfeeding participants than to non-breastfeeding postpartum participants.
- Encouraging and teaching women how to communicate their decision to breastfeed to prenatal care providers; hospital staff; and others involved in the prenatal and postpartum care of women and their infants.

PEER COUNSELORS

Local agencies are encouraged to use Peer Counselors to provide breastfeeding information and support for pregnant participants.

CONTRAINDICATIONS

Contraindications to breastfeeding may exist for the participant. These contraindications will occur in few participants. Breastfeeding is not appropriate and should not be promoted if ANY of the following conditions exist:

- The infant has galactosemia
- The mother is HIV-positive
- Drug abuse (exceptions: use of cigarettes, alcohol)
- Specific medications not compatible with breastfeeding
- The mother or infant is unable to breastfeed because of other physical or medical reasons

DOCUMENTATION

All breastfeeding education and support contacts received by participants must be documented in the participant health record. To facilitate continuity of care, documentation of encouragement to breastfeed should include all aspects of breastfeeding discussed with the participant (e.g., identification of barriers to breastfeeding, plans for overcoming barriers, topics discussed). Local agencies are encouraged to develop a comprehensive flow sheet for documenting breastfeeding education for participants in the prenatal period.

DEFINITIONS

Breast milk substitute/artificial baby milk (ABM): Infant formula.
Contraindication: Any circumstance that makes breastfeeding medically inadvisable.

REFERENCE

7 CFR 246.11(c)(7)(iv) Nutrition Education, State Responsibilities
7 CFR 246.11(e)(1) Participant Contacts

Postpartum Support for Women and Infants

Policy

All breastfeeding women will be provided with support, information, and appropriate referrals needed to successfully establish and maintain breastfeeding for one year or longer.

Promotion and Support Resources/Activities

Breastfeeding promotion and support are enhanced when breastfeeding support and assistance is provided throughout the postpartum period, particularly at critical times when the mother is most likely to need assistance. Promotion and support resources and activities may include:

- Offering telephone support, home visits, and support groups, Peer Counselors, and referrals.
- Identifying women with special support needs (multiple births, illness, returning to work/school, etc.) and providing education and support needed or making community referrals to appropriate support resources.
- Supplying breastfeeding equipment as needed. See Chapter 6, Section B.
- Providing positive reinforcement for breastfeeding in all postpartum contacts.
- Coordinating breastfeeding support with other programs and groups such as hospitals, health clinics, and La Leche League.

National WIC Association Position

The National WIC Association position paper, *Guidelines for Breastfeeding Promotion and Support in the WIC Program*, outlines recommendations for breastfeeding promotion.

Reference

7 CFR 246.11(c)(7)(iv) Nutrition Education, State Responsibilities

Supplemental Formula Use During Breastfeeding

Policy

Infant food packages will be tailored to encourage continued breastfeeding when mothers choose not to exclusively breastfeed.

All infants are eligible to receive the full amount of infant formula authorized upon the participant's request and after the breastfeeding support counseling steps (listed below) have been followed.

Definition

The USDA/FNS definition of breastfeeding is the practice of feeding a mother's breastmilk to her infant(s) on average at least once a day.

The USDA/FNS definition of a partially breastfed infant is an infant who is breastfed, but also receives formula from the WIC Program, in an amount not to exceed approximately one-half the amount of formula allowed for a fully formula-fed infant.

BACKGROUND

If breastfeeding is not going well, supplemental formula may aggravate the problem. Use of supplemental formula can decrease the amount of milk the mother produces, especially in the first month of the postpartum period.

When supplemental formula is requested, counseling support is required to ensure the continuation of breastfeeding. Ideally, the breastfed infant should require no supplemental formula, especially during the first month of life.

Cluster feeding is normal newborn behavior for a breastfeeding infant. Cluster feeding is spacing feeding closer together at certain times of the day (often in the evening) and going longer between feedings at other times. As babies grow, they begin to go longer between feedings.

COUNSELING

Staff must provide counseling before checks for formula are issued to breastfeeding infants. Follow the counseling steps below to support the breastfeeding infant and mother.

The appropriate person to provide counseling is a staff member who has completed breastfeeding training. Whenever possible, the counseling shall be provided by an RD, RN, Lactation Educator, Breastfeeding Promotion Coordinator, or health professional who has completed formal breastfeeding training.

Counseling shall include the following steps:

- The first priority is to help the woman successfully breastfeed. Assess milk supply, latch, and weight gain. Discuss milk transfer, hunger cues of the infant, and how to increase milk supply.
- Consider use of a breast pump rather than issuing formula, if appropriate.
- Inform the breastfeeding woman of the impact of supplementation on breastfeeding (i.e., that milk production will be decreased when a woman breastfeeds less frequently).
- Inform the exclusively breastfeeding woman that her food package will be changed if she accepts supplemental formula.

INFANT FOOD PACKAGE (FOR >1 MONTH ONLY)

If after counseling, the mother's decision is to give formula or if her infant is already receiving supplemental formula, refer to Supplemental Powdered Formula for Partially Breastfed Infant table (located at the end of this section) for description of amounts available.

If the mother is unsure how many feedings need to be supplemented, recommend she begin with one can and request that she contact WIC if she feels she needs more.

Provide powdered formula, if available, since it can be prepared in small quantities as needed.

Provide follow-up breastfeeding support after the introduction of formula.

- Encourage substantial breastfeeding as the norm.
- Discuss the importance of exclusive breastfeeding even if formula has been given.
- Remind the participant that if at her next appointment formula is no longer needed, she may receive an exclusively breastfeeding food package.

A breastfeeding woman of an infant who is 6 months or older and receiving greater than 50% supplemental formula will no longer be eligible to receive a food package. However, the breastfeeding

woman is still eligible to participate in WIC and receive nutrition education, breastfeeding promotion and support, appropriate breastfeeding equipment, and referrals to health and social services.

Table: Supplemental Powdered Formula for Partially Breastfed Infant

Usual Daily Intake of Formula by Infant	Percent Breastfeeding	Number of Cans to Provide per Month	
		Age of infant in months	Similac Advance, Enfamil ProSobee
1 to 4 oz. per day	75%	1 through 11	1 can
5 to 8 oz. per day	75%	1 through 11	2 cans
9 to 16 oz. per day	50%	1 through 3 4 through 5 6 through 11	4 cans 5 cans 4 cans
Greater than 16 oz. per day Breastfeeding at least one time per day	25%*	1 through 3 4 through 5 6 through 11	6 cans 7 cans 5 cans
	25% Full formula	1 through 3 4 through 5 6 through 11	9 cans 10 cans 7 cans

REFERENCE

7 CFR 246.2 Definitions
7 CFR 246.11(c)(7)(iv) State Agency Responsibilities
7 CFR 246: FNS Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages, Interim Rule, December 6, 2007
WRO Policy Memo 804-H Questions and Answers on the Enhanced Food Package for Breastfeeding Women (Food Package VII) (11-18-94)
WRO Policy Memo 805-B Breastfeeding Support During Certification and Food Package Issuance (03-31-92)

LOCAL AGENCY BREASTFEEDING PROMOTION COORDINATOR

POLICY

Each local agency will appoint a Breastfeeding Promotion Coordinator

OVERVIEW

The local agency Breastfeeding Promotion Coordinator is a staff member who serves as a resource person and central contact for the coordination of breastfeeding promotion and support activities in the local agency. The local agency Breastfeeding Promotion Coordinator shall be given support from the local agency to ensure that the resources are available to perform the duties and responsibilities of this position.

RESPONSIBILITIES

Responsibilities are to include but are not limited to the following:

- Lead the implementation of a breastfeeding promotion and support plan for the local agency
- Review breastfeeding data with local agency WIC Coordinator on a regular basis to determine the effectiveness of the plan
- Maintain current, accurate breastfeeding information resources such as posters, handouts, breastfeeding equipment, resource and referral information, etc., to optimally support breastfeeding in all clinics
- Work with local agency WIC Coordinator and WIC staff to provide a baby friendly/breastfeeding friendly clinic environment for all WIC participants
- Participate in and conduct or coordinate ongoing training for WIC staff on breastfeeding promotion and support issues and information
- Collaborate and interact with the local breastfeeding coalition/promotion council
- Conduct and/or coordinate World Breastfeeding Week activities annually
- Monitor breastfeeding classes, counseling, and charting

REFERENCE

7 CFR 246.11 (c)(7)(ii) State Agency Responsibilities

PEER COUNSELORS

POLICY

Local agencies may employ breastfeeding Peer Counselors to assist in breastfeeding promotion and support efforts using the Best Practice Guidelines set forth by the USDA/FNS model, Using Loving Support for Peer Counseling Programs, and the Idaho Implementation Plan for Breastfeeding Peer Counseling.

DEFINITION OF BREASTFEEDING PEER COUNSELOR

A breastfeeding Peer Counselor for WIC is a woman who, at a minimum:

- Is familiar with WIC
- Current or previous WIC participant preferred
- Has similarities with WIC participants served

- Has successfully breastfed at least one child (at least 6 months)
- Can communicate effectively
- Is enthusiastic about breastfeeding
- Can document and keep accurate records

Job descriptions and duties are detailed in the Idaho Implementation Plan for Breastfeeding Peer Counseling, pages 10-12.

PROCEDURE

Breastfeeding Peer Counselors will be recruited, trained, and employed under the direction of the local agency Breastfeeding Coordinator.

Breastfeeding Peer Counselors must be recruited and trained in accordance with the Idaho Implementation Plan for Breastfeeding Peer Counseling.

REFERENCE

7 CFR 246.11(c)(2) State Agency Responsibilities

PEER COUNSELOR TRAINING

POLICY

Local agency Breastfeeding Coordinators must assure that breastfeeding Peer Counselors are qualified, trained, and perform appropriate duties.

Local agencies who use Peer Counselors must use guidelines established in the Idaho Implementation Plan for Breastfeeding Counseling.

All Peer Counselors must be fully trained using one of the approved training manuals listed or documentation of training from another state prior to unsupervised counseling.

- USDA/FNS Loving Support Peer Counseling Training Manual
- California WIC Breastfeeding Peer Counselor Training Manual
- Texas WIC Breastfeeding Peer Counselor Training Manual

All Peer Counselors must also observe an experienced Peer Counselor or Breastfeeding Coordinator for a minimum of five telephone calls, one breastfeeding class, and one face-to-face visit prior to providing services.

All training must be documented and kept in a training log by the local agency Breastfeeding Coordinator.

REFERENCE

7 CFR 246.11(c)(2) Nutrition Education
State Policy

SECTION B: BREASTFEEDING EQUIPMENT AND INVENTORY

OVERVIEW

The Idaho WIC Program promotes breastfeeding as the normal way to feed infants. Breastfeeding support is provided primarily through education, referral, and follow-up support. Most women can establish and maintain lactation without the aid of equipment. Careful consideration should be taken when issuing breastfeeding equipment that it does not impede a mother's confidence in her ability to breastfeed. Breastfeeding management problems should always be addressed prior to issuing any equipment. Breastfeeding equipment can be helpful in establishing and/or maintaining successful lactation. In such circumstances, equipment may be provided in addition to education and support when determined necessary by an authorized staff member.

IN THIS SECTION

Guidelines for Issuance
- Breast Shells
- Manual Pumps
- SNS
- Single User Electric Pumps
- Hospital Grade Rental Pump
- Hospital Grade Rental Pump Issued in Hospital

Ordering and Inventory Procedure

GUIDELINES FOR ISSUANCE - BREAST SHELLS

BACKGROUND

Often, hormonal changes in pregnancy and childbirth cause nipples to protrude naturally. Breastfeeding experts are not in agreement that breast shells should be used for flat or inverted nipples.

ELIGIBILITY CRITERIA

A person must be an active WIC participant prior to receiving any breastfeeding equipment. Before issuing breast shells, the following should be considered:

- It is recommended that breast shells be issued in the postpartum period if there is difficulty with latch due to flat or inverted nipples. Studies have found that women given breast shells during pregnancy were less successful at breastfeeding.
- If a mother reports sore nipples, she should be referred immediately to the Breastfeeding Coordinator or healthcare provider for further assessment. Once the cause of sore nipples has been addressed, shells can be issued to protect a mother's nipples from her bra or clothing. Caution: Overuse of breast shells can contribute to plugged ducts and nipple soreness.
- Other needs as determined by the local agency Breastfeeding Coordinator or Lactation Consultant.

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or a trained RD is preferred. If the above staff members are unavailable, a Clinical Assistant or Peer Counselor who has had advanced training in issuance of this equipment that is documented in the Breastfeeding Training Log may also provide equipment.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow up and referrals as necessary
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. She should not sell or give issued equipment away due to health concerns.

GUIDELINES FOR ISSUANCE - MANUAL BREAST PUMP

BACKGROUND

The WIC Program provides pumps that meet quality standards for the most effective pumping session.

ELIGIBILITY CRITERIA

A person must be an active Idaho WIC participant prior to receiving any breastfeeding equipment.

One or more of the following may be reason for issuing a two-handed manual pump:

- Short term use or infrequent need to pump
- Part time work or school
- Breastfeeding management problem that does not require an electric pump

One or more of the following may be reason for issuing a one-handed manual pump

- Carpal Tunnel Syndrome or other condition that might make it difficult to use a two-handed pump
- Part time work or school that does not qualify participant for a single user double electric pump

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or a trained RD is preferred. If the above staff members are unavailable, a Clinical Assistant or Peer Counselor who has had advanced training in issuance of this equipment documented in the Breastfeeding Training Log may also provide equipment.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly

- Care plan for follow-up and referrals as necessary
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. Due to health concerns, she should not sell or give issued equipment away.

GUIDELINES FOR ISSUANCE - SNS AND DISPOSABLE SNS (INFANT FEEDING TUBE DEVICE)

BACKGROUND

An SNS should not be recommended casually for short term use. Other options should be considered prior to mentioning the SNS because of the dedication it takes.

ELIGIBILITY CRITERIA

A person must be an active Idaho WIC participant prior to receiving any breastfeeding equipment.

One or more of the following may be a reason for issuing a disposable SNS:

- Helping baby transition from another feeding method
- Inducing lactation/relactation
- Providing extra supplement
- Other reasons as determined by local agency Breastfeeding Coordinator

For longer term use, one or more of the following may be a reason for issuing a non-disposable SNS:

- Prematurity
- Down's Syndrome
- Cardiac problems
- Cleft palate
- Failure to thrive
- Neurological impairment
- Weak suck

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or trained RD. Referral and follow-up through IBCLC and MD are necessary.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (DVD, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow-up and referral to IBCLC and MD
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. Due to health concerns, she should not sell or give issued equipment away.

GUIDELINES FOR ISSUANCE - SINGLE USER DOUBLE ELECTRIC BREAST PUMP

BACKGROUND

The WIC Program provides pumps that meet quality standards for the most effective pumping session.

ELIGIBILITY CRITERIA

A person must be an active Idaho WIC participant prior to receiving any breastfeeding equipment. To receive a single user double electric breast pump, all of the following must apply:

- Participant exclusively breastfeeding
- Baby at least 4 weeks old
- Does not meet criteria for hospital rental pump
- No current breastfeeding problems
- Meets criteria for work/school hours set by State Breastfeeding Workgroup
- Pump will assist in maintaining well-established milk supply
- Participant plans to exclusively breastfeed for 4-6 months

AUTHORIZED STAFF

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or a trained RD is preferred. If the above staff members are unavailable, a Clinical Assistant or Peer Counselor who has had advanced training in issuance of this equipment documented in the Breastfeeding Training Log may also provide equipment.

REQUIRED DOCUMENTATION

- Determination of need (why equipment was given)
- Equipment given and accompanying materials (video, handout)
- Instruction provided with demonstration of assembly
- Care plan for follow up and referrals as necessary
- Information on who to contact with question/concerns
- Document on local agency Quarterly Distribution Record

If a participant chooses to discontinue use of equipment issued, she may save it for later use or dispose of it as she sees fit. Due to health concerns, she should not sell or give issued equipment away.

If formula is requested after pump is issued, follow guidelines in the table in Chapter 6, Section A.

GUIDELINES FOR ISSUANCE - HOSPITAL GRADE ELECTRIC RENTAL PUMP

BACKGROUND

Most pumps will only be approved for a one- to two-month period based on prescription and need. If the prescription has no time period specified, it is assumed to be valid for one month. If the prescription has a time period greater than two months, the local agency Breastfeeding Coordinator must provide follow-up after two months to reassess the need for the pump.

Eligibility Criteria

A person must be an active Idaho WIC participant prior to receiving any breastfeeding equipment. To be eligible for a hospital grade electric rental pump, one of the following must apply:

- High-risk breastfeeding women and infants establishing or maintaining lactation
- Prematurity
- Medical condition that affects ability to suck
- Mother-infant separation for more than 24 hours due to medical condition
- Weight loss greater than 7% of birth weight in first 72 hours of life
- Severe engorgement or soreness
- Other reasons as deemed appropriate by MD, IBCLC, or local agency Breastfeeding Coordinator

Authorized Staff

Local agency Breastfeeding Coordinator, local agency Lactation Consultant, or trained RD. Referral and follow-up through IBCLC and MD are necessary.

Required Documentation

- Prescription
- Request For Nutritional Supplies: Electric Breast Pump Rental and Attachment Kit form must be completed and faxed or mailed to the State agency and breast pump vendor
- Participant must sign “WIC Participant Responsibilities” section of RFNS form if they are present or at their next appointment.
- Instruction provided on collecting and storing breast milk
- Care plan for follow-up and referrals as necessary
- Information on who to contact with questions/concerns

Idaho Medicaid

For active Idaho Medicaid participants, breast pumps may be covered as durable medical equipment. Please refer to the most current Idaho Medicaid Provider Handbook at www.healthandwelfare.idaho.gov.

Guidelines for Issuance - Hospital Grade Electric Rental Pump Issued in Hospital to WIC Participant

Background

If a WIC participant or her infant is in the hospital due to a medical condition, a pump may be issued by the hospital staff using the following procedure. The local agency WIC clinic that provides services to the WIC participant must be notified within 48 hours of the pump issuance.

Eligibility Criteria

A person must be an active Idaho WIC participant prior to receiving any breastfeeding equipment. To be eligible for a hospital grade electric rental pump, one of the following must apply:

- High-risk breastfeeding women and infants establishing or maintaining lactation
- Prematurity
- Medical condition that affects ability to suck
- Mother-infant separation for more than 24 hours due to medical condition

- Weight loss greater than 7% of birth weight in first 72 hours of life
- Severe engorgement or soreness
- Other reasons as deemed appropriate by Local WIC Agency Breastfeeding Coordinator.

AUTHORIZED STAFF

Trained hospital staff—RN, IBCLC, RD, or MD—are authorized to issue an electric pump using this procedure.

REQUIRED DOCUMENTATION

- Prescription
- Hospital Form for WIC
- Medical Supply Vendor Breast Pump Referral Form

PROCEDURE

- Fax required documentation above to medical supply vendor and corresponding Local WIC Agency within 48 hours of issuing breast pump
- Instruction provided on collecting and storing breast milk
- Care plan for follow-up and referrals as necessary
- Information on who to contact with questions/concerns

IDAHO MEDICAID

For active Idaho Medicaid participants, breast pumps may be covered as durable medical equipment. Please refer to the most current Idaho Medicaid Provider Handbook at www.healthandwelfare.idaho.gov.

ORDERING AND INVENTORY PROCEDURE

Staff responsible for inventory should not be the same staff involved in the ordering or issuance of equipment. It is the expectation of the State agency that all equipment is accounted for with each quarterly inventory report. Inventory should be issued using first-in, first-out method so that the oldest inventory is issued before newly-ordered inventory.

If procedures are found to be unsatisfactory (e.g., excessive amounts of equipment stored, not completing or submitting quarterly reports, not following above procedures for issuance of specific equipment), a corrective action plan will be implemented with the local agency Breastfeeding Coordinator, local agency WIC Coordinator, State agency Breastfeeding Coordinator, and State agency WIC Manager. The State agency reserves the right to discontinue payment for breastfeeding equipment from a local agency that is practicing unsatisfactory ordering and inventory procedures and does not adhere to corrective action plan measures.

Quarterly Reports
Submit with local agency Coordinator's Quarterly Report. Also submit the Quarterly Distribution Record (lists which participants received what equipment) with your quarterly report.

WSCA Breastfeeding Equipment Order Form
Each agency should order on an as needed basis via phone, fax, or e-mail from the WSCA contract. The equipment that can be ordered on this form includes flanges, manual pumps, electric breast pumps, and limited accessories. It is recommended that you request an order confirmation.

Please review these forms with staff who may assist in completing inventory and ordering. Also, please review the WSCA contract for further details.

CHAPTER 7: FOOD DELIVERY

OVERVIEW

This chapter describes the different types of supplemental food packages available for issuing to participants. Supplemental Foods are defined as *those foods containing nutrients determined by nutritional research to be lacking in the diets of pregnant, breastfeeding, and postpartum women, infants, and children*, as found in the Child Nutrition and WIC Reauthorization Act of 2004.

IN THIS CHAPTER

Section A Food Packages

Section B Infant Formulas and Nutritionals

Section C Issuing Food Checks/CVVs

SECTION A: FOOD PACKAGES

OVERVIEW

The Idaho WIC Program authorizes food packages based on federal requirements and the nutritional needs of the participant. Multiple food packages are available for each participant category.

IN THIS SECTION

Approved Foods
Breastfeeding Food Packages
Common Food Packages for Participants by Category
Food Packages Requiring Medical Documentation
Homeless Food Packages

APPROVED FOODS

DEFINITION

WIC participants are pregnant women, postpartum women, infants and children, the breastfed infants of participant breastfeeding women, and breastfeeding women who are receiving supplemental foods or food instruments. In addition, breastfeeding women of infants who are greater than 6 months of age and receiving greater than the authorized amount of supplemental formula do not receive a food package, but are still eligible to receive nutrition education, breastfeeding promotion and support, and breastfeeding equipment and referrals.

POLICY

Criteria for approving products for inclusion in the Idaho WIC Authorized Food List are based on federal regulations, State agency requirements, cost, nutritional value, and cultural/participant acceptability.

The Idaho WIC Program Food Selection Committee determines all aspects of the Idaho Authorized Food List per the Food Authorization Procedure and based on the criteria found in this policy.

Food packages are available by category of participant with the federal maximum quantity allowed. However, an individual participant may be issued a tailored food package based on further nutrition assessment and nutrition risk.

- WIC food products shall meet all federal requirements governing the WIC food package to be considered for approval through the Idaho WIC Program.
- WIC food products shall be widely available throughout the state.
- WIC food products shall have been available in retail stores in Idaho for six months prior to request for approval.
- In addition to the criteria specified in this policy, the Idaho WIC Food Selection Committee reserves the right to restrict the number of brands and types of products in order to contain costs and/or minimize confusion on the part of participants and vendors.
- Idaho WIC also reserves the right to disallow food category substitutions offered to participants in order to contain costs following the criteria in FNS Instruction 804-1 WIC Program – Food Package Design: Administrative Adjustments and Nutrition Tailoring.

- WIC food product composition and marketing approach must be consistent with the promotion of good nutrition and education.

MILK

Milk and milk alternatives conforming to the standards as stated in this section are authorized for children and women.

Cow's Milk

Federal Standards

- Must conform to FDA standard of identity for whole, reduced fat, lowfat, or nonfat milks.
- Must be pasteurized and contain at least 400 IU of vitamin D per quart (100 IU per cup) and 2000 IU of vitamin A per quart (500 IU per cup) following FDA fortification standards.
- May be flavored or unflavored, fluid, shelf stable, or evaporated.
- Cultured milks (buttermilk. acidophilus) must conform to FDA standard of identity for cultured milk.
- The substitution rate for evaporated milk is 16 fluid ounces of evaporated milk per 32 ounces of fluid milk or a 1:2 fluid ounce substitution ratio.
- The substitution rate for dry milk is 1 pound of nonfat or lowfat milk per 5 quarts of fluid whole milk or 1 pound of dry whole milk per 3 quarts of fluid whole milk.
- Whole milk is the only type of milk authorized for 1 year old children (12 through 23 months).
- Only milk with 2% milk fat or less is authorized for children 2 years of age and older, and for women (pregnant, postpartum, and breastfeeding).

State Standards

- All fluid milk products (fat free skim or non-fat milk, low fat ½% and 1%, reduced fat, and whole) must be purchased in half-gallon or gallon size containers unless otherwise stated on the WIC voucher.
- Non-fat dry powdered, canned evaporated, acidophilus and lactose free milk is authorized, but must be specified on the WIC voucher.
- RD approval and documentation is required prior to issuing acidophilus, lactose reduced, or lactose free.
- Organic, flavored, sweetened condensed, and UHT milk are not allowed.
- Flavored or sweetened cow's milk are not allowed

Goat's Milk

Federal Standards

- Must conform to FDA standard of identity for whole, reduced fat, lowfat, or non-fat milks.
- Must be pasteurized and contain at least 400 IU of vitamin D per quart (100 IU per cup) and 2000 IU of vitamin A per quart (500 IU per cup), following FDA fortification standards.
- May be flavored or unflavored. May be fluid, shelf stable, or evaporated.

State Standards

- Goat's milk must be specified on the WIC voucher.
- Powdered goat's milk is not allowed.
- RD approval and documentation is required prior to issuing goat's milk.

Soy-based Beverage

Federal Standards

- Must be fortified to meet the following nutrient levels: 276 mg calcium per cup, 8 g protein per cup, 500 IU vitamin A per cup, 100 IU vitamin D per cup, 24 mg magnesium per cup, 222 mg phosphorus per cup, 349 mg potassium per cup, 0.44 mg riboflavin per cup, and 1.1 mcg vitamin B12 per cup, in accordance with fortification guidelines issued by FDA.

- Medical documentation is required prior to issuing soy-based beverage to a child. The qualifying conditions include, but are not limited to, milk allergy, severe lactose maldigestion, and vegan diets. Refer to Food Packages Requiring Medical Documentation section of this chapter.
- Only types and brands of soy-based beverage that appear on food voucher are authorized.
- Soy-based beverage must be specified on the WIC voucher.
- Soy-based beverage is not currently allowed for women.

State Standards

- Only types and brands of soy-based beverages that appear on food voucher are authorized.
- Soy-based beverage must be specified on the WIC voucher.
- Soy-based beverage is not currently allowed for women.

CHEESE

Federal Standards

- Domestic cheese made from 100% pasteurized cow's milk
- Must conform to FDA standard of identity
- Monterey Jack, Colby, natural Cheddar, Swiss, Brick, Muenster, Provolone, part-skim or whole Mozzarella, pasteurized processed American, or blends of any of these cheese are WIC-eligible. Cheeses that are labeled low, free, reduced, less or light in the nutrients of sodium, fat, or cholesterol are WIC-eligible.
- Cheese may be substituted at the rate of one pound per three quarts of milk. No more than one pound of cheese may be substituted for milk for all categories except for fully breastfeeding women who may have up to two pounds of cheese substituted for milk.
- With medical documentation (e.g. allergy, extreme lactose intolerance) cheese may be substituted for milk up to the maximum amount.
- Cream cheese, cottage cheese, Velveeta™, cheese food, spreads, or cheese products are not allowed.

State Standards

- Only types of cheese that appear on the current Idaho Authorized Food List are authorized.
- Only one pound of cheese, maximum, is allowed for children, pregnant women and postpartum women. Fully breastfeeding women can receive a maximum of two pounds of cheese.
- Natural, regular, or lowfat block cheese, unsliced, vacuum-packed in 16 ounce (one pound) package is approved unless otherwise printed on the check. Only 16 ounce multi-stick bag of mozzarella string cheese is authorized.
- Shredded, grated, cubed, organic, extra sharp or white cheddar, flavored, added ingredients, or cheese purchased at the deli are not allowed.

TOFU

Federal Standards

- Calcium-set tofu prepared with only calcium salts (e.g. calcium sulfate). May not contain added fats, sugars, oils, or sodium.
- Calcium-set tofu may be substituted for milk at the rate of one pound of tofu per one quart of milk.
- No more than four pounds of tofu may be substituted for milk for all categories except for fully breastfeeding women, who may have up to six pounds of tofu substituted for milk.
- Medical documentation is required for tofu to be substituted for milk for children.
- With medical documentation (e.g. allergy, extreme lactose intolerance), tofu may be substituted for milk up to the maximum amount.

State Standard

- Tofu is not currently an allowed Idaho WIC food.

EGGS

Federal Standards

- Must conform to standard of identity
- Fresh shell domestic hens' eggs or died eggs mix or pasteurized liquid whole eggs

State Standards

- One-dozen carton, any size except extra-large or jumbo white eggs are authorized
- Specialty eggs or nutrient enhanced (omega 3/vitamin E), Eggland's Best™, Nature's Nest™, egg substitutes, brown, organic, or dried egg mix are not allowed.

BREAKFAST CEREAL

Federal Standards

- Hot or cold cereal that contains a minimum of 28 milligrams of iron per 100 grams of dry cereal and not more than 21.2 grams of sucrose and other sugars per 100 grams of dry cereal (6 grams per ounce) is authorized.
- At least half of the cereals authorized must have whole grain as the primary ingredient by weight and meet labeling requirements for making a health claim as a "whole grain food with moderate fat content."
- Infant cereal may be substituted for adult cereal at a rate of 32 dry ounces of infant cereal to 36 dry ounces of adult cereal. A medical prescription showing the need for increased iron, finer texture for swallowing, or other reason must be documented.

State Standards

- Only brands and types of cereal that appear on the current Idaho Authorized Food List are authorized.
- WIC reserves the right to determine the number and brands of cereal which include at least one hot cereal and at least one cereal from each grain group. Grain groups are defined as corn, wheat, oat, rice, or multi-grain.
- Cereals that contain greater than or equal to 200 micrograms or 50% Recommended Dietary Intake (RDI) of folic acid, greater than or equal to 2 grams of fiber per serving, contain no partially-hydrogenated fat/trans fat, contain less than 325 milligrams per dry ounce of sodium, contain no artificial dyes or sweeteners, and are made from whole grains will be given preference for their higher nutritional standards.
- Culturally acceptable cereals, cereals targeting specific ethnic groups, or cereals more suitable for children shall be considered.
- The minimum package size authorized is 11.8 ounces for hot and 12 ounces for cold.

WHOLE GRAINS

Federal Standards

- Whole grain must be the primary ingredient by weight in all whole grain bread products.
- Whole wheat bread must conform to FDA standard of identity.
- Whole wheat must be the primary ingredient by weight in all whole wheat bread products.
- Whole grain bread must meet labeling requirements for making a health claim as a "whole grain food with moderate fat content."
- Brown rice, bulgur (cracked wheat), oatmeal, and whole-grain barley without added sugars, fats, oils, or salt (sodium). May be instant, quick, or regular cooking.
- Soft corn or whole wheat tortillas are authorized.

State Standards

- Only brands and types of whole grains that appear on the current Idaho Authorized Food List are authorized.

- Any brand of 100% whole wheat bread in 16oz (1 pound) loaf that meets federal nutrition requirements will be allowable on the Idaho Authorized Food List. Bread must state “100% whole wheat” on the label and whole wheat must be the first ingredient on the ingredient’s list.
- Bulgur (cracked wheat) and whole-grain barley are not currently allowed. Oatmeal is not allowed as a whole grain substitute.

JUICE

Federal Standards

- Must conform to FDA standard of identity for fruit juice and vegetable juice.
- Must be pasteurized 100% unsweetened juice.
- Must contain a minimum of 30 milligrams of vitamin C per 100 milliliters of single strength or reconstituted concentrate.
- Juice may be fresh, from concentrate, frozen, canned or shelf-stable.
- Vegetable juice may be regular or lower in sodium.
- Juice is not authorized for infants.

State Standards

- Only brands and types of juice that appear on the current Idaho Authorized Food List are authorized.
- Any brand of 100% orange juice in allotted container sizes is authorized.
- Calcium/vitamin D fortified orange juice is authorized to accommodate participants whose diets may be low in these nutrients as a result of a complete nutrition assessment, which is conducted at the certification appointment.
- Juice is authorized in 64 ounce plastic containers or 11.5-12 ounce frozen cans.
- Country style (extra pulp), pulp free, or reduced/low acid orange juice is authorized.
- Blended juices, juice cocktails, or artificially sweetened juices are not allowed to decrease participant and vendor confusion.

FRUITS AND VEGETABLES

Federal Standards

- Any variety of fresh whole or cut fruit without added sugars
- Any variety of fresh whole or cut vegetable, except white potatoes, without added sugars, fats, or oils (orange yams and sweet potatoes are allowed)
- Any variety of canned fruits that conform to standard of identity including applesauce, juice pack or water pack without added sugars, fats, oils, or salt
- Any variety of frozen fruits without added sugars.
- Any variety of canned or frozen vegetables that conform to FDA standard of identity, except white potatoes, without added sugars, fats, or oils. May be regular or lower in sodium.
- Any type of dried fruits or dried vegetables without added sugars, fats, oils, or salt (sodium).
- Herbs or spices; edible blossoms and flowers, e.g., squash blossoms (broccoli, cauliflower, and artichokes are allowed) are not authorized.
- Creamed or sauced vegetables; vegetable-grain (pasta or rice) mixtures; fruit-nut mixtures; breaded vegetables; fruits and vegetables for purchase on salad bars; peanuts; ornamental and decorative fruits and vegetables (painted pumpkins, garlic on a string); fruit baskets and party vegetable trays; and baked items (blueberry muffins) are not authorized.

State Standards

- Only physical forms listed on current Idaho Authorized Food List are authorized.
- Organic fruits and vegetables are authorized for purchased with Cash Value Vouchers, since there is already a set price limit on these vouchers.
- Participants may pay the difference if the total purchase price for the Cash Value Voucher goes over the amount specified on the CVV.

MATURE LEGUMES

Federal Standards

- Any type of mature dry beans and peas, including but not limited to plain lentils, black, black-eyed peas, garbanzo, great northern, kidney, lima, navy, pinto, soy, and split peas are authorized.
- All categories exclude soups.
- Immature varieties such as green peas, green beans, snap beans, orange beans, and wax beans are not authorized.
- May not contain added sugars, fats, oils or meat as purchased.
- May be dry or canned.
- Canned legumes may be regular or lower in sodium.
- Canned legumes may be substituted for dried legumes at the rate of 64 ounces of canned beans for one pound dried beans.
- Baked beans without any added meat may be provided for participants with limited cooking facilities.

State Standards

- Only brands and types of beans that appear on the current Idaho Authorized Food List are authorized.
- Only one pound (16 ounce) package or bulk dry beans is authorized.
- Frozen, fresh, soup mix, barley, rice, or flavored beans or peas are not allowed because they do not meet federal standards.

PEANUT BUTTER

Federal Standards

- Must conform to FDA standard of identity for peanut butter or reduced fat peanut butter.
- Creamy, chunky, regular or reduced fat, salted or unsalted forms are authorized.

State Standards

- Any commercially prepared brands of peanut butter, including creamy, crunchy, and extra crunchy are authorized.
- Peanut butter may be substituted for dry beans at a rate of 18 ounces of peanut butter for one pound dry beans.
- Only 16 to 18 ounce containers are authorized.
- Peanut butter is not provided for children less than 2 years of age because of the risk of choking.
- Peanut butter blends, peanut spreads, and added jelly or candy are not allowed because they do not meet federal standards.
- Fortified, low sodium, gourmet, reduced fat, added honey roasted, added honey, other added ingredients not listed, and low carbohydrate diet peanut butters are not allowed.

CANNED FISH

Federal Standards

- Light tuna and salmon must conform to FDA standard of identity.
- Sardines and mackerel are allowed.
- Albacore or white fancy tuna are not allowed due to the high mercury content.
- May be packed in water or oil. Pack may include bones or skin.
- May be regular or lower in sodium.

State Standards

- Any brand chunk light tuna or pink salmon packed in water or oil is authorized.
- Only 5 or 6 to 6⅛ ounce cans are authorized.
- Atlantic and wild Alaskan red salmon are not allowed.
- Low sodium, dietetic, smoked, and pouches are not allowed.

INFANT FOODS

Federal Standards

- Infant cereal must contain a minimum of 45 milligrams of iron per 100 grams of dry cereal.
- Infant fruits and/or vegetables: any variety of single ingredient commercial infant food without added sugars, starches, or salt (sodium). Texture may range from strained through diced.
- Combination of single ingredients fruit is authorized (e.g., apple and banana).
- Combination of single ingredients vegetable is authorized (e.g., peas and carrots).
- Fresh banana may replace up to 16 ounces of infant food fruit at a rate of one pound of bananas per eight ounces of infant food fruit.
- Infant meat (only for infants of fully breastfeeding women): any variety of commercial infant food meat or poultry, as a single major ingredient, with added broth or gravy. Added sugars or salt (sodium) are not allowed. Texture may range from pureed through diced.
- Infant food combinations with meat, pasta, cereal, dinners, or desserts are not allowed.

State Standards

- Only brand, varieties and sizes listed on Idaho Authorized Food List are authorized.
- Organic, added DHA/ARA, added specialty ingredients, or specialty infant foods are not allowed.
- Fresh bananas are not currently allowed.

REFERENCES

Public Law 108-265; WIC Reauthorization Act of 2004
7 CFR 246 FNS Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages; Interim Rule, December 6, 2007
ASM 99-105
ASM 99-112

BREASTFEEDING FOOD PACKAGES

OVERVIEW

The goal of the breastfeeding food package is to promote and encourage breastfeeding among participants by providing additional WIC foods that support the extra nutritional needs of these participants.

POLICY

Food Package 7 – Fully Breastfeeding
A breastfeeding woman whose infant does not receive any infant formula from the WIC Program, a woman who partially breastfeeds multiple (two or more) infants, or a pregnant woman carrying two or more fetuses will receive food package 7. The participant may remain as category B until she is one year postpartum or no longer eligible as a breastfeeding woman.

Breastfeeding Enhanced Multiples Food Package (7M)
A participant who is fully breastfeeding multiple infants (two or more) may receive 1.5 times the supplemental foods provided in this food package.

PROCEDURE

A fully breastfeeding participant can be issued a food package 7 for one, two, or three months. A fully breastfeeding participant of multiples (two or more) can be issued food package 7M for one, two or three months, depending on the local agency policy and procedure for multi-month check/CVV issuance and the nutritional risk assessment of the participant.

When to Change Category

A breastfeeding woman is issued food package 7 or 7M for more than one month. Later, she contacts the local agency requesting formula for her infant(s). Local agency staff should request that the participant bring in all remaining food package 7 or 7M checks before issuing formula checks. Local agency staff should void remaining checks/CVVs, complete a Check Audit form, and issue appropriate food packages. If the mother does not present with the requested checks/CVVs or has already redeemed the checks/CVVs for food package 7 or 7M, refer to the WIC Food Packages section of the training manual under the heading *Procedure for Breastfeeding Women Who Request Formula*.

Common Food Packages for Participants by Category

Policy

Food packages are available by category of participant. The food packages are designed to be consistent with the current Dietary Guidelines for Americans for the specified category and must meet the federal and state requirements. Refer to Section B of this chapter for more information about infant formulas.

NOTE: The maximum monthly amount of reconstituted liquid concentrate infant formula is the full nutrition benefit (FNB). If powder infant formula is provided, at the least, the number of reconstituted fluid ounces as the maximum allowance for the liquid concentrate form of the same product in the same food package up to the maximum monthly allowance for powder must be provided. Whole containers that are all the same size must be issued.

Food Package 1 – Infants birth through 5 months

Package Description	Age	Formula Amounts
Fully breastfed	A fully breastfed infant will not receive a food package until s/he reaches 6 months of age	
Partially breastfed	Birth through 1 month	Infant must be >1 month of age in order to receive a partial formula package
Partially breastfed	1 through 3 months	FNB is 364 fl oz reconstituted liquid concentrate per month; maximum of 435 fl oz reconstituted powder, 384 fl oz reconstituted RTF
Fully formula fed	Birth through 3 months	FNB is 806 fl oz reconstituted liquid concentrate per month; maximum of 870 fl oz reconstituted powder, 832 fl oz reconstituted RTF
Partially breastfed	4 through 5 months	FNB is 442 fl oz reconstituted liquid concentrate per

Package Description	Age	Formula Amounts
		month; maximum of 522 fl oz reconstituted powder, 448 fl oz reconstituted RTF
Fully formula fed	4 through 5 months	FNB is 884 fl oz reconstituted liquid concentrate per month; maximum of 960 fl oz reconstituted powder, 896 fl oz reconstituted RTF

Food Package 2 – Infants 6 through 11 months

Package Description	Food Amounts	Formula Amounts
Fully breastfed	Infant cereal – 24 oz Infant fruits/vegetables – 256 oz Infant food meat – 77.5 oz	
Partially breastfed	Infant cereal – 24 oz Infant fruits/vegetables – 128 oz	FNB is 312 fl oz reconstituted liquid concentrate per month; maximum of 384 fl oz reconstituted powder, 320 fl oz reconstituted RTF
Fully formula fed	Infant cereal – 24 oz Infant fruits/vegetables – 128 oz	FNB is 624 fl oz reconstituted liquid concentrate per month; maximum of 696 fl oz reconstituted powder, 640 fl oz reconstituted RTF

Food Package 3 – Participants with Qualifying Conditions

This food package is reserved for issuance to woman, infant, and child participants who have a documented qualifying condition that requires the use of a WIC formula (infant, exempt, or WIC-eligible nutritional) because the use of conventional food is precluded, restricted, or inadequate to address their special nutritional needs.

Participants with qualifying medical conditions will receive up to the same maximum monthly amount of supplemental foods unless medically contraindicated, as those same participant categories. Women and children may also receive up to 455 fluid ounces liquid concentrate WIC formula (infant, exempt, or WIC-eligible nutritional). Please refer to Section B of this chapter for further guidance.

Food Package 4 – Children 1 through 4 years

- Juice – 128 fluid ounces (two 64 ounce containers)
- Milk – 16 quarts (4 gallons)
- Breakfast cereal – 36 ounces

- Eggs – 1 dozen
- Fruits and vegetables - $8 Cash Value Voucher
- Whole wheat bread/whole grain – 2 pounds (32 ounces)
- Legumes (dry) – 1 pound or peanut butter – 18 ounces

Food Package 5 – Pregnant and Partially Breastfeeding Women

- Juice – 144 fluid ounces (three 12 ounce frozen concentrate containers)
- Milk – 22 quarts (5½ gallons)
- Breakfast cereal – 36 ounces
- Eggs – 1 dozen
- Fruits and vegetables - $10 Cash Value Voucher
- Legumes (dry) – 1 pound and peanut butter – 18 ounces

Food Package 6 – Postpartum Women

- Juice – 96 fluid ounces (two 12 ounce frozen concentrate containers)
- Milk – 16 quarts (4 gallons)
- Breakfast cereal – 36 ounces
- Eggs – 1 dozen
- Fruits and vegetables - $10 Cash Value Voucher
- Legumes (dry) – 1 pound or peanut butter – 18 ounces

Food Package 7 – Fully Breastfeeding or Pregnant with Multiples

- Juice – 144 fluid ounces (three 12 ounce frozen concentrate containers)
- Milk – 24 quarts (6 gallons)
- Breakfast cereal – 36 ounces
- Cheese –1 pound
- Eggs – 2 dozen
- Fruits and vegetables - $10 Cash Value Voucher
- Whole wheat bread/whole grain – 1 pound (16 ounces)
- Fish (canned) – 30 ounces
- Legumes (dry) – 1 pound and peanut butter – 18 ounces

Food Package 7M – Fully Breastfeeding Multiples (amounts to be averaged over two-month timeframe)

<u>Month 1</u>

- Juice – 216 fluid ounces (five 12 ounce frozen concentrate containers)
- Milk – 36 quarts (9 gallons)
- Breakfast cereal – 54 ounces
- Cheese – 2 pounds
- Eggs – 3 dozen
- Fruits and vegetables - $15 Cash Value Voucher
- Whole wheat bread/whole grain – 1.5 pounds (24 ounces)
- Fish (canned) – 45 ounces
- Legumes (dry) – 2 pounds and peanut butter – 36 ounces

<u>Month 2</u>

- Juice – 216 fluid ounces (four 12 ounce frozen concentrate containers)
- Milk – 36 quarts (9 gallons)
- Breakfast cereal – 54 ounces
- Cheese – 1 pound
- Eggs – 3 dozen
- Fruits and vegetables - $15 Cash Value Voucher
- Whole wheat bread/whole grain – 1.5 pounds (24 ounces)
- Fish (canned) – 45 ounces
- Legumes (dry) – 1 pound and peanut butter – 18 ounces

FOOD PACKAGES REQUIRING MEDICAL DOCUMENTATION

POLICY

The following supplemental foods will require a local agency registered dietitian to obtain medical documentation from a health care professional licensed to write medical prescriptions under State law using the Medical Documentation form. The health care professional must made a medical determination that the participant has a qualifying condition (refer to Section B of this chapter for further clarification).

- Any non-contract brand infant formula (refer to Section B of this chapter for further clarification)
- Any infant formula prescribed to a child or adult who receives Food Package 3
- Any exempt infant formula (refer to Section B of this chapter for further clarification)
- Any WIC-eligible nutritional (refer to Section B of this chapter for further clarification)
- Any authorized supplemental food issued to participants who receive Food Package 3
- Any authorized soy-based beverage or tofu issued to children who receive Food Package 4
- Any additional authorized tofu and cheese issued to women who receive Food Package 5 and 7 that exceeds the maximum substitution rate

HOMELESS FOOD PACKAGES

POLICY

Homeless food packages are specifically designed for participants who may not have access to a stove or refrigerator. The homeless food package may not be appropriate for all homeless participants. Tailoring should be based upon the family's individual needs. Often, a standard food package will work for a homeless family.

A participant must have a "Y" entered in the Homeless field of the Family Basic screen to receive a homeless food package. Homeless food package checks can be issued for one month.

OPTIONS

Adjustments have been made in the food packages to allow for different circumstances. The food packages generally contain six checks.

A variety of food package options is available for each category. They are on the Food Package screen of the Idaho WIC Computer System.

It may be necessary to contact a local vendor to determine if specific foods issued in the homeless food package are stocked by the vendor.

Food Package 1 – Infants birth through 5 months
Infants eligible to receive a homeless food package may receive 8 ounce bottles of ready-to-feed infant formula in place of standard powder, concentrate or 32 ounce (quart) ready-to-feed infant formula.

Food Package 2 – Infants 6 thought 11 months
Infants eligible to receive a homeless food package may receive the standard infant foods with the issuance of 8 ounce bottles of ready-to-feed infant formula.

- Fully breastfed (BF) – 24 ounces infant cereal, 256 ounces infant food fruits and vegetables, and 77.5 ounces infant food meat
- Partially breastfed (BF/FF) – 8 ounce bottles of ready-to-feed infant formula, 24 ounces infant cereal, 128 ounces infant food fruits and vegetables
- Fully formula fed (FF) – 8 ounce bottles of ready-to-feed infant formula, 24 ounces infant cereal, 128 ounces infant food fruits and vegetables

Food Package 3 – Participants with Qualifying Conditions
This food package is reserved for issuance to women, infants, and child participants who have a documented qualifying condition that requires the use of a WIC formula (infant, exempt, or WIC-eligible nutritional) because the use of conventional food is precluded, restricted, or inadequate to address their special nutritional needs.

Participants with qualifying medical conditions will receive up to the same maximum monthly amounts of supplemental foods unless medically contraindicated, as those same participant categories. Women and children may also receive up to 455 fluid ounces liquid concentrate WIC formula (infant, exempt, or WIC-eligible nutritionals). Please refer to Section B of this chapter for further guidance.

Food Package 4 – Children 1 through 4 years
- Juice – 128 fluid ounces (two 64 ounce containers or as requested individual juices 5.5-6 ounces as printed on check)
- Evaporated milk, dry powdered milk, or shelf stable soy beverage – 16 quarts (4 gallons)
- Eggs – 1 dozen*
- Fruits and vegetables - $8 Cash Value Voucher
- Whole wheat bread/whole grain – 2 pounds (32 ounces)
- Beans (canned) – 64 ounces or peanut butter – 18 ounces

Food Package 5 – Pregnant and Partially Breastfeeding Women
- Juice – 144 fluid ounces (three 12 ounce frozen concentrate containers or as requested individual juices 5.5-6 ounces as printed on check)
- Evaporated milk or dry powdered milk – 22 quarts (5½ gallons)
- Breakfast cereal – 36 ounces
- Eggs – 1 dozen*
- Fruits and vegetables - $10 Cash Value Voucher
- Whole wheat bread/whole grain – 1 pound (16 ounces)
- Beans (canned) – 64 ounces or peanut butter – 18 ounces

Food Package 6 – Postpartum Women
- Juice – 96 fluid ounces (two 12 ounce frozen concentrate containers or as requested individual juices 5.5-6 ounces as printed on check)
- Evaporated milk or dry powdered milk – 16 quarts (4 gallons)
- Breakfast cereal – 36 ounces
- Eggs – 1 dozen*
- Fruits and vegetables - $10 Cash Value Voucher
- Beans (canned) – 64 ounces or peanut butter – 18 ounces

Food Package 7 – Fully Breastfeeding or Pregnant with Multiples
- Juice – 144 fluid ounces (three 12 ounce frozen concentrate containers or as requested individual juices 5.5-6 ounces as printed on check)
- Evaporated milk or dry powdered milk – 24 quarts (6 gallons)
- Breakfast cereal – 36 ounces
- Cheese – 1 pound (16 ounces)
- Eggs – 2 dozen*
- Fruits and vegetables - $10 Cash Value Voucher
- Whole wheat bread/whole grain – 1 pound (16 ounces)
- Fish (canned) – 30 ounces
- Beans (canned) – 64 ounces or peanut butter – 18 ounces

Food Package 7M – Fully Breastfeeding Multiples (amounts to be averaged over two-month timeframe)

Month 1

- Juice – 216 fluid ounces (five 12 ounce frozen concentrate containers or as requested individual juices 5.5-6 ounces as printed on check)
- Evaporated milk or dry powdered milk – 36 quarts (9 gallons)
- Breakfast cereal – 54 ounces
- Cheese – 2 pounds (32 ounces)
- Eggs – 3 dozen*
- Fruits and vegetables - $15 Cash Value Voucher
- Whole wheat bread/whole grain – 1.5 pounds (24 ounces)
- Fish (canned) – 45 ounces
- Beans (canned) – 64 ounces and peanut butter – 36 ounces

Month 2

- Juice – 216 fluid ounces (five 12 ounce frozen concentrate containers or as requested individual juices 5.5-6 ounces as printed on check)
- Evaporated milk or dry powdered milk – 36 quarts (9 gallons)
- Breakfast cereal – 54 ounces
- Cheese – 1 pound (16 ounces)
- Eggs – 3 dozen*
- Fruits and vegetables - $15 Cash Value Voucher
- Whole wheat bread/whole grain – 1.5 pounds (24 ounces)
- Fish (canned) – 45 ounces
- Beans (canned) – 32 ounces and peanut butter – 18 ounces

* 1 dozen eggs can be substituted for 1 pound legumes or 18 ounces peanut butter or 64 ounces canned beans.

REFERENCE

7CFR Part 246: Revisions in the WIC Food Packages: Interim Rule

SECTION B: INFANT FORMULAS AND NUTRITIONALS

OVERVIEW

Breastfeeding provides a healthy and economical means of feeding an infant. The WIC Program strives to promote and support breastfeeding by providing food packages that encourage continued breastfeeding when mothers choose not to fully breastfeed.

Infant formula and nutritionals are the most expensive items in the WIC food package. In 1988, Congress mandated that all WIC state agencies implement some form of infant formula cost containment. In 1989, Congress added the requirement that states use competitive bidding in their cost containment efforts. The Idaho WIC Program is part of the Western States Contracting Alliance to contain the costs of infant formula. Once the contract is awarded, the contract brand iron-fortified formula is issued for the length of the contract. The money saved through infant formula rebate contracts is used to serve more participants.

IN THIS SECTION

General Policy and Definitions
Contract Brand Infant Formulas
Returned Infant Formula
Food Package 3: Participants with Qualifying Medical Conditions
Packaging

GENERAL POLICY AND DEFINITIONS

POLICY

Local agency staff shall issue infant formula and nutritionals according to the following guidelines set forth by the State agency:

- Infant formulas and WIC-eligible nutritionals are issued only to active participants.
- Infant formulas and WIC-eligible nutritionals may not be provided to participants while they are hospitalized.
- The Medicaid Program is the primary payor for exempt infant formulas and nutritionals needed by WIC participants who are also Medicaid beneficiaries. Please refer to the most current Idaho Medicaid Provider Handbook at www.healthandwelfare.idaho.gov.

DEFINITIONS

Contract brand infant formula is an iron-fortified milk-based, soy-based, lactose-free or added rice starch formula intended as a food substitute for human milk for healthy, term infants produced by the manufacturer awarded the infant formula cost containment contract. Contract formulas are routinely provided to infants enrolled in the WIC Program.

Non-contract infant formula is an iron-fortified milk-based, soy-based, lactose-free, or added rice starch formula that is nutritionally comparable to contract brand formula (noted above) and is not covered by an

infant formula cost containment contract. Such infant formulas are not provided by WIC and prescriptions or medical documentation for these formulas will not be accepted under any circumstances.

Exempt infant formula is intended as a food substitute for human milk for use by infants who have inborn errors of metabolism, prematurity, low birth weight, or who otherwise have an unusual medical or dietary condition.

WIC-eligible nutritional refers to certain enteral products that are specifically formulated to provide nutritional support for participants (women, infants, or children) with a diagnosed medical condition where conventional food is precluded, restricted, or inadequate. Such WIC-eligible nutritionals must serve calories and one or more nutrients; be designed for enteral digestion via oral or tube feeding; and may not be a conventional food, drug, flavoring, or enzyme.

For more information about procedures related to infant formulas and WIC-eligible nutritionals, refer to the Idaho WIC Program Paraprofessional Training Manual.

REFERENCES

Section 412 (h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350a(h))
WRO Policy Memo 804-Q: *Medicaid Primary Payor for Exempt Infant Formulas and Medical Foods*

CONTRACT BRAND INFANT FORMULAS

POLICY

Contract brand iron-fortified milk-based, and soy-based infant formulas will be issued to all infants unless there is medical documentation for an exempt formula or a WIC-eligible nutritional. Non-contract non-exempt infant formulas that are nutritionally equivalent to contract brand formulas or low-iron formulas will not be issued and prescriptions will not be accepted under any circumstances.

Contract brand iron-fortified infant formulas can be issued by competent professional authorities (CPAs). At this time, the contract formulas are:

- Similac Advance (cow's milk-based) – powder (small cans), liquid concentrate, RTF *
- Enfamil ProSobee (soy-based) – powder (small cans), liquid concentrate, RTF *

* RTF = ready-to-feed. See packaging policy in this section for guidance on issuing RTF.

RETURNED INFANT FORMULA

RECEIVING FORMULA FROM PARTICIPANTS

When receiving cans of formula from participants, all formula received must be checked to make sure it is sealed and has not been recalled or expired. Dispose of formula that has been recalled, opened, or is expired.

Contract brand formula received is provided only to participants for the purpose of challenging exempt infant formulas and WIC-eligible nutritionals with a contract formula.

Non-contract formula that is received shall be disposed of or donated to an organization that helps individuals in need. This will be done at the discretion of the local agency Coordinator.

Exempt infant formulas and WIC-eligible nutritionals will be returned to the medical supply company. If purchased from a retail grocer, they may be donated or disposed of at the discretion of the local agency Coordinator.

An inventory log is recommended to keep track of returned formula and its distribution or disposal.

Inappropriate Issuance

Returned formula cannot be provided when the issued food package does not last the entire month. It is important to help infant caregivers understand that WIC is a supplemental food program and may not provide enough formula for a full month for an older infant.

Returned formula must not be distributed after the expiration date stamped on the can.

Food Package 3: Participants with Qualifying Medical Conditions

Policy

The Medicaid Program is the primary payer for exempt infant formulas and nutritionals needed by WIC participants who are also Medicaid beneficiaries. Please refer to the most current Idaho Medicaid Provider Handbook at www.healthandwelfare.idaho.gov.

Exempt infant formulas and WIC-eligible nutritionals are issued to woman, infant, and child participants because the use of conventional foods is precluded, restricted, or inadequate to address their special nutritional needs. Participants eligible to receive exempt infant formulas and WIC-eligible nutritionals must have one or more qualifying conditions and have a completed Medical Documentation form prior to issuance.

All information on the Medical Documentation form must be completed by a physician or other licensed health care professional who is authorized to write medical prescriptions under Idaho state law to issue an exempt infant formula or WIC-eligible nutritional and, if tolerated, supplemental WIC foods. A local agency registered dietitian may complete the form via telephone. The Medical Documentation form is needed:

- To issue an exempt formula or a WIC-eligible nutritional
- When an infant turns 6 months of age
- Every 12 months for children or women
- Upon a change in amount or type of product or supplemental foods issued

The form is kept in the participant's chart.

The WIC Program is not required to provide exempt infant formulas and WIC-eligible nutritionals if the diagnosed medical condition does not warrant such product. Qualifying conditions include, but are not limited to:

- Premature birth
- Low birth weight
- Failure to thrive
- Inborn errors of metabolism and metabolic disorders
- Gastrointestinal disorder
- Malabsorption syndromes
- Immune system disorders
- Severe food allergies that require an elemental formula
- Life threatening disorders

- Diseases and medical conditions that impair ingestion, digestion, absorption, or the utilization of nutrients that could adversely affect the participant's nutrition status

Exempt infant formulas and WIC-eligible nutritionals **may not** be issued for the following:

- To any participant solely for the purpose of enhancing nutrient intake or managing body weight without an underlying qualifying condition
- Infants whose only condition is a diagnosed formula intolerance or food allergy to lactose, sucrose, milk protein or soy protein that does not require the use of an exempt infant formula
- A non-specific formula or food intolerance
- Women and children who have a food intolerance to lactose or milk protein that can be successfully managed with the use of one of the other WIC food packages

The following are not authorized for reimbursement by the WIC Program:

- Medicines or drugs
- Hyperalimentation feedings (nourishment administered through a vein)
- Enzymes
- Oral rehydration fluids or electrolyte solutions
- Flavoring agents
- Feeding utensils or devices (e.g., feeding tubes, bags, pumps) designed to administer a WIC-eligible formula

For a complete list of exempt infant formulas and WIC-eligible nutritionals, refer to "Formulas Provided by the Idaho WIC Program" in the WIC Formula Handbook.

Formulas or WIC-eligible nutritionals may be provided for oral or enteral tube (i.e. nasogastric tube or g-tube) consumption.

NOTE: Formulas or WIC-eligible nutritionals are not provided by WIC to participants while they are hospitalized.

REGISTERED DIETITIAN REVIEW

Review of all requests for WIC-eligible exempt formulas/nutritionals by a local agency registered dietitian must happen immediately upon receipt of the request. A review of the request must include some type of contact between the registered dietitian and Responsible Adult or caregiver. It is possible the registered dietitian may have to contact the health care provider for additional information. The local agency registered dietitian must document the recommendations given by the health care provider. The responsibility remains with the participant's health care provider for medical oversight and instructions. It is the responsibility of the local agency dietitian to ensure that only the amount of supplemental food prescribed by the participant's health care provider are issued in the participant's food package.

Participants receiving an exempt infant formula or a WIC-eligible nutritional must be seen be a local agency registered dietitian at least once during a certification period. Typically, high risk participants would be seen more frequently in clinic depending on their nutritional risk codes. Checks will be issued for one, two, or three months at the discretion of the local agency registered dietitian.

If an exempt infant formula or WIC-eligible nutritional is not available at a local vendor, a medical supply company may provide it. In these cases, the Responsible Adult will receive it at the local clinic. Exceptions allowing the product to be shipped directly to the participant's home must be approved by the local agency registered dietitian on a limited, case-by-case basis. Refer to Section C of this chapter for issuing a food package using a medical supply company.

Exempt formulas and WIC-eligible nutritionals can be issued by a CPA after a local agency registered dietitian has received a prescription and approved its use.

Challenge with Contract Brand Infant Formula

A challenge with an appropriate contract brand infant formula is made at the discretion of the local agency registered dietitian. The plan for and result of a formula challenge is documented in the participant's chart.

Quantities

Participants with qualifying medical conditions will receive up to the same maximum monthly amounts of supplemental foods, unless medically contraindicated, as those same participant categories. In lieu of infant foods (cereal, fruit and vegetables), infants greater than 6 months of age may receive exempt infant formulas or WIC-eligible nutritionals at the same maximum monthly allowance as instants ages 4 through 5 months of age of the same feeding option. Women and children may also receive up to 455 fluid ounces liquid concentrate WIC formula (infant, exempt, or WIC-eligible nutritional). Powder and ready-to-feed may be substituted at rates that provide comparable nutritive value.

Children over age 2 and women who are receiving WIC-eligible nutritionals and need additional calories may receive whole milk if necessary.

References

WRO Policy Memo 804-Q: *Medicaid Primary Payor for Exempt Infant Formulas and Medical Foods*
7 CFR 246.10 Supplemental Foods
7 CFR 246.16a Infant Formula Cost Containment

Packaging

Policy

The Responsible Adult may freely choose either powder or concentrate formula. Women who are partially breastfeeding infants are encouraged to choose powder formula.

Ready-to-feed (RTF) formula may only be authorized by the local agency registered dietitian for the following:

- unsafe water supply
- poor refrigeration
- the person caring for the infant has difficulty diluting concentrate or powder formula correctly
- the participant is homeless

The reason for issuance must be documented in the participant's chart.

If the water supply is deemed unsafe but the caretaker refuses to use RTF formula for personal reasons, a signed refusal statement should be obtained and kept in the participant’s chart.

Exception

A formula or nutritional which is available only in RTF form may be issued regardless of the above criteria.

Reference

7 CFR 246.10 Supplemental Food

SECTION C: ISSUING FOOD CHECKS/CVVS

OVERVIEW

IN THIS SECTION

Shopping for Authorized Foods
Check/CVV Security
Check/CVV Printing
Issuing Checks/CVVs
Check/CVV Register
Proxies
Mailing Checks/CVVs
Voiding Checks/CVVs
Unmatched Redemptions
Lost or Stolen Checks/CVVs
Direct Bill
Check/CVV Issuance
Check/CVV Issuance Parameter Guidance

SHOPPING FOR AUTHORIZED FOODS

AUTHORIZED STORES

WIC participants can only shop at Idaho authorized WIC stores.

FOOD DESCRIPTIONS

Food descriptions are printed on the check/CVV. An Idaho WIC Authorized Food List is given to the WIC participant, Responsible Adult, or Authorized Signer to identify foods/brands allowed.

PAYMENT FOR WIC FOODS

- Participants receive computer printed food checks/CVVs on a tri-monthly, bi-monthly, or monthly basis.
- WIC foods need to be separated in the shopping cart, not only from non-WIC foods, but also by check/CVV if two or more checks/CVV are being used at one time.
- When using a WIC check/CVV, the WIC participant needs to verify that the dollar amount on each check/CVV is for the purchase price of the food items listed on each check/CVV prior to signing the check/CVV.
- By signing the WIC check(s)/CVVs after the amount is written in the “Pay Exactly” box, the WIC participant is verifying that the amount on the check/CVV is correct.
- One of the signatures on the check/CVV must match the signature on the Identification (ID) Folder exactly.

CHECK/CVV SECURITY

POLICY

All checks/CVVs must be accounted for, including unused checks/CVVs (damaged or voided checks/CVVs). This is accomplished by entering information on the check/CVV register, data in the computer system, and/or special notes in the participant's file.

Voided checks/CVVs must be either shredded or destroyed so the participant's personal information is not identifiable.

NOTE: Do not leave preprinted checks/CVVs unattended. Preprinted computer checks/CVVs must be kept in a locked, controlled area.

CHECK/CVV PRINTING

ACCESS

Access to WIC checks/CVVs must be limited to the designated individuals on the Idaho WIC Identification (ID) Folder.

To the extent possible, different staff members should print and issue checks/CVVs. For example, one staff member would certify and print checks/CVVs for a participant. Another staff member would be responsible for issuing the checks/CVVs and having the WIC participant sign the check/CVV register.

PRINTERS

- Checks/CVVs are printed at the clinic upon demand.
- The check/CVV printers are laser printers that use a higher heat to bond the ink to the check/CVV paper. The ink cartridge is a special MICR ink used for bank processing. The alignment of the paper in the printer is important to ensure accurate banking data.
- It is important to monitor the check/CVV printer for ink smudges, faded ink, and accurate print positions on the check/CVV.
- Poorly printed checks/CVVs should not be issued.

PRINTING

Checks/CVVs should not be printed until they are ready to be given to the WIC participant. Remote clinics which receive their checks/CVVs from the central agency are an exception to this procedure.

PRINTING CHECKS/CVVS

Timeframe

- Checks/CVVs can be printed after the client is certified and one day after the "Last Day to Use" date.
- Checks/CVVs can be printed three days before a participant comes into the clinic, if the certification is current.
- For clinic prints, the checks/CVVs can be printed four days in advance.

ISSUING CHECKS/CVVS

POLICY

Identification (ID) Folder

A WIC ID Folder is issued to a WIC participant or Responsible Adult/caregiver at the initial certification appointment. Only one ID Folder may be issued on behalf of a participant. If a request is made for an additional ID Folder, the other person may act as a proxy between certification appointments providing the local agency has a signed note from the certifying participant or Responsible Adult/caregiver on file making such a request and specifying the length of the request. Additional information on issuing an ID Folder can be found in the Idaho WIC Paraprofessional Training Manual.

The following steps are taken when issuing a WIC check/CVV:

- Request the WIC participant's ID Folder.
- Verify identification by checking the WIC participant's Folder. If the ID Folder is forgotten, another form of identification can be used, such as photo identification. A visual identification is permissible if the individual is known to you. A new WIC ID Folder must be issued.
- Print the appropriate checks/CVVs for the participant.
- Review the checks/CVVs for accuracy of name, foods, and dates.
- Ask the WIC participant, Responsible Adult or Authorized Signer to examine the checks/CVV for the correct foods.
- Have the WIC participant, Responsible Adult or Authorized Signer sign the check register for each participant's series of checks/CVVs. The signature provides proof that the checks/CVVs were received by the WIC participant/ Responsible Adult or Authorized Signer. At the same time, verify the signature on the check register with the signature on the WIC ID Folder.
- Remind the WIC participant/Responsible Adult or Authorized Signer that checks/CVVs cannot be used before the "First Day to Use" date or after the "Last Day to Use" date.
- One of the signatures on the check/CVV must match the WIC ID Folder exactly.
- Write the next appointment date and time on the ID Folder. Notify the WIC participant of any return certifications or reasons a participant may no longer be eligible for program participation before the next appointment (e.g., child turning 5 years old).
- Remind the WIC participant/Responsible Adult or Authorized Signer to bring the WIC ID Folder with him/her each and every time they shop with the WIC checks/CVVs at the store. The store will refuse the use of WIC checks/CVVs without the WIC ID Folder.
- Remind the WIC participant/Responsible Adult to bring the WIC ID Folder to all appointments.

CHECK REGISTER

DESCRIPTION

The check register is an audit trail for printed checks/CVVs. It shows when checks/CVVs were given or mailed to a participant (date), for whom the checks/CVVs were issued (participant ID number), check/CVV numbers, and who received the checks/CVVs (Responsible Adult, proxy, or Authorized Signer's signature). The registers are pre-numbered with check/CVV numbers to make it easier to account for all checks/CVVs. The following procedures apply for filling out the check register.

DATE

The date only needs to be entered once per check register page or when the date changes from the original date written on the page. The new date must be written on the register.

- Each page of the check register must have a date.

- The date refers to when the checks/CVVs were issued to the participant, voided, or mailed. This is not the date the checks/CVVs were printed.

PARTICIPANT IDENTIFICATION (ID) NUMBER

The participant ID number only needs to be written once.

- Write the participant ID number next to the checks/CVV that were printed for that participant.
- Local agencies may use ditto marks or arrows down indicating that a group of checks/CVV belongs to the previously written participant ID number.

PARTICIPANT SIGNATURE

The participant, Responsible Adult, proxy, or Authorized Signer only needs to sign once on each page of the check register next to the appropriate group of checks/CVV that the client receives.

- If a client's checks/CVV cover two pages, the client needs to sign once on each page.
- Ditto marks, arrows, or other markers can be used to group checks/CVV together.
- Blank lines are not acceptable in the signature area on the check register.

MAILING CHECKS/CVVS

- Group the checks/CVVs mailed to each participant with some identifying mark (ditto marks, arrows).
- Since the participant, Responsible Adult, proxy, or Authorized Signer is not available to sign the register, the staff person responsible for mailing the check/CVVs needs to initial or sign his/her name (not the participant's) next to the group of checks/CVVs and indicate the date the checks/CVVs were mailed.

VOIDING CHECKS/CVVS

- Document that the checks/CVVs are voided.
- The person responsible for voiding the checks/CVVs needs to initial or sign his/her name (not the participant's name) next to the group of checks/CVVs. This shows who took responsibility for voiding the checks/CVVs.

CORRECTING THE WRONG SIGNATURE

- Draw one line through the mistake and have the participant, Responsible Adult, proxy or Authorized Signer sign in the correct place(s).
- Do not use correction fluid or obliterate the previous signature.

AUTHORIZED SIGNER

PURPOSE

To provide a Responsible Adult who is unable to come to the WIC clinic or shop for WIC foods an alternate procedure for obtaining and using WIC checks/CVVs.

DEFINITION

Responsible Adult: The Responsible Adult is usually the participant, parent, or caretaker who makes initial contact to apply for WIC services and attends the certification appointment to apply for WIC for

herself or for the children. It is acceptable for either parent to be the Responsible Adult for infant and child participants.

Generally, the Responsible Adult should be the parent or caretaker who will most often attend appointments on behalf of the infant or child participant.

POLICY

- A WIC Responsible Adult may designate an individual to act as an Authorized Signer at any time during a certification period. Physical presence is required by both parties. The Authorized Signer may act on behalf of the Responsible Adult when they are unable to attend a WIC appointment or redeem the WIC checks/CVVs at an Idaho WIC authorized vendor.
- The Responsible Adult may identify one Authorized Signer who can sign the WIC ID Folder. If an Authorized Signer is not named, the second signature line on the WIC ID Folder is voided with a black marker.
- The Authorized Signer will be instructed on the rules and regulations of the WIC Program, including how to use WIC checks/CVVs.
- The Authorized Signer should be over 18 years of age.
- The Authorized Signer can pick up WIC checks/CVVs and redeem them at an Idaho WIC authorized vendor.
- The Authorized Signer can attend nutrition education appointments when the Responsible Adult is unable. The Authorized Signer should be encouraged to share information with the Responsible Adult.
- All guidelines and policies that apply to a Responsible Adult/caregiver also apply to an Authorized Signer.

PROCEDURE

- The Authorized Signer must be present with the Responsible Adult.
- The Authorized Signer must provide identification.
- The Authorized Signer must read and sign the Rights, Responsibilities and Consent form. A new signature is required for each certification period an individual is an Authorized Signer.
- The Authorized Signer signs the WIC ID Folder.
- Instruct the participant or the Responsible Adult to notify WIC staff in writing when the Authorized Signer is no longer authorized to pick up and use the participant's WIC checks/CVVs. When the Authorized Signer is no longer authorized to receive and use WIC checks/CVVs, a new WIC ID Folder must be issued.
- If a WIC ID Folder that contains WIC checks/CVVs is lost or stolen, refer to Lost or Stolen Checks later in this Section for further guidance.

DOCUMENTATION

Obtain an authorized signature on the Rights, Responsibilities and Consent form for each certification period during which an individual is authorized.

Retain Responsible Adult's written notice of termination of Authorized Signer.

EXCEPTIONS

Exceptions regarding the minimum age and attendance at appointments are permitted on a case-by-case basis if approved by the local agency Coordinator or supervisor, or State staff if no one is available locally.

REFERENCES

7 CFR 246.2 Definitions
7 CFR 246.12 (r) Issuance of food instruments and authorized supplemental foods

PROXIES

DEFINITION

Proxy means any person designated by a woman participant, or by a parent or caretaker of an infant or child participant, to obtain and transact food instruments to obtain supplemental foods on behalf of the participant. Parents or caretakers applying on behalf of a participant are not proxies.

POLICY

To reduce barriers to participation, a Responsible Adult may designate someone to act on her/his behalf. The Responsible Adult may authorize a proxy for a specified amount of time, not to exceed the end of the certification period. If no length of time is specified, the proxy authorization is assumed to be for the current appointment only.

A proxy should attend nutrition education appointments. The proxy should be encouraged to share information with the Responsible Adult.

Due to the confidential information required for eligibility determination, allowing a proxy for certification appointments is discouraged.

The proxy should be over the age of 18 years.

PROCEDURE

- All guidelines and policies apply to a proxy the same as if she/he were the Responsible Adult/caregiver.
- The proxy must present written permission from the Responsible Adult at the time of the appointment unless prior written approval has been documented. If there is a question concerning a valid permission, staff should compare the Responsible Adult's signatures on the written permission and the participant's chart.
- The proxy must provide identification.
- The proxy must read and sign the Participant Rights, Responsibilities and Consent. A new signature is required for each certification period an individual is a proxy.
- Issue a WIC ID Folder to the proxy and provide instruction on the section entitled, "Shopping with WIC Checks/CVVs."
- Issue the participant(s) checks/CVVs to the proxy according to standard check/CVV issuance procedures.
- At a minimum, the proxy must be informed that she (or he) is responsible for adhering to all check/CVV-related procedures and failure to comply with check/CVV-related procedures will be considered program misuse and is subject to sanctions. Reference the WIC ID Folder for detailed information about shopping with WIC checks/CVVs and rights and responsibilities.

DOCUMENTATION

Retain the written permission note in the participant chart.

Obtain a proxy signature on the Participant Rights, Responsibilities and Consent form for each certification period during which an individual is a proxy.

Document instruction of the procedures in the participant's file, including a date and signature or initials of the staff person providing the instructions.

EXCEPTIONS

Exceptions regarding the minimum age and not allowing a proxy for certification appointments are permitted on a case-by-case basis if approved by the local agency Coordinator.

- Limit check/CVV issuance to one month.
- Require a signature on the Participant Rights, Responsibilities and Consent for each instance an individual is a proxy within a certification period (i.e., a repeat proxy who is the same person).

REFERENCES

7 CFR 246.2 Definitions
7 CFR 246.12 (r) (1-4) Issuance of food instruments and authorized supplemental foods
ASM 803-AI Strengthening Integrity in WIC Certification Process (3/10/99)

MAILING CHECKS/CVVS

GUIDELINES

Mailing WIC checks/CVVs is discouraged as it hinders the delivery of health and nutrition education services. However, some circumstances may require mailing of WIC checks/CVVs:

- Computer equipment breakdown or malfunction preventing check/CVV printing before the WIC participant leaves the clinic.
- Participants added in outlying clinics that do not have computers.
- Extenuating circumstances, such as:
  - Illness, medical reason
  - Difficulty in accessing the local agency (e.g., snowstorm, natural disaster, etc.)

LIMITATIONS

Mailing checks/CVVs is limited to one time during a certification period. If checks/CVVs need to be mailed more than one time per certification, approval by the local agency Coordinator, in consultation with the State WIC Office, is required. Most situations can be resolved by using an alternate (proxy) shopper.

MAILING PROCEDURE

- Checks/CVVs must be sent on or before the valid date printed on the check/CVV in an envelope sturdy enough to hold several checks/CVVs.
- Do not use window envelopes.
- Check/CVV security envelopes which prevent identification of checks/CVVs is required.
- The return address on the envelope must be sufficient to ensure the return of undeliverable mail without identifying the local agency or clinic as the sender (i.e., P.O. Box or street address only).
- "DO NOT FORWARD" must be printed on the envelope to ensure return of undeliverable mail.
- Enclose a letter with the checks/CVVs explaining steps the WIC participant is to follow upon receiving checks/CVVs in the mail:
- WIC participant must sign and return enclosed self-addressed, stamped postcard by return mail to acknowledge receipt of checks/CVVs. This postcard will be filed in the participants file for four (4) years for audit documentation.
- Document the reason for mailing checks/CVVs in the participant's file.

- Sign or initial and note the date checks were mailed on the appropriate line(s) in the check/CVV register.

Checks/CVVs Returned as Undeliverable

Checks/CVVs must be stamped "VOID" in the "Pay Exactly" box and coded as voided in the computer. Envelopes marked as undeliverable should be filed in the client's chart for future reference.

Voiding Checks/CVVs

Reasons

Checks/CVVs unusable due to the following reasons must be voided:

- already cashed
- computer problems
- damaged checks/CVVs (physically presented)
- destroyed checks/CVVs (natural disaster)
- domestic issue (per policy manual)
- food intolerance/already cashed
- food intolerance
- improper data
- lost check
- mailed checks not received
- moved to new area
- no show
- participant refused checks
- printer problem
- staff error
- state office approval
- stolen (per policy manual)
- stopped breastfeeding
- unused check/CVV
- over 90 days old

Procedure

- Stamp or write "VOID" on the face of the check/CVV in the "Pay Exactly" box and in the signature box before you enter the data in the computer. This will prevent a check/CVV that was voided from being cashed.
- Stamp or write the date and "VOID" in the corresponding check/CVV register signature area. Record the participant ID number on the register and put the reason the check/CVV was voided.
- Void the checks/CVVs in WISPr.
- Voided checks/CVVs should be properly destroyed.
- Preprinted checks/CVVs that are not claimed must be voided. Unclaimed checks/CVVs should be voided within one week of printing, but no later than the last day of the month.

Unmatched Redemptions

Definition

"Unmatched redemptions" refers to checks/CVVs that have been issued and cashed, but for which no computer records exist to match the checks/CVVs with the participants. These checks/CVVs are flagged for research to determine possible fraud.

JUSTIFICATION PROCEDURE

An “unmatched redemptions” report is researched monthly at the State level.

- If there are questions regarding the issuance of WIC checks/CVVs, an email is sent to the local agency WIC Coordinator.
- The local agency Coordinator is obligated to research the checks/CVVs to make sure the participant is a valid WIC participant and that no fraud was committed.
- A justification or clarification of the problem must be sent back to the State agency within 60 days of receipt of request to research. The justification must state what actions are being taken to prevent future incidents or to recover the money.

PREVENTION

To prevent unmatched redemptions:

- Do not give voided computer checks/CVVs to the participant.
- If a check/CVV must be voided for food intolerance, fill out a Check Audit form.
- Rarely will you void checks/CVVs in WISPr that you do not have in hand.
- Fill out a Check Audit form for participants who did not receive checks/CVVs in the mail and for whom more checks/CVVs are issued.

LOST OR STOLEN CHECKS/CVVS

POLICY

LARGE AMOUNTS FROM THE CLINIC

If a large amount of preprinted class/clinic checks/CVVs (30 or more) are lost or stolen from a clinic, contact your local WIC Coordinator immediately. Follow procedure as instructed by the Coordinator.

PROCEDURE

- The WIC Coordinator may notify the local police.
- Contact the State agency and give them the missing check/CVV numbers. They will research the computer system for the customer names, ID numbers, and store numbers on the checks/CVVs.
- Write the date, participant numbers, and your signature on the check/CVV register. Include a note of the circumstances that surround the checks/CVVs (i.e., lost or stolen).
- If the reported checks/CVVs were improperly redeemed, further steps will be taken by the State agency.

SMALL AMOUNTS FROM THE CLINIC

If a small amount of checks/CVVs (1-30) are missing from someone’s desk, call the State agency and report the missing check/CVV numbers. The State agency will research these checks/CVVs and notify the clinic if there are further questions.

LOST OR STOLEN CHECKS/CVVS IN THE MAIL

If checks/CVVs have been mailed to a WIC participant and the participant reports that they have not received the checks/CVVs:

Review your documentation to see when the checks/CVVs were mailed. Has there been enough time allowed for the checks/CVVs to be delivered to the participant? If so:

- Void and reissue checks/CVVs. Do not mail checks/CVVs again. The participant needs to come in to the clinic to pick them up. This differs from the policy of "not replacing lost or stolen checks/CVVs" because the participant never received the checks/CVVs.
- Fill out a Check Audit form and send it to your local agency WIC Coordinator.
- Instruct the participant that if he/she receives the old checks/CVVs in the mail, they need to destroy them or bring them back to the clinic. The checks/CVVs are no longer valid. If the participant redeems them, the participant will be responsible for reimbursing the State for the amount of the checks/CVVs.

LOST OR STOLEN FROM PARTICIPANT

WIC participants are responsible for their checks/CVVs once they have received them from the WIC clinic. Checks/CVVs that are lost, misplaced, destroyed, or stolen are not to be replaced unless one of the following situations has occurred:

Recognizable Criminal Act

- Defined as a loss with a minimum value of $500, not including the value of the WIC checks/CVVs (e.g., burglary or theft). A valid police report must verify claim of loss.

Major Catastrophe

- In case of a fire, the client needs to bring in some verification that there was a major fire: a Fire Investigation Report, a Fire Incident Report, or a newspaper clipping. If anyone on the WIC staff personally knows the circumstances of the fire, a verbal verification can be used to document the fire.
- Since the foods from previously redeemed checks/CVVs will probably be destroyed in a fire or flood, you may need to replace checks/CVVs that have already been redeemed. If the recipient's next appointment is one or two weeks away, you may not need to replace the full food package.
- Void the appropriate checks/CVVs and reissue them.
- Fill out a Check Audit form and send it to the State agency.
- Fill out the check/CVV register.
- Instruct the WIC participant that you are voiding the previous checks/CVVs. If she/he happens to find that the checks/CVVs were not destroyed, instruct the participant not to cash them to avoid having to reimburse the State for the amount of the checks/CVVs.

Replacing Infant Checks

If a Responsible Adult/Authorized Signer reports infant checks lost or stolen (with a police report) follow these steps:

- Alert the Responsible Adult/Authorized Signer that there is a three (3) business day waiting period to replace lost/stolen checks.
- Refer to local food assistance programs as needed.
- After the three (3) business day waiting period, designated staff will call the State agency to report lost/stolen checks and see if the current month's checks have cleared the bank.
- If checks reported lost/stolen have cleared the bank and the signature matches previous check redemption signatures on file, they will not be replaced.
- If checks have not cleared the bank, designated staff may replace each month of lost checks.
- Lost or stolen checks will only be replaced for the participant one time during the infant certification period.
- Designated staff must inform the Responsible Adult/Authorized Signer that he/she may be required to reimburse Idaho WIC either the dollar amount or quantity and type of items of a check if both a reportedly lost/stolen check and its replacement check are redeemed. The State agency will check bank files for each month checks have been replaced to see if both a reportedly lost/stolen check and its replacement check have cleared the bank and both checks' signatures

match previous check redemption signatures on file. Designated staff must complete a Check Audit form and document that checks were reissued.
- If upon further investigation the checks appear to have been stolen and redeemed, the State agency will follow up on a case-by-case basis with the local agency Coordinator.
- If a scenario occurs that is not covered above, the local agency Coordinator may consult with the State agency on a case-by-case basis to review circumstances.

Damaged or Mutilated Checks/CVVs

If a WIC participant, Responsible Adult, Proxy or Authorized Signer can produce the damaged, mutilated, or washed checks/CVVs, the WIC clinic personnel should replace damaged checks or CVVs.

There are situations where the State agency can approve checks/CVVs to be replaced. Special circumstances need to be reviewed case by case by the local agency Coordinator in consultation with the State agency.

Direct Bill

Policy

A Direct Bill is an alternative to issuing checks that is used in very limited circumstances when formula/nutritional cannot be purchased with WIC checks. The form replaces WIC checks and must be filled out completely by a local agency registered dietitian.

Limited Use

A Direct Bill is primarily used for exempt infant formula/WIC-eligible nutritional not readily available in a grocery store. It can only be used for one month at a time.

Vendor

The vendor must submit a legible copy of the Direct Bill with the original invoice to the State agency for payment.

Parameters

The amount (include number and size of cans) and specific formula/nutritional(s) must be itemized under the appropriate section of the form.

The vendor will only be paid for what is listed. See the Idaho WIC Program Paraprofessional Training Manual for specific procedures.

Reference

State policy

Check/CVV Issuance

Policy

WIC participants are eligible to receive 1-, 2-, or 3-month sets of checks/CVVs at each visit. Participants have the option to request and receive monthly check/CVV issuance, even if the local WIC agency has decided to schedule multi-month check/CVV issuance for all appropriate participants.

NOTE: The State WIC Office has the option to direct local agency staff to issue monthly checks/CVVs to a participant, for example, if the participant is under investigation for non-compliance.

The local WIC agency has the option to limit certain categories of participants to 1- or 2-month check/CVV issuance. If the local WIC agency decides to limit certain categories of participants, the local WIC agency will develop a written policy to include:

- A statement authorizing the Competent Professional Authority (CPA, CA) or local agency registered dietitian (RD) as the person responsible for determining participant eligibility for
- 1-, 2- or 3-month checks/CVVs.
- A list of participant characteristics which would require the participant to receive 1- or 2-month check/CVV issuance. Distinction should be made between participants able to receive 2-month versus 1-month checks/CVVs.
- A statement or notation describing the reason why a participant has been determined to receive 1- or 2-month check/CVV issuance.

NOTE: The policy and proposed revisions shall be submitted to the State agency for review prior to implementation. A copy of the policy will be on file at the local WIC agency.

JUSTIFICATION

The choice of 1-, 2-, or 3-month check/CVV issuance provides flexibility for participants and for clinic staffing. Multi-month check/CVV issuance can enhance clinic resources, participant satisfaction, and nutrition services because each check/CVV pick-up is associated with nutrition education.

PROCEDURE

Local WIC agency clinic(s) have on file the policy for 1-, 2-, or 3-month check/CVV issuance before implementing 3-month check/CVV issuance.

- Review participant's priority status, care plan and your local agency policy to determine appropriateness of 1-, 2-, or 3-month check/CVV issuance.
- Determine a proposed check/CVV pick-up schedule with the participant. It is recommended to schedule all family members according to the same check/CVV issuance schedule.
- Follow procedure for issuing checks/CVVs. In WIC ID Folder, place first month's checks/CVVs in first pocket (left side), second month's checks/CVVs in middle pocket, and third month's checks/CVVs in last pocket (right side) to avoid participant confusion. Local agency may wish to staple each month's checks/CVVs in upper left-hand corner to avoid checks/CVVs from other month(s) inadvertently getting mixed up.
- Advise participants that if they miss their next scheduled appointment or fail to reschedule, it may be necessary to adjust the check/CVV issuance schedule based on certification/re-certification scheduling.
- Advise participants who call in to change a scheduled appointment to let the receptionist know if they are receiving 1-, 2-, or 3-month checks/CVV.
- Advise participants that if their nutritional status changes, they may need to come in more frequently for WIC to provide better follow-up of care.
- Advise participants that 2- or 3-month check/CVV issuance is on a case-by-case basis decided by each local agency to better serve WIC participants and meet specific local agency requirements. Two- or 3-month check/CVV issuance is not one of their rights as a WIC participant.

CHECK/CVV ISSUANCE PARAMETER GUIDANCE

PARAMETERS

Rationale for limiting participant eligibility for multi-month check/CVV issuance will vary across the State. In writing the local WIC agency policy regarding 2- or 3-month check/CVV issuance, clinic staff may want to consider the following issues:

- Nutritionally high-risk participants: These participants may require a follow-up nutrition education contact with an RD or breastfeeding consultant more than once during a certification period. The RD may want to determine multi-month check/CVV issuance for these participants on a case-by-case basis.

- Pregnant women: The local WIC agency clinic may partner with another program to provide comprehensive prenatal services. Pregnant women may need to be scheduled monthly to coordinate with these services. Pregnant women who have not seen a health care provider may need to be seen monthly for better monitoring and follow-up of referral needs.

- Breastfeeding or postpartum women and their infants: Breastfeeding or postpartum women may need to be scheduled more frequently to ensure feeding is well established and supported during the first three to six months.

- Participants who missed their second nutrition education appointment or infants who missed the six-month health assessment: Reschedule the missed appointment as soon as possible and try to keep the participant on the same issuance schedule. If the appointment must be scheduled for the following month, the participant may need to change to a different issuance schedule (e.g., 1- or 2-month check/CVV issuance).

- Homeless participants

- Foster children in short term care: It may be beneficial to schedule these participants on a monthly basis.

- Participants receiving WIC-eligible nutritionals: No change to current policy. (Special circumstances per local agency Coordinator and/or RD discretion)

- Potential difficulty of participant/caregiver to manage multiple sets of checks: An example is the possibility of losing checks/CVVs or cashing checks/CVVs out of the valid date. The local agency registered dietitian (RD) or CPA may want to determine multi-month issuance for these participants on a case-by-case basis.

- Mailing checks/CVVs: Mailing WIC food checks is discouraged as it hinders the delivery of health nutrition education services. Checks/CVVs may be mailed for one month only issuance.

- Transfers from one clinic to another or from one state to another: No change to current policy.

- Changing food packages, formula intolerance, or returning formula: No change to current policy.

- Proxy check/CVV pick-up.

- Any check/CVV violations/sanctions or other issues related to check/CVV misuse.

CHAPTER 8: STAFF TRAINING

OVERVIEW

Three levels of clinical competency are available to paraprofessional staff employed by the Idaho WIC Program.

The first competency is basic skills, the second is advanced skills and the third is continuing skills. This chapter discusses training and measuring competency.

IN THIS CHAPTER

Section A Training Competency

Section B Continuing Skills Training

SECTION A: TRAINING COMPETENCY

OVERVIEW

There are three levels of clinical competency available to paraprofessional staff.

- *Basic skills* (required) include the ability to determine WIC program eligibility, tailor supplemental WIC food packages, and make referrals to other health and social services. Basic skills should be completed within six months of hire.
- *Advanced skills* (recommended) include effectively providing accurate, simple, and appropriate nutrition education messages to WIC participants. Advanced skills should be completed within 12 months of hire.
- *Continuing skills* (recommended) includes counseling skills and other job related training related to WIC program services. A minimum of 4 hours should be achieved annually.

IN THIS SECTION

Paraprofessional Training Manual
Competencies for Competent Professional Authorities
Measuring CPA Competency

PARAPROFESSIONAL TRAINING MANUAL

POLICY

A competency-based, self-instructional manual is used to teach skills. The manual is available on CD-ROM. Resources were developed by local agency and State Office RDs and staff, and were field tested by staff throughout the State.

The Idaho WIC Program Paraprofessional Training Manual combines reading, progress checks, worksheets, viewing of audiovisuals, and other learning activities to convey knowledge. Clinic observation and practice sessions are used to augment learning and enhance clinical skills. The Idaho WIC Program Paraprofessional Training Manual is divided into two units: Basic Skills and Advanced Skills.

ORDERING TRAINING MANUALS

Each local agency should have at least one Idaho WIC Program Paraprofessional Training Manual at the main clinic site.

Additional manuals are available from the State Office. Orders are placed either by e-mail or telephone to the Nutrition Education Coordinator.

Staff are encouraged to keep the manuals to use as reference after completing the program and during the time of their employment.

TRAINING GOALS

- To improve the consistency and accuracy of services provided to participants.
- To increase nutrition knowledge and improve the counseling skills of staff.
- To increase staff confidence and job satisfaction.
- To organize and standardize staff training.

REFERENCE

State policy

COMPETENCIES FOR COMPETENT PROFESSIONAL AUTHORITIES (CPA)

POLICY

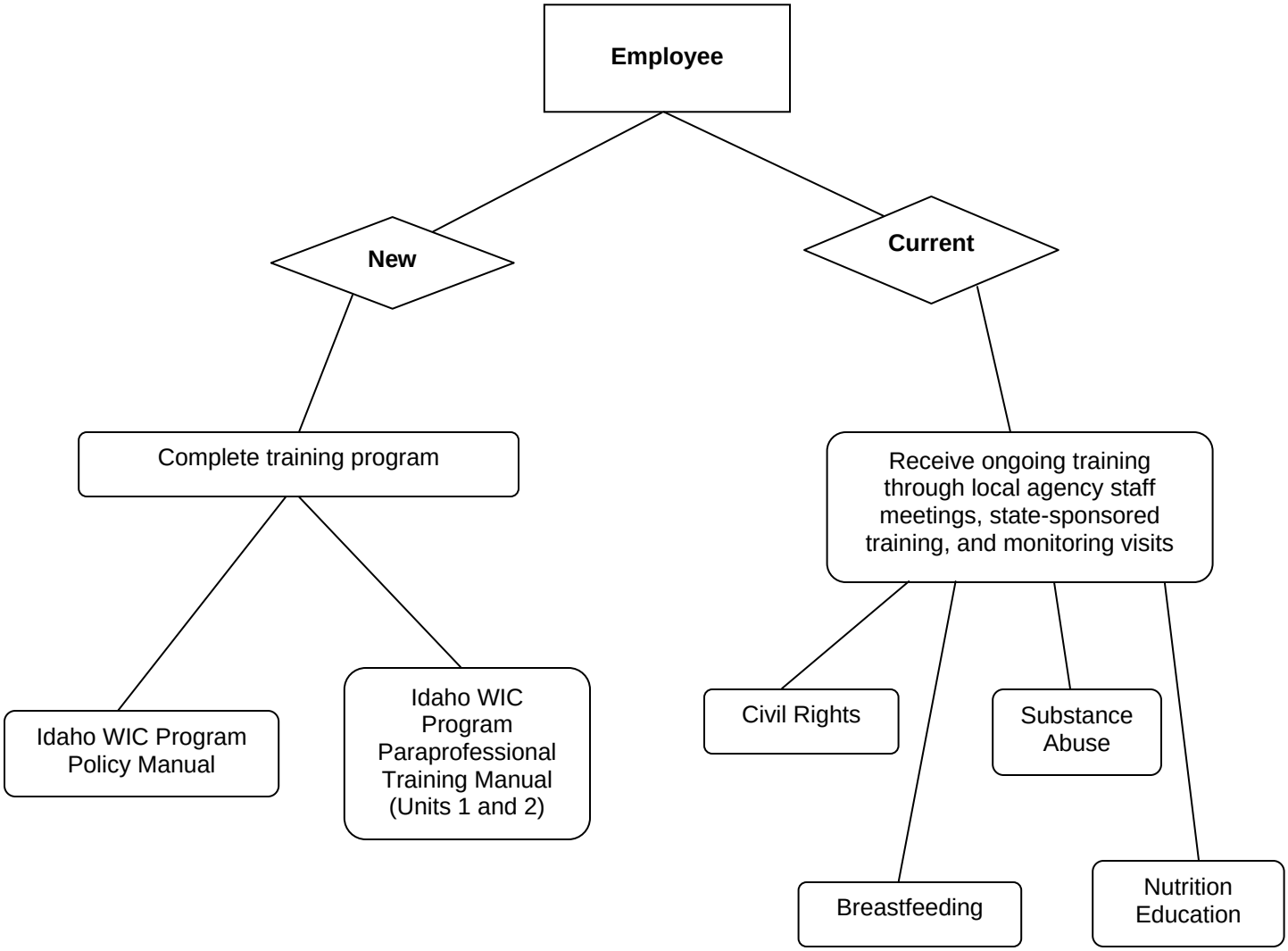
The Idaho WIC Program Paraprofessional Training Manual is administered by a local agency appointed trainer (a registered dietitian or a trained paraprofessional with at least three years of WIC experience) under whose supervision the trainee will:

- Deliver WIC program services according to established policies and procedures
- Assess the nutritional status of participants by collecting, recording, and comparing to standards the following to determine nutritional risk criteria:
    - Anthropometric Measurements
    - Biochemical Measurements
    - Dietary Data
    - Health
- Demonstrate knowledge of basic nutrition and its application to all WIC participants
- Use appropriate communication techniques during nutrition education contacts
- Plan for the nutritional care of participants based upon assessment findings by:
    - Assisting participants in prioritizing nutrition or health risks
    - Identifying community and agency services that might help resolve risks
    - Tailoring appropriate WIC food packages with participant input
    - Selecting the most practical and relevant nutrition education messages and arranging the most conducive environment in which to communicate them
- Implement nutrition care for participants using planned referral, food delivery, and nutrition education strategies
- Evaluate nutrition care given participants through subsequent assessment of nutritional status, use of WIC foods, and follow-through on nutritional advice and referrals.
- Enter eligibility and education information into the Idaho WIC Computer System.

REFERENCE:

7 CFR 246.11(c)(2) Nutrition Education

TRAINING FOR COMPETENT PROFESSIONAL AUTHORITIES (CPA)



MEASURING CPA COMPETENCY

POLICY

Each trainee's ability to meet the skills and objectives for each lesson in the Idaho WIC Program Paraprofessional Training Manual is rated by the trainer, who supervises progress through the training program. The learning objectives of each section of the manual combine both knowledge and application objectives to support the program competencies. Competency is further assessed through observation, interviewing, quizzes and chart reviews after each section of the manual is completed.

TRAINING PROGRAM EVALUATION

A record of the sections completed by each trainee is kept by local agency Coordinators along with results of observations, interviews, quizzes, and chart reviews. Basic Skills (Unit 1) should be completed within the first six months of employment. Advanced Skills (Unit 2) should be completed within the first year of employment.

The Idaho WIC Program Paraprofessional Training Manual is updated and revised periodically based on staff comments and changes in WIC program policies and procedures.

SECTION B: CONTINUING SKILLS COMPETENCY

OVERVIEW

Updates to policies and procedures are typically handled either through training provided by the State Office and/or training materials provided to local agency Coordinators to conduct training for staff.

IN THIS SECTION

Minimum Training Requirements
Breastfeeding Training
Civil Rights Training
Customer Service Training

MINIMUM TRAINING REQUIREMENTS

POLICY

Local agencies must provide ongoing training to the staff.

Certain topics must be provided at least annually:

- Breastfeeding
- Civil rights/nondiscrimination
- Customer service training
- Immunizations
- Suspected child abuse reporting (recommended, but not mandatory)

DOCUMENTATION

Agendas with clearly identified training objectives or minutes must be maintained. A roster of staff attending the training or some other means of tracking individual staff must be maintained.

These items will be reviewed during on-site monitoring visits.

REFERENCE

State policy

BREASTFEEDING TRAINING

POLICY

Breastfeeding promotion and support training will be included in staff orientation training and offered on an ongoing basis. Any training related to nutrition education and counseling provided to local staff will include breastfeeding as part of the subject matter.

Support Staff

- Complete “Introduction to WIC” section of the Paraprofessional Training Manual within six months of hire.
- Observe at least two different WIC breastfeeding classes.
- Participate in ongoing breastfeeding staff training.

Competent Professional Authorities

- Complete the breastfeeding section of the Paraprofessional Training Manual within six months of hire.
- If available, attend Peer Counselor training.
- Observe at least two different WIC breastfeeding classes.
- Participate in ongoing breastfeeding staff training.
- Attend training seminars as funding permits and state-sponsored training as requested by the State agency.

Professional Staff

- Complete the breastfeeding section of the Paraprofessional Training Manual within six months of hire.
- Observe one of each WIC breastfeeding class.
- Attend a 1- to 5-day breastfeeding training within 12 months of hire or document prior attendance at such training in personnel file.
- Participate in and conduct ongoing breastfeeding staff training.
- Attend training seminars as funding permits and state-sponsored training as required by the State agency.

Advanced Training

- Staff will participate in advanced training opportunities as they are available and funding allows.

Reference

7 CFR 246.11(c)(7)(iii)

Civil Rights Training

Policy

Local agencies are required to conduct annual civil rights training for WIC staff unless it is provided by the State agency.

Training Topics

- This training must include, but is not limited to, the following topics:
- Collection and recording of the Race data field on the Participant Info screen in WISPr.
- Discrimination complaint procedures.
- Reasonable accommodation, including equal assess to program services for the disabled.
- How to provide language assistance services to Limited English Proficiency participants.

Documentation

An outline and attendance records for the training should be maintained to document the training occurred.

Reference

7 CFR 246.8 Nondiscrimination (01/01/03)
FNS Instruction 113-2, Rev. 1 (06/29/83)
State policy

Customer Service Training

Minimum Requirements

Include positive customer service as a component of training for all new employees. At a minimum, conduct an annual in-service on quality customer service. Have staff brainstorm ways to improve WIC services on topics such as:

- Nonverbal communication
- Working with difficult participants
- Teamwork
- Preserving participant confidentiality
- Stress management

Reference

State policy

CHAPTER 9: VENDOR RELATIONS

OVERVIEW

This chapter describes various functions related to vendors contracted to provide foods to participants.

IN THIS CHAPTER

Section A Local Agency Responsibilities

Section B State Agency Responsibilities

SECTION A: LOCAL AGENCY RESPONSIBILITIES

OVERVIEW

IN THIS SECTION

Local Agency Contract Agreements
Returned Checks/CVVs
Foods Not Available
Conducting a Preauthorization Visit for New Vendors

LOCAL AGENCY CONTRACT AGREEMENTS

POLICY

The local agency is required by contract agreement to:

- Use the State food delivery system
- Address vendor issues per the following:
  - Provide two staff people to assist with compliance investigations two days per year
  - Provide at least one local agency staff person to be present at each vendor training session held within the agency's service area
  - Contact a vendor with customer/vendor concerns

ON-SITE REVIEW

A local agency may be asked to conduct an initial on-site review for a new store using the New Vendor Authorization Visit form.

A local agency may be asked to conduct a store authorization visit using the New Vendor Authorization Visit form for stores who are currently authorized but have changed names.

INCIDENT REPORT

When a local agency receives a Complaint or Incident Report from a participant, the local agency will immediately send the report to the State agency.

CHECKOUT PROCEDURE

A local agency shall discuss checkout procedures with the participant at the first visit and subsequent visits as needed. Checkout procedures should include, but are not limited to, using checks/CVVs according to the printed dates, choosing the correct foods printed on the check/CVV from the Idaho WIC Authorized Food List, signing WIC checks/CVVs <u>after</u> verifying the correct dollar amount.

PREAUTHORIZATION VISIT

All new authorized vendors are required to have an initial authorization visit conducted by a State agency or local agency employee. Refer to "Conducting a Preauthorization Visit."

RETURNED CHECKS/CVVS

When the local agency receives a copy of returned checks/CVVs from the State agency, the local agency will discuss the check/CVV return problem(s) and corrective action with the participant.

- The Rights and Responsibilities form will need to be signed again at this time.
- Comments from the participant should be noted in the participant's file and a copy mailed to the State agency.

REFERENCE

State policy

RETURNED CHECKS/CVVS

POLICY

All unpaid returned checks/CVVs require the following actions:

- WIC staff must re-educate the participant
- Vendors must return the original check(s)/CVVs to the State agency immediately for possible reimbursement.
- Vendors must retrain personnel on proper check/CVV cashing procedures found in the WIC Vendor Guide.

The bank returns checks/CVVs to vendors unpaid for the reasons listed below.

Missing Signature
When the signature is missing from the Authorized Signature box (must be signed at the vendor counter), the check/CVV will be returned unpaid to the vendor from the bank.

Invalid Vendor
When a participant uses a WIC check/CVV at a vendor other than an Idaho WIC authorized vendor, the bank will return the check/CVV unpaid to the vendor as “Invalid Vendor.”

Post Dated
When a check/CVV is used prior to the “First Day to Use” date printed on the check/CVV, the bank will return the check/CVV unpaid to the vendor as “Post Dated.”

Stale Dated (Expired Dates)
When a WIC check/CVV is used after the “Last Day to Use” date printed on the check/CVV, the bank will return the check/CVV unpaid to the vendor as “Stale Dated.”

Alterations
Altered checks/CVVs are returned to the vendor unpaid. Check/CVV alterations consist of, but are not limited to:

- Using correction fluid anywhere on the WIC check/CVV
- Crossing out or writing over any printed information on the check/CVV
- Dollar amount or signature(s) blacked out, written over, or unreadable
- Changing or writing over the first signature

The clinic will be asked to investigate the reason for the alteration and reply to the Vendor Coordinator.

Encoding Error
Checks with encoding errors will be returned to the vendor. These errors can be corrected by either the vendor or the vendor's bank and resubmitted to the bank. The vendor also has the option to send the check to the State agency for possible reimbursement.

Vendors should return unpaid checks/CVVs to the State agency immediately for possible reimbursement.

ACH Payments
The bank will automatically pay checks returned for "Excessive Dollar Amount" with an ACH Payment. Checks/CVVs that are initially rejected because the dollar amount written in the "Pay Exactly" box exceeds the maximum amount allowable for that check are saved as a batch and paid at the end of each week as a lump sum to each vendor that had an "Excessive Dollar Amount" check. **Checks returned for Excessive Dollar Amount do not need to be returned to the State agency.** Excessive dollar amount checks/CVVs may be caused by, but are not limited to:

- Vendor provides more food than what is printed on the check/CVV, (e.g., 37 ounces of cereal instead of 36 ounces, or six 32 ounce cans of Enfamil instead of six 16 ounce cans)
- Dollar amounts transposed or multi-check/CVV transactions
- Infant cereal with added fruit is purchased (not allowed on WIC)
- Illegible handwriting appears in the "Pay Exactly" box.

REFERENCE

State policy

FOODS NOT AVAILABLE

POLICY

Credit slips or rain checks are not allowed.

INFANT FORMULA

If there is not enough formula in stock to fill the amount printed on the check/CVV there are other options available.

- Preferred option: The participant may shop at another Idaho WIC authorized vendor.
- Alternate option: If the vendor's freight shipment is due in that evening or the next morning, the vendor may ask the participant to come back later that evening or the next day to purchase the infant formula.
- No substitutions are allowed.

OTHER FOODS

The participant may choose to not purchase the food item that is out of stock.

- A participant may come back later that day or the next day to purchase everything on the check/CVV.
- If the check/CVV will expire before the food item ordered arrives, the participant may choose to purchase similar authorized food items in stock
- The local agency or State agency may contact the vendor to ensure the minimum stocking requirements are being met.
- The local agency should encourage the participant to use checks/CVVs before the Last Day to Use.

NOTE: Participants should be encouraged to use the checks/CVVs before the "Last Day to Use" to avoid the possibility of forfeiting the food items on that check/CVV.

REFERENCE

State policy

CONDUCTING A PREAUTHORIZATION VISIT FOR NEW VENDORS

POLICY

This visit is conducted by either State agency or local agency staff. The State vendor team will work with the local agency Coordinator if this responsibility will fall to local staff. The State vendor team will provide all necessary forms and documentation prior to the visit.

INSTRUCTIONS

1. Staff person must identify herself or himself to the store or manager prior to conducting the preauthorization visit. The staff person may have the store director or manager escort them around the store to answer any questions they may have.
2. Staff person must verify all food prices against a copy of the vendor's price list.
3. Staff person must complete all the appropriate questions on the New Vendor Authorization Visit form.
4. After food prices on the price lists have been verified and the new vendor form has been completed, the staff person can recommend this store for WIC approval.
5. The State staff will conducted training sessions, either prior to or at the time the store is authorized as a WIC store. Staff person must ask if store personnel have any questions regarding the WIC Vendor Guide and Idaho Authorized Food List.

VISIT RESULT - APPROVED

If the vendor is approved, the store manager will receive a signed copy of the contract during the training visit or sent via mail.. Return all documentation to the State agency.

VISIT RESULT - DISAPPROVE

If the vendor is not approved, the person who conducted the visit must document the reasons for disapproval and return all documentation to the State agency.

REFERENCE

State policy

SECTION B: STATE AGENCY RESPONSIBILITIES

OVERVIEW

This section describes the vendor-related activities which are the responsibility of the State agency.

IN THIS SECTION

Vendor Selection and Authorization
Above 50 Percent Vendor Determination
SNAP Authorization
Vendor Closure or Owner Change
Vendor Price Update
Vendor Training
Vendor Monitoring
Vendor Hearing

VENDOR SELECTION AND AUTHORIZATION

POLICY

A prospective vendor must complete and submit an Idaho WIC Program Vendor Agreement to the State vendor team for consideration of possible authorization. See “Idaho WIC Program Vendor Agreement” for details.

All new authorized vendors are required to have an initial authorization visit and training session conducted by a State staff member or a local agency staff member.

All Idaho WIC Program Vendor Agreements are for a three-year period unless the vendor is found to be out of compliance, has committed fraud, or has otherwise abused the program.

REFERENCE

State policy

ABOVE 50 PERCENT VENDOR DETERMINATION

POLICY

All WIC authorized vendors should be assessed for above 50 percent at initial application, within 6 months, and annually.

REFERENCE

State policy

SNAP (Supplemental Nutrition Assistance Program) Authorization

Policy

Each vendor should have their SNAP identification number, SNAP authorization status, and history of SNAP sanctions verified in STARS at initial authorization, annually and at reauthorization. Documentation should occur in the Vendor Information Checklist spreadsheet.

Reference

State policy

Vendor Closure or Owner Change

Policy

When vendor ownership changes, the existing Vendor Agreement is immediately terminated. Vendor Agreements are non-transferable. New owners are required to submit a new Vendor Agreement to be considered for authorization.

All vendor owner changes and closures must be reported to the State vendor team by the owner.

Reference

State policy

Vendor Price Update

Policy

The food and infant formula price updates will occur at least twice a year.

Reference

State policy

Vendor Training

Policy

Vendors are required to receive interactive training annually. Vendors are notified of the training requirements. Vendors are also instructed, when necessary, to send a representative from each store for face-to-face training.

The content of materials and proof of vendor participation in annual vendor training should be documented to prove compliance with federal WIC training regulations. Documentation should be kept for four years.

Training Topics

During the training, the State vendor team provides updated information such as:

- The purpose of the WIC Program
- Authorized supplemental food
- Vendor minimum stocking requirements
- Obtaining infant formula from the list provided by Idaho WIC Program
- Procedures for transacting and redeeming WIC checks/CVVs
- Incentive items
- The vendor sanction system
- The vendor complaint process
- Claims procedure
- Changes to the WIC Program

Vendors are required to provide training to their employees who handle WIC transactions. If a vendor experiences multiple check redemption problems, training is provided by the State vendor team.

Vendor bulletins are provided as needed. Bulletins are prepared when program changes occur (e.g., new sole source infant formula rebate contractor selected).

The WIC Vendor Guide is updated as necessary and distributed during new vendor training, Agreement renewal or when significant changes occur. Complaint or Incident Report forms are available online and provided upon request.

Incident Reports

Vendors are informed when a Complaint or Incident Report form has been filed against the store for various reasons (e.g., charging sales tax, out of stock of authorized WIC foods).

Reference

State policy

Vendor Monitoring

Policy

On-site monitoring visits are conducted on a minimum of five (5) percent of all authorized vendors. Follow-up on-site monitoring may be conducted with a new vendor.

- All on-site monitoring visits will be documented and a copy left with the vendor at the time of the visit.
- On-site monitoring visits may be conducted unannounced.

Compliance Investigation

All compliance investigations are conducted at an unannounced vendor location. Compliance investigations are documented immediately upon exiting the store.

Criteria have been established by the State vendor team to determine if a store warrants a compliance investigation. Compliance investigations are conducted to determine if a vendor requires additional training.

Original checks/CVVs are obtained from the bank by the State agency to compare with the sales receipt received at the time of the transaction. Vendors are notified in writing by the State agency.

Vendors are instructed and provided with materials to retrain all personnel who handle checks/CVVs on the proper checkout procedures and authorized food items.

If a vendor has a repeat compliance investigation with negative results, follow-up action will be taken as stated in the Idaho WIC Program Vendor Agreement, Appendix A: Sanction Point System.

REFERENCE

State policy

VENDOR HEARING

POLICY

All administrative proceedings shall be governed by the provisions of IDAPA 16.05.03.

A vendor may request an administrative hearing under the following circumstances:

- Application for participation is denied
- Vendor is disqualified
- Any other adverse action is taken which affects participation in the WIC Program

When a vendor is notified of the decision by the State agency denying participation, a 15-day advance written notice is given. The vendor is advised at that time that a written request for a hearing must be made within 35 days.

SNAP DISQUALIFICATION

The State agency will disqualify a vendor who has been disqualified from the SNAP Program. The disqualification will be for the same length of time as the SNAP Program disqualification. The disqualification may begin at a later date than the SNAP Program disqualification, and shall not be subject to administrative or judicial review under the WIC Program. Additionally, disqualification of a vendor from the WIC Program may result in a disqualification from the SNAP Program. The disqualification shall not be subject to administrative or judicial review under the SNAP Program.

PROCEDURE

A hearing will be provided at the State level. Any vendor asking for information about hearings should be referred to the State WIC Vendor Manager.

REFERENCE

7 CFR 246.18(a)(1) Vendor Appeals
IDAPA 16.05.03 Rules Governing Contested Case Proceedings and Declaratory Ruling

CHAPTER 10: MONITORING

OVERVIEW

The State agency will conduct on-site monitoring reviews of each local agency at least once every two years. The local agencies will be responsible for completing self-monitoring reviews. The local agency Coordinators will complete performance reviews on a quarterly basis. This chapter describes the expectations and procedures for monitoring and Quarterly Reports.

IN THIS CHAPTER

Section A Local Agency Monitoring

Section B Quarterly Reports

SECTION A: LOCAL AGENCY MONITORING

OVERVIEW

It is the purpose of this section to ensure that local agencies comprehend and comply with federal and state regulations, policies and procedures.

IN THIS SECTION

Quality Assurance (QA) Local Agency On-Site Monitoring
Quality Assurance (QA) Local Agency Self-Monitoring

QUALITY ASSURANCE (QA) LOCAL AGENCY ON-SITE MONITORING

POLICY

Each local agency's clinical operations, fiscal management and food delivery systems shall be monitored for compliance with state and federal regulations, rules, and policies and procedures at least once every two years (biannually). The State agency may conduct additional on-site reviews if it determined to be necessary in the interest of the efficiency and effectiveness of the program.

The reviews will include an on-site visit to a minimum of 20% of the clinics in each local agency or one clinic, whichever is greater.

Monitoring of local agencies must encompass evaluation of the following areas:

- Management
- Certification
- Nutrition education
- Breastfeeding promotion and support
- Participant services
- Civil rights compliance
- Accountability
- Financial management systems
- Food delivery

PURPOSE

The on-site review assesses:

- How the local agency is providing services to WIC participants
- Clarification needed on guidance provided by state and federal policies
- Training needs of local agencies
- Information flow
- Questions/discussion related to program service improvement

PROCEDURE

Upon notification by the State agency of an on-site quality assurance (QA) monitoring review, the local agency Coordinator will work with the Clinic Operations Coordinator to determine a mutually agreeable schedule for the on-site review. Once a date for the on-site review has been agreed upon, the Clinic Operations Coordinator will confirm via written correspondence on department letterhead the date of the on-site review, State staff that will be on site, and any additional information needed by the local agency prior to the review.

The local agency Coordinator shall make available requested documentation, including, but not limited to, participant records, staff training logs, equipment inventory, and local agency policies/procedures differing from State for review by State staff while on site.

Local agencies may be asked by the State agency staff to complete monitoring forms prior to the actual on-site review.

PRE-VISIT CONFERENCE CALL

The pre-visit conference call replaces the preliminary meeting typically scheduled for the first day of the local agency program review, allowing the review team to spend more time engaging with the clinic staff. The pre-visit call provides time to discuss the review process, including forms, requested documents, and the local agency review questionnaire.

The local agency Coordinator is expected to be in attendance and may invite the local agency Director or other staff they would like to attend, including the clinic supervisor or any lead staff coordinating Value Enhanced Nutrition Assessment (VENA) and/or Participant Centered Services (PCS). The local agency Coordinator will work with the Clinic Operations Coordinator to determine a mutually agreeable schedule for the pre-visit conference call. The call should be scheduled prior to the program review.

Once the pre-visit conference call has been scheduled, the Clinic Operations Coordinator will send an electronic confirmation to the local agency Coordinator. This confirmation will include the local agency review questionnaire.

BRIEF ENTRANCE MEETING

Upon arrival at the local agency, the State staff will meet with the local agency Coordinator for a clinic tour, meet clinic staff, collect the required onsite documents, obtain the clinic appointment schedule, and discuss any questions or concerns before beginning the review.

EXIT MEETING

At the completion of the on-site QA monitoring review, the State staff will meet with the local agency Coordinator and any others the Coordinator wishes to have present at the exit meeting. State staff will discuss the results of the on-site review and any areas requiring corrective action on the part of the local agency.

REPORT(S)

The Clinic Operations Coordinator for the State will compile the results of the on-site QA monitoring review into a formal written report within 60 days on return to the State agency, to be shared with the local agency Coordinator and/or contracting agency contacts.

The local agency must submit a corrective action plan, including implementation timeframes, within 60 days of receipt of the State agency report of the QA monitoring review containing a findings of program non-compliance.

Sample On-site Monitoring Forms

- State Monitoring Clinic Site Review
- State Financial Review
- State Observation
- State Chart Review
- State Class Observation (if applicable)
- State Ineligible/Terminated Files

Quality Assurance (QA): Local Agency Self-Monitoring

Policy

Each local agency will conduct a QA self-monitoring of each clinic at least every two years (bi-annually). Self-monitoring does not need to be conducted in clinic sites where the State agency performs on-site monitoring. The clinic sites designated for self-monitoring by the local agency Coordinator will be reviewed using the standard Local Agency Self-Monitoring form.

Monitoring of clinic sites must encompass the following areas:

- Management
- Certification
- Nutrition education
- Breastfeeding promotion and support
- Participant services
- Civil rights compliance
- Accountability
- Financial management systems
- Food delivery

Purpose

The clinic review assesses:

- How the clinic is providing services to WIC participants
- Clarification needed on guidance provided by state and federal policies
- Training needs for clinic staff
- Information flow
- Questions/discussion related to program service improvement

Procedure

Each local agency Coordinator or designated registered dietitian (RD) will schedule and conduct an on-site review of each clinic as described above. The WIC Coordinator must use the standard Local Agency Self-Monitoring form. The following table depicts the number of charts to review using the chart review form based on clinic participant number.

Clinic Size	Number of Chart Reviews
Less than 500	5

501-3000	10
3001+	15

The following table depicts the number of observations to be completed using the Observation Review form based on the number of clinic participants.

Clinic Size	Number of Staff Observations
Less than 500	2-4
501-3000	5-7
3001+	8-10

Reports

The local agency Coordinator must send a copy of the completed Local Agency Self-Monitoring form along with the chart review forms for each clinic monitored to the Clinic Operations Coordinator at the State agency. This may be done as the clinic reviews are completed or may be provided to the State agency by September 30 of each year.

Self-monitoring Forms

- Local Agency Self-Monitoring Clinic Site Review
- Local Agency Observation
- Local Agency Chart Review
- Local Agency Ineligible/Terminated Files

Reference

7 CFR 246.19(b) State Agency Responsibilities
State of Idaho, Dept. of Health and Welfare Contract with Local Agency-Scope of Work

SECTION B: QUARTERLY REPORTS

OVERVIEW

It is the purpose of this section to ensure that local agencies understand and review their clinics' performance to ensure compliance with federal and state regulations, policies, and procedures.

IN THIS SECTION

Performance Review Local Agency Quarterly Reports

QUARTERLY REPORTS

POLICY

On a quarterly basis, local agency Coordinators must complete and submit the Quarterly Report form accompanied by applicable supporting documents to the State WIC Office Clinic Operations Coordinator.

PURPOSE

The purpose of the Quarterly Report is to measure local agency performance and progress towards meeting their Nutrition Education Plan goals and objectives, creating corrective action plans in response to monitoring findings and changes related to monitoring recommendations. The Peer Counseling report helps the State understand program progress and how to best provide technical assistance. The Fiscal Operating Detail Report will help ensure fiscal accountability.

PROCEDURE

- Reports are due by the end of the month of the first quarter month. The local agency Coordinator must electronically submit copies (preferred method) to the Clinic Operations Coordinator at the State WIC Office.
- Applicable support documents are to be submitted with the Quarter Report form.
- The State agency will review the report and provide feedback and/or request additional information within 30 days of receiving the report from local agencies.
- Local agency Coordinators will provide information requested by the State agency within 30 days of receiving the report from the State WIC Office.

FORMS

- Quarterly Report
- Comment
- Current Staff List
- Semi-annual Certification
- Peer Counseling Budget and Quarterly Report
- Fiscal Operating Detail Report (IBIS Query)

REFERENCE

7 CFR 246.19(b) State Agency Responsibilities
State of Idaho, Dept. of Health and Welfare Contract with Local Agency-Scope of Work

DEFINITIONS

ABUSE

To cause harm or threaten harm with words

ARTIFICIAL BABY MILK (ABM)

Breast milk substitute; infant formula

ATTEMPT (CONCERNING PROGRAM VIOLATIONS)

A participant's action in violation to program rules that is persistent and/or coercive, whether the intended result is achieved or not.
Example: A participant tries to purchase a non-authorized cereal by repeatedly trying to talk the store clerk into letting him/her purchase it, stating they always buy this product here, or saying another vendor allows them to purchase the wrong item.

AUTHORIZED SIGNER

BREASTFEEDING

The USDA/FNS definition of breastfeeding is the practice of feeding a mother's breastmilk to her infant(s) on average at least once a day.

BREASTFEEDING PROMOTION COORDINATOR

Registered Dietitian or licensed nurse who serves as a resource person and central contact for the coordination of breastfeeding promotion and support activities in the local WIC agency.

CASH VALUE VOUCHER (CVV)

A WIC check with a fixed dollar amount for purchase of fresh fruits and vegetables. Amount varies based on participant category.

CFR – CONSOLIDATED FEDERAL REGULATIONS

COMPETENT PROFESSIONAL AUTHORITY (CPA)

An individual on the local agency staff who is trained and authorized by the Idaho WIC Program as competent to determine applicant eligibility, nutritional risk, assign priority, and prescribe appropriate food packages.

CONTRACT BRAND INFANT FORMULA

An iron-fortified milk-based, soy-based, lactose-free or added rice starch formula intended as a food substitute for human milk for healthy, term infants produced by the manufacturer awarded the infant formula cost containment contract. Contract formulas are routinely provided to infants enrolled in the WIC Program.

Contraindication (related to Breastfeeding)

Any circumstance that makes breastfeeding medically inadvisable.

Disqualification

The act of removing a participant from the program and prohibiting further participation for specified period of time. The participant must reapply for program benefits at the end of the disqualification. Disqualification can last from one month to one year.

Disruptive Action

Acting in a manner which disturbs other clients at the clinic, WIC or vendor staff, vendor's customers or disrupting or obstructing clinic or vendor operations.
Example: Refusing to leave premises when asked to do so, throwing literature in a fit of anger, other actions which cause discomfort or fear.

Dual Enrollment

Active participant enrollment in two or more WIC clinics or WIC programs during the same time period. A dually enrolled participant may or may not have more than one set of WIC checks issued for the same benefit month. If the participant redeems only one set of WIC checks, the WIC participant must be terminated from the other WIC clinic/program.

Dual Participation

Participant receiving and cashing WIC checks from one or more WIC clinics/programs for the same time period. This results in excessive food benefits of the federal food allowance for the time period.

Exempt Infant Formula

Intended as a food substitute for human milk for use by infants who have inborn errors of metabolism, prematurity, low birth weight, or who otherwise have an unusual medical or dietary condition.

FNB – Full Nutrition Benefit

Fraud

An intentional misrepresentation of the truth to deceive others for the purpose of acquiring something of value, such as money or WIC benefits. Anything calculated to deceive, whether by a single act or combination, or by the suppression of truth, or by suggestion of what is false, whether it is by a direct lie, silence, look, or gesture.

FTE – Full-time Employee

In-state Transfer

A participant transferring from one local agency to another local agency within the state of Idaho.

Intent (concerning Program Violations)

Action carried out or attempted with the purpose to accomplish a result contrary to program rules.

Knowledge (concerning Program Violations)

Action carried out when participant has been made aware it is contrary to program rules or has information which would lead a reasonable person in the same situation to believe action is contrary to program rules.

Licensed Dietitian

A person licensed by the State to practice as a Registered Dietitian.

Medical Food

See WIC-eligible Medical Food

Misuse (concerning Program Violations)

Violations of the program rules which could lead to warning, repayment, suspension or disqualification or other sanctions applicable to State or Federal law.

Non-compliance

Failure on the part of the participant to follow program rules. The participant may or may not act with intent or knowledge.

Non-contract Infant Formula

An iron-fortified milk-based, soy-based, lactose-free, or added rice starch formula that is nutritionally comparable to contract brand formula (noted above) and is not covered by an infant formula cost containment contract. Such infant formulas are not provided by WIC and prescriptions or medical documentation for these formulas will not be accepted under any circumstances.

Out-of-state Transfer

A participant transferring into Idaho from another state or a participant transferring out of Idaho to another state.

Partially Breastfed Infant

The USDA/FNS definition of a partially breastfed infant is an infant who is breastfed, but also receives formula from the WIC Program, in an amount not to exceed approximately one-half the amount of formula allowed for a fully formula-fed infant.

Participant

The participant, parent, Responsible Adult (e.g., guardian, caretaker,) proxy, Authorized Signer, infant, child, pregnant woman, postpartum woman, and/or breastfeeding woman who receive supplemental foods from the WIC program.

Participant Violation

Any intentional action or activity by a participant or authorized representative or proxy to obtain benefits to which he or she is not entitled and/or to misuse benefits received.

PEER COUNSELOR

A breastfeeding Peer Counselor for WIC is a woman who, at a minimum:

- Is familiar with WIC
- Current or previous WIC participant preferred
- Has similarities with WIC participants served
- Has successfully breastfed at least one child (at least 6 months)
- Can communicate effectively
- Is enthusiastic about breastfeeding
- Can document and keep accurate records

PHYSICAL ABUSE

Physical contact or actions with WIC staff, vendor staff, or other participants which cause pain or injury.
Example:
Pushing, shoving, spitting, scratching, and throwing WIC foods or other objects at an intended target or targets.

PROJECT DIETITIAN

Individual with a B.S. in Nutrition who is a Registered Dietitian (RD) and Idaho Licensed Dietitian (LD). This person oversees nutritional risk certification, nutrition education, and high-risk counseling at the local WIC agency.

REGISTERED DIETITIAN (RD)

A person registered with the Commission on Dietetic Registration (the certifying agency of the American Dietetic Assocation).

RTF – READY-TO-FEED

SANCTION

A penalty for violating WIC program rules, regulations, or policies.

SUBSEQUENT INCIDENT

A second (or more) substantiated and documented occurrence of participant non-compliance and/or program violation. When a subsequent incident occurs and the action falls within the same or similar category, the program response for the subsequent incident is applied. When the action falls in a category different from the first incident (the action is a lesser or a greater violation of program rules), professional judgment is used to determine which response is appropriate.

SUSPENSION

The act of withholding benefits for a designated period of three to six months. The participant will continue on the program without reapplying if still within a current eligibility period at the end of the suspension.

THREATS

Communicating directly or indirectly the intent to cause injury, property damage, or any other act intended to harm the threatened person(s) with respect to their health and safety.
Example:

Raising a fist; making a bomb threat; walking to the back of the counter toward staff in a manner which staff consider intimidating; throwing an object in the vicinity of person; showing weapons or objects which can be used as weapons; and intimidating or threatening with harmful consequences.

Unmatched Redemptions

Checks/CVVs that have been issued and cashed, but for which no computer records exist to match the checks/CVVs with the participants. These checks/CVVs are flagged for research to determine possible fraud.

Violations

Intentionally not following WIC program rules and regulations.

WIC-eligible Medical Food

Certain enteral products that are specifically formulated to provide nutritional support for participants (women, infants, or children) with a diagnosed medical condition where conventional food is precluded, restricted, or inadequate. Such WIC-eligible medical foods must serve calories and one or more nutrients; be designed for enteral digestion via oral or tube feeding; and may not be a conventional food, drug, flavoring, or enzyme.

NUTRITION RISK CRITERIA

CODE	NUTRITION RISK CRITERIA
101★	UNDERWEIGHT WOMAN
103★	UNDERWEIGHT / AT RISK FOR UNDERWEIGHT—INFANTS/CHILDREN
111★	OVERWEIGHT WOMAN
113★	OBESE—CHILDREN (2-5)
114★	OVERWEIGHT---CHILDREN (2-5)
115★	HIGH WEIGHT-FOR-LENGTH---INFANTS/CHILDREN (< 24 MONTHS)
121★	SHORT STATURE/AT RISK OF SHORT STATURE—INFANTS/CHILDREN
131★	LOW MATERNAL WEIGHT GAIN
132★	MATERNAL WEIGHT LOSS IN PREGNANCY
133★	HIGH MATERNAL WEIGHT GAIN
134	FAILURE TO THRIVE
135★	INADEQUATE GROWTH
141★	LOW BIRTH WEIGHT
142★	PREMATURITY
153★	LARGE FOR GESTATIONAL AGE
201★	LOW HEMATOCRIT/LOW HEMOGLOBIN
301	HYPEREMESIS GRAVIDARUM
302	GESTATIONAL DIABETES
303	HX GESTATIONAL DIABETES
304	HISTORY OF PREECLAMPSIA
311	HX PRETERM DELIVERY (≤37 WK)
312	HX LOW BIRTH WEIGHT
321	HX FETAL OR NEONATAL LOSS
331★	PREGNANCY—YOUNG AGE
332★	CLOSELY SPACED PREGNANCY
334	LACK OF OR INADEQUATE PRENATAL CARE
335★	MULTIFETAL GESTATION

NUTRITION RISK CRITERIA

CODE	NUTRITION RISK CRITERIA
336	FETAL GROWTH RESTRICTION
337	HX BIRTH LGA INFANT
338	PREGNANT AND BREASTFEEDING
339	HX BIRTH—CONGENITAL DEFECT
341	NUTRIENT DEFICIENCY DISEASES
342	GASTRO-INTESTINAL 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
352	INFECTIOUS DISEASES
353	FOOD ALLERGY
354	CELIAC DISEASE
355	LACTOSE INTOLERANCE
356	HYPOGLYCEMIA
357	DRUG NUTRIENT INTERACTIONS
358	EATING DISORDERS
359	RECENT MAJOR SURGERY, TRAUMA, BURNS
360	OTHER MEDICAL CONDITIONS
361	DEPRESSION
362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT
363	PRE-DIABETES
371	MATERNAL SMOKING

NUTRITION RISK CRITERIA

CODE	NUTRITION RISK CRITERIA
372	ALCOHOL OR ILLEGAL DRUG USE
381	ORAL HEALTH CONDITIONS
382	FETAL ALCOHOL SYNDROME
401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANCS
411	INAPPROPRIATE NUTRITION PRACTICES—INFANT
425	INAPPROPRIATE NUTRITION PRACTICES—CHILD
427	INAPPROPRIATE NUTRITION PRACTICES—WOMAN
428	DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES
501	POSSIBILITY OF REGRESSION
502★	TRANSFER OF CERTIFICATION (VOC)
601	BF MOM OF INFANT AT NUTRITIONAL RISK
602	BF COMPLICATION—WOMAN
603	BF COMPLICATION—INFANT
701	BORN TO WIC MOM / BORN TO POTENTIAL WIC MOM
702	BF INFANT OF MOM AT NUTRITIONAL RISK
801★	HOMELESSNESS
802★	MIGRANCY
902	FEEDING SKILLS LIMITATION
903★	FOSTER CARE
904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE (ETS)

Nutrition Risk Criteria **101★ UNDERWEIGHT WOMAN**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant: Body Mass Index (BMI) less than (<) 18.5.

- Use pre-pregnancy weight in BMI calculation.

Breastfeeding/Non-breastfeeding: BMI less than (<) 18.5.

- Use pre-pregnancy weight in BMI calculation ***or*** current weight in BMI calculation for all women who are less than 6 months postpartum.
- Use current weight for breastfeeding women who are equal or greater than 6 months postpartum.

Note: A BMI table is attached to assist in determining weight classifications. Until research supports the use of different BMI cut-offs for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility (1).

Required Documentation

Pregnant

- Pre-pregnancy weight
- Height
- BMI

Breastfeeding/Non-breastfeeding

- Pre-pregnancy weight
- Current weight
- Height
- BMI

Justification

Underweight women who become pregnant are at a higher risk for delivery of low birth weight (LBW) infants, retarded fetal growth, and perinatal mortality. Pre-pregnancy underweight is also associated with a higher incidence of various pregnancy complications, such as antepartum hemorrhage, premature rupture of membranes, anemia, endometriosis, and cesarean delivery.

The goal in prenatal nutritional counseling provided by WIC is to achieve recommended weight gain by emphasizing food choices of high nutritional quality; and for the underweight woman, by encouraging increased consumption and/or the inclusion of some calorically dense foods.

The 2009 Institute of Medicine (IOM) report: *Weight Gain During Pregnancy: Reexamining the Guidelines* (1) updated the pregnancy weight categories to conform to the categories developed by the World Health Organization and adopted by the National Heart Lung and Blood Institute in 1998 (3). The reexamination of the guidelines consisted of a review of the determinants of a wide range of short-and long-term consequences of variation in weight gain during pregnancy for both the mother and her infant. The IOM prenatal weight gain recommendations based on prepregnancy weight status categories are associated with improved maternal and child health outcomes (1).

Included in the 2009 IOM guidelines is the recommendation that the BMI weight categories used for adult women be used for pregnant adolescents as well. More research is needed to determine whether special categories are needed for adolescents. It is recognized that the IOM BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM BMI cut-off will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Pre-pregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the pre-pregnancy weight. In most cases therefore, pre-pregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery. The one exception is the woman with a BMI of <18.5 during the immediate 6 months after delivery. Underweight at this stage may indicate inadequate weight gain during pregnancy, depression, an eating disorder or disease; any of which need to be addressed (4).

While being on the lean side of normal weight is generally considered healthy, being underweight can be indicative of poor nutritional status, inadequate food consumption, and/or an underlying medical condition. Underweight women who are breastfeeding may be further impacting their own nutritional status. Should she become pregnant again, an underweight woman is at a higher risk for delivery of low birth weight (LBW) infants, retarded fetal growth, and perinatal mortality. The role of the WIC Program is to assist underweight women in the achievement of a healthy dietary intake and body mass index.

References

1. Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines (Prepublication Copy). National Academy Press, Washington, D.C.; 2009. www.nap.edu. Accessed June 2009.
2. Institute of Medicine. WIC Nutrition Risk Criteria: A Scientific Assessment. National Academy Press, Washington, D.C.; 1996.
3. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. NIH Publication No. 98-4083,1998. www.nih.gov. Accessed June 2009.
4. Crowel DT. Weight changes in the postpartum period: a review of the literature. Journal of Nurse-Midwifery. Vol. 40, No. 5, September/October 1995; 418-423.

Additional Related References

1. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol, 1992; 79:664-9.
2. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol, 1994; 84:565-73.

3. Suitor CW, editor. Maternal weight gain: A report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

Nutrition Risk Criteria **103★ UNDERWEIGHT OR AT RISK OF UNDERWEIGHT – INFANTS/CHILDREN**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

UNDERWEIGHT:
BIRTH TO AGE 2: Weight-for-length less than or equal to (≤) 2.3rd percentile.*

CHILDREN AGE 2 TO 5 YEARS: Body Mass Index-for-age less than or equal to (≤) 5th percentile.**

AT RISK OF UNDERWEIGHT:
BIRTH TO AGE 2: greater than (>) 2.3rd percentile through less than or equal to (≤) 5th percentile weight-for-length.*

CHILDREN AGE 2 TO 5 YEARS: greater than (>) 5th percentile through less than or equal to (≤) 10th percentile Body Mass Index (BMI)-for-age.**

***Based on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (1) based on 2006 World Health Organization (WHO) international growth standards (3). For the Birth to <24 months "underweight" definition, CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts. For more information about the percentile cut-off, please see Clarification.

**Based on National Center for Health Statistics/Centers for Disease Control and Prevention age/sex specific growth charts (2000).

Required Documentation

DOB
Weight
Height
BMI
CDC/WHO growth charts, CDC growth charts

Justification

The CDC uses the 2.3rd percentile weight-for-length (for birth to 24 months of age) and the 5th percentile BMI-for-age (for 2-5 years of age), as the cut-offs to define underweight in its Pediatric Nutrition Surveillance System (1,2). However, CDC does not have a position regarding the cut-off percentile, which should be used to determine at risk of underweight as a nutrition risk in the WIC Program. At risk of underweight is included in this criterion to reflect the preventive emphasis of the WIC program.

A review of literature on weight-for-length or stature cut-off percentiles indicates that: a) many children at or below the 5th percentile for weight are in need of nutritional intervention, and b) those at or below the 10th percentile may be at nutritional risk and in need of preventive nutritional intervention, or at least further evaluation (4).

Weight-for-length/stature describes body proportionality and is sensitive to

acute undernutrition, but can also reflect long-term status (5). Physical growth delay is used as a proxy for the deleterious effects undernutrition can have on immune function, organ development, hormonal function and brain development (6).

Implications for WIC Nutrition Services

Participation in WIC has been associated with improved growth in both weight and height in children (7). An infant or child determined to be underweight at WIC certification should be monitored at regular intervals during the certification period, as appropriate. Through client-centered counseling, WIC staff can assist families in making nutritionally balanced food choices to promote adequate weight gain. Also, the foods provided by the WIC program are scientifically-based and intended to address the supplemental nutritional needs of the Program's target population, and can be tailored to meet the needs of individual participants.

In addition, WIC staff can greatly assist families by providing referrals to medical providers and other services, if available, in their community. Such resources may provide the recommended medical assessments, in order to rule out or confirm medical conditions, and offer treatment when necessary and/or in cases where growth improvement is slow to respond to dietary interventions.

Clarification

The cut-off for underweight for infants and children <24 months is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy Birth to 24 months growth charts. Electronic charts should use the 2.3rd percentile as the cut-off.

References

1. Centers for Disease Control and Prevention. Use of World Health Organization and CDC growth charts for children aged 0-59 months in the United States. MMWR 2010; 59 (No. RR-9). Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w. Accessed September 2010.
2. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.
3. World Health Organization. WHO child growth standards: Length/height-for-age, weight-for-age, weight-for-height and body mass index-for-age: Methods and development. Geneva, Switzerland: World Health Organization; 2006. Available at http://www.who.int/childgrowth/publications/technical report pub/en/index.html. Accessed September 2010.
4. Food and Nutrition Information Center, National Agriculture Library. Update of analysis of literature regarding cut-off percentiles for low weight for length in infants. Washington, D.C.; February 5, 1991.
5. Sherry B. Epidemiology of inadequate growth. In: Kessler DB, Dawson P, Editors. Failure to thrive and pediatric under nutrition: A transdisciplinary approach. Baltimore: Paul H. Brooks Publishing Company, Inc.; 1999.
6. Metallinos-Katsaras E, Gorman KS. Effects of under nutrition on growth and development. Kessler DB, Dawson P, editors. Failure to thrive and pediatric under nutrition: A transdisciplinary approach. Baltimore: Paul H. Brooks Publishing Company, Inc.; 1999. p. 38.
7. Disbrow DD. The costs and benefits of nutrition services: a literature review. J Am Diet Assoc. 1989; 89:S3-66.

Nutrition Risk Criteria **111 ★ OVERWEIGHT WOMAN**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant: Body Mass Index (BMI) greater than or equal to (≥) 25.

- Use pre-pregnancy weight in BMI calculation.

Breastfeeding/Non-breastfeeding: BMI greater than or equal to (≥) 25.0.

- Use pre-pregnancy weight in BMI calculation for all women who are less than 6 months postpartum.
- Use current weight for breastfeeding women who are equal or greater than 6 months postpartum.

Note: A BMI table is attached to assist in determining weight classifications. Until research supports the use of different BMI cut-offs for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility (1).

Required Documentation

Pregnant

- Pre-pregnancy weight
- Height
- BMI

Breastfeeding/Non-breastfeeding

- Pre-pregnancy weight
- Current weight
- Height
- BMI

Justification

Maternal overweight and obesity are associated with higher rates of cesarean delivery, gestational diabetes mellitus, preeclampsia and other pregnancy-induced hypertensive disorders, as well as postpartum anemia (2). Several studies have established an association between obesity and an increased risk for hypertension, dyslipidemia, diabetes mellitus, cholelithiasis, coronary heart disease, osteoarthritis, sleep apnea, stroke and certain cancers (1).

One goal of prenatal nutritional counseling is to achieve recommended weight gain. For the overweight woman, emphasis should be on selecting food choices of high nutritional quality and avoiding calorie rich foods, thereby minimizing further risks associated with increased overweight and obesity.

The 2009 Institute of Medicine (IOM) report: *Weight Gain During Pregnancy: Reexamining the Guidelines* (1) updated the pregnancy weight categories to conform to the categories developed by the World Health Organization and adopted by the National Heart, Lung and Blood Institute in 1998 (3). The reexamination of the guidelines consisted of a review of the determinants of a wide range of short-and long-term consequences of variation in weight gain during pregnancy for both the mother and her infant. The IOM prenatal weight gain recommendations based on prepregnancy weight status categories are associated with improved maternal and child health outcomes (1).

Included in the 2009 IOM guidelines is the recommendation that the BMI weight categories used for adult women be used for pregnant adolescents as well. More research is needed to determine whether special categories are needed for adolescents. It is recognized that the IOM BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM BMI cut-offs will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Pre-pregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the pre-pregnancy weight. In most cases therefore, pre-pregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery.

The percentage of adolescents who are overweight is increasing rapidly and more than 60% of adults in the U.S. are overweight. Due to the significant impact that overweight and obesity have on morbidity and mortality, it is imperative that every effort be made to identify individuals who are overweight and to assist them in achieving a more healthful weight. The WIC Program is in a position to play an important role in helping to reduce the prevalence of overweight not only by working with postpartum women on improving their own weight status, but also by helping them to see their role in assisting their children to learn healthful eating and physical activity behaviors.

References

1. Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines (Prepublication Copy). National Academy Press; Washington, D.C.; 2009. www.nap.edu. Accessed June 2009.
2. Bodnar LM, Catov JM, Klbanoff MA, Ness RB, Roberts JM. Prepregnancy body mass index and the occurrence of severe hypertensive disorders of pregnancy. Epidemiology 2007;18(2):234-239.
3. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. NIH Publication No. 98-4083, 1998. www.nhlbi.nih.gov. Accessed June 2009.
4. Crowell DT. Weight changes in the postpartum period: a review of the literature. Journal of Nurse-Midwifery. Vol. 40, No. 5, September/October 1995; 418-423.

Additional Related References

1. Naye, R.L.: Maternal body weight and pregnancy outcome. American Journal Clin. Nutr.; 1990; 52:273-279.
2. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol, 1992; 79:664-9.
3. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol, 1994; 84:565-73.

4. Suitor CW, editor. Maternal weight gain: A report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

Nutrition Risk Criteria **113★ OBESE – CHILDREN (2-5)**

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	CHILDREN	3	RD

Definition

Children Age 2 and Older: Body mass index-for-age greater than or equal to (≥) 95th percentile. Based on Centers for Disease Control and Prevention (CDC) age and sex specific growth charts.*

*The cut-off is based on standing height measurements. Therefore, recumbent length measurements may not be used for this risk. See Clarification for more information.

Required Documentation

DOB
Weight
Height
BMI
CDC growth charts

Justification

The rapid rise in the prevalence of obesity in children and adolescents is one of the most important public health issues in the United States today. The National Health and Nutrition Examination Survey (NHANES) from the mid-1960s to the early 2000s document a significant increase in obesity among children from preschool age through adolescence. These trends parallel a concurrent increase in obesity among adults, suggesting that fundamental shifts occurring in dietary and/or physical activity behaviors are having an adverse effect on overall energy balance (3).

The causes of increased obesity rates in the United States are complex. Both genetic make-up and environmental factors contribute to the obesity risk. Important contributors include a large and growing abundance of calorically dense foods and an increased sedentary lifestyle for all ages. Although obesity tends to run in families, a genetic predisposition does not inevitably result in obesity. Environmental and behavioral factors can influence the development of obesity in genetically at-risk people (3).

BMI is a measure of body weight adjusted for height. While not a direct measure of body fatness, BMI is a useful screening tool to assess adiposity (3). Children ≥ 2 years of age, with a BMI-for-age ≥ 85th and < 95th percentile are considered *overweight* and those at or above the 95th percentile, *obese* (4). Research on BMI and body fatness shows that the majority of children with BMI-for-age at or above the 95th percentile have high adiposity and less than one-half of the children in the 85th to < 95th percentiles have high adiposity (4). Although an imperfect tool, elevated BMI among children most often indicates increased risk for future adverse health outcomes and/or development of diseases (5). BMI should serve as the initial screen and as the starting point for classification of health risks (3).

Use of the 95th percentile to define obesity identifies those children with a greater likelihood of being obese as adolescents and adults, with increased risk of obesity-related disease and mortality. It is recommended that an obese child (≥ 95th percentile) undergo a medical assessment and careful evaluation to identify

any underlying health risks or secondary complications (3). Obesity can result from excessive energy intake, decreased energy expenditure, or a medical condition that impairs the regulation of energy metabolism. In addition, obesity in early childhood may signify problematic feeding practices or evolving family behaviors that, if continued, may contribute to health risks in adulthood related to diet and inactivity.

Implications for WIC Nutrition Services

The WIC Program plays an important role in public health efforts to reduce the prevalence of obesity by actively identifying and enrolling young children who may be obese or at risk of overweight/obesity in later childhood or adolescence. When identifying this risk, it is important to communicate with parents/caregivers in a way that is supportive and nonjudgmental, and with a careful choice of words that convey an empathetic attitude and minimize embarrassment or harm to a child's self-esteem (4). In recognition of the importance of language, the 2007 American Medical Association Expert Committee Report recommends the use of the terms *overweight* and *obese* for documentation and risk assessment **only** and the use of more neutral terms (e.g., weight disproportional to height, BMI) when discussing a child's weight with a parent/caregiver (3).

BMI is calculated and plotted on growth charts at each WIC certification. However, growth charts are meant to be used as a screening tool and comprise only one aspect of the overall growth assessment. A clinical assessment to determine if a child is at a healthy weight is more complex. Weight classification (derived from the growth chart) should be integrated with the growth pattern, familial obesity, medical risks and dietary and physical activity habits to determine the child's obesity risk (1, 5).

The goal in WIC nutrition counseling is to help the child achieve recommended rates of growth and development. WIC staff can frame the discussion to make achieving normal growth a shared goal of the WIC Program and the parent/caregiver and make clear that obesity is a medical condition that can be addressed (4). Parents/caregivers of children may need education on recognition of satiety dues and other physiological needs that lead to crying, and ways to comfort a child (holding, reading, rocking) other than by feeding. The foods provided by the WIC Program are scientifically-based and intended to address the supplemental nutritional needs of the program's target population and can be tailored to meet the needs of individual participants. Emphasis can be placed on promoting food choices of high nutritional quality while avoiding unnecessary or excessive amounts of calorie rich foods and beverages, and reducing inactivity (like decreasing sedentary TV viewing).

Beliefs about what is an attractive or healthy weight, the importance of physical activity, what foods are desirable or appropriate for parents to provide to children, family mealtime routines, and many other lifestyle habits are influenced by different cultures, and should be considered during the nutrition assessment and counseling (6). The following resources for obesity prevention can be found:

- Fit WIC Materials: http://www.nal.usda.gov/wicworks/Sharing_Center/gallery/foodfunfamilies.htm.
- MyPyramid for Preschoolers: http://www.mypyramid.gov/preschoolers/index.html

In addition, WIC staff can greatly assist families by providing referrals to medical providers and other services, if available, in their community. Such resources

may provide the recommended medical assessments, in order to rule out or confirm medical conditions, and offer treatment when necessary and/or in cases where growth improvement is slow to respond to dietary interventions.

Clarification

The 2000 CDC Birth to 36 Months growth charts cannot be used as a screening tool for the purpose of assigning this risk because these charts are based on recumbent length rather than standing height data. However, these charts may be used as an assessment tool for evaluating growth in children aged 24-36 months who are not able to be measured for the standing height required for the 2000 CDC 2-20 Years growth charts.

References

1. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.
2. Grummer-Strawn LM, Reinold C, Krebs NF. Use of World Health Organization and CDC growth charts for children aged 0-59 Months in the United States. CDC Morbidity and Mortality Weekly Report (September 2010); no 59 (rr09); 1-15. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w. Accessed September 2010.
3. Barlow, SE, Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics 2007; 120; S164-S192.
4. Ogden CL, Flegal KM. Changes in Terminology for childhood overweight and obesity. National health statistics reports; no. 25. Hyattsville (MD): National Center for Health Statistics. 2010.
5. U.S. Department of Health and Human Services. The Surgeon General's vision for a healthy and fit nation. Rockville (MD): U.S. Department of Health and Human Services, Office of the Surgeon General. 2010.
6. Krebs NF, Himes JH, Jacobson D, Nicklas TA, Guilday P, Styne D. Assessment of child and adolescent overweight and obesity. Pediatrics 2007; 120 Suppl 4: S103-S228.

Nutrition Risk Criteria **114★ OVERWEIGHT – CHILDREN (2-5)**

Category, Priority and Referral

Category	Priority	Referral
CHILDREN	3	-

Definition

Overweight:

Children age 2 and older: Being ≥ 24 months of age and ≥ 85th and < 95th percentile Body Mass Index (BMI)*-for-age as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 Years gender specific growth charts (1, 2).*

*DO NOT USE if NRC 113 Obese Children applies

*The cut-off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk. See Clarification for more information.

Required Documentation

DOB
Weight
Height
BMI
CDC growth charts

Justification

The rise in the prevalence of overweight in children and adolescents is one of the most important public health issues in the United States today. The National Health and Nutrition Examination Survey (NHANES) from the mid-1960s to the early 2000s document a significant increase in overweight among children from preschool age through adolescence. These trends parallel a concurrent increase in overweight among children from preschool age through adolescence. These trends parallel a concurrent increase in obesity among adults, suggesting that fundamental shifts in dietary and/or physical activity behaviors are having an adverse effect on overall energy balance (3).

BMI is a measure of body weight adjusted for height. While not a direct measure of body fatness, BMI is a useful screening tool to assess adiposity (3). Children ≥ 2 years of age, with a BMI-for-age ≥ 85th and < 95th percentile are considered overweight and those at or above the 95th percentile, *obese* (4). Research on BMI and body fatness shows that the majority of children with BMI-for-age at or above the 95th percentile have high adiposity and less than one-half the children in the 85th to < 95th percentiles have high adiposity (4). Although an imperfect tool, elevated BMI among children most often indicates increased risk for future adverse health outcomes and/or development of diseases (5). BMI should serve as the initial screen and as the starting point for classification of health risks (3).

Increasingly, attention is being focused on the need for comprehensive strategies that focus on preventing overweight/obesity and a sedentary lifestyle for all ages. Scientific evidence suggests that the presence of obesity in a parent greatly increases the risk of overweight in preschoolers, even when no other overt signs of increasing body mass are present (6). The presence of parental obesity should lead to greater efforts by nutrition services staff to assist families in establishing or improving healthy behaviors (3).

Implications for WIC Nutrition Services

The WIC Program plays an important role in public health efforts to reduce the prevalence of obesity by actively identifying and enrolling infants and children who may be overweight or at risk of overweight in childhood or adolescence. When identifying this risk, it is important to communicate it in a way that is supportive, nonjudgmental, and with a careful choice of words to convey an empathetic attitude and to minimize embarrassment or harm to a child's self-esteem (4). In recognition of the importance of language, the 2007 American Medical Association expert committee report recommends the use of the terms *overweight* and *obese* for documentation and risk assessment **only** and the use of more neutral terms (e.g., *weight disproportional to height, excess weight, BMI*) when discussing a child's weight with a parent/caregiver (3).

BMI is calculated and plotted on growth charts at each WIC certification. However, growth charts are meant to be used as a screening tool and comprise only one aspect of the overall growth assessment. A clinical assessment to determine if a child is at a healthy weight is more complex. Weight classification (derived from the growth chart) should be integrated with the growth pattern, familial obesity, medical risks, and dietary and physical activity habits to determine the child's obesity risk (1, 5).

The goal in WIC nutrition counseling is to help the child achieve recommended rates of growth and development. WIC staff can frame the discussion to make achieving normal growth a shared goal of the WIC Program and the parent/caregiver. Studies have shown that the early childhood eating environment provides a great opportunity for preventive intervention (7). Parents/caregivers of infants and toddlers may need recognition of satiety cues and other physiological needs that lead to crying, and ways to comfort a child (holding, reading, rocking) other than by feeding. Young children look upon their parents as role models for eating behaviors. Through client-centered counseling, WIC staff can emphasize the importance of prevention and can assist families in making changes that improve parenting skills that promote healthy eating, and physical activity behaviors and a healthy weight in children. Also, the foods provided by the WIC Program are scientifically-based and intended to address the supplemental nutritional needs of the Program's target population and can be tailored to meet the needs of individual participants.

Beliefs about what is an attractive or healthy weight, the importance of physical activity, what foods are desirable or appropriate for parents to provide children, family mealtime routines, and many other lifestyle habits are influenced by different cultures, and should be considered during the nutrition assessment and counseling (8). The following resources for obesity prevention can be found at:

- Fit WIC Materials
  http://www.nal.usda.gov/wicworks/Sharing_Center/gallery/foodfunfamilies.htm
- MyPyramid for Preschoolers:
  http://www.mypyramid.gov/preschoolers/index.html

In addition, WIC staff can greatly assist families by providing referrals to medical providers and other services, if available, in their community. Such resources may provide the recommended medical assessments, in order to rule out or confirm medical conditions, and offer treatment when necessary and/or in cases where growth improvement is slow to respond to dietary interventions.

Clarification	The 2000 CDC Birth to 36 months growth charts cannot be used as a screening tool for the purpose of assigning this risk because these charts are based on recumbent length rather than standing height data. However, these charts may be used as an assessment tool for evaluating growth in children aged 24-36 months who are not able to be measured for the standing height required for the 2000 CDC 2-20 years growth charts.

References

1. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.
2. Grummer-Strawn LM, Reinold C, Krebs NF. Use of World Health Organization and CDC growth charts for children aged 0-59 Months in the United States. CDC Morbidity and Mortality Weekly Report (September 2010); no 59 (rr09); 1-15. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w. Accessed September 2010.
3. Barlow SE, Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics. 2007; 120; S164-S192.
4. Ogden CL, Flegal KM. Changes in Terminology for childhood overweight and obesity. National health statistics reports; no. 25. Hyattsville (MD): National Center for Health Statistics. 2010.
5. U.S. Department of Health and Human Services. The Surgeon General's vision for a healthy and fit nation. Rockville (MD): U.S. Department of Health and Human Services, Office of the Surgeon General. 2010.
6. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. N.Eng.J.Med. September 25,1997; Vol 337; No 13: pgs 869-873.
7. Anzman SL, Rolllins BY, Birch LL. Parental influence on children's early eating environments and obesity risk: implications for prevention. International Journal of Obesity 34, 1116-1124 (July 2010).
8. Krebs NF, Himes JH, Jacobson D, Nicklas TA, Guilday P, Styne D. Assessment of child and adolescent overweight and obesity. Pediatrics 2007; 120 Suppl 4: S103-S228.

Nutrition Risk Criteria **115** **HIGH WEIGHT-FOR-LENGTH (INFANTS AND CHILDREN <24 MONTHS OF AGE)**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	-	-
CHILDREN	3	-

Definition

High weight-for-length for infants and children < 24 months of age is defined as follows:

Age	Cut-Off Value
Birth to less than (<) 24 months	Greater than or equal to (≥) 97.7th percentile weight-for-length as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (1) (available at: www.cdc.gov/growthcharts).*
**Based on the 2006 World Health Organization (WHO) international growth standards (2). CDC labels the 97.7th percentile as the 98th percentile on the Birth to 24 months gender specific growth charts. For more information about the percentile cut-off, please see Clarification.*	

Required Documentation

DOB
Weight
Length
CDC Growth Charts (based on the WHO growth standards)

Justification

The WHO and CDC growth charts are similar in that both describe weight-for-age, length (or stature)-for-age, weight-for-length (or stature) and body mass index (BMI) for age. However, they differ in the approach taken to create the growth charts. The WHO growth charts are growth standards that describe how healthy children grow under optimal environmental and health conditions. The 2000 CDC charts are a growth reference, not a standard, and describe how certain children grew in a particular place and time (2).

The WHO growth standards for children < 24 months are based on data collected from 1997-2003 in 6 countries (including the U.S.), from children who were born between 37 and 42 weeks gestation, breastfed for at least 12 months, and introduced to complementary food by at least 6 months but not before 4 months. Infants and children of low-income mothers and/or mothers who smoked were not included in the data sample (2).

The 2000 CDC charts for infants and children < 36 months are based on birth weight (from 1968 to 1980 and from 1985 to 1994) and birth length data (from 1989 to 1994) obtained from U.S. birth certificates, National Health and Nutrition Examination Survey (NHANES) data, and measurements from infants who had been breastfed and formula fed (approximately 50% ever breastfed and approximately 33% who were still breastfeeding at 3 months). Very low birth weight infants were not included in the sample population. This was the only

exclusion criterion applied to the sample population (2, 3).

Prior to making its recommendation, CDC convened an Expert Panel with the National Institutes of Health and the American Academy of Pediatrics to review the scientific evidence and discuss the potential use of the WHO growth standards in the U.S. The recommendation to use WHO growth standards for infants and children < 24 months was made on the basis of input from the Expert Panel. In addition, CDC concluded that the WHO growth standards are based on a high quality study and, since breastfeeding is the recommended infant feeding practice, it is appropriate to use the breastfed infant as the standard against which all other infants are compared (2).

The WHO growth standards use values of 2 standard deviations away from the median to identify children whose growth might be indicative of adverse health conditions (1). The CDC Birth to 24 months growth charts (based on the WHO growth standards) labels 2 standard deviations above the median as the 97.7th percentile. Thus, an infant or child (< 24 months) is categorized as high weight-for-length when plotted at or above the 97.7th percentile, labeled as the 98th percentile on the CDC Birth to 24 months growth charts. The CDC recommends that all infants and children < 24 months be assessed using the CDC Birth to 24 months growth charts regardless of type of feeding (formula or breastfed) (2). (See clarification for information about standard deviations and the cut-off used to determine high weight-for-length.)

In 2006, WHO released international growth standards for infants and children aged 0-59 months (2), similar to the 2000 CDC growth references. Since then, the CDC has developed Birth to 24 months growth charts, based on the WHO growth standards, and recommends their use in the United States (1). For persons 2-20 years, the 2000 CDC growth charts will continue to be used (1).

Implications for WIC Nutrition Services

The WIC Program plays an important role in public health efforts to reduce the the prevalence of obesity by actively identifying and enrolling infants and young children who may be at risk of overweight/obesity in later childhood or adolescence. When identifying this risk, it is important to communicate with parents/caregivers in a way that is supportive and nonjudgmental, and with a careful choice of words that convey an empathetic attitude and minimize embarrassment or harm to a child's self-esteem (4). In recognition of the importance of language, the 2007 American Medical Association Expert Committee Report recommends the use of more neutral terms such as *weight disproportional to height*, *excess weight*, and *high weight-for-length* when communicating with a parent/caregiver (5).

Height and weight measurements are plotted on growth charts at each WIC certification. However, growth charts are meant to be used as a screening tool and comprise only one aspect of the overall growth assessment. A clinical assessment to determine if a child is at a healthy weight is more complex. Weight classification (derived from the growth chart) should be integrated with the growth pattern, familial obesity, medical risks, and dietary and physical activity habits to determine the child's obesity risk (3, 6).

The goal in WIC nutrition counseling is to help the child achieve recommended rates of growth and development. WIC staff can frame the discussion to make achieving normal growth a shared goal of the WIC Program and the parent/caregiver. Studies have shown that the early childhood eating environment provides a great opportunity for preventive intervention (7).

Parents/caregivers of infants and toddlers may need education on recognition of satiety cues and other physiological needs that lead to crying, and ways to comfort a child (holding, reading, rocking) other than by feeding. Young children look upon their parents as role models for eating behaviors. Through client-centered counseling, WIC staff can emphasize the importance of prevention and can assist families in making changes that improve parenting skills that promote healthy eating, physical activity behaviors and a healthy weight in children. Also, the foods provided by the WIC Program are scientifically-based and intended to address the supplemental nutrition needs of the program's target population and can be tailored to meet the needs of individual participants.

Beliefs about what is an attractive or healthy weight, the importance of physical activity, what foods are desirable or appropriate for parents to provide to children, family mealtime routines, and many other lifestyle habits are influenced by different cultures, and should be considered during the nutrition assessment and counseling (8). The following resources for obesity prevention can be found:

- Fit WIC Materials: http://www.nal.usda.gov/wicworks/Sharing_Center/gallery/foodfunfamilies.htm.
- MyPyramid for Preschoolers: http://www.mypyramid.gov/preschoolers/index.html.

In addition, WIC staff can greatly assist families by providing referrals to medical providers and other services, if available, in their community. Such resources may provide the recommended medical assessments, in order to rule out or confirm medical conditions, and offer treatment when necessary and/or in cases where growth improvement is slow to respond to dietary interventions.

Clarification

Standard deviation is a measurement widely used in statistical analysis. It shows how much variation there is from the median. The WHO growth charts use standard deviations to illustrate the proximity of a given child's growth from that of the average child of the same age and gender. For infants and children < 24 months of age, 2 standard deviations above the median indicates high weight-for-length. A measurement of 2 standard deviations below the median indicates underweight. Since most health care providers in the U.S. are more familiar with percentiles, the CDC developed growth charts based on the WHO growth standards, but converted standard deviations into percentile readings. Two standard deviations above the median is the 97.7th percentile; however, for ease of use, CDC labels it as the 98th percentile on the hard copy Birth to 24 months growth charts. Electronic charts should use the 97.7th percentile as the cut-off.

References

1. Centers for Disease Control and Prevention. Use of World Health Organization and CDC growth charts for children aged 0-59 months in the United States. MMWR 2010; 59 (No. RR-9). Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w. Accessed September 2010.
2. World Health Organization. WHO child growth standards: Length/height-for-age, weight-for-age, weight for height and body mass index-for-age: Methods and development. Geneva, Switzerland: World Health Organization; 2006. Available at http://www.who.int/childgrowth/publications/technical_report_pub/en/index.html. Accessed September 2010.

3. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics, 2000.
4. Ogden CL, Flegal KM. Changes in Terminology for childhood overweight and obesity. National health statistics reports; no. 25. Hyattsville (MD): National Center for Health Statistics. 2010.
5. Barlow SE, Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics. 2007; 120; S164-S192.
6. U.S. Department of Health and Human Services. The Surgeon General's vision for a healthy and fit nation. Rockville (MD): U.S. Department of Health and Human Services, Office of the Surgeon General. 2010.
7. Anzman SL, Rolllins BY, Birch LL. Parental influence on children's early eating environments and obesity risk: implications for prevention. International Journal of Obesity 34, 1116-1124 (July 2010).
8. Krebs NF, Himes JH, Jacobson D, Nicklas TA, Guilday P, Styne D. Assessment of child and adolescent overweight and obesity. Pediatrics 2007; 120 Suppl 4: S103-S228.

Nutrition Risk Criteria **121★ SHORT STATURE OR AT RISK OF SHORT STATURE-INFANTS/CHILDREN**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-
CHILDREN	3	-

Definition

Short Stature
Birth up to 2 years: Less than or equal (≤) to 2.3rd percentile length-for-age as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (1).*

2 to 5 years: Less than or equal (≤) to 5th percentile stature (height)-for-age as plotted on the 2000 CDC age/gender specific growth charts (2).

At Risk of Short Stature
Birth up to 2 years: Greater than (>) 2.3rd percentile and less than or equal (≤) 5th percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts (1).*

2 to 5 years: Greater than (>) 5th percentile and less than or equal (≤) 10th percentile stature-for-age as plotted on the 2000 CDC age/gender specific growth charts (2).

*Based on 2006 World Health Organization international growth standards (3). CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts. For more information about the percentile cut-off, please see Clarification.

Notes:

1. The Birth to 24 months and the 2000 CDC growth charts are available at: www.cdc.gov/growthcharts.
2. For premature infants and children (with a history of prematurity) up to 2 years of age, assignment of this risk criterion will be based on adjusted gestational age. For information about adjusting for gestational age see: Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants.

Required Documentation

DOB
Height
CDC growth charts, CDC growth charts based on the WHO growth standards

Justification

The CDC uses the 2.3rd percentile (for birth to 24 months of age) and the 5th percentile (for 2-5 years of age) stature-for-age, as the cut-offs to define short stature in its Pediatric Nutrition Surveillance System (1, 2). However, CDC does not have a position regarding the cut-off percentile which should be used to determine *at risk of short stature* as a nutritional risk in the WIC Program. *At risk of short stature* is included in this criterion to reflect the preventive emphasis of the WIC Program.

Abnormally short stature in infants and children is widely recognized as a

response to an inadequate nutrient supply at the cellular level (4). This indicator can help identify children whose growth is stunted due to prolonged undernutrition or repeated illness (3). Short stature is related to the lack of total dietary energy and to a poor dietary quality that provides inadequate protein, particularly animal protein, and inadequate amounts of micronutrients such as zinc, vitamin A, iron, copper, iodine, calcium, and phosphorus (4). In these circumstances, maintenance of basic metabolic functions takes precedence, and thus resources are diverted from linear growth.

Demonstrable differences in stature exist among children of different ethnic and racial groups. However, racial and ethnic differences are relatively minor compared with environmental factors (1). Growth patterns of children of racial groups whose short stature has traditionally been attributed to genetics have been observed to increase in rate and in final height under conditions of improved nutrition (5, 6).

Short stature may also result from disease conditions such as endocrine disturbances, inborn errors of metabolism, intrinsic bone diseases, chromosomal defects, fetal alcohol syndrome, and chronic systemic diseases (4).

Implications for WIC Nutrition Services

Participation in WIC has been associated with improved growth in both weight and height in children (7). A more in-depth dietary assessment and/or referral to a health care provider may be necessary to determine if short stature is a result of dietary inadequacy or a disease condition. Also, more frequent follow-up to monitor growth is appropriate for children in these categories. Through client-centered counseling WIC staff can assist families in improving dietary intake to promote healthy growth and development. In addition, the foods provided by the WIC Program are scientifically-based and intended to address the supplemental nutritional needs of the Program's target population, and can be tailored to meet the needs of the individual participants.

In addition, WIC staff can greatly assist families by providing referrals to medical providers and other services, if available, in their community. Such resources may provide the recommended medical assessments, in order to rule out or confirm medical conditions, and offer treatment when necessary and/or in cases where growth improvement is slow to respond to dietary interventions.

Clarification

The cut-off for short stature for infants and children > 24 months is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the Birth to 24 months hard copy growth charts. Electronic charts should use the 2.3rd percentile as the cut-off.

References

1. Centers for Disease Control and Prevention. Use of World Health Organization and CDC growth charts for children aged 0-59 months in the United States. MMWR 2010; 59 (No. RR-9). Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w. Accessed September 2010.
2. Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al. CDC growth charts: United States. Advance data from vital and health statistics; no. 314. Hyattsville, Maryland: National Center for Health Statistics. 2000.
3. World Health Organization. WHO child growth standards: Length/height-for-age, weight-for-age, weight for height and body mass index-for-age:

Methods and development. Geneva, Switzerland: World Health Organization; 2006. Available at: http://www.who.int/childgrowth/publications/technical_report_pub/en/index.html. Accessed September 2010.
4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. Washington (DC): National Academy Press; 1996. p. 104-109.
5. Pipes PL, Trahms CM. Nutrition in infancy and childhood, 6th edidition. Seattle (WA): WCB/McGraw-Hill; 1997. p. 2.
6. Berhane R, Dietz WH. Clinical assessment of growth. In: Kessler DB, Dawson P., editors. Failure to thrive and pediatric undernutrition: A transdisciplinary approach. Baltimore (MD): Paul H. Brooks Publishing Company, Inc.; 1999. p. 199.
7. Disbrow DD. The costs and benefits of nutrition services: a literature review. J Am Diet Assoc. 1989; 89:S3-66.

Nutrition Risk Criteria **131★ LOW MATERNAL WEIGHT GAIN**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT	1	RD

Definition

Low maternal weight gain is defined as:

1. A low rate of weight gain, such that in the 2nd and 3rd trimesters, for singleton pregnancies (1):
   - Underweight women gain less than an average of 1 lb per week
   - Normal weight women gain less than an average of .8 lbs per week
   - Overweight women gain less than an average of .5 lbs per week
   - Obese women gain less than an average of .4 lbs per week

OR

2. Low weight gain at any point in pregnancy, such that using an Institute of Medicine (IOM)-based weight gain grid, a pregnant woman's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective prepregnancy weight category (1), as follows:

Prepregnancy Weight Groups	Definition (BMI)	Total Weight Gain Range (lbs)
Underweight	< 18.5	28-40
Normal Weight	18.5 to 24.9	25-35
Overweight	25.0 to 29.9	15-25
Obese	≥ 30.0	11-20

Multi-fetal Pregnancies: See Justification for information.

Note: A BMI table is attached to assist in determining weight classifications. Also, until research supports the use of different BMI cut-offs to determine weight categories for adolescent pregnancies, the same BMI cut-offs to determine weight categories for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.

Required Documentation

Self-reported weight loss is acceptable as long as it meets the criteria.

Pre-pregnancy weight
Height
Weeks gestation
Amount of weight gained to date

Justification

Maternal weight gain during the 2nd and 3rd trimesters is an important determinant of fetal growth. Low maternal weight gain is associated with an increased risk of small for gestational age (SGA) infants, especially in underweight and normal-weight women (1). In addition, low maternal weight gain

is associated with failure to initiate breastfeeding and preterm birth among underweight and to a lesser extent normal weight women (1).

The 2009 Institute of Medicine (IOM) report: Weight Gain During Pregnancy: Reexamining the Guidelines (1) updated the pregnancy weight categories to conform to the categories developed by the World Health Organization and adopted by the National Heart, Lung and Blood Institute in 1998 (2). The reexamination of the guidelines consisted of a review of the determinants of a wide range of short and long term consequences of variation in weight gain during pregnancy for both the mother and her infant. The IOM prenatal weight gain recommendations based on prepregnancy weight status categories are associated with improved maternal and child health outcomes (1).

Included in the 2009 IOM guidelines is the recommendation that the BMI weight categories used for adult women be used for pregnant adolescents as well. More research is needed to determine whether special categories are needed for adolescents.

It is recognized that the IOM BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM BMI cut-offs will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines; normal-weight women should gain 37-54 lbs; overweight women, 31-50 lbs; and obese women, 25-42 lbs. There was insufficient information for the IOM committee to develop even provisional guidelines for underweight women with multiple fetuses (1). A consistent rate of weight gain is advisable. A gain of 1.5 lbs per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy (3). In triplet pregnancies the overall gain should be around 50 lbs with a steady rate of gain of approximately 1.5 lbs per week throughout the pregnancy (3). For WIC eligibility determinations, multi-fetal pregnancies are considered a nutrition risk in and of themselves (ID NRC 61, USDA Code 335, Multi-Fetal Gestation), aside from the weight gain issue.

The supplemental foods, nutrition education, and counseling related to the weight gain guidelines provided by the WIC Program may improve maternal weight status and infant outcomes (4).

Clarification

The Centers for Disease Control and Prevention (CDC) defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

First Trimester: 0-13 weeks
Second Trimester: 14-26 weeks
Third Trimester: 27-40 weeks

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the estimated date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data

on pregnant women participating in the WIC Program

References

1. Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines (Prepublication Copy). National Academy Press, Washington, D.C.; 2009. www.nap.edu. Accessed June 2009.
2. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults, NIH Publication No.: 98-4083, 1998. www.nhlbi.nih.gov, Accessed June 2009.
3. Brown JE and Carlson M. Nutrition and multifetal pregnancy. J Am Diet Assoc. 2000; 100:343-348.
4. Institute of Medicine. (1996) *WIC Nutrition Risk Criteria: A Scientific Assessment.* National. Academy Press, Washington, D.C.

Additional Related References

1. Brown JE, Schloesser PT. Pregnancy weight status, prenatal weight gain, and the outcome of term twin gestation. Am. J. Obstet. Gynecol. 1990; 162:182-6.
2. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol, 1992; 79:664-9.
3. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol, 1994; 84:565-73.
4. Suitor, CW. (1997) Maternal Weight Gain: A Report of an Expert Work Group. Arlington, VA: National Center for Education in Maternal and Child Health. Sponsored by Maternal and Child Health Bureau. Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.
5. Williams RL, Creasy RK, Cunningham GC< Hawes WE, Norris FD, Tashiro M. Fetal growth and perinatal viability in California. Obstet. Gynecol. 1982; 59:624-32.

Nutrition Risk Criteria **132★ MATERNAL WEIGHT LOSS DURING PREGNANCY**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD

Definition

FIRST TRIMESTER (weeks 1-13) Any weight loss below pre-pregnancy weight.
SECOND TRIMESTER (weeks 14-26) Weight loss of 2 lbs or greater.
THIRD TRIMESTER (weeks 27-40+) Weight loss 2 lbs or greater.

Required Documentation

Self-reported weight loss is acceptable as long as it meets the criteria
Pre-pregnancy
Height
Weeks gestation
Amount of weight gained to date

Justification

Weight loss during pregnancy may indicate underlying dietary or health practices or health or social conditions associated with poor pregnancy outcomes. These outcomes could be improved by the supplemental food, nutrition education, and referrals provided by the WIC Program.

References

1. Brown JE. Prenatal weight gain considerations for WIC. Final report. Commissioned by the Risk Identification and Selection Collaborative. 1998.
2. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.
3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
4. Metropolitan Life Insurance Company. New weight standards for men and women. Stat.Bull.Metrop.Life Insur.Co., 1959.

Nutrition Risk Criteria **133★ HIGH MATERNAL WEIGHT GAIN**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant Women

1. A high rate of weight gain, such that in the 2nd and 3rd trimesters, for singleton pregnancies (1):
   - Underweight women gain more than 1.3 lbs per week
   - Normal weight women gain more than 1 lb per week
   - Overweight women gain more than .7 lbs per week
   - Obese women gain more than .6 lbs per week

OR

2. High weight gain at any point in pregnancy, such that using an Institute of Medicine (IOM)-based weight gain grid, a pregnant woman's weight plots at any point above the top line of the appropriate weight gain range for her respective prepregnancy weight category.

Breastfeeding or Non-breastfeeding Women (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the IOM's recommended range (2) based on Body Mass Index (BMI) for singleton pregnancies, as follows (1):

Prepregnancy Weight Groups	Definition (BMI)	Cut-off Value
Underweight	< 18.5	> 40 lbs
Normal Weight	18.5 to 24.9	> 35 lbs
Overweight	25.0 to 29.9	> 25 lbs
Obese	≥ 30.0	> 20 lbs

Multifetal Pregnancies: See Justification for information.

Note: A BMI table is attached to assist in determining weight classification. Also, until research supports the use of different BMI cut-offs to determine weight categories for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility. (See Justification for a more detailed explanation.)

Required Documentation

Self-reported weight gain is acceptable as long as it meets the criteria.

Pre-pregnancy weight
Height
Weeks gestation
Amount of weight gained to date

Justification

Women with excessive gestational weight gains are at increased risk for cesarean delivery and delivering large for gestational age infants that can secondarily lead to complications during labor and delivery. There is a strong association between higher maternal weight gain and both postpartum weight retention and subsequent maternal obesity. High maternal weight gain may be associated with glucose abnormalities and gestational hypertension disorders, but the evidence is inconclusive. (1)

Childhood obesity is one of the most important long-term child outcomes related to high maternal weight gain. A number of epidemiologic studies show that high maternal weight gain is associated with childhood obesity as measured by BMI. (1)

The 2009 Institute of Medicine (IOM) report: *Weight Gain During Pregnancy: Reexamining the Guidelines* (1) updated the pregnancy weight categories to conform to the categories developed by the World Health Organization and adopted by the National Heart, Lung and Blood Institute in 1998 (2). The reexamination of the guidelines consisted of a review of the determinants of a wide range of short and long term consequences of variation in weight gain during pregnancy for both the mother and her infant. The IOM prenatal weight gain recommendations based on prepregnancy weight status categories are associated with improved maternal and child health outcomes (1).

Included in the 2009 IOM guidelines is the recommendation that the BMI weight categories used for adult women be used for pregnant adolescents as well. More research is needed to determine whether special categories are needed for adolescents.

It is recognized that both the IOM BMI cut-offs for defining weight categories will classify some adolescents differently than the CDC BMI-for-age charts. For the purpose of WIC eligibility determination, the IOM BMI cut-offs will be used for all women regardless of age. However, due to the lack of research on relevant BMI cut-offs for pregnant and postpartum adolescents, professionals should use all of the tools available to them to assess these applicants' anthropometric status and tailor nutrition counseling accordingly.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines: normal weight women should gain 37-54 lbs; overweight women, 31-50 lbs; and obese women, 25-42 lbs. There was insufficient information for the IOM committee to develop even provisional guidelines for underweight women with multiple fetuses (1). A consistent rate of weight gain is advisable. A gain of 1.5 lbs per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy (3). In triplet pregnancies the overall gain should be around 50 lbs with a steady rate of gain of approximately 1.5 lbs per week throughout pregnancy (3). Education by the WIC nutritionist should address a steady rate of weight gain that is higher than for singleton pregnancies. For WIC eligibility determinations, multi-fetal pregnancies are considered a nutrition risk in and of themselves (ID NRC 61, USDA Code 335, Multi-Fetal Gestation), aside from the weight gain issue.

The supplemental foods, nutrition education, and counseling related to the weight gain guidelines provided by the WIC Program may improve maternal weight status and infant outcomes (1). In addition, WIC nutritionists can play an important role, through nutrition education and physical activity promotion, in

assisting postpartum women achieve and maintain a healthy weight.

Clarification

The Centers for Disease Control and Prevention (CDC) defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

First Trimester: 0-13 weeks
Second Trimester: 14-26 weeks
Third Trimester: 27-40 weeks

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the estimated date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data on pregnant women participating in the WIC Program.

References

1. Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines (Prepublication Copy), National Academy Press, Washington, D.C.; 2009. www.nap.edu. Accessed June 2009.
2. National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. National Institutes of Health Publication No.: 98-4083, 1998. www.nhibi.nih.gov. Accessed June 2009.
3. Brown JE and Carlson M. Nutrition and multifetal pregnancy. J Am Diet Assoc. 2000; 100:343-348.
4. Institute of Medicine. WIC nutrition risk criteria: a scientific assessment. National Academy Press, Washington, D.C., 1996.

Additional Related References

1. Carmichael S, Abrams B, Selvin S. The pattern of maternal weight gain in women with good pregnancy outcomes. Am. J. Pub. Hlth. 1997; 87; 12:1984-1988.
2. Brown JE, Schlosser PT. Pregnancy weight status, prenatal weight gain, and the outcome of term twin gestation. Am. J. Obstet. Gynecol. 1990; 162:182-6.
3. Parker JD, Abrams B. Prenatal weight gain advice: an examination of the recent prenatal weight gain recommendations of the Institute of Medicine. Obstet Gynecol 1992; 79:664-9.
4. Siega-Riz AM, Adair LS, Hobel CJ. Institute of Medicine maternal weight gain recommendations and pregnancy outcomes in a predominately Hispanic population. Obstet Gynecol, 1994; 84:565-73.
5. Suitor CW, editor. Maternal weight gain: A report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.
6. Waller K. Why neural tube defects are increased in obese women. Contemporary OB/GYN 1997; p. 25-32.

Nutrition Risk Criteria **134** **FAILURE TO THRIVE**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

Presence of failure to thrive (FTT) diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Note: For premature infants with a diagnosis of FTT also see: "Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants" (FNS Policy Memorandum 98-9, Revision 7, April 2004).

Required Documentation

N/A

Justification

Failure to thrive (FTT) is a serious growth problem with an often complex etiology. Some of the indicators that a physician might use to diagnose FTT include:

- weight consistently below the 3rd percentile for age;
- weight < 80% of ideal weight for height/age;
- progressive fall-off in weight to below the 3rd percentile; or
- a decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile.

FTT may be a mild form of Protein Energy Malnutrition (PEM) that is manifested by a reduction in rate of somatic growth. Regardless of the etiology of FTT, there is inadequate nutrition to support weight gain.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Berkow R, Fletcher AJ. The Merck manual of diagnosis and therapy. Rahway, N.J.: Merck Sharp & Dohme Research Laboratories, 1992.
2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **135★ INADEQUATE GROWTH (FORMERLY WEIGHT GAIN)**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

An inadequate rate of weight gain as defined below.

A. Infants who are age birth to one month with either of these conditions:
- Excessive weight loss after birth (10%) or more
- Not back to birth weight by age 2 weeks

B. Infants from birth to 6 months of age:
Based on two weights taken at least one month apart, the infant's actual weight gain is less than the calculated expected minimal weight gain based on the table below. See Attachment 135-A for metric equivalents and for examples.

Age	Average Weight Gain			
Birth-1 mo	18 g/day	4½ oz/wk	19 oz/mo	1 lb 3 oz/mo
1-2 mos	25 g/day	6¼ oz/wk	27 oz/mo	1 lb 11 oz/mo
2-3 mos	18 g/day	4½ oz/wk	19 oz/mo	1 lb 3 oz/mo
3-4 mos	16 g/day	4 oz/wk	17 oz/mo	1 lb 1 oz/mo
4-5 mos	14 g/day	3½ oz/wk	15 oz/mo	
5-6 mos	12 g/day	3 oz/wk	13 oz/mo	

C. Infants and children from 6 months to 59 months of age:

Option 1: Based on two weights taken at least three months apart, the infant's or child's actual weight gain is less than the calculated expected weight gain based on the table below. See Attachment 135-A for metric equivalents and for examples.

Age	Average Weight Gain			
6-12 mos	9 g/day	2¼ oz/wk	9½ oz/mo	3 lbs 10 oz/6 mos
12-59 mos	2½ g/day	0.6 oz/wk	2.7 oz/mo	1 lb/6 mos

OR

Option II: A low rate of weight gain over a six-month period (+ or – 2 weeks) as defined by the following chart. See Attachment 135-B for guidance on using measurements not taken within a 5-6 month interval.

Age in months at end of 6-month interval	Weight gain per 6-month interval in lbs
6	≤ 7
9	≤ 5
12	≤ 3
18-60	≤ 1

Attachment 135-A:

Metric Equivalents for Average Weight Gain

Infants from birth to 6 months of age (need two weights taken at least one month apart):

Age	Average Weight Gain (Metric Equivalents)		
Birth-1 mo	18 g/day	126 g/wk	0.54 kg/mo
1-2 mos	25 g/day	175 g/wk	0.75 kg/mo
2-3 mos	18 g/day	126 g/wk	0.54 kg/mo
3-4 mos	16 g/day	112 g/wk	0.48 kg/mo
4-5 mos	14 g/day	98 g/wk	0.42 kg/mo
5-6 mos	12 g/day	84 g/wk	0.36 kg/mo

Infants and children from 6 months to 59 months of age (need two weights taken at least three months apart):

Age	Average Weight Gain (Metric Equivalents)			
6-12 mos	9 g/day	63 g/wk	0.27 kg/mo	1.62 kg/6 mos
12-59 mos	2½ g/day	17½ g/wk	0.08 kg/mo	0.45 kg/6 mos

Examples Using Calculated Expected Minimal Weight

General steps:
1. Determine if time interval between measures is sufficient.
2. Calculate actual weight gain.
3. Calculate expected minimal weight gain using the chart in the definition. *(Note: Due to a variety of reasons, including rounding, different approaches to calculating the expected minimal weight gain may result in slightly different answers.)*
4. Compare the actual weight gain with the calculated expected weight gain to see if person is eligible for WIC using this criterion.

Example #1

Date of Measures	Weight
9/13/98 (birth)	7 lbs 6 oz
9/23/98 (10 days old)	8 lbs 1 oz
10/26/98 (6 wks, 1 day old)	9 lbs 3 oz

1. Interval between birth and 10/26/98 measures = 43 days
2. Actual wt gain = 1 lb 13 oz
3. Expected minimal weight gain is: (540 g) + (13 days x 25 g/day) = 865 g = 30 oz = 1 lb 15 oz
4. Actual weight gain from birth is less than expected minimal weight gain = eligible for WIC using this criterion

Example #2

Date of Measures	Weight
2/27/00 (17½ mos old)	25 lbs
9/13/00 (24 mos old)	26½ lbs

1. Interval between two measures is 6½ months
2. Actual weight gain = 1½ lbs
3. Expected minimal weight gain is: (1 lb per 6 months) divided by (0.5 mo x 2.7 oz/mo) = 1 lb 1.35 oz
4. Actual weight gain is MORE than expected weight gain so NOT eligible for WIC using this criterion.

Attachment 135-B

Steps to calculate a low rate of weight gain when the two weight measurements are NOT within a 5½ - 6½ month interval:

1. Use the two bullets below to determine if the two measurements were taken within an acceptable time interval for this risk to apply. If they do, proceed to step #2. If they do not, Option II CANNOT be used to determine eligibility for WIC.

    - For children > 5 months through 17 months of age, the two measurements must be taken within a 5-7 month range *(remember, for measurements taken within a 5½ - 6½ month interval, you do not need to proceed with steps 2-5, just use the chart to determine the applicability of the risk).*

    - For children 18 months to < 60 months of age, the two measurements must be taken within a 4-9 month interval *(remember, for measurements taken within a 5½ - 6½ month interval, you do not need to proceed with the steps 2-5, just use the chart to determine the applicability of the risk).*

2. Plot both weights on an age and sex specific CDC growth grid.

3. From the chart, choose the age from column 1 that most closely matches the child's age when the second weight was taken and choose the weight gain from column 2 that corresponds with this age.

4. Add this weight gain figure to the first of the two weights and plot the sum of the weights on the growth grid at a point exactly 6 months from the date of the first weight.

5. Connect the point for the first weight with the point for the sum of the weights with a straight line *(extend the line if there is a seven month interval between the two weights).* If the point for the second weight is on or below the line then the child's growth is inadequate.

Required Documentation

DOB
Weight
Height
BMI
CDC growth charts

Justification

Weight for age is a sensitive indicator of acute nutritional inadequacy. The rate of gain during infancy—especially early infancy—is rapid, and abnormalities in rate of weight gain may often be detected in just a few months. There is little question that decrease in the rate of weight gain during infancy is the earliest indication of nutritional failure. In contrast, children beyond infancy grow rather slowly, and many months of observation may be required to demonstrate that the rate of weight gain is unusually slow. During the first 18 months of life, the rate of change in weight fluctuates and then declines rapidly. Because of this deceleration, it may be difficult to differentiate normal growth slowing from an abnormal rate. After 18 months, weight gain becomes more linear, so

assessment becomes easier.

Infants and children with abnormally slow growth can benefit from nutrition and health interventions to improve weight and height gain. The diagnosis of slow growth must consider possible causes of growth changes, including undereating and disease conditions. Undereating, for any number of reasons, and disease conditions are the main causes of abnormally slow growth. Factors associated with undereating by an infant or child include inadequate sources of nutrient dense foods; lack of social support for the caregiver; an adverse social and psychological environment; a disorganized family; depressed parents or caregivers; and the caregiver's lack of education, health and nutrition knowledge, mental and physical abilities, and responsibility for child care. There is good evidence that through nutrition education, supplemental foods, and referrals to other health and social services, participation in the WIC Program will benefit infants and children with slow growth. In keeping with the preventive nature of the WIC Program, a cut-off point approximating the 10th percentile rate of change in weight for age was chosen.

References

1. Baumgartner RN, Roche AF, Himes JH. Incremental growth tables: Supplementary to previously published charts. Am.J.Clin.Nutr. 1986; 43:711-722.
2. Fomon SJ. Nutrition of normal infants. St. Louis: Mosby, 1993.
3. Guo S, Roche AF, Fomon SF, Nelson SE, Chumlea WC, Rogers RR, et al. Reference data on gains in weight and length during the first two years of life. J.Pediatr. 1991; 119:355-362.
4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **141★ LOW BIRTH WEIGHT**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD

Definition

Low Birth Weight (LBW)
Birth weight defined as less than or equal to (≤) 5 lbs 8 oz (≤ 2500g) for infants and children less than 24 months.

Required Documentation

DOB
Birth weight

Justification

Low Birth Weight (LBW) is one of the most important biologic predictors of infant death and deficiencies in physical and mental development during childhood among those babies who survive and continues to be a strong predictor of growth in early childhood. Infants and children born with LBW, particularly if caused by fetal growth restriction, need an optimal nutrient intake to survive, meet the needs of an extended period of relatively rapid postnatal growth, and complete their growth and development.

References

1. Groh-Wargo S, Thompson M, Cox JH, Hartline JV. Nutritional care for high-risk newborns. editors Sharon Groh-Wargo, Melody Thompson, Janice Hovasi Cox; consulting editor John V. Hartline. Chicago: Precept Press, Inc, 1994.
2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **142★ PREMATURITY**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN (less than 24 months of age)	3	RD

Definition

Birth at less than or equal to (≤) 37 weeks gestation for infants and children up to age 24 months (2 years**).**

Note: See "Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants" (FNS Policy Memorandum 98-9, Revision 7, April 2004) for more information on the anthropometric assessment and nutritional care of premature infants.

Required Documentation

N/A

Justification

Premature infants may have physical problems that have nutritional implications, including immature sucking, swallowing and immature digestion and absorption of carbohydrates and lipids. Premature infants have increased nutrient and caloric needs for rapid growth. Premature infants grow well on breast milk. WIC promotes breastfeeding and provides nutrition education about infant feeding.

Reference

Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **153★ LARGE FOR GESTATIONAL AGE**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	-

Definition

Large for Gestational Age
Birth weight greater than or equal to (≥) 9 lbs (4000g);

OR

Presence of large for gestational age diagnosed by a physician. If self-reported diagnosis by a physician by the applicant/participant/caregiver, then local agency RD must verify diagnosis with physician or medical care provider and document in progress notes.

Required Documentation

DOB
Birth weight

Justification

Infant mortality rates are higher among full-term infants who weigh > 4,000 g (> 9 lbs) than for infants weighing between 3,000 and 4,000 g (6.6 and 8.8 lbs). Oversized infants are usually born at term; however, preterm infants with weights high for gestational age also have significantly higher mortality rates than infants with comparable weights born at term. Large for Gestational Age may be a result of maternal diabetes (which may or may not have been diagnosed before or during pregnancy) and may result in obesity in childhood that may extend into adult life.

Very large infants regardless of their gestational age, have a higher incidence of birth injuries and congenital anomalies (especially congenital heart disease) and developmental and intellectual retardation. When large for gestational occurs with pre-term birth, the mortality risk is higher than when either condition exists alone.

Weight should be plotted weekly on an intrauterine or postnatal growth chart and monitored for progress. Intrauterine growth charts have been developed by compiling birth weight, length, and head circumference of infants at varying gestational ages and reflect intrauterine growth, while postnatal growth charts were developed from extrauterine growth data. Both types of growth charts have limitations that should be considered. Choice and use of growth charts are typically facility-specific and determined by the medical team. The Oregon Intrauterine Growth Chart (Babson/Benda), Denver Intrauterine Growth Chart (Lubchenco), and the Hall/Shaffer and Wright Postnatal Growth Charts are generally available to monitor growth by gestational age. Copies of the Babson/Benda and Lubchenco charts are provided in the Reference Material Section.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Babson SG, Benda GI. Growth graphs for the clinical assessment of infants of varying gestational age. J.Pediatr. 1976; 89:814-20.
2. Behrman RE, Kliegman R, Jenson HB. Nelson textbook of pediatrics. Philadelphia: Saunders, 2000.
3. Lubchenco LO, Hansman C, Boyd E. Intrauterine growth in length and head circumference as estimated from live births at gestational ages from 26 to 42 weeks. Pediatrics 1966; 37:403-8.

Nutrition Risk Criteria **201★ LOW HEMATOCRIT/LOW HEMOGLOBIN**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD if
BREASTFEEDING WOMEN	1	Hct ≤ 31.0, Hb ≤
NON-BREASTFEEDING WOMEN	6	10.0, or no rise on
INFANTS	1	recheck
CHILDREN	3	

Definition

Hematocrit or hemoglobin value below a baseline for healthy, well nourished individuals of the same age, sex. Adjustments are made for trimester of pregnancy, smoking status, and altitude. The baseline is the 95th confidence interval (0.025th percentile).

Refer to Table 1 HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES for each clinic site.

Required Documentation

ALL: Hematocrit or Hemoglobin value and date, clinic altitude (tables)
INFANTS/CHILDREN: DOB
PREGNANT: Weeks gestation
WOMEN: Smoking status

Justification

Hemoglobin (Hb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hb and Hct reflect the amount of functional iron in the body. Changes in Hb concentration and Hct occur at the late stages of iron deficiency. While neither an Hb or Hct test are direct measures of iron status and do not distinguish among different types of anemia, these tests are useful indicators of iron deficiency anemia.

Iron deficiency is by far the most common cause of anemia in children and women of childbearing age. It may be caused by a diet low in iron, insufficient assimilation of iron from the diet, increased iron requirements due to growth or pregnancy, or blood loss. Anemia can impair energy metabolism, temperature regulation, immune function, and work performance. Anemia during pregnancy may increase the risk of prematurity, poor maternal weight gain, low birth weight, and infant mortality. In infants and children, even mild anemia may delay mental and motor development. The risk increases with the duration and severity of anemia, and early damages are unlikely to be reversed through later therapy.

Clarification

1. **Basis for bloodwork assessment:** For pregnant women being assessed for iron deficiency anemia, bloodwork must be evaluated using trimester values established by CDC. Thus, a pregnant woman would be certified, based on the trimester in which her bloodwork was taken.

2. **Definition of Trimester:** CDC defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

   First Trimester: 0-13 weeks
   Second Trimester: 14-26 weeks

Third Trimester: 27-40 weeks.

3. **Adjustments for smoking:** A State agency may elect to use only one cutoff for all smokers rather than making specific adjustments based on the individual applicant's smoking frequency. If the State chooses to use only one category for this issue, the "up to < 1 pack/day" cutoff values category as shown on Tables 201-A and 201-B is the only one that may be used.

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the estimated date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data on pregnant women participating in the WIC Program.

References

1. Centers for Disease Control and Prevention. Criteria for anemia in children and childbearing-aged women. MMWR 1998:47: RR-3.
2. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.
3. Institute of Medicine. Iron deficiency anemia: recommended guidelines for the prevention, detection, and management among U.S. children and women of childbearing age. National Academy Press, Washington, D.C.; 1993.
4. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
5. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 1: PANHANDLE WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Athol Bonners Ferry Hayden Kellogg Priest River Sandpoint St. Maries	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Athol Bonners Ferry Hayden Kellogg Priest River Sandpoint St. Maries	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 2: NORTH CENTRAL WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lewiston Moscow Orofino	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---
3000-3999 ft. Grangeville	NON-SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lewiston Moscow Orofino	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---
3000-3999 ft. Grangeville	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 3: SOUTHWEST WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Canyon County Canyon Springs Council Emmett Farmway Village Grand View Homedale Payette Teen Parent Weiser Wilder	NON-SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 3: SOUTHWEST WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Canyon County Canyon Springs Council Emmett Farmway Village Grand View Homedale Payette Teen Parent Weiser Wilder	NON-SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 4: CENTRAL WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Boise Glenns Ferry Horseshoe Bend	NON- SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---
3000-3999 ft. Garden Valley Idaho City Mountain Home	NON- SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---
4000-4999 ft. Cascade	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. McCall	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 4: CENTRAL WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Boise Glenns Ferry Horseshoe Bend	NON- SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---
3000-3999 ft. Garden Valley Idaho City Mountain Home Mtn Home AFB	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---
4000-4999 ft. Cascade	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. McCall	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 5: SOUTH CENTRAL WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
3000-3999 ft. Gooding Jerome Shoshone Twin Falls	NON-SMOKER	11.2	10.7	11.2	12.0	11.2	11.3
	SMOKER	11.5	11.0	11.5	12.3	---	---
4000-4999 ft. Burley	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. Bellevue Hailey	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 5: SOUTH CENTRAL WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
3000-3999 ft. Gooding Jerome Shoshone Twin Falls	NON-SMOKER	33.5	32.5	33.5	36.2	33.4	33.5
	SMOKER	34.5	33.5	34.5	37.2	---	---
4000-4999 ft. Burley	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. Bellevue Hailey	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 6: SOUTHEASTERN WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Aberdeen American Falls Blackfoot Fort Hall Malad Preston Pocatello Roosevelt Teen	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. Arco Montpelier Soda Springs	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 6: SOUTHEASTERN WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Aberdeen American Falls Blackfoot Fort Hall Malad Preston Pocatello Roosevelt Teen	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. Arco Montpelier Soda Springs	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 7: EASTERN WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Idaho Falls, Rexburg, Rigby, Salmon, St. Anthony, Terreton	NON-SMOKER	11.3	10.8	11.3	12.1	11.3	11.4
	SMOKER	11.6	11.1	11.6	12.4	---	---
5000-5999 ft. Challis, Dubois	NON-SMOKER	11.5	11.0	11.5	12.3	11.5	11.6
	SMOKER	11.8	11.3	11.8	12.6	---	---
6000-6999 ft. Driggs	NON-SMOKER	11.7	11.2	11.7	12.5	11.7	11.8
	SMOKER	12.0	11.5	12.0	12.8	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

DISTRICT 7: EASTERN WIC PROGRAM

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
4000-4999 ft. Idaho Falls, Rexburg, Rigby, Salmon, St. Anthony, Terreton	NON-SMOKER	34.0	33.0	34.0	36.7	33.9	34.0
	SMOKER	35.0	34.0	35.0	37.7	---	---
5000-5999 ft. Challis, Dubois	NON-SMOKER	34.5	33.5	34.5	37.2	34.4	34.5
	SMOKER	35.5	34.5	35.5	38.2	---	---
6000-6999 ft. Driggs	NON-SMOKER	35.0	34.0	35.0	37.7	34.9	35.0
	SMOKER	36.0	35.0	36.0	38.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

AGENCY 8: NEZ PERCE WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lapwai	NON- SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Kamiah Lapwai	NON- SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---

TABLE 1: HEMOGLOBIN AND HEMATOCRIT BASELINE VALUES

AGENCY 11: BENEWAH WIC PROGRAM

HEMOGLOBIN

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Plummer	NON- SMOKER	11.0	10.5	11.0	11.8	11.0	11.1
	SMOKER	11.3	10.8	11.3	12.1	---	---

HEMATOCRIT

Values less than baseline values for healthy, well-nourished individuals are considered at risk. Adjustments are made for trimester of pregnancy, smoking status, and altitude. Baseline is the 95th confidence interval (0.025th percentile).

CLINIC SITES	SMOKING STATUS	PREGNANT WOMEN			ALL POSTPARTUM WOMEN	INFANTS AND CHILDREN	
		FIRST 1-13 WKS	SECOND 14-26 WKS	THIRD 27-40+ WKS		6-23 MO	2-5 YRS
<3000 ft. Plummer	NON- SMOKER	33.0	32.0	33.0	35.7	32.9	33.0
	SMOKER	34.0	33.0	34.0	36.7	---	---

Nutrition Risk Criteria **301 HYPEREMESIS GRAVIDARUM**

	Category	Priority	Referral
Category, Priority and Referral	PREGNANT WOMEN	1	RD

Definition

Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. Presence of Hyperemesis Gravidarum diagnosed by physician as self reported by applicant/participant/caregiver, or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Document in participant file source of information (i.e. self report of diagnosis by physician; written physician diagnosis).

Justification

Nausea and vomiting are common early in gestation; 50% or more of normal pregnant women experience some vomiting. However, pregnant women with severe vomiting during pregnancy are at risk of weight loss, dehydration, and metabolic imbalances. Nutrition risk is based on chronic conditions, not single episodes.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Reference

Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **302 GESTATIONAL DIABETES**

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	PREGNANT WOMEN	1	RD

Definition

Gestational diabetes mellitus (GDM) is defined as any degree of glucose/ carbohydrate intolerance with onset or first recognition during pregnancy (1, 2).

Presence of gestational diabetes diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Document in participant file source of information (i.e. self-report of physician diagnosis or physician documentation).

Justification

The definition of GDM applies regardless of whether insulin or only diet modification is used for treatment, or whether the condition persists after pregnancy. Included in this classification are women who may have had undiagnosed diabetes prior to pregnancy but who are first diagnosed during pregnancy (1, 2). Pregnant women requiring the use of exogenous steroids, tocolytics, or other medications, or who have medical conditions that alter glucose tolerance, may develop GDM (2). GDM represents nearly 90% of all pregnancies complicated by diabetes (1). The criteria for the diagnosis of GDM (3) are shown in Table 1 (see Clarification).

Pregnancy is an insulin-resistant and diabetogenic state (2). Deterioration of glucose tolerance occurs normally during pregnancy, particularly in the 3rd trimester (1, 2). Untreated or poorly treated GDM results in a higher risk of morbidity and mortality for both the mother and the fetus (2).

Established risk factors for GDM are advanced maternal age, obesity, and family history of diabetes (4). Risk assessment for GDM should be undertaken at the first prenatal visit. Women with clinical characteristics consistent with a high risk for GDM (e.g., those with marked obesity, personal history of GDM or delivery of a previous large-for-gestation-age infant, glycosuria, polycystic ovary syndrome, or a strong family history of diabetes) should undergo glucose testing as soon as possible (5). Unquestionably, there are also ethnic differences in the prevalence of GDM. In the U.S., Native Americans, Asians, Hispanics, and African American women are at a higher risk for GDM than non-Hispanic White women. Besides obesity, there is a suggestion that physical inactivity, diets high in saturated fat and smoking are associated with increasing risk for GDM or recurrent GDM (4).

Infants of women with GDM are at an increased risk of developing obesity, impaired glucose tolerance or diabetes as children or young adults (4). GDM is associated with a higher incidence of maternal and fetal complications. Maternal complications include polycythemia, respiratory distress syndrome, and increased rate of stillbirth (6). Although rarely seen in GDM, congenital anomalies, neural tube defects, cardiac abnormalities and/or caudal regression may occur if a woman has GDM in the early first trimester (6, 7).

Since GDM is a risk factor for subsequent type 2 diabetes after delivery, lifestyle modifications aimed at reducing weight and increasing physical activity are

recommended (8). The National Diabetes Education Program (NDEP) is currently promoting a GDM Prevention Initiative, targeting both providers and women with a GDM history (). Key messages are illustrated in Table 2 (see Clarification).

Medical Nutrition Therapy (MNT) is the primary treatment for the management of GDM (7). MNT for GDM primarily involves a carbohydrate-controlled meal plan that promotes optimal nutrition for maternal and fetal health with adequate energy for appropriate gestational weight gain, achievement and maintenance of normoglycemia, and absence of ketosis (7, 8). Breastfeeding should be strongly encouraged as it is associated with maternal weight loss and reduced insulin resistance for both mother and offspring (10). WIC nutrition services can reinforce and support the medical and diet therapies (such as MNT) that participants with GDM receive form their health care providers.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Women at high risk for GDM who have tested negative at the initial screening, and women at average risk for GDM should be tested by a license medical provider, between 24 and 28 weeks of gestation. Women of average risk should be tested at 24-28 weeks of gestation. Testing should follow one of two approaches:

- **One-step approach:** perform a diagnostic 100-g OGTT (Oral Glucose Tolerance Test)

- **Two-step approach:**
  1. A screening test (glucose challenge test) that measures plasma or serum glucose is done 1 hour after a 50 g oral glucose load without regard for time of day or time of last meal. If a plasma or serum glucose level meets or exceeds the threshold (≥ 130 mg/dl [7.2 mmol/L] or ≥ 140 mg/dl [7.8 mmol/L] respectively), an OGTT is performed (3).

  2. A diagnosis of GDM is made with a 100 g oral glucose load after an overnight fast. Using a 3-hour test, if two or more plasma or serum glucose levels meet or exceed the threshold, a diagnosis of GDM is made. Alternatively, the diagnosis can be made using a 75 g oral glucose load. The glucose threshold values for both tests are listed in Table 1 (10). The 75 g glucose load test is not as well validated as the 100 g OGTT.

With either the 75 g OGTT or the 100 g OGTT, it is recommended that the test be performed after an overnight fast of at least 8 hours but no longer than 14 hours. For 3 days prior to the test the woman should consume an unrestricted diet (≥ 150 g carbohydrate per day) and maintain unrestricted physical activity. Women need to remain seated and not smoke during the test. (1, 2).

Table 1. Diagnosis of Gestational Diabetes Mellitus with a 100 g or 75 g Oral Glucose Load

Time (h)	100 g Oral Glucose Load	75 g Oral Glucose Load
Fasting	95 mg/dL (5.3 mmol/L)	95 mg/dL (5.3 mmol/L)
1	180 mg/dL (10.0 mmol/L)	180 mg/dL (10.0 mmol/L)
2	155 mg/dL (8.6 mmol/L)	155 mg/dL (8.6 mmol,/L)
3	140 mg/dL (7.8 mmol/L)	

Two or more of the venous plasma concentrations must be met or exceeded for a positive diagnosis.
Source: American Diabetes Association (3).

Table 2. Gestational Diabetes Mellitus (GDM) Prevention Initiative from the National Diabetes Education Program

- GDM imparts lifelong risk for diabetes, mostly type 2
- Modest weight loss and physical activity can delay or prevent type 2 diabetes
- Offspring can lower risk of diabetes by eating healthy foods, being active, and not becoming overweight

Conservative recommendations to patients include:

- Let health care practitioners know of any history of GDM.
- Get glucose testing at 6 to 12 weeks postpartum, then every 1-2 years.
- Reach pre-pregnancy weight 6 to 12 months postpartum.
- If still overweight, lose at least 5 to 7% of weight slowly, over time, and keep it off.

Adapted from the National Diabetes Education Program (9).

References

1. American Diabetes Association: Diagnosis and classification of diabetes mellitus. Diabetes Care, Jan 2008; 31 Suppl 1:S55-60.
2. Franz MJ, Biastre SA, Slocum J, Diabetes in the life cycle and research. In: Gestational Diabetes – A core curriculum for diabetes education, American Association of Diabetes Educators. 5th ed. 2003.
3. American Diabetes Association. Gestational diabetes mellitus (position statement), Diabetes Care. 2003; 26 Suppl 1:S103-105.
4. Ferrara, A. Increasing prevalence of gestational diabetes mellitus: a public health perspective. Proceedings of the fifth international workshop – conference on Gestational Diabetes Mellitus. Diabetes Care. Jul 2007; 30 Suppl 2:S141-46.
5. American Diabetes Association. Standards of medical care in diabetes (position statement). Diabetes Care. Jan 2007; 30 Suppl 2:S4-41.
6. Thomas AM, Gutierrez YM. American Dietetic Association guide to gestational diabetes mellitus in postpartum considerations. Eds. American Dietetic Association; 2005:101-113.
7. Brian SR, Nickless N, Thung SF, Inzucchio SE. Gestational diabetes update: screening, medical management and follow-up. Practical Diabetology. Mar 2007; 10-18.
8. American Diabetes Association. Diagnosis and classification of diabetes mellitus. Diabetes Care. 2008 Jan; 31 Suppl 1:S55-60.
9. Ratner, RE. Prevention of type 2 diabetes in women with previous gestational diabetes. Proceedings of the fifth international workshop – conference on gestational diabetes mellitus. Diabetes Care. Jul 2007; 30 Suppl 2:S242-245.
10. Evert AG, Vande Hei K. Gestational diabetes education and diabetes prevention strategies. Diabetes Spectrum. 2006; 19(3):135-139.

Nutrition Risk Criteria **303 HISTORY OF GESTATIONAL DIABETES**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

History of diagnosed gestational diabetes mellitus (GDM).

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Document in participant file source of information (i.e. self report of diagnosis by physician).

Justification

Women who have had a pregnancy complicated by GDM are 40-60% more likely to develop diabetes within 15-20 years (1), usually type 2 (2). This risk of subsequent diabetes is greatest in women with GDM who are diagnosed early in the pregnancy, exhibit the highest rates of hyperglycemia during the pregnancy, and are obese.

Approximately 30-50% of the women with a history of GDM will develop GDM in a subsequent pregnancy. Studies have found that the risk factors for subsequent GDM include insulin use in the index pregnancy, obesity, diet composition*, physical inactivity, failure to maintain a healthy BMI and weight gain between pregnancies (2, 3). In addition, if a woman's lipid levels are elevated, a history of GDM is also a risk factor for cardiovascular disorders (3).

There is evidence to suggest that some women with a history of GDM show relative beta-cell dysfunction during and after pregnancy (3). Most women with a history of GDM are insulin resistant. Changes in lifestyle (dietary and physical activity) may improve postpartum insulin sensitivity and could possibly preserve B-cell function to slow the progression to type 2 diabetes (2, 3).

During WIC nutrition education and counseling, obese women with a history of GDM should be encouraged to lose weight before a subsequent pregnancy. Breastfeeding has been shown to lower the blood glucose level and to decrease the incidence of type 2 diabetes in women with a history of GDM (2, 3). Exercise also has a beneficial effect on insulin action by enhancing peripheral tissue glucose uptake (3). Medical Nutrition Therapy (MNT) is an essential component in the care of women with a history of GDM.

Women with a history of GDM but without immediate subsequent postpartum diagnosis of diabetes should be advised to discuss with their medical provider the importance of having a Glucose Tolerance Testing (GTT) at 6 to 12 weeks postpartum (see Clarification, Table 1); to have a pre-pregnancy consultation before the next pregnancy, and to request early glucose screening in the next pregnancy (4). The National Diabetes Education Program (NDEP) is currently promoting a GDM Diabetes Prevention Initiative, targeting both providers and women with a history of GDM (5). Key messages are illustrated in Table 2. (See Clarification).

WIC nutrition services can support and reinforce the MNT and physical activity recommendations that participants receive from the health care providers. In addition, WIC nutritionists can play an important role in providing women with counseling to help manage their weight after delivery. Also, children of women with a history of GDM should be encouraged to establish and maintain healthy dietary and lifestyle behaviors to avoid excess weight gain and reduce their risk for type 2 diabetes (1).

***Diet Composition**
Carbohydrate is the main nutrient that affects postprandial glucose evaluations. During pregnancy complicated with GDM, carbohydrate intake can be manipulated by controlling the total amount of carbohydrate, the distribution of carbohydrate over several meals and snacks, and the type of carbohydrate. These modifications need not affect the total caloric intake level/prescription (6).

Because there is wide inter-individual variability in the glycemic index each woman needs to determine, with the guidance of the dietitian, which foods to avoid or use in smaller portions at all meals or during specific times of the day, for the duration of her pregnancy. Practice guidelines have avoided labeling foods as “good” or “bad”

Meal plans should be culturally appropriate and individualized to take into account the patient’s body habits, weight gain and physical activity; and should be modified as needed throughout pregnancy to achieve treatment goals (6).

Clarification

Self-reporting for “History of…”conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that she was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

Table 1. Reasons for Delayed Postpartum Glucose Testing of Women with Prior Gestational Diabetes Mellitus (GDM)

1. The substantial prevalence of glucose abnormalities detected by 3 months postpartum.
2. Abnormal test results identify women at high risk of developing diabetes over the next 5 to 10 years.
3. Ample clinical trial evidence in women with glucose intolerance that type 2 diabetes can be delayed or prevented by lifestyle interventions or modest and perhaps intermittent drug therapy.
4. Women with prior GDM and impaired glucose tolerance (IGT) have cardiovascular disease (CVD) risk factors. Interventions may reduce subsequent CVD, which is the leading cause of death in both types of diabetes.
5. Identification, treatment, and planning of pregnancy in women developing diabetes after GDM should reduce subsequent early fetal loss and major congenital malformations.

Kitzmiller JL, Dang-Kilduff L, Taslimi MM

Table 2. Gestational Diabetes Mellitus (GDM) Prevention Initiative form the National Diabetes Education Program

- GDM imparts lifelong risk for diabetes, mostly type 2.
- Modest weight loss and physical activity can delay or prevent type 2 diabetes.
- Offspring can lower risk by eating healthy foods, being active, and not becoming overweight.

Conservative recommendations to patients include:

- Let health care practitioners know of any history of GDM.
- Get glucose testing at 6 to 12 weeks postpartum, then every 1-2 years.
- Reach prepregnancy weight 6 to 12 months postpartum.
- If still overweight, lose at least 5 to 7 % of weight slowly, over time, and keep it off.

Adapted from the National Diabetes Education Program.

References

1. Evert AG, Vande Hei K. Gestational diabetes education and diabetes prevention strategies. Diabetes Spectrum. 2006; 19 (3):135-139.
2. Franz MJ, Biastre SA, Slocum J. Diabetes in the life cycle and research. In: Gestational diabetes – A core curriculum for diabetes education, American Association of Diabetes Educators. 5th ed. 2003; 145-163.
3. Thomas AM, Gutierrez YM. American Dietetic Association guide to gestational diabetes mellitus in postpartum considerations. Eds. American Dietetic Association. 2005; 101-113.
4. Kitzmiller JL, Dang-Kilduff L, Taslimi MM. Gestational diabetes after delivery: short-term management and long-term risks. Proceedings of the fifth international workshop – conference on Gestational Diabetes Mellitus. Diabetes Care. Jul 2007; 30 Suppl 2:S225-231.
5. Ratner RE. Prevention of type 2 diabetes in women with previous gestational diabetes. Proceedings of the fifth international workshop—conference on Gestational Diabetes Mellitus. Diabetes Care. Jul 2007; 30 Suppl 2:S242-245.
6. Reader DM. Medical nutrition therapy and lifestyle interventions. Proceedings of the fifth international workshop – conference on Gestational Diabetes Mellitus. Diabetes Care. Jul 2007; 30 Suppl 2:S188-193.

Nutrition Risk Criteria **304 HISTORY OF PREECLAMPSIA**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

History of diagnosed preeclampsia.

Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under a physician's orders.

Required Documentation

Document in participant file source of information (i.e. self report of physician diagnosis or written documentation from physician).

Justification

Preeclampsia is defined as pregnancy-induced hypertension (> 140mm Hg systolic or 90mm diastolic) with proteinuria developing usually after the twentieth week of gestation (1, 2). Clinical symptoms of preeclampsia may include edema, renal failure, and the HELLP syndrome (Hemolysis, Elevated Liver enzymes and Low Platelets).

Preeclampsia is a leading cause of maternal death and a major contributor to maternal and perinatal morbidity (3). Women who have had preeclampsia in a prior pregnancy have an increased risk of recurrence (about 20% overall) (4). The risk is greater in women who have had preeclampsia occurring early in pregnancy or who have had preeclampsia in more than one pregnancy. Additionally, maternal pre-pregnancy obesity with BMI ≥ 30 is the most prevalent risk factor for preeclampsia (4).

Risk factors for preeclampsia include (2, 4, 5):

- Pre-pregnancy obesity BMI ≥ 30
- Preeclampsia in a prior pregnancy
- Nulliparity (no prior delivery)
- Maternal age > 35 years
- Endocrine disorders (e.g., diabetes),autoimmune disorders (e.g., lupus), renal disorders
- Multi-fetal gestation
- Genetics
- Black race

There are few established nutrient recommendations for the prevention of preeclampsia. However, vitamin D may be important because it influences vascular structure and function, and regulates blood pressure (4). Also, calcium may prevent preeclampsia among women with very low baseline calcium intake (4).

There is no treatment for preeclampsia. The condition resolves itself only when the pregnancy terminates or a placenta is delivered (4). Early prenatal care, therefore, is vital to the prevention of the onset of the disease.

WIC is well poised to provide crucial strategies during the critical interconceptual

period to help reduce the risk of recurrence of preeclampsia in a subsequent pregnancy.

WIC nutrition education encourages practices shown by research to have a protective effect against developing preeclampsia (2, 4, 5). These include:

- Gaining recommended weight based on pre-pregnancy BMI, in order to help return to a healthy postpartum weight
- Scheduling early prenatal care visits
- Consuming a diet adequate in calcium and vitamin D
- Taking prenatal vitamins
- Engaging in regular physical activity
- Discontinuing smoking and alcohol consumption

Postpartum Women: Women who have had preeclampsia should be advised that they are at risk for recurrence of the disease and development of cardiovascular disease (CVD) later in life (4, 7). WIC nutrition education can emphasize measures that support the prevention of preeclampsia in a future pregnancy, such as reaching or maintaining a healthy BMI and lifestyle between pregnancies, consuming a nutritionally adequate diet consistent with the Dietary Guidelines for Americans, and engaging in regular physical activity.

Pregnant Women: The WIC Program provides supplemental foods rich in nutrients, especially calcium and vitamin D, which research has shown to have a protective effect on preeclampsia (4). During nutrition education, WIC can encourage actions or behaviors that also have been shown to have a protective effect against preeclampsia: early prenatal care, taking a prenatal vitamin, and engaging in physical activity (6). WIC can also discourage smoking and alcohol consumption (2), and counsel pregnant women to gain recommended weight based on pre-pregnancy BMI (8) and to return to pre-pregnancy weight or a healthy BMI of < 25 for the benefit of future pregnancies.

Clarification

Self-reporting for “history of...” conditions should be treated in the same manner as self-reporting for current conditions requiring a physician’s diagnosis, e.g., the applicant may report to the CPA that she was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
2. American Dietetic Association, Pediatric Nutrition Practice Group. Pediatric manual of clinical dietetics. Chicago: Pediatric Nutrition Dietetic Practice Group, American Dietetic Association, 1998.
3. Stenson W. The esophagus and stomach. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkins 1999. p. 1125-1133.
4. Beyer PL. Medical nutrition therapy for upper gastrointestinal tract disorders. In: Mahan LK, Escott-Slump S, editors. Krause’s food nutrition and diet therapy. 11th ed. Philadelphia: Saunders; 2004. p. 688-690.
5. American Dietetic Association. Nutrition Care Manual. Gastrointestinal disease; Peptic ulcers; 2006. http://www.nutritioncaremanual.org. Accessed 1/08.

6. Allied Health Sciences Section Ad Hoc Nutrition committee: Aills L, Blankenship J, Buffington C, Furtado M and Parrot J. Bariatric nutrition: suggestions for the surgical weight loss patient. Review. Surgery for Obesity and Related Diseases 2008 May 17.
7. Scolapio JS, Fleming R. Short Bowel Syndrome. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkins; 1999. p. 1135-1140.
8. Farrell M. Gastrointestinal disorders of infancy and childhood (with nutrition support and probiotics) In: Ekvall SW, Ekvall VK. Editors. Pediatric nutrition in chronic diseases and developmental disorders. 2nd ed. Oxford University Press; 2005. p. 248-249.
9. Griffiths A. Inflammatory bowel disease. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkins; 1999. p. 1141-1149.
10. Lieber CS. Nutrition in liver disorders. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams 7 Wilkins; 1999. p. 1177-1189.
11. Raimondo m, Dimagno EP. Nutrition in pancreatic disorders. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkinds; 1999. p. 1169-1176.
12. Hasse JM, Matarese JE. Medical nutrition therapy for liver, biliary system and exocrine pancreas disorders. In: Mahan LK, Escott-Stump S, editors. Krause's food nutrition and diet therapy. 11th ed. Philadelphia: Saunders; 2004. p. 758-760.

Nutrition Risk Criteria **311 HISTORY OF PRETERM DELIVERY**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Birth of an infant at ≤ 37 weeks gestation

Pregnant Women: any history of preterm delivery
Breastfeeding/Non-breastfeeding: most recent pregnancy

Required Documentation

N/A

Justification

Preterm birth causes at least 75% of neonatal deaths not due to congenital malformations (1). In most cases of preterm labor, the cause is unknown. Epidemiologic studies have consistently reported low socioeconomic status, nonwhite race, maternal age of ≤ 18 years or ≥ 40 years, and low prepregnancy underweight as risk factors. A history of one previous preterm birth is associated with a recurrent risk of 17-37% (2, 3); the risk increases with the number of prior preterm births and decreases with the number of term deliveries.

References

1. American College of Obstetricians and Gynecologists. Preterm Labor. Technical Bulletin 206. Washington, DC: ACOG, 1995.
2. Hoffman HJ, Bakketeig LS. Risk factors associated with the occurrence of preterm birth. Clin.Obstet.Gynecol. 1984; 27:539-52.
3. Keiirse MJNC, Rush RW, Anderson AB, Turnbull AC. Risk of preterm delivery in patients with a previous preterm delivery and/or abortion. Br.J.Obstet.Gynecol. 1978; 85:81-85.

Nutrition Risk Criteria **312 HISTORY OF LOW BIRTH WEIGHT**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Birth of an infant weighing ≤ 5 lbs 8 oz (≤ 2500 g)

Pregnant Women: any history of low birth weight
Breastfeeding/Non-breastfeeding: most recent pregnancy

Required Documentation

N/A

Justification

A woman's history of a delivery of a low birth weight (LBW) baby is the most reliable predictor for LBW in her subsequent pregnancy (1). The risk for LBW is 2-5 times higher than average among women who have had previous LBW deliveries and increases with the number of previous LBW deliveries (1). This is true for histories in which the LBW was due to premature birth, fetal growth restriction (FGR) or a combination of these factors. The extent to which nutritional interventions (dietary supplementation and counsel) can decrease risk for repeat LBW, depends upon the relative degree to which poor nutrition was implicated in each woman's previous poor pregnancy outcome. Nutritional deficiencies and excesses have been shown to result in LBW and pregnancy loss. The pregnant woman's weight gain is one of the most important correlates of birth weight and of FGR (2, 3).

References

1. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.
2. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
3. Kramer MS. Intrauterine growth and gestational duration determinants. Pediatrics 1987; 80:502-11.

Nutrition Risk Criteria **321** **HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

A spontaneous abortion (SAB) is the spontaneous termination of a gestation at < 20 weeks gestation or < 500 g.
Fetal death is the spontaneous termination of a gestation at ≥ 20 weeks
Neonatal death is the death of an infant within 0-28 days of life.

Pregnant women: any history of fetal or neonatal death or 2 or more spontaneous abortions
Breastfeeding women: most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living
Non-breastfeeding: most recent pregnancy

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

N/A

Justification

Pregnancy:

Previous fetal and neonatal deaths are strongly associated with preterm low birth weight (LBW) and small for gestational age (SGA) and the risk increases as the number of previous poor fetal outcomes goes up.

Spinnillo et al found that the risk for future small for gestational age outcomes increased two fold if a woman had 2 or more SAB. Adverse outcomes related to history of SAB include recurrent SAB, low birth weight (including preterm and small for gestational age infants), premature rupture of membranes, neural tube defects and major congenital malformations. Nutrients implicated in human and animal studies include energy, protein, folate, zinc, and vitamin A.

Postpartum women:

A SAB has been implicated as an indicator of a possible neural tube defect in a subsequent pregnancy. Women who have just had a SAB or a fetal or neonatal death should be counseled to increase their folic acid intake and delay a subsequent pregnancy until nutrient stores can be replenished.

The extent to which nutritional interventions (dietary supplementation and counseling) can decrease the risk for repeat poor pregnancy outcomes depends upon the relative degree to which poor nutrition was implicated in each woman's previous poor pregnancy outcome. WIC Program clients receive foods and services that are relevant and related to ameliorating adverse pregnancy

outcomes. Specifically, WIC food packages include good sources of implicated nutrients. Research confirms that dietary intake of nutrients provided by WIC foods improve indicators of nutrient status and/or fetal survival in humans and/or animals.

NOTE: A woman who becomes pregnant within 16 months after a SAB (her first) would qualify for risk #332, Closely Spaced Pregnancies.

Clarification

Self-reporting for "History of…" conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that she was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

References

1. American College of Obstetricians and Gynecologists. Preterm Labor. Technical Bulletin 206. Washington, DC: ACOG, 1995.
2. Carmi R, Gohar J, Meizner I, Katz M. Spontaneous abortion--high risk factor for neural tube defects in subsequent pregnancy [see comments]. Am.J.Med.Genet. 1994; 51:93-7.
3. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.
4. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
5. Kramer MS. Intrauterine growth and gestational duration determinants. Pediatrics 1987; 80:502-11.
6. Paz JE, Otano L, Gadow EC, Castilla EE. Previous miscarriage and stillbirth as risk factors for other unfavourable outcomes in the next pregnancy. Br.J.Obstet.Gynecol. 1992; 99:808-12.
7. Shapiro S, Ross LF, Levine HS. Relationship of selected prenatal factors to pregnancy outcome and congenital anomalies. Am.J.Public Health 1965; 55; 2:268-282.
8. Spinillo A, Capuzzo E, Piazzi G, Nicola S, Colonna L, Iasci A. Maternal high-risk factors and severity of growth deficit in small for gestational age infants. Early Hum.Dev. 1994; 38:35-43.
9. Thorn DH. Spontaneous abortion and subsequent adverse birth outcomes. Am.J.Obstet.Gyn. 1992; 111-6.

Nutrition Risk Criteria **331★ PREGNANCY AT YOUNG AGE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Conception ≤ 17 years of age.

Pregnant Women: current pregnancy
Breastfeeding/Non-breastfeeding: most recent pregnancy

Required Documentation

DOB
EDC

Justification

Pregnancy before growth is complete, is a nutritional risk because of the potential for competition for nutrients for the pregnancy needs and the woman's growth.

The pregnant teenager is confronted with many special stresses that are superimposed on the nutritional needs associated with continued growth and maturation.

Younger pregnant women of low socioeconomic status tend to consume less than recommended amounts of protein, iron, and calcium, and are more likely to come into pregnancy already underweight. Pregnant teens who participate in WIC have been shown to have an associated increase in mean birth weight and a decrease in LBW outcomes.

Adolescent mothers frequently come into pregnancy underweight, have extra growth related nutritional needs, and because they often have concerns about weight and body image, are in need of realistic, health promoting nutrition advice and support during lactation. Diets of adolescents with low family incomes typically contain less iron, and less vitamin A than are recommended during lactation.

The adolescent mother is also confronted with many special stresses superimposed on the normal nutritional needs associated with continued growth. Nutrition status and risk during the postpartum period follow from the nutritional stresses of the past pregnancy, and in turn have an impact on nutrition related risks in subsequent pregnancies. Poor weight gain and low intakes of a variety of nutrients are more common in pregnant adolescents. Therefore, participation in the WIC Program should be of substantial benefit.

References

1. Endres J, Dunning S, Poon SW, Welch P, Duncan H. Older pregnant women and adolescents: nutrition data after enrollment in WIC. J.Am.Diet.Assoc. 1987; 87:1011-6, 1019.
2. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
3. Kennedy ET, Kotelchuck M. The effect of WIC supplemental feeding on birth weight: a case-control analysis. Am.J.Clin.Nutr. 1984; 40:579-85.
4. Story M, editor. Nutrition management of the pregnant adolescent a practical reference guide. Washington, D.C.: National Clearinghouse; 1990. Sponsored by the March of Dimes Birth Defects Foundation, U.S. Department of Health and Human Services, U.S. Department of Agriculture.

Nutrition Risk Criteria **332★ CLOSELY SPACED PREGNANCIES**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Conception before 16 months postpartum.

Pregnant Women: current pregnancy
Breastfeeding/Non-breastfeeding: most recent pregnancy

Required Documentation

EDC
Previous pregnancy end date

Justification

Pregnancy stimulates an adjustment of the mother to a new physiological state which results in rapid depletion of maternal stores of certain nutrients. Mothers with closely spaced pregnancies do not have sufficient time to replenish the nutritional deprivations of the previous pregnancy. Breastfeeding places further nutritional demands on the mother and may increase risks to the pregnancy. After birth, readjustments take place. It is undesirable for another pregnancy to occur before the readjustment is complete since a short interconceptional time period may leave the woman in a compromised nutritional state and at risk for a poor pregnancy outcome. Among low income, inner-city, multiparous women, inter-pregnancy intervals of less than 12 months have been associated with lower folate levels in the postpartum period.

There is a sharply elevated relative risk for low birth weight (LBW) when the interconception interval is less than 6 months. An increased risk persists for inter-pregnancy intervals of up to 18 months and holds when adjusted for potential confounders. The increased risk is for small gestational age term births rather than for LBW due to prematurity.

In one study, postpartum women who received WIC supplements for 5-7 months, delivered higher mean birth weights and lengths and had a lower risk of low birth weight than women who received supplements for two months or less. Women who were supplemented longer had higher mean hemoglobin values and a lower risk of maternal obesity at the subsequent pregnancy. Recognizing the potential problems associated with closely spaced pregnancies, WIC Program Regulations specifically include this condition.

References

1. Caan B, Horgen DM, Margen S, King JC, Jewell NP. Benefits associated with WIC supplemental feeding during the interpregnancy interval. Am.J.Clin.Nutr. 1987; 45:29-41.
2. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.
3. Lang JM, Lieberman E, Ryan KJ, Monson RR. Interpregnancy interval and risk of preterm labor [see comments]. Am.J.Epidemiol. 1990; 132:304-9.
4. Lieberman E, Lang JM, Ryan KJ, Monson RR, Schoenbaum SC. The

association of inter-pregnancy interval with small for gestational age births. Obstet.Gynecol. 1989; 74:1-5.
5. Schall JL, et al. Maternal micronutrient and short interpregnancy interval. In: Society for Epidemiologic Research Annual Meeting 1991 Abstracts; Buffalo, New York; 1991;134;7:770.
6. WIC Program Regulations, Sect. 246.7 (e)(2)(ii).
7. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria **334 LACK OF OR INADEQUATE PRENATAL CARE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-

Definition

Prenatal care beginning after the 1st trimester (after 13th week), or based on an Inadequate Prenatal Care Index published in a peer review articlesuch as the one by Kessner et al. (4).

First prenatal visit in the third trimester (7-9 months) or:

Weeks Gestation	Number of Prenatal Visits (2)
14-21	0 or unknown
22-29	1 or less
30-31	2 or less
32-33	3 or less
34 or more	4 or less

Required Documentation

Number of prenatal care visits (or no visits).

Justification

Women who do not receive early and adequate prenatal care are more likely to deliver premature, growth retarded, or low birth weight infants (3). The Kessner Index can be used to assess the adequacy of prenatal care for a woman with an uncomplicated pregnancy. Women with medical or obstetric problems, as well as younger adolescents, may need closer management; the frequency of prenatal visits should be determined by the severity of identified problems (1). Several studies have reported significant health and nutrition benefits for pregnant women enrolled in the WIC Program (3).

Clarification

The Centers for Disease Control and Prevention (CDC) defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

- First Trimester: 0-13 weeks
- Second Trimester: 14-26 weeks
- Third Trimester: 27-40 weeks

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the established date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data on pregnant women participating in the WIC Program.

References

1. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. Washington, D.C.: AAP, ACOG; 1997.
2. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.
3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
4. Kessner DM, Singer J, Kalk CE, Schlesinger ER. Infant Death: An analysis by maternal risk and health care. Contrasts in Health Status; Vol. I. Washington, D.C.: Institute of Medicine, National Academy of Sciences; 1973.

Nutrition Risk Criteria **335★ MULTIFETAL GESTATION**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	-

Definition

Pregnant Women: more than one (> 1) fetus in current pregnancy.

Breastfeeding and Non-breastfeeding Women: most recent pregnancy.

Required Documentation

Document source of information in participant file (self report or physician diagnosis).

Justification

Multifetal gestations are associated with low birth weight, fetal growth restriction, placental and cord abnormalities, preeclampsia, anemia, shorter gestation and an increased risk of infant mortality. Twin births account for 16% of all low birth weight infants. The risk of pregnancy complications is greater in women carrying twins and increases markedly as the number of fetuses increases.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines: normal weight women should gain 37-54 lbs; overweight women, 31-50 lbs; and obese women, 25-42 lbs (3). There was insufficient information for the IOM committee to develop even provisional guidelines for underweight women with multiple fetuses. A consistent rate of weight gain is advisable. A gain of 1.5 lbs per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy (2). In triplet pregnancies the overall gain should be around 50 lbs with a steady rate of gain of approximately 1.5 lbs per week throughout the pregnancy (2). Education by the WIC nutritionist should address a steady rate of weight gain that is higher than for singleton pregnancies.

Pregnant or breastfeeding women with twins have greater requirements for all nutrients than women with only one infant. Postpartum, non-breastfeeding women delivering twins are at greater nutritional risk than similar women delivering only one infant. All three groups of women would benefit greatly from the nutritional supplementation provided by the WIC Program.

References

1. Brown JE and Carlson M. Nutrition and multifetal pregnancy. J Am Diet Assoc. 2000; 100:343-348.
2. Institute of Medicine. WIC nutrition risk criteria: a scientific assessment. National Academy Press, Washington, D,C.; 1996.
3. Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines (Prepublication Copy). National Academy Press, Washington, D.C.; 2009. www.nap.edu. Accessed June 2009.

Additional Related References

1. Brown JE, Schloesser PT. Pregnancy weight status, prenatal weight gain, and the outcome of term twin gestation. Am.J.Obstet.Gynecol.

1990;162:182-6.
2. Suitor CW, editor. Maternal weight gain a report of an expert work group. Arlington, Virginia: National Center for Education in Maternal and Child Health; 1997. Sponsored by Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.
3. Williams RL, Creasy RK, Cunningham GC, Hawes WE, Norris FD, Tashiro M. Fetal growth and perinatal viability in California. Obstet.Gynecol. 1982;59:624-32.
4. Worthington-Roberts, BS. Weight gain patterns in twin pregnancies with desirable outcomes. Clin.Nutr. 1988;7:191-6.

Nutrition Risk Criteria **336 FETAL GROWTH RESTRICTION**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD

Definition

Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation (IUGR)), may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight $< 10^{th}$ percentile for gestational age.

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

See above

Justification

Fetal Growth Restriction (FGR) usually leads to low birth weight (LBW), which is the strongest possible indicator of perinatal mortality risk. Severely growth restricted infants are at increased risk of fetal and neonatal death, hypoglycemia, polycythemia, cerebral palsy, anemia, bone disease, birth asphyxia, and long term neurocognitive complications. FGR may also lead to increased risk of ischemic heart disease, hypertension, obstructive lung disease, diabetes mellitus, and death from cardiovascular disease in adulthood. FGR may be caused by conditions affecting the fetus such as infections and chromosomal and congenital anomalies. Restricted growth is also associated with maternal height, prepregnancy weight, birth interval, and maternal smoking. WIC's emphasis on preventive strategies to combat smoking, improve nutrition, and increase birth interval, may provide the guidance needed to improve fetal growth.

References

1. Altman DG, Hytten FE. Intrauterine growth retardation: let's be clear about it. Br.J.Obstet.Gynaecol. 1989;96:1127-32.
2. Barros FC, Huttly SR, Victora CG, Kirkwood BR, Vaughan JP. Comparison of the causes and consequences of prematurity and intrauterine growth retardation: a longitudinal study in southern Brazil. Pediatrics 1992;90:238-44.
3. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
4. Institute of Medicine. Nutrition during pregnancy; part I, weight gain and part II, nutrient supplements. National Academy Press, Washington, D.C. 1990.
5. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
6. Kramer MS, Olivier M, McLean FH, Dougherty GE, Willis DM, Usher RH. Determinants of fetal growth and body proportionality. Pediatrics 1990;86:18-26.
7. Kramer MS, Olivier M, McLean FH, Willis DM, Usher RH. Impact of intrauterine growth retardation and body proportionality on fetal and neonatal outcome. Pediatrics 1990;86:707-13.
8. Stein ZA, Susser M. Intrauterine growth retardation: epidemiological issues

and public health significance. Semin.Perinatol. 1984;8:5-14.
9. Williams SR. Nutrition and diet therapy. St. Louis, Missouri: Times Mirror/Mosby College Pub, 1989.
10. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria **337 HX LARGE FOR GESTATIONAL AGE (LGA) INFANT**

Category, Priority, and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	**RD**
BREASTFEEDING WOMEN	1	**-**
NON-BREASTFEEDING WOMEN	6	**-**

Definition

Pregnant Women: **Any** history of giving birth to an infant weighing greater than or equal to (≥) 9 lbs (4000 g).

Breastfeeding/Non-breastfeeding Women: Most recent pregnancy; or history of giving birth to an infant weighing greater than or equal to (≥) 9 lbs (4000 g).

Required Documentation

Diagnosed by a physician or self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Justification

Women with a previous delivery of an infant weighing more than 9 lbs (4000 g) are at an increased risk of giving birth to a large for gestational age infant. Macrosomia may be an indicator of maternal diabetes (current or gestational) or a predictor of future diabetes.

The incidence of maternal, fetal, and neonatal complications is high with neonates weighing 9 lbs (4000 g). Risks for the infant include dystocia, meconium aspiration, clavicular fracture, brachia plexus injury, and asphyxia.

References

1. Boyd, M.E, et al. (1983) Fetal Macrosomia: Prediction, risks, proposed management. *Obstet. Gynecol*. 1983; 61:715-722.
2. Institute of Medicine. (1990) *Nutrition During Pregnancy*. National Academy Press. p. 117, 187.
3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. Washington (DC): National Academy Press; 1996. p. 117.

Nutrition Risk Criteria **338** **PREGNANT WOMAN CURRENTLY BREASTFEEDING**

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	PREGNANT WOMEN	1	RD

Definition

Breastfeeding woman now pregnant.

Required Documentation

Justification

Breastfeeding during pregnancy can influence the mother's ability to meet the nutrient needs of her growing fetus and nursing baby. Generally, pregnancy hormones cause the expectant mother's milk supply to drastically decline (until after delivery). If the mother conceived while her nursing baby was still solely or predominantly breastfeeding, the baby could fail to receive adequate nutrition. In addition to changes in milk volume and composition, mothers who breastfeed throughout a pregnancy usually report that their nipples, previously accustomed to nursing, become extremely sensitive (presumably due to pregnancy hormones). When women nurse through a pregnancy it is possible that oxytocin released during breastfeeding could trigger uterine contractions and premature labor. When a mother chooses to nurse through a pregnancy, she needs breastfeeding counseling.

Reference

Mohrbacher N, Stock J, La LL, I. The breastfeeding answer book. Schaumburg, Ill: La Leche League International, 1997.

Nutrition Risk Criteria **339** **HISTORY OF BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess vitamin A.

Pregnant Women: any history of birth with nutrition-related congenital or birth defect
Breastfeeding/Non-breastfeeding: most recent pregnancy

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

See above

Justification

The single greatest risk factor for a pregnancy with a neural tube defect is a personal or family history of such a defect. More than 50% of recurrences can be prevented by taking folic acid before conception. Recent studies suggest that intake of folic acid may also be inversely related to the occurrence of cleft lip and palate. The WIC Program provides nutrition education and folic acid-rich foods to women to help prevent future birth defects.

Recurrent birth defects can also be linked to other inappropriate nutritional intake prior to conception or during pregnancy, such as inadequate zinc (LBW) or excess vitamin A (cleft palate or lip). The food package and nutrition education provided to WIC participants help women at risk make food choices that provide appropriate nutrient levels.

Clarification

Self-reporting for “History of…”conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that she was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

References

1. Federal Register, Part III, DHHS, FDA, 21 CFR Part 101, Food Labeling: Health Claims and Label Statements, Folate and Neural Tube Defects. Proposed and Final Rule. March 5, 1996;61;44:8752-8781.
2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **341 NUTRIENT DEFICIENCY DISEASES**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micronutrients. Diseases include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beri Beri, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Cheilosis, Menkes Disease, Xerophthalmia.

Presence of nutrient deficiency diseases diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

The presence of macro- and micro-nutrient deficiencies indicates current nutrition health risks.

Persistent malnutrition may lead to elevated morbidity and mortality rates. Important functional disturbances may occur as a result of single or multiple nutrient deficiencies. Examples include impaired cognitive function, impaired function of the immune system, and impaired function of skeletal muscle. Participation in the WIC Program provides key nutrients and education to help restore nutrition status and promote full rehabilitation of those with an overt nutrient deficiency.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis (“My doctor says that I have/my son or daughter has…” Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
2. Worthington-Roberts BS, Williams SR. Nutrition throughout the life cycle, 4th edition. Boston: McGraw-Hill, 2001.

Nutrition Risk Criteria **342 GASTRO-INTESTINAL DISORDERS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Disease(s) or condition(s) that interferes with the intake, digestion, and/or absorption of nutrients. The diseases and/or conditions include, but are not limited to:

- peptic ulcer
- post-bariatric surgery
- short bowel syndrome
- inflammatory bowel disease, including ulcerative colitis or Crohn's disease
- liver disease
- pancreatitis
- gastroesophageal reflux disease (GERD)
- biliary tract diseases

Presence of gastro-intestinal disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Gastrointestinal disorders increase nutrition risk through a number of ways, including impaired food intake, abnormal deglutition, impaired digestion of food in the intestinal lumen, generalized or specific nutrient malabsorption, or excessive gastrointestinal losses of endogenous fluids and nutrients. Frequent loss of nutrients through vomiting, diarrhea, malabsorption, or infections can result in malnourishment and lowered resistance to disease (1, 2).

Gastroesophageal Reflux Disease (GERD)
GERD is irritation and inflammation of the esophagus due to reflux of gastric acid into the esophagus (3). Nutritional care of GERD includes avoiding eating within 3 hours before going to bed; avoiding fatty foods, chocolate, peppermint, and spearmint, which may relax the lower esophageal sphincter; and coffee and alcoholic beverages, which may increase gastric secretion (4). Consumption of these items may need to be limited depending on individual tolerance.

Peptic Ulcer
Peptic ulcer normally involves the gastric and duodenal regions of the gastrointestinal tract (4). Because the primary cause of peptic ulcers is Helicobacter pylori infection, the focus of treatment is the elimination of the bacteria with antibiotic and proton pump inhibitor therapy. Dietary advice for persons with peptic ulcers is to avoid alcohol, coffee (with and without caffeine), chocolate, and specific spices, such as black pepper (4, 5).

Post-bariatric Surgery
Many types of surgical procedures are used for the intervention of morbid obesity. These procedures promote weight loss by restricting dietary intakes, e.g., adjustable gastric banding (AGB), and/or bypassing some portion of intestine to cause incomplete digestion and/or malabsorption of nutrients, e.g., Roux-y gastric bypass (RYGB). Therefore, the risks for developing nutritional deficiencies after bariatric surgery are greatly increased. Since gastric bypass individuals have both a decreased availability of gastric acid and intrinsic factor, vitamin B_{12} deficiency can develop without supplementation. Taking daily nutritional supplements and eating foods high in vitamins and minerals are important aspects of the nutritional management for the individuals who have had bariatric surgery (6).

Short Bowel Syndrome (SBS)
SBS is the result of extensive small bowel restriction. SBS in infants is mostly the result of small bowel resection for the treatment of congenital anomalies, necrotizing enterocolitis, and congenital vascular. In adults, Crohn's disease, radiation enteritis, mesenteric vascular accidents, trauma, and recurrent intestinal obstruction are the most common conditions treated by small bowel resection and resulting in SBS (4). The loss of a large segment of the small bowel causes malabsorption syndrome. Total parental nutrition usually is started within the first few days after intestinal resection. Gradual supplementation with enteral feeding promotes intestinal adaptation in order to wean from parenteral nutrition therapy. Supplementation with fat soluble vitamins and vitamin B_{12} may be needed (7). The pediatric client's nutritional status must be assessed and growth closely monitored (8).

Inflammatory Bowel Disease (IBD)
Inflammatory bowel disease includes Crohn's disease and ulcerative colitis. Weight loss, growth impairment, and malnutrition are the most prevalent nutritional problems observed in IBD. Nutritional support is essential. Exclusive elemental nutrition has been used in attaining the remission of Crohn's disease. However, symptoms tend to recur promptly after resuming the conventional diet (9).

Liver Disease
Since the liver plays an essential role in the metabolic processes of nutrients, liver disorders have far-reaching effects on nutritional status. Acute liver injury is often associated with anorexia, nausea and vomiting. Therefore, inadequate nutritional intakes are common. Decreased bile salt secretion is associated with the maldigestion and impaired absorption of fat and fat-soluble vitamins. Defects in protein metabolism associated with chronic liver failure include decreased hepatic synthesis of albumin, coagulation factors, urea synthesis and metabolism of aromatic amino acids. For nutritional therapy, an important consideration should be the balance between preventing muscle wasting and promoting liver regeneration without causing hepatic encephalopathy. It is recommended that persons with chronic liver disease consume the same amount of dietary protein as that required by normal individuals (0.74 g/kg) (10).

Pancreatic Disease
In chronic pancreatitis, there is reduced secretion of pancreatic enzymes leading to malabsorption. In severe cases, tissue necrosis can occur. It is suggested that for patients with pancreatitis, a high carbohydrate, low-fat, low protein diet may be helpful (11).

Biliary Tract Diseases

Common diseases of the biliary tract are:

- Cholelithiasis (gallstones, without infection)
- Choledocholithiasis (gallstone in the bile duct causing obstruction, pain and cramps)
- Cholecystitis (inflammation of gallbladder caused by bile duct obstruction).

Obesity or sever fasting may increase risk for these disorders. Since lipids stimulate gallbladder contraction, a low fat diet with 25% to 30% of total calories as fat is recommended. Greater fat limitation is undesirable as some fat is required for stimulation and drainage of the biliary tract. Supplementation with fat-soluble vitamins may be needed for persons with fat malabsorption or a chronic gall bladder condition (12).

WIC nutritionists can provide counseling to support the medical nutrition therapy given by clinical dietitians, and monitor compliance with therapeutic dietary regimens. They can also review and provide WIC-approved medical foods or formulas prescribed by the health care providers. In certain circumstances, WIC staff may recommend an appropriate medical food or formula to the health care provider. They should also make referrals to an appropriate health care provider for medical nutrition therapy by a clinical dietitian when indicated.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
2. American Dietetic Association, Pediatric Nutrition Practice Group. Pediatric manual of clinical dietetics. Chicago: Pediatric Nutrition Dietetic Practice Group, American Dietetic Association, 1998.
3. Stenson W. The esophagus and stomach. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkins 1999. p. 1125-1133.
4. Beyer PL. Medical nutrition therapy for upper gastrointestinal tract disorders. In: Mahan LK, Escott-Slump S, editors. Krause's food nutrition and diet therapy. 11th ed. Philadelphia: Saunders; 2004. p. 688-690.
5. American Dietetic Association. Nutrition Care Manual. Gastrointestinal disease; Peptic ulcers; 2006. http://www.nutritioncaremanual.org. Accessed 1/08.
6. Allied Health Sciences Section Ad Hoc Nutrition committee: Aills L, Blankenship J, Buffington C, Furtado M and Parrot J. Bariatric nutrition: suggestions for the surgical weight loss patient. Review. Surgery for Obesity and Related Diseases 2008 May 17.
7. Scolapio JS, Fleming R. Short Bowel Syndrome. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkins; 1999. p. 1135-1140.
8. Farrell M. Gastrointestinal disorders of infancy and childhood (with nutrition support and probiotics) In: Ekvall SW, Ekvall VK. Editors. Pediatric nutrition

in chronic diseases and developmental disorders. 2nd ed. Oxford University Press; 2005. p. 248-249.

9. Griffiths A. Inflammatory bowel disease. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkins; 1999. p. 1141-1149.
10. Lieber CS. Nutrition in liver disorders. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams 7 Wilkins; 1999. p. 1177-1189.
11. Raimondo m, Dimagno EP. Nutrition in pancreatic disorders. In: Maurice ES, Olson JA, Shike M, Ross AC, editors. Modern nutrition in health and disease. 9th ed. Lippincott Williams & Wilkinds; 1999. p. 1169-1176.
12. Hasse JM, Matarese JE. Medical nutrition therapy for liver, biliary system and exocrine pancreas disorders. In: Mahan LK, Escott-Stump S, editors. Krause's food nutrition and diet therapy. 11th ed. Philadelphia: Saunders; 2004. p. 758-760.

Nutrition Risk Criteria **343 DIABETES MELLITUS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both (1).

Presence of diabetes mellitus diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Diabetes mellitus may be broadly described as a chronic, systemic disease characterized by:

- Abnormalities in the metabolism of carbohydrates, proteins, fats and insulin; and
- Abnormalities in the structure and function of blood vessels and nerves (2).

The chronic hyperglycemia of diabetes is associated with long-term damage, dysfunction, and failure of various organs, especially the eyes, kidneys, nerves, heart, and blood vessels (1,2) and includes type 1 diabetes mellitus, type 2 diabetes mellitus, and Maturity Onset Diabetes of the Young (MODY). MODY is a series of familial disorders characterized by early onset and mild hyperglycemia. Specific genetic defects have been identified on chromosomes 7, 12, and 20 (2). MODY is often diagnosed before the age of 25 years. It is caused by dominantly inherited defect of insulin secretion. Persons with MODY are often non-obese and without metabolic syndrome (3).

The two major classifications of diabetes are Type 1 Diabetes (beta-cell destruction, usually leading to absolute insulin deficiency) and Type 2 Diabetes (ranging from predominantly insulin resistance with relative insulin deficiency to predominantly an insulin secretory defect with insulin resistance). The Expert Committee (see reference below), working under the sponsorship of the American Diabetes Association, has identified the following as criteria for the diagnosis of diabetes mellitus (1, 2) (see clarification).

Long-term complications of diabetes include retinopathy with potential loss of vision, nephropathy leading to renal failure; peripheral neuropathy with risk of foot ulcers, amputations, and Charcot joints; and, autonomic neuropathy causing gastrointestinal, genitourinary, cardiovascular symptoms and sexual dysfunction. Patients with diabetes have an increased incidence of atherosclerotic cardiovascular, peripheral arterial and cerebrovascular diseases. Hypertension and abnormalities of lipoprotein metabolism are often found in people with diabetes (1).

WIC nutrition services can reinforce and support the medical and dietary therapies (such as Medical Nutrition Therapy) that participants with diabetes receive from their health care providers (4).

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Clarification

Diabetes mellitus is sometimes described by both patients and health professionals as "a little bit of sugar" or "high sugar." In reality, "sugar" is only one component of the pathology and clinical manifestations of the multifaceted syndrome of diabetes mellitus (2).

Diabetes mellitus is diagnosed by a licensed medical provider using any one of the following three methods:

1. Fasting plasma glucose ≥ 126 mg/dL (7.0 mmol/l). Fasting is defined as no caloric intake for at least 8 hours.
2. Symptoms of hyperglycemia plus casual plasma glucose concentration ≥ 200 mg/dl (11.1 mmol/L).
    - Casual implies any time of day without regard to time since last meal.
    - The classic symptoms of hyperglycemia include polyuria, polydipsia, and unexplained weight loss.
3. Two-hour plasma glucose ≥ 200mg/dL (11.1 mmol/L) during a 75 g oral glucose tolerance test (OGTT) (1).

In the absence of unequivocal hyperglycemia, these criteria should be confirmed by repeat testing on a different day. The third measure (OGTT) is not recommended for routine clinical use.

Reference

1. American Diabetes Association. Diagnosis and classification of diabetes mellitus. Diabetes Care. Jan 2008;31 Suppl 1:S55-60.
2. Franz MT, Ratner RE. Diabetes and Complications. In: Pathophysiology of the diabetes disease state: a Core Curriculum for Diabetes Educators American Association of Diabetes Educators. 5th ed. 2003.
3. Dean L, McEntrye J. The genetic landscape of diabetes. 2004; Bethesda: NCBI, 2004.
4. Http://www.ncbi.nlm.nih.gov/books/bv.fcgi?call=by.view.,showtoc&rid=diabetes.toc&depth=1.
5. American Diabetes Association. Nutrition recommendations and interventions for diabetes: a position statement of the American Diabetes Association. Diabetes Care. 2006; 29: 2140-2157:S48-S65.

Nutrition Risk Criteria **344 THYROID DISORDERS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Thyroid Dysfunction	Definition
Hyperthyroidism	Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter).
Hypothyroidism	Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.
Congenital Hyperthyroidism	Excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation).
Congenital Hypothyroidism	Infants born with an under active thyroid gland and presumed to have had hypothyroidism in-utero.
Postpartum Thyroiditis	Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous.

Presence of condition diagnosed, documented, or reported by a physician or someone working under physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Justification

The thyroid gland manufactures three thyroid hormones: thyroxine (T_4), triiodothyronine (T_3), and calcitonin. The thyroid hormones regulate how the body gets energy from food (metabolism). Iodine is an essential component of the T_4 and T_3 hormones (1) and must come from the diet. (Note: In nature, iodine does not exist as a free element; rather, it forms compounds such as sodium iodide (2, 3). For more information see Clarification section.) Iodine is available from various foods, and is present naturally in soil and sea water. A dysfunctional thyroid gland can become enlarged (goiter) as a result of a n overproduction of thyroid hormones (hyperthyroidism) or conversely, from insufficient thyroid hormone production (hypothyroidism). Thyroid hormones influence virtually every organ system in the body.

Maternal needs for dietary iodine and thyroid hormone medication (if prescribed) increase during pregnancy as maternal thyroid hormones and iodine are transferred to the fetus along with an increased loss of iodine through the maternal kidneys (3). Concurrently, the fetus is unable to produce thyroid hormones during the first trimester and is entirely dependent on the maternal supply of thyroid hormones. As a result, maternal production of T_4 must increase by at least 50% during pregnancy (4). If the pregnant woman is receiving thyroid hormone therapy, often a 30% - 50% increase in thyroid hormone medication is also needed.

Hyperthyroidism

Hyperthyroidism is a condition in which the thyroid gland is overactive, manufacturing too much thyroid hormone (T_4 and T_3). An excessive consumption or iodine (> 1000 µg/d) may cause fetal and maternal hyperthyroidism (5). In other circumstances, the thyroid might develop nodules which secrete excessive amounts of thyroid hormone regardless of iodine status (5). Enlargement of the thyroid gland (goiter) is a common symptom, as well as weight loss, fatigue, muscle weakness and an irregular heartbeat.

Hyperthyroidism is relatively uncommon in pregnancy (4). However, when it occurs, uncontrolled hyperthyroidism (especially in the second half of pregnancy) may result in infection, miscarriage, preterm delivery, preeclampsia, or congestive heart failure. Fetal complications may include prematurity, small for gestational age, fetal or neonatal thyrotoxicosis, or death (6). Postpartum maternal hyperthyroidism is likely in women with prenatal hyperthyroidism (7).

The primary medical therapy for hyperthyroidism is radioactive iodine therapy which is contraindicated during pregnancy and lactation 97). If hyperthyroidism occurs during this period, low doses of thiomide (antithyroid drug) are given instead.

Hypothyroidism

Hypothyroidism is a condition in which the thyroid gland does not make enough thyroid hormone. Maternal and fetal hypothyroidism may occur when preconception maternal iodine stores are insufficient and there is inadequate maternal iodine intake in early pregnancy. In this instance, the maternal iodine balance may become negative and may never be restored, even with eventual iodine supplementation (4).

Mothers with iodine deficiency during the first half of pregnancy may produce offspring with severe, irreversible brain damage (8). Maternal thyroid deficiency has been associated with neonatal developmental problems which may cause lasting changes in the brain structure and cognitive function.

Uncontrolled hypothyroidism in the second half of pregnancy can cause maternal complications such as anemia, preeclampsia, miscarriage, premature delivery, and postpartum thyroid disease. Fetal or neonatal complications include prematurity, low birth weight, congenital anomalies, poor neuropsychological development, and stillbirth (6).

When iodine nutrition status is adequate, autoimmune thyroid disease (AITD) – also called Hashimoto’s thyroiditis – is the most common type of hypothyroidism during pregnancy (4). Pregnant women with AITD are at increased risk of miscarriage and postpartum thyroid disease (including thyroiditis,

hyperthyroidism and hypothyroidism). There is an increased risk of permanent and significant impairment in cognitive function for their infants (9).

Congenital Hyperthyroidism and Hypothyroidism

Congenital hyperthyroidism is rare in neonates. Transient congenital hyperthyroidism is caused by maternal Graves' disease. Thyroid stimulating immunoglobulin passes from the mother to the fetus via the placenta and causes thyrotoxicosis in the fetus and subsequently, the neonate. After the baby is born, improvement is rapid if the condition is treated using antithyroid drugs and the hyperthyroidism will subside within several weeks (10). Persistent congenital hyperthyroidism is a familial non-autoimmune disease. It is caused by a genetic mutation resulting in an increase in the constitutive activity of the TSH receptor (11).

Congenital hypothyroidism due to maternal iodine deficiency is a leading cause of preventable mental retardation (10). Over-treatment of thyroid hormone, during pregnancy, as well as prolonged maternal iodine therapy (more than two weeks of therapy or more than 1000 µg/iodine) can also cause congenital hypothyroidism (6). The condition is exacerbated by coexisting selenium and vitamin A deficiencies or iron deficiency (5). Treatment for neonatal hypothyroidism should be started as soon as possible, as every day of delay may result in loss of IQ. Unless treated shortly after birth (within the first 18 days of life), the resulting mental retardation will be irreversible (10).

Postpartum Thyroiditis

Postpartum thyroiditis, an autoimmune inflammation of the thyroid, occurs within the first year after delivery or sometimes after termination of pregnancy. It can be a transient thyroid dysfunction with a brief thyrotoxic phase followed by hypothyroidism, usually with a spontaneous resolution (10). Smoking is a significant precipitating factor in the onset of postpartum thyroiditis (9). Women with a past history of postpartum thyroiditis have a risk of long-term permanent hypothyroidism and recurrence of postpartum thyroiditis in subsequent pregnancies (12). Tests for this condition consist of radioactive products necessitating a temporary cessation of breastfeeding (usually up to 3 days).

Implications for WIC Nutrition Services

Individuals with thyroid disorders can benefit from WIC foods and WIC nutrition services can reinforce and support the medical and dietary therapy prescribed by the participants' health care provider. The following nutrition education messages may be appropriate depending on the type of thyroid disorder:

> Encourage iodine sufficiency, unless contraindicated, with an adequate intake of foods high in iodine such as iodized table salt, bread, saltwater fish, kelp, egg yolks (because of iodine supplementation in chicken feed), milk and milk products (because of the treatment of cows with supplemental dietary iodine) (5). It is important to note that the salt used in manufactured foods is not iodized.
>
> Advise women to review the iodine content of their prenatal supplement. It is recommended that all prenatal vitamin-mineral supplements for use during pregnancy and lactation contain at least150 micrograms of iodine a day (13). Currently, less than 50 percent of prenatal vitamins on the market contain iodine (5, 7).

Promote breastfeeding, as there are no contraindications to breastfeeding and thyroid hormone replacement therapy as long as normal thyroxine levels in the maternal plasma are maintained. Breast milk provides iodine to the infant and is influenced by the dietary intake of the pregnant and lactating mother (14). Hyperthyroidism can develop for the first time during the postpartum period, but the mother's ability to lactate is not affected. However, if a woman with untreated hypothyroidism breastfeeds, her milk supply may be insufficient. In such instances, replacement thyroid hormone therapy is necessary to help increase milk production.

Weight management – hyperthyroidism: The elevated plasma levels of thyroid hormones may cause increased energy expenditure and weight loss along with increased appetite. Following medical treatment, individuals with hyperthyroidism usually regain their typical body weight with a concurrent decrease in appetite (4). Therefore, the monitoring of weight status and dietary adequacy are recommended.

Weight management – hypothyroidism: Many individuals with hypothyroidism experience an increase in weight due to both a decrease in basal metabolic rate and an excessive accumulation of water and salt. Most of the weight gained is due to the excess water and salt retention. After medical treatment, a small amount of weight may be lost, usually less than 10% of body weight (15). Once hypothyroidism has been treated and thyroid hormones are within normal levels, it is less likely that the weight gain is solely due to the thyroid. If an overweight condition persists, weight control therapy may be necessary.

Recommend the cautionary use of soy formula and the avoidance of foods or supplements rich in soy, fiber, or iron when therapeutic thyroid medications are prescribed, since soy, iron, calcium, fiber and phytates may interfere with the absorption of oral thyroid hormone therapy (16, 17).

Discourage smoking as the compound thiocynate found in tobacco smoke inhibits iodine transport (9).

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Iodine (I_2) is an element. In the ambient temperature, it is volatile and forms blue-violet gas. In nature, it does not exist as free element. Instead, it forms compounds, such as sodium **iodide** (NaI), and potassium **iodide** (KI). To prevent iodine deficiency, potassium iodide is added to the salt (most commonly to table salt) to form iodized salt (2, 3).

References

1. National Academy of Sciences. Institute of Medicine. Food and Nutrition Board. Dietary reference intakes: The essential guide to nutrient requirements. 2001.
2. Los Alamos National Labs Chemistry Division Periodic Table. http://periodic.lanl.gov/elements/53.html. Accessed December 2009.
3. WebElements: The periodic table on the web. http://www.webelements.com/iodine/. Accessed December 2009.
4. Smallridge RD, Glinore D, Hollowell JG, Brent G. Thyroid function inside and outside of pregnancy: What do we know and what don't we know? Thyroid. 2005; 15 (1): 54-59.
5. Lee SL, Ananthakrishnan S, Pearce EN. Iodine deficiency. [updated July27, 2006]. Available from: http://www.emedicine.com/med/topic1187.htm.
6. Nguyen PH. Autoimmune thyroid disease and pregnancy. [updated December 21, 2004; cited 2007 Sept 7]. Available from: http://www.emedicine.com.
7. American Association of Clinical Endocrinologists (AACE) Thyroid Task Force. AACE Medical guidelines for clinical practice for the evaluation and treatment of hyperthyroidism and hypothyroidism. 2006 Amended Version. Endocrine Practice 2002; 8 (6): 457-469.
8. LaFranchi SH, Haddow JE, Hollowell JG. Is thyroid inadequacy during gestation a risk factor for adverse pregnancy and developmental outcomes? Thyroid 2005; 15 (1): 60-71.
9. Muller AF, Drexhage HA, Berghout A. Postpartum thyroiditis and autoimmune thyroiditis in women of childbearing age: Recent insights and consequences for antenatal and postnatal care. Endocrine Reviews. 2001 Oct; 22 (5): 605-630.
10. Association for Clinical Biochemistry, British Thyroid Association, British Thyroid Foundation. UK guidelines for the use of thyroid function tests. 2006 July; 1-86.
11. Polak M, Legac I, Vuillard E, Guibourdenche J, Castanet M, Luton D. Congenital hyperthyroidism: The fetus as a patient. Horm Res. 2006; 65: 235-242 (DOI: 10.1159/000092454)
12. O'Malley B, Hickey H, Nevens E. Thyroid dysfunction – weight problems and the psyche: The patients' perspective. J Hum Nutr Dietet. 2000 May; 13: 243-248.
13. American Thyroid Association. American Thyroid Association statement on early maternal thyroidal insufficiency: Recognition, clinical management and research directions. Consensus statement #2. Thyroid. 2005; 15 (1): 77-79.
14. Riordan J. Breastfeeding and human lactation, 3rd ed. Jones & Bartlett Publishers, Inc., 2005; p. 157, 461.
15. American Thyroid Association. Thyroid and weight, 2005. Available from: http://www.thyroid.org
16. American Academy of Pediatrics. American Thyroid Association, Lawson Wilkins Endocrine Society. Update of newborn screening and therapy for congenital hypothyroidism. Pediatrics. 2006; Jun; 117 (6): 2290-2303.
17. American Academy of Pediatrics Committee on Nutrition. Use of Soy protein-based formulas in infant feeding. Pediatrics. 2008; 121 (5): 1062-1068 (doi: 10.1542/peds.2008-0564).

Additional Reference

Hashimoto's Thyroiditis online reference: http://www.medicinenet.com/hashimotos_thyroiditis/article.htm

Nutrition Risk Criteria **345** **HYPERTENSION AND PREHYPERTENSION (INCLUDES CHRONIC AND PREGNANCY INDUCED)**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Hypertension, commonly referred to as high blood pressure, is defined as persistently high arterial blood pressure with systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90 mm Hg (1). People with high blood pressure can be asymptomatic for years (2). Untreated hypertension leads to many degenerative diseases, including congestive heart failure, end-stage renal disease, and peripheral vascular disease.

There is a large segment of the population that falls under the classification of prehypertension, with blood pressure readings between 130/80 to 139/89 mm Hg (3). People with prehypertension are twice as likely to develop hypertension (3).

There is no cure for hypertension (2); however, lifestyle modifications can prevent high blood pressure and are critical in the management of hypertension and prehypertension (3).

Risk factors for hypertension include (4):

- Age (increases with age)
- Race/ethnicity (occurs more often and earlier in African Americans)
- Overweight and obesity
- Male gender
- Unhealthy nutrient consumption and lifestyle habits (e.g. high sodium intake, excessive alcohol consumption, low potassium intake, physical inactivity, and smoking)
- Family history
- Chronic stress

Management of hypertension includes lifestyle modifications and medication. In prehypertensive individuals, implementing lifestyle changes can prevent or delay the onset of hypertension (3, 5). In hypertensive individuals, dietary intervention is not only effective in reducing blood pressure but also in delaying drug treatment (6).

Lifestyle changes to manage hypertension and prehypertension include:

- Consuming a diet consistent with the Dietary Guidelines for Americans

or following the DASH (Dietary Approaches to Stop Hypertension) eating plan, if recommended by a physician
- Limiting dietary sodium
- Engaging in regular physical activity
- Achieving and maintaining a healthy weight
- Smoking cessation

The WIC Program provides fruits, vegetables, low fat milk and cheese, which are important components of the DASH eating plan. WIC nutritionists provide nutrition education counseling to reduce sodium intakes, achieve/maintain proper weight status, promote physical activity, and make referrals to smoking cessation programs, which are the lifestyle interventions critical to the management of hypertension/prehypertension.

Pregnant Women: Hypertension is the most common medical complication of pregnancy, occurring in 7% of all pregnancies. Hypertension during pregnancy may lead to low birth weight, fetal growth restriction, and premature delivery, as well as maternal, fetal and neonatal morbidity (7). Hypertensive disorders of pregnancy are categorized as (8, 9):

- Chronic Hypertension: Hypertension that was present before pregnancy. It increases perinatal mortality and morbidity through an increased risk of SGA (small for gestational age) infants. Women with chronic hypertension are at risk for complications of pregnancy such as preeclampsia. There is a 25% risk of superimposed preeclampsia and an increased risk for preterm delivery, fetal growth restriction, congestive heart failure and renal failure.
- Preeclampsia: A pregnancy-specific syndrome observed after the 20th week of pregnancy with elevated blood pressure accompanied by significant proteinuria.
- Eclampsia: The occurrence of seizures, in a woman with preeclampsia, that cannot be attributed to other causes.
- Preeclampsia superimposed upon chronic hypertension: Preeclampsia occurring in a woman with chronic hypertension. It is the major leading factor of maternal and infant mortality and morbidity.
- Gestational Hypertension: Blood pressure elevation detected for the first time after midpregnancy without proteinuria. It presents minimal risks to mother and baby, when it does not progress to preeclampsia.

The term “pregnancy-induced hypertension” includes gestational hypertension, preeclampsia and eclampsia. For more information about preeclampsia, please see Nutrition Risk Criteria 304, History of Preeclampsia.

The following conditions are associated with an increased incidence of pregnancy-induced hypertension (4):

- Inadequate diet
- Nutritional deficiencies, including low protein, essential fatty acid, or magnesium intake
- Inadequate calcium intake in early pregnancy (7)
- Obesity
- Primigravidity
- Age (pregnancy before age 20 or after age 40)
- Multi-fetal gestation
- Genetic disease factors
- Familial predisposition

The impact of hypertension continues after delivery. Special consideration must be given to lactating women with high blood pressure, especially if their care plan includes medication. It is important that the hypertensive lactating woman inform her physician of her breastfeeding status if she is also taking medication to determine whether they pose any risks to the infant. However, hypertension is not a contraindication for lactation. Lactation, as suggested in research, is thought to present some therapeutic advantages in the management of the disease in women (10, 11, 12).

Children: Hypertension during childhood is age-specific, and is defined as blood pressure readings greater than the 95th percentile for age, gender, and height on at least three separate occasions. Blood pressure reading between the 90th and 95th percentile is considered prehypertension (13). Children with high blood pressure are more likely to become hypertensive adults (15). Therefore, they should have their blood pressure checked regularly beginning at the age of three (14, 15).

Epidemiologic data suggests an association between childhood obesity and high blood pressure (16). Blood pressure and overweight status have been suggested as criteria to identify hypertensive children. Weight control decreases blood pressure, sensitivity to salt and other cardiovascular risk factors (13).

Nutrition-related prevention efforts in overweight hypertensive children should aim at achieving a moderate weight loss or preventing further weight gain. Additionally, a decrease in time spent in sedentary activities with subsequent increase in physical activity should be emphasized.

Dietary changes conductive to weight management in children include:

- Portion control
- Decreased consumption of sugar-containing beverages and energy-dense snacks
- Increased consumption of fresh fruits and vegetables
- Regular meals, especially breakfast

The WIC Program provides nutritious supplemental foods and nutrition education compatible with changes needed to promote a healthy weight and decrease the impact of hypertension in children.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. American Dietetic Association. Nutrition Care Manual. Hypertension: 2006. http://www.nutritioncaremanual.org. Accessed May 2009.
2. Krummel DA. Medical nutrition therapy in hypertension. In: Manhan LK, Escott-Stum[S, editors. Krause's food nutrition and diet therapy. 11th ed. Philadelphia Saunders; 2004, p. 901-902.
3. Chobian, AV, Blakris, GL, Black, HR, et al. The seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure, the JNC 7 report, JAMA, 2003. Downloaded from

www.jama.com at the University of Florida on May/2009.
4. National Heart Lung and Blood Institute. www.nhlbi.nih.gov. Accessed May 2009.
5. Chobian, AV. Prehypertension Revisited. Hypertension 2006. Downloaded from hyper.ahajournals.org at Health Science Library on May/2009.
6. Appel LJ, Brands MW, Daniels SR, Karanja N, Elmer PJ, Sacks FM; American Heart Association. Dietary approaches to prevent and treat hypertension: a scientific statement from the American Heart Association. Hypertension 2006; 47:296-308.
7. Roberts JM, Bodnar LM. Report on the WIC nutrition risk criterion for hypertension in pregnancy. July 2007. Unpublished.
8. National Heart Lung and Blood Institute. Report of the working group on research on hypertension during pregnancy, 2001. www.nhlbi.nih.gov. Accessed May 2009.
9. National Heart, Lung and Blood Institute. Working group report on high blood pressure in pregnancy; 2000 Jul. NIH Publication No. 00-3029.
10. Lawrence RA, Lawrence RM. Breastfeeding a guide for the medical profession. 6th ed. Philadelphia: Elsevier Mosby; 2005. p. 590.
11. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Breastfeeding handbook for physicians. 2006. p. 179.
12. Lee, SY, Kim, MT, Jee, SH, Yang, HP. Does long-term lactation protect premenopausal women against hypertension risk? A Korean women's cohort study. Preventive Medicine, 2005. Available online at www.sciencedirect.com. Accessed May 2009.
13. US Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute. The fourth report on the diagnosis, evaluation, and treatment of high blood pressure in children and adolescents. Revised May 2005.
14. Hassink SG. Pediatric obesity: Prevention, intervention, and treatment strategies for primary care. American Academy of Pediatrics; 2007. p. 179.
15. Luma GB, Spiotta RT. Hypertension in children and adolescents. Am Fam Physician 2006 May 6;73: 1158-68.
16. Committee on Nutrition, American Academy of Pediatrics. Pediatric nutrition handbook. 6th ed. Elk Grove, Ill: American Academy of Pediatrics; 2009.

Nutrition Risk Criteria **346** **RENAL DISEASE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Renal disease can result in growth failure in children and infants. In pregnant women, fetal growth is often limited and there is a high risk of developing a preeclampsia-like syndrome. Women with chronic renal disease often have proteinuria, with risk of azotemia if protein intake becomes too high.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Reference

Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **347** **CANCER**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status.

Presence of cancer diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

An individual's nutritional status at the time of diagnosis of cancer is associated with the outcome of treatment. The type of cancer and stage of disease progression determines the type of medical treatment, and if indicated, nutrition management. Individuals with a diagnosis of cancer are at significant health risk and under specific circumstances may be at increased nutrition risk, depending upon the stage of disease progression or type of ongoing cancer treatment.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Reference

Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.

Nutrition Risk Criteria **348 CENTRAL NERVOUS SYSTEM DISORDERS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Conditions which affect energy requirements and may affect the individual's ability to feed self that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to:

- epilepsy
- cerebral palsy (CP) and
- neural tube defects (NTD), such as spina bifida or myelomeningocele
- Parkinson's disease
- multiple sclerosis (MS)

Presence of central nervous system disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Epileptics are at nutrition risk due to alterations in nutritional status from prolonged anti-convulsant therapy, inadequate growth, and physical injuries from seizures (1). The ketogenic diet has been used for the treatment of refractory epilepsy in children (2). However, children on a ketogenic diet for six months or more have been observed to have slower gain in weight and height (3,4). Growth monitoring and nutrition counseling to increase energy and protein intakes while maintaining the ketogenic status are recommended (4). In some cases, formula specifically prepared for children on a ketogenic diet is necessary. Women on antiepileptic drugs (AEDs) present a special challenge. Most AEDs have been associated with the risk of neural tube defects on the developing fetus. Although it is unclear whether folic acid supplementation protects against the embryotoxic and teratogenic effects of AEDs, folic acid is recommended for women with epilepsy as it is for other women of childbearing age (5-7).

Oral motor dysfunction is associated with infants and children with cerebral palsy (CP). These infants and children often have poor growth due to eating impairment, such as difficulty in spoon feeding, biting, chewing, sucking, drinking from a cup and swallowing. Rejection of solid foods, choking, coughing, and spillage during eating are common among these children (8,9). Growth monitoring and nutrition counseling to modify food consistency and increase energy and nutrient intakes are recommended. Some children may require tube feeding and referral to feeding clinics, where available.
Limited mobility or paralysis, hydrocephalus, limited feeding skills, and genitourinary problems, put children with neural tube defects (NTDs) at increased risk of abnormal growth and development. Ambulatory disability, atrophy of the lower extremities, and short stature place NTDs affected children

at high risk for increased body mass index (10). Growth monitoring and nutrition counseling for appropriate feeding practices are suggested.

In some cases, participants with Parkinson's disease require protein redistribution diets to increase the efficacy of the medication used to treat the disease (11). Participants treated with levodopa-carbidopa may also need to increase the intake of B vitamins (12). Participants with Parkinson's disease will benefit from nutrition education/counseling on dietary protein modification, which emphasizes adequate nutrition and meeting minimum protein requirements. Additionally, since people with Parkinson's often experience unintended weight loss (13), it is important to monitor for adequate maternal weight gain. Individuals with multiple sclerosis (MS) may experience difficulties with chewing and swallowing that require changes in food texture in order to achieve a nutritionally adequate diet (14). Obesity and malnutrition are frequent nutrition problems observed in individuals with MS. Immobility and the use of steroids and anti-depressants are contributing factors for obesity. Dysphagia, adynamia, and drug therapy potentially contribute to malnutrition. Both obesity and malnutrition have detrimental effects on the course of the disease. Adequate intakes of polyunsaturated fatty acids, vitamin D, vitamin B_{12} and a diet low in animal fat have been suggested to have beneficial effects in relapsing-remitting MS (15-17). Breastfeeding advice to mothers with MS has been controversial. However, there is no evidence to indicate that breastfeeding has any deleterious effect on women with MS. In fact, breastfeeding should be encouraged for the health benefits to the infant (18). In addition, mothers who choose to breastfeed should receive the necessary support to enhance breastfeeding duration. As a public health nutrition program, WIC plays a key role in health promotion and disease prevention. As such, the nutrition intervention for participants with medical conditions should focus on supporting, to the extent possible, the medical treatment and/or medical/nutrition therapy a participant may be receiving. Such support may include: investigating potential drug-nutrient interactions; inquiring about the participant's understanding of a prescribed special diet; encouraging the participant to keep medical appointments; tailoring the food package to accommodate the medical condition; and referring the participant to other health and social services.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine. Food and Nutrition Board. WIC nutrition risk criteria: A scientific assessment. Washington, DC: National Academy Press; 1996.
2. Nelson JK, Mayo C. Mayo clinic diet manual a handbook of nutrition practices. St. Louis: Mosby; 1994.
3. Peterson SJ, Tangney CC, Pimentel-Zablah EM, Hjelmgren B, Booth F, Berry-Kravis E. Changes in growth and seizure reduction in children on the ketogenic diet as a treatment for intractable epilepsy. JADA. 2005 May;105(5):718-724.
4. Santoro KB, O'Flaherty T. Children and the ketogenic diet. JADA. 2005 May;105(5):725-726.
5. Yerby MS. Management issues for women with epilepsy: neural tube defects and folic acid supplementation. Neurology. 2003 Sep;1:61 (6 Suppl 2): S23-6.
6. Champel V, Radal M, Moulin-Vallez M, Jonville-Bera AP, Autret-Leca E. Should folic acid be given to women treated with valproic acid and/or carbamazepine? Folic acid and pregnancy in epilepsy. (Abstract) Rev Neurol (Paris). 1999 Mar;155(3): 220-4.
7. Yerby MS. Clinical care of pregnant women with epilepsy: neural tube defects and folic acid supplementation. Epilepsia. 2003;44 Suppl 3:33-40.
8. Fung EB, Samson-Fang L, Stallings VA, Conaway M, Liptak G, Henderson RC, Worley G, O'Donnell M, Calvert R, Rosenbaum P, Chumlea W, Stevenson RD. Feeding dysfunction is associated with poor growth and health status in children with cerebral palsy. JADA. 2002; 102(3):361-373.
9. Yilmaz S, Basar P, Gisel EG. Assessment of feeding performance in patients with cerebral palsy. Int J Rehabil Res. 2004 Dec; 27(4):325-329.
10. Ekvall SW. Pediatric nutrition in chronic diseases and developmental disorders: prevention, assessment, and treatment. New York Oxford University Press; 1993.
11. Karstaedt PJ, Pincus JH. Protein redistribution diet remains effective in patients with fluctuating parkinsonism. Arch Neurol. 1992 Feb;49(2):149-151.
12. Valkovic P, Benetin J, Blazicek P, Valkovicova L, Gmitterova K, Kukumberg P. Reduced plasma homocysteine levels in levodopa/entacapone treated Parkinson patients. Parkinsonism Relat Disord. 2005 Jun;11(4):253-6. Epub 2005 Apr 20.
13. Chen H, Zhang SM, Heman MA, Willett WC, Ascherio A. Weight loss in Parkinson's disease. Ann Neurol. 2003 May;53(5):676-9.
14. Schapiro R. Managing the symptoms of multiple sclerosis. 4th ed. New York: Demos Medical Publishing; 2003. Ch.13 Swallowing Difficulties.
15. Payne A. Nutrition and diet in the clinical management of multiple sclerosis. J Hum Nutr Dietet. 2001;14:349-357.
16. Schwarz S, Leweling H. Multiple sclerosis and nutrition. Multiple Sclerosis. 2005;11:24-32.
17. Mark BL, Carson JS. Vitamin D and autoimmune Disease-Implications for practice from the multiple sclerosis literature. JADA. 2006 Mar; 106(3): 418-424.
18. Gulick EE, Johnson S. Infant health of mothers with multiple sclerosis. West J Nurs Res. 2004 Oct; 26(6): 632-49.

Nutrition Risk Criteria **349 GENETIC AND CONGENITAL DISORDERS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. May include, but is not limited to, cleft lip or palate, Down's syndrome, thalassemia major, sickle cell anemia (not sickle cell trait), and muscular dystrophy.

Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

For women, infants, and children with these disorders, special attention to nutrition may be required to achieve adequate growth and development and/or to maintain health.

Severe cleft lip and palate anomalies commonly cause difficulty with chewing, sucking and swallowing, even after extensive repair efforts (5). Surgery is required for many gastrointestinal congenital anomalies. (Examples are trachea-esophageal fistula, esophageal atresia, gastroschisis, omphalocele, diaphragmatic hernia, intestinal atresia, and Hirschsprung's Disease.)

Impaired esophageal atresia and trachea-esophageal fistula can lead to feeding problems during infancy. The metabolic consequences of impaired absorption in short bowel-syndrome, depend on the extent and site of the resection or the loss of competence. Clinical manifestations of short bowel syndrome, include diarrhea, dehydration, edema, general malnutrition, anemia, dermatitis, bleeding tendencies, impaired taste, anorexia, and renal calculi. Total parenteral feedings are frequently necessary initially, followed by gradual and individualized transition to oral feedings. After intestinal resection a period of adaptation by the residual intestine begins and may last as long as 12-18 months (3). Even after oral feedings are stabilized, close follow-up and frequent assessment of the nutritional status of infants with repaired congenital gastro-intestinal anomalies is recommended (5).

Sickle-cell anemia is an inherited disorder in which the person inherits a sickle gene from each parent. Persons with sickle-cell trait carry the sickle gene, but under normal circumstances are completely asymptomatic. Good nutritional status is important to individuals with sickle-cell anemia to help assume adequate growth (which can be compromised) and to help minimize complications of the disease since virtually every organ of the body can be affected by sickle-cell anemia (i.e., liver, kidneys, gall ladder, and immune system). Special attention should be given to assuring adequate caloric, iron,

folate, vitamin E and vitamin C intakes as well as adequate hydration.

Muscular dystrophy is a familial disease characterized by progressive atrophy and wasting of muscles. Changes in functionality and mobility can occur rapidly and as a result children may gain weight quickly (up to 20 lbs in a 6 month period). Early nutrition education that focuses on foods to include in a balanced diet, limiting foods high in simple sugars and fat and increasing fiber intake can be effective in minimizing the deleterious effects of the disease.

References

1. American Dietetic Association, Pediatric Nutrition Practice Group. Pediatric manual of clinical dietetics. Chicago: Pediatric Nutrition Dietetic Practice Group, American Dietetic Association, 1998.
2. Ekvall S. Pediatric nutrition in chronic diseases and developmental disorders prevention, assessment, and treatment. New York: Oxford University Press 1993. p. 289-292.
3. Grand RJ, Sutphen JL, Dietz WH. Pediatric nutrition theory and practice. Boston: Butterworths, 1987.
4. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
5. Ohio Neonatal Nutritionists. Nutritional care for high risk newborns. Philadelphia, PA: G.F. Stickley Publishers, 1985.

Nutrition Risk Criteria **351 INBORN ERRORS OF METABOLISM**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD
CHILDREN	3	RD
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat.

Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body, including but not limited to:

Inborn Errors of Metabolism*	
Amino Acid Disorders	Urea Cycle Disorders
Organic Acid Metabolism Disorders	Carbohydrate Disorders
Fatty Acid Oxidation Disorders	Peroxisomal Disorders
Lysosomal Storage Diseases	Mitochondrial Disorders
*For information about additional IEM, please see Clarification.	

Presence of condition diagnosed, documented, or reported by a physician or someone working under physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Copy of written physician diagnosis in participant file or documentation in notes of self-report of physician diagnosis.

Justification

The inheritance of most metabolic disorders is rare. IEM disorders may manifest at any stage of life, from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities for those affected (1).

All states screen newborns for IEM, although the type and number of IEM screened for may vary from state to state. Typically, infants are screened for amino acid disorders, urea cycle disorders, organic acid disorders, and fatty acid oxidation defects. A few States are working toward including lysosomal storage diseases and peroxisomal disorders among their newborn screening panels (2).

In most states, treatment of an IEM is referred to a specialized metabolic treatment facility. Please see Clarification for contact information for treatment facilities. IEM treatment is based on symptomatic therapy which may include the following strategies: substrate restriction; stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy (3). Avoidance of catabolism is essential at all treatment stages.

Nutrition therapy is integral to the treatment of IEM. Nutrition therapy should both correct the metabolic imbalance and ensure adequate energy, protein, and

nutrients for normal growth and development among affected individuals. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet (4). It is important that caregivers of infants and children with IEM ensure that the patient follows the prescribed dietary regimen.

Amino Acid Metabolism Disorders (3)

- Phenylketonuria (included clinically significant hyperphenylalaninemia variants)
- Maple syrup urine disease
- Homocystinuria
- Tyrosinemia

Amino Acid Metabolism Disorders are characterized by the inability to metabolize a certain essential amino acid. The build-up of the amino acid that is not metabolized can be toxic. Treatment of amino acid disorders involves restricting one or more essential amino acids to the minimum required for growth and development and supplying the missing product due to the blocked reaction.

Carbohydrate Disorders (5)

- Galactosemia
- Glycogen storage disease type 1
- Glycogen storage disease type II (see also Pompe disease)
- Glycogen storage disease type III
- Glycogen storage disease type IV (Anderson Disease)
- Glycogen storage disease type V
- Glycogen storage disease type VI
- Hereditary Fructose Intolerance (Fructose 1-phosphate aldolase deficiency, Fructose 1, 6, biphosphatase deficiency, fructose kinase deficiency)

This group of disorders includes an enzyme deficiency or its cofactor that affects the catabolism or anabolism of carbohydrate. Carbohydrate disorders are complex and affect neurological, physical, and nutritional status.

Fatty Acid Oxidation Defects (5)

- Medium-chain acyl-CoA dehydrogenase deficiency
- Long-chain 3-hydroxyacl-CoA dehydrogenase deficiency
- Trifunctional protein deficiency type 1 (LCHAD deficiency)
- Trifunctional protein deficiency type 2 (mitochondrial trifunctional protein deficiency)
- Carnitine uptake defect (primary carnitine deficiency)
- Very long-chain acyl-CoA dehydrogenase deficiency

Fatty acid oxidation defects include any enzyme defect in the process of mitochondrial fatty acid oxidation (FAO) system. The biochemical characteristic of all FAO defects is abnormal low ketone production as a result of the increased energy demands. This results in fasting hypoglycemia with severe acidosis secondary to the abnormal accumulation of intermediate metabolites of FAO, which can result in death.

Organic Acid Disorders (AKA organic aciduria or organic academia) (6)

- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- Glutaric acidemia type I
- Glutaric acidemia type II
- 3-hydroxy-3-methylglutaryl-coenzyme A lyase deficiency
- Multiple carboxylase deficiency (Biotinidase deficiency, Holocarboxylase synthetase deficiency)
- Methylmalonic acidemia
- Propionic acidemia
- Beta-ketothiolase deficiency

Organic Acid Disorders are characterized by the excretion of non-amino organic acids in the urine. Most of the disorders are caused by a deficient enzyme involving the catabolism of specific amino acid(s). As a result, the non-metabolized substance accumulates due to the blockage of the specific metabolic pathway, which is toxic to certain organs and may also cause damage to the brain (7).

Lysomomal Storage Diseases (6, 8)

- Fabry disease (α-galactosidase A deficiency)
- Gauchers disease (glucocerebrosidase deficiency)
- Pompe disease (glycogen storage disease Type II, or acid α-glucosidase deficiency)

Lysosomal storage diseases are a group of related conditions characterized by increased storage of undigested large molecule in lysosomes. Lysosome is a cellular organelle responsible for intracellular degradation and recycling of macromolecules. Due to a defect in a specific lysosomal enzyme, the macromolecule that normally would be metabolized is not broken down; instead, it accumulates in the lysosomes. This leads to tissue damage, organ failures and premature death. Common clinical features include bone abnormalities, organomegaly, developmental impairment and central, peripheral nervous system disorders.

Mitochondrial Disorders (6, 8)

- Leber hereditary optic neuropathy
- Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)
- Mitochondrial neurogastrointestinal encephalopathy disease (MNGIE)
- Myoclonic epilepsy with ragged-red fibers (MERRF)
- Neuropathy, ataxia, and retinitis pigmentosa (NARP)
- Pyruvate carboxylase deficiency

Mitochondrial Disorders are caused by the dysfunction of the mitochondrial respiratory chain, or electron transport chain (ETC). Mitochondria play an essential role in energy production. The ETC dysfunction increases free radical production, which causes mitochondrial cellular damage, cell death and tissue necrosis and further worsens ETC dysfunction and thus forms a vicious cycle. The disorders can affect almost all organ systems. However, the organs and cells that have the highest energy demand, such as the brain and muscles (skeletal and cardiac) are most affected. The clinical features vary greatly among

this group of disorders, but most have multiple organ dysfunctions with severe neuropathy and myopathy.

Peroxisomal Disorders (6, 8, 9)

- Zellweger Syndrome Spectrum
- Adrenoleukodystrophy (x-ALD)

There are two types of peroxisomal disorders: single peroxisomal enzyme deficiencies and peroxisomal biogenesis disorders. These disorders cause severe seizures and psychomotor retardation (9). Peroxisomes are small organelles found in cytoplasm of all cells. They carry out oxidative reactions which generate hydrogen peroxides. They also contain catalase (peroxidase), which is important in detoxifying ethanol, formic acid and other toxins. Single peroxisomal enzyme deficiencies are diseases with dysfunction of a specific enzyme, such as acyl coenzyme A oxidase deficiency. Peroxisomal biogenesis disorders are caused by multiple peroxisome enzymes such as Zellweger syndrome and neonatal adrenoleukodystrophy.

Urea Cycle Disorders (6, 5)

- Citrullinemia
- Argininosuccinic aciduria
- Carbamoyl phosphate synthetase deficiency

Urea Cycle Disorders occur when any defect or total absence of any of the enzymes or the cofactors used in the urea cycle results in the accumulation of ammonia in the blood. The urea cycle converts waste nitrogen into urea and excretes it from the kidneys. Since there are no alternate pathways to clear the ammonia, dysfunction of the urea cycle results in neurologic damages.

Implications for WIC Nutrition Services

WIC can provide exempt infant formulas and WIC-eligible medical foods, including those specifically formulated for IEM. Most of the dietary regimens for IEM require a combination of medical food (special formula in most cases) and standard infant formula or prescribed conventional foods. For example, participants with IEM related to essential amino acid metabolism (such as PKU, MSUD), who are not developmentally ready for conventional foods; require both medical food without the offending amino acid(s), and human milk or standard infant formula.

It is recommended that WIC nutritionists collaborate with the clinical dietitians at the metabolic treatment facility, where available, to prescribe WIC food packages (Food Package III) according to the therapeutic diet ordered by the metabolic team, monitor the compliance of the restricted diet, and follow up on the growth and developmental status of the participants with IEM.

Note: Infants with classic galactosemia cannot be breastfed due to lactose in human milk.

Clarification

IEM not listed within this write-up may be found under: http://rarediseases.info.nih.gov/GARD. Please keep in mind these additional resources are not meant for medical advice nor to suggest treatment.

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

The link below lists newborn screening coordinators. The coordinator can direct families to appropriate metabolic treatment facilities based on the newborn screening result: http://genes-r-us.uthscsa.edu/State_contacts.pdf

References

1. Metabolic backgrounder: The Ross metabolic formula system for meeting special nutrition needs. Columbus, OH: Ross Products Division; 2007.
2. Levy PA. Inborn Errors of Metabolism: part 1: Overview. Pediatr Rev. 2009 Apr; 30 (4): 131-7.
3. Wilcken B. An introduction to nutritional treatment in inborn errors of metabolism – different disorders, different approaches. Southeast Asian J Trop med Public Health. 2003; 34 Suppl 3: 198-201.
4. Hendricks KM, Duggan C. Manual of pediatric nutrition, 4th ed. 2005; 626-657.
5. Ekval S, Ekvall, VK, editors. Pediatric nutrition in chronic diseases and developmental disorders: prevention, assessment and treatment. 2nd ed. Oxford University Press; 2005. Part III. Chapters 37-59.
6. GeneReviews are expert-authored, peer-reviewed, current disease descriptions that apply genetic testing to the diagnosis, management, and genetic counseling of patients and families with specific inherited conditions. Available at: http://www.ncbi.nlm.nih.gov/sites/GeneTests/review?db=GeneTests (last accessed 8/5/2010).
7. Stanley CA. Disorders of fatty acid oxidation. In: Fernandes J, et al editors. Inborn metabolic diseases. Berlin Springer; 2000. P. 141-150.
8. Agamanolis D. Inherited metabolic disorders in neuropathology: an illustrated interactive course for medical students and residents. Akron OH: Akron Children's Hospital, Northeastern Ohio University College of Medicine. Available at: http://www.neuropathologyweb.org/chapter10/chapter10aLSDgeneral.html.
9. Van Veldhoven, PP, Leuven KU. Biochemistry and genetic disorders of inherited disorders of peroxisomal fatty acid metabolism. J Lipid Res. 2010 June. Available at: http://www.jlr.org/cgi/rapidpdf/jlr.R005959v1.

Nutrition Risk Criteria **352 INFECTIOUS DISEASES**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to:

- tuberculosis
- pneumonia
- meningitis
- parasitic infections
- hepatitis
- bronchiolitis (3 episodes in last 6 months)
- HIV (Human Immunodeficiency Virus infection)*****
- AIDS (Acquired Immunodeficiency Syndrome)*****

The infectious disease must be present within the past 6 months, and diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Chronic, prolonged, or repeated infections adversely affect nutritional status through increased nutrient requirements as well as through decreased ability to take in or utilize nutrients.

Catabolic response to infection increases energy and nutrient requirements and may increase the severity of medical conditions associated with infection. Bronchiolitis is a lower respiratory tract infection that affects young children, usually under 24 months of age. It is often diagnosed in winter and early spring, and is caused by the respiratory syncytial virus (RSV). Recurring episodes of bronchiolitis may affect nutritional status during a critical growth period and lead to the development of asthma and other pulmonary diseases.

HIV is a member of the retrovirus family. HIV enters the cell and causes cell dysfunction or death. Since the virus primarily affects cells of the immune system, immunodeficiency results (AIDS). Recent evidence suggests that monocytes and macrophages may be the most important target cells and indicates that HIV can infect bone marrow stem cells. HIV infection is associated with the risk of malnutrition at all stages of infection.

Developments in the management and prevention of hepatitis have changed the management of infected women during pregnancy and have made breastfeeding safe. The following are guidelines for breastfeeding women with hepatitis, as found in the Technical Information Bulletin (10/97) "A Review of the Medical Benefits and Contraindications to Breastfeeding in the United States":

Hepatitis A: Breastfeeding is permitted as soon as the mother receives gamma globulin.

Hepatitis B: Breastfeeding is permitted after the infant receives HBIG (Hepatitis B specific immunoglobin) and the first dose of the series of Hepatitis B vaccine.

Hepatitis C: Breastfeeding is permitted for mothers without co-infection (e.g., HIV).

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 184-186.
2. Berkow, et al.: Merck Manual; 1992; 16th Edition.
3. Grand, Stupen, and Dietz: Pediatric Nutrition: Theory and Practice; Butterworths; 1987; pp. 549-570, 571-578, 651-664.
4. Lawrence, Ruth A: Maternal and Child Health Technical Information Bulletin: A Review of Medical Benefits and Contraindications to Breastfeeding in the United States; 1997; pp. 14-17.

Nutrition Risk Criteria **353 FOOD ALLERGY**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	1	RD
CHILDREN	3	RD

Definition

Food allergies are adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food. (1)

Presence of condition (food allergy) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Documentation in participant file of source of information (i.e. self-report of diagnosis by physician or written documentation by physician).

Justification

The actual prevalence of food allergies is difficult to establish due to variability in study designs and definitions of food allergies; however recent studies suggest a true increase in prevalence over the past 10 to 20 years (1). A meta-analysis conducted by the National Institute of Allergy and Infectious Disease (NIAID) found the prevalence of food allergy among all age groups between 1-10% (2). Further research has found that food allergy affects more children than recently reported with the prevalence estimated to be 8% (2). Food allergies are a significant health concern as they can cause serious illness and life-threatening reactions. Prompt identification and proper treatment of food allergies improves quality of life, nutritional well-being and social interaction.

Food allergy reactions occur when the body's immune system responds to a harmless food as if it were a threat (3). The most common types of food allergies involve immunoglobulin E (IgE)-mediated responses. The immune system forms IgE against offending food(s) and causes abnormal reactions. IgE is a distinct class of antibodies that mediates an immediate allergic reaction. When food allergens enter the body, IgE antibodies bind to them and release chemicals that cause various symptoms. (1)

According to an expert panel sponsored by the National Institute of Allergy and Infectious Disease, individuals with a family history of any allergic disease are susceptible to developing food allergies and are classified as "at risk" or "high risk." Individuals who are "at risk" are those with a biological parent of sibling with existing, or history of, allergic rhinitis, asthma or atopic dermatitis. Individuals who are "high risk" are those with preexisting severe allergic disease and/or family history of food allergies. (1)

Food Allergies vs. Intolerances

Food intolerances are classified differently from food allergies based on the pathophysiological mechanism of the reactions. Unlike food allergies, food intolerances do not involve the immune system. Food intolerances are adverse reactions to food caused either by the properties of the food itself, such as a toxin, or the characteristics of the individual, such as a metabolic disorder (4).

Food intolerances are often misdiagnosed as food allergies because the symptoms are often similar. Causes of food intolerances may include food poisoning, histamine toxicity, food additives such as monosodium glutamate (MSG), or sulfites (5). The most common food intolerance is lactose intolerance (see Nutrition Risk Criterion 355 *Lactose Intolerance*).

Common Food Allergens

Although reactions can occur from the ingestion of any food, a small number of foods are responsible for the majority of food-induced allergic reactions (6). The foods that most often cause allergic reactions include:

-Cow's milk (and foods made from cow's milk)
-Eggs
-Peanuts
-Tree nuts (walnuts, almonds, cashews, hazelnuts, pecans, brazil nuts)
-Fish
-Crustacean shellfish (e.g. shrimp, crayfish, lobster, and crab)
-Wheat
-Soy

For many individuals, food allergies appear within the first two years of life. Allergies to cow's milk, eggs, wheat and soy generally resolve in early childhood. In contrast, allergy to peanuts and tree nuts typically persist to adulthood. Adults may have food allergies continuing from childhood or may develop sensitivity to food allergens encountered after childhood, which usually continue through life. (1)

Symptoms

There are several types of immune responses to food including IgE-mediated, non-IgE-mediated or mixed. In an IgE-mediated response, the immune system produces allergen-specific IgE antibodies (sigE) when a food allergen first enters the body. Upon re-exposure to the food allergen, the sigE identifies it and quickly initiates the release of chemicals, such as histamine (3). These chemicals cause various symptoms based on the area of the body in which they were released. These reactions occur within minutes or up to 4 hours after ingestion and include symptoms such as urticaria (hives), angioedema, wheezing, cough, nausea, vomiting, hypotension and anaphylaxis (7).

Food-induced anaphylaxis is the most severe form of IgE-mediated food allergies. It often occurs rapidly, within seconds to a few hours after exposure, and is potentially fatal without proper treatment. Food-induced anaphylaxis often affects multiple organ systems and produces many symptoms, including respiratory compromise (e.g., dyspnea, wheeze and bronchospasm), swelling and reduced blood pressure (7). Prompt diagnosis and treatment is essential to prevent life-threatening reactions. Tree nuts, peanuts, milk, egg, fish and crustacean fish are the leading causes of food-induced anaphylaxis (1).

Food allergens may also induce allergic reactions which are non-IgE-mediated. Non-IgE-mediated reactions generally occur more than 4 hours after ingestion, primarily result in gastrointestinal symptoms and are more chronic in nature (7). Examples of non-IgE-mediated reactions to specific foods include celiac disease (see nutrition risk criterion 354 Celiac Disease), food protein-induced enterocolitis syndrome (FPIES), food protein-induced proctocolitis (FPIP), food protein-induced gastroenteropathy, food-induced contact dermatitis and food-

induced pulmonary hemosiderosis (Heiner's syndrome) (accessed May 2012) (8).

The diagnosis of food allergies by a health care provider (HCP) is often difficult and can be multifaceted (see Clarification for more information). Food allergies often coexist with severe asthma, atopic dermatitis (AD), eosinophilic esophagitis (EoE) and exercise-induced anaphylaxis. Individuals with a diagnosis of any of these conditions should be considered for food allergy evaluation. (1)

Prevention

Currently, there is insufficient evidence to conclude that restricting highly allergenic foods in the maternal diet during pregnancy or lactation prevents the development of food allergies in the offspring (9). Adequate nutrition intake during pregnancy and lactation is essential to achieve positive health outcomes. Unnecessary food avoidance can result in inadequate nutrition. There is also a lack of evidence that delaying the introduction of solids beyond 6 months of age, including highly allergenic foods, prevents the development of food allergies. If the introduction of developmentally appropriate solid food is delayed beyond 6 months of age, inadequate nutrient intake, growth deficits and feeding problems can occur. (1)

The protective role that breastfeeding has in the prevention of food allergies remains unclear. There is some evidence for infants at high risk of developing food allergies that exclusive breastfeeding for at least 4 months may decrease the likelihood of cow's milk allergy in the first 2 years of life (9). The American Academy of Pediatrics (AAP) continues to recommend that all infants, including those with a family history of food allergies, be exclusively breastfed until 6 months of age, unless contraindicated for medical reasons (1, 10). For infants who are partially breastfed or formula fed, partially hydrolyzed formulas may be considered as a strategy for preventing the development of food allergies in at-risk infants. According to the AAP, there is no convincing evidence for the use of soy formula as a strategy for preventing the development of food allergies in at-risk infants and therefore it is not recommended. (9)

Management

Food allergies have been shown to produce anxiety and alter the quality of life of those with the condition. It is recommended that individuals with food allergies and their caregivers be educated on food allergen avoidance and emergency management that is age and culturally appropriate. Individuals with a history of severe food allergic reactions, such as anaphylaxis, should work with their HCP to establish an emergency management plan. (1)

Food allergen avoidance is the safest method for managing food allergies. Individuals with food allergies must work closely with their HCP to determine the food(s) to be avoided. This includes the avoidance of any cross-reactive foods, i.e., similar foods within a food group (see Clarification for more information). Nutrition counseling and growth monitoring is recommended for all individuals with food allergies to ensure a nutritionally adequate diet. Individuals with food allergies should also be educated on reading food labels and ingredient lists. (1)

Infants who are partially breastfed or formula fed, with certain non-IgE mediated allergies, such as, FPIES and FPIP may require extensively hydrolyzed casein or amino acid-based formula. According to food allergy experts, children with FPIES can be re-challenged every 18-24 months and, infants/children with FPIP

be re-challenged at 9-12 months of age. The re-challenging of foods should be done with HCP oversight. (8)

Implications for WIC Nutrition Services

Through client-centered counseling, WIC staff can assist families with food allergies in making changes that improve quality of life and promote nutritional well-being while avoiding offending foods. Based on the needs and interests of the participant, WIC staff can (as appropriate):

-Facilitate and encourage the participant's ongoing follow-up with the HCP for optimal management of the condition.
-Promote exclusive breastfeeding until six months of age and continue through the first year (10).
-Provide hypoallergenic formula for participants with appropriate medical documentation, as needed.
-Tailor food packages to substitute or remove offending foods.
-Educate participants about reading food labels and identifying offending foods and ingredients.
See resources below:

http://www.fda.gov/downlaods/ForConsumers/ConsumerUpdates/UCM254727.pdf
Accessed May 2012.
http://www.webmd.com/allergies/foodtriggers. Accessed May 2012.
http://www.foodallergy.org/section/how-to-read-a-label. Accessed May 2012.

-Educate participants on planning meals and snacks for outside the home.
-Refer participants to their HCP for a re-challenge of offending foods, as appropriate.
-Establish/maintain communication with participant's HCP.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Food allergies are diagnosed by a HCP by evaluating a thorough medical history and conducting a physical exam to consider possible trigger foods to determine the underlying mechanism of the reaction, which guides testing. Along with a detailed history of the disorder, such as symptoms, timing, common triggers and associations, there are several types of tests that the HCP may use in diagnosing food allergies. These include the following:

- Food Elimination Diet
- Oral Food Challenges
- Skin Prick Test (SPT)
- Allergen-specific serum IgE (sigE)
- Atopy Patch Test

Diagnosing food allergies is difficult because the detection of sigE does not necessarily indicate a clinical allergy. Often, more than one type of test is

required to confirm a diagnosis. The double-blind, placebo-controlled food challenge is considered the gold standard in testing for food allergies. (11)

Children often outgrow allergies to cow's milk, soy, egg, and wheat quickly; but are less likely to outgrow allergies to peanut, tree nuts, fish, and crustacean shellfish. If the child has had a recent allergic reaction, there is no reason to retest. Otherwise, annual testing may be considered to see if the allergy to cow's milk, soy, egg, or wheat has been outgrown so the diet can be normalized. (1)

Cross-reactive food: When a person has allergies to one food, he/she tends to be allergic to similar foods within a food group. For example, all shellfish are closely related; if a person is allergic to one shellfish, there is a strong chance that person is also allergic to other shellfish. The same holds true for tree-nuts, such as almonds, cashews and walnuts. (1)

References

1. Boyce, J. et al. Guidelines for the diagnosis and management of food allergy in the United States: Report of the NIAID-Sponsored Expert Panel. Journal of Allergy and Clinical Immunology. 2012; 126(6):S1-S58. http://www.jacionline.org/artical/S0091-6749(10)01566-6/fulltext. Accessed May 2012.
2. Gupta, R. et al. The prevalence, severity and distribution of childhood food allergy in the United States. Pediatrics. 2011;128(1):e9-e17. Available at: http://pediatrics.aappublications.org/content/128/1/e9.full.html. Accessed May 2012.
3. National Institute of Allergy and Infectious Disease website: How do allergic reactions work? Available at: http://www.niaid.nih.gov/topics/foodallergy/understanding/pages/whatisit.aspx. Accessed May 2012.
4. Cianferoni, A, Spergel, JM. Food Allergy: review, classification and diagnosis. Allergology International. 2009; 58:457-466.
5. National Institute of Allergy and Infectious Disease. Food allergy: An overview. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2010 (NIH Publication No. 11-5518). Available at: http://www.niaid.nih.gov/topics/foodallergy/understanding/pages/whatisit.aspx. Accessed May 2012.
6. Sampson, HA. Food Allergy. Part 1: Immunopathogenesis and clinical disorders. Journal of Allergy and Clinical Immunology. 1999; 103(5):717-728.
7. Davis, C. Food allergies: clinical manifestations, diagnosis, and management. Current Problems in Pediatric Adolescent Health Care. 2009: 39:236-254.
8. Metcalfe DD, Sampson HA, Simon RA, editors. Food allergy: adverse reactions to food and food additives. 4th ed. Malden (MA): Blackwell Publishing; 2008.
9. Greer, F. et al. American Academy of Pediatrics Committee on Nutrition. Effects of early nutritional interventions on the development of atopic disease in infants and children: the role of maternal dietary restriction, breastfeeding, timing of introduction of complementary foods, and hydrolyzed formulas. Pediatrics. 2008; 121(1), pages 183-191.
10. Gartner LM, Morton J, Lawrence RA, et al. American Academy of Pediatrics. Policy Statement: Breastfeeding and the use of human milk. Pediatrics. 2005; 115 (2): 496-506.
11. Sicherer S.H., Sampson, HA. Food allergy. Journal of Allergy and Clinical Immunology. 2010; (125):S116-S125.

Nutrition Risk Criteria **354** **CELIAC DISEASE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Celiac Disease (CD) is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. (1). (For more information about the definition of CD, please see the Clarification section)

CD is also known as:

- Celiac Sprue
- Gluten-sensitive Enteropathy
- Non-tropical Sprue

Presence of Celiac Disease diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Documentation in participant file of source of information (i.e. self-report of diagnosis by physician or written documentation by physician).

Justification

CD affects approximately 1% of the U.S. population (2,3). CD can occur at any age and the treatment requires strict adherence to a gluten-free diet for life. CD is both a disease of malabsorption and an abnormal immune reaction to gluten. When individuals with CD eat foods or ingest products containing gluten, their immune system responds by damaging or destroying villi---the tiny, fingerlike protrusions lining the small intestine. Villi normally allow nutrients from food to be absorbed through the walls of the small intestine into the bloodstream (4). The destruction of villi can result in malabsorption of nutrients needed for good health. Key nutrients often affected are iron, calcium and folate as they are absorbed in the first part of the small intestine. If damage occurs further down the small intestinal tract, malabsorption of carbohydrates (especially lactose), fat and fat-soluble vitamins, protein and other nutrients may also occur (2,5).

In addition to the gastrointestinal system, CD affects many other systems in the body, resulting in a wide range and severity of symptoms. Symptoms of CD may include chronic diarrhea, vomiting, constipation, pale foul-smelling fatty stools and weight loss. Failure to thrive may occur in infants and children. The vitamin and mineral deficiencies that can occur from continued exposure to gluten may result in conditions such as anemia, osteoporosis and neurological disorders such as ataxia, seizures and neuropathy.

Individuals with CD who continue to ingest gluten are also at increased risk for developing other autoimmune disorders (e.g. thyroid disease, type 1 diabetes, Addison's disease) and certain types of cancer, especially gastrointestinal malignancies (2).

Continued exposure to gluten increases the risk of miscarriage or having a low birth weight baby, and may result in infertility in both women and men. A delay in diagnosis for children may cause serious nutritional complications including growth failure, delayed puberty, iron-deficiency anemia, and impaired bone health. Mood swings or depression may also occur (2, 6). See Table 1 for Nutritional Implications and Symptoms.

Table 1. Nutritional Implications and Symptoms of CD

Common in Children:

Digestive Symptoms- more common in infants and children, may include:

- Vomiting
- Chronic diarrhea
- Constipation
- Abdominal bloating and pain
- Pale, foul-smelling, or fatty stool

Other Symptoms:

- Delayed puberty
- Dental enamel abnormalities of the permanent teeth
- Failure to thrive (delayed growth and short stature)
- Weight loss
- Irritability

Common in Adults:

Digestive Symptoms- same as above, less common in adults

Other Symptoms- adults may instead have one or more of the following:

- Unexplained iron-deficiency anemia
- Other vitamin and mineral deficiencies (A,D,E, K, calcium)
- Lactose intolerance
- Fatigue
- Bone or joint pain
- Arthritis
- Depression or anxiety
- Tingling numbness in the hands and feet
- Seizures
- Missed menstrual periods
- Infertility (men and women) or recurrent miscarriage
- Canker sores inside the mouth
- Itchy skin rash- dermatitis herpetiformis
- Elevated liver enzymes

Sources:

Case, Shelley, Gluten-Free Diet, A Comprehensive Resource Guide, Case Nutrition Consulting Inc., 2008.

National Institute of Diabetes and Digestive and Kidney Diseases, Celiac Disease, NIH Publication No. 08-4269 September 2008.

http://digestive.niddk.nih.gov/ddiseases/pubs/celiac/#what. Accessed May 2012.

The risk for development of CD depends on genetic, immunological, and environmental factors. Recent studies suggest that the introduction of small amounts of gluten while the infant is still breast-fed may reduce the risk of CD. Both breastfeeding during the introduction of dietary gluten, and increasing the duration of breastfeeding were associated with reduced risk in the infant for the development of CD. It is not clear from studies whether breastfeeding delays the onset of symptoms or provides a permanent protection against the disease. Therefore, it is prudent to avoid both early (<4 months) and late (≥7 months) introduction of gluten and to introduce gluten gradually while the infant is still breast-fed, as this may reduce the risk of CD. (7)

The only treatment for CD is a gluten-free diet. Individuals with CD should discuss gluten-free food choices with a dietitian or physician that specializes in CD. Individuals with CD should always read food ingredient lists carefully to make sure that the food does not contain gluten. Making informed decisions in the grocery stores and when eating out is essential for the successful treatment of the disease (5, 8).

Implications for WIC Nutrition Services

Through client-centered counseling, WIC staff can assist participants with CD in making gluten-free food choices that improve quality of life and promote nutritional well-being. WIC can provide nutrition education/counseling on alternatives to gluten-containing food products as well as provide gluten-free grain selections available in the WIC food packages. Based on the needs and interests of the participant, WIC staff may (as appropriate):

- Promote breastfeeding throughout the first year of life, with exclusive breastfeeding until 4-6 months of age.
- In consultation with the guidance of a medical provider, introduce gluten-containing foods between 4 and 6 months to infants at risk of CD, including infants with a parent or sibling with CD.
- Tailor food packages to substitute or remove gluten-containing foods.
- Educate participants on meeting nutritional needs in the absence of gluten-containing foods.
- Encourage high fiber, gluten-free grain selections.
- Monitor participant's growth pattern and weight status.
- Educate participants on planning gluten-free meals and snacks for outside the home.
- Provide educational materials outlining allowed foods and foods to avoid, for example:
  http://www.celiac.nih.gov/Default.aspx. Accessed May 2012.
  http://www.naspghan.org/user-assets/Documents/pdf/diseaseInfo/GlutenFreeDietGuide-E.pdf. Accessed May 2012

Provide referrals as appropriate.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

The 2006 American Gastroenterological Association (AGA) Institute Technical Review on the Diagnosis and Management of Celiac Disease refers to CD as "a unique disorder that is both a food intolerance and autoimmune disorder" (9). According to the 2010 NIAID-Sponsored Expert Panel definition, CD is a non-IgE mediated food allergy (10). (See nutrition risk criterion 353 Food Allergy.) However, the Expert Panel did not include information about CD in its report but rather refers readers to existing clinical guidelines on CD including the AGA Institute's Technical Review. (5,9,10)

References

1. National Institute of Allergy and Infectious Disease. Food allergy: an overview. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2010 (NIH Publication No. 11-5518). Available at: http://www.niaid.nih.gov/topics/foodallergy/understanding/pages/whatisit.aspx. Accessed May 2012.
2. Case, S. Gluten-free diet: A comprehensive resource guide. Case Nutrition Consulting Inc., 2008.
3. Green, PHR, Cellier, C. Medical progress-celiac disease. The New England Journal of Medicine. 2007 Oct 25:1731-1743.
4. National Institute of Diabetes and Digestive and Kidney Diseases, Celiac Disease, National Institute of Health. Celiac disease. Available at: http://digestive.niddk.nih.gov/ddiseases/pubs/celiac/#what. Accessed May 2012.
5. National Institute of Diabetes and Digestive and Kidney Diseases, Celiac Disease, NIH Publication No. 08-4269 September 2008.
6. Guideline for the Diagnosis and Treatment of Celiac Disease in Children: Recommendation of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. J Pediatr Gastroenterol Nutr. 2005 Jan;40(1):1-19.
7. ESPGHAN Committee on Nutrition: Agostoni, C. et al. Complementary feeding: A commentary by the ESPGHAN Committee on Nutrition, Medical Position Paper. Journal of Pediatric Gastroenterology. 2006 September: 67-92.
8. Raymond, N, Heap, J, Case, S. The gluten-free diet: An update for health professionals. Practical Gastroenterology. 2006 September: 67-92.
9. American Gastroenterological Association (AGA) Institute Technical Review on the Diagnosis and Management of Celiac Disease. Gastroenterology. 2006 Dec;131(6):1981-2002.
10. Boyce, J. et al. Guidelines for the diagnosis and management of food allergy in the United States: Report of the NIAID-Sponsored Expert Panel. Journal of Allergy and Clinical Immunology. 2010;126(6):S1-S58. http://www.jacionline.org/article/S0091-6749(10)01566-6/fulltext. Accessed May 2012.

Nutrition Risk Criteria **355 LACTOSE INTOLERANCE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	1	RD
CHILDREN	3	RD

Definition

Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.

Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Documentation in participant file of source of information (i.e. self-report of diagnosis by physician or written documentation by physician).

Justification

Lactose intolerance occurs because of a deficiency in the levels of the lactase enzyme (1). Many variables determine whether a person with lactase deficiency develops symptoms. They include: the dose of lactose ingested; the residual intestinal lactase activity; the ingestion of food along with lactose; the ability of the colonic flora to ferment lactose; and, the individual sensitivity to the products of lactose fermentation (1). Some forms of lactase deficiencies may be temporary, resulting from premature birth or small bowel injuries, and will correct themselves, leaving individuals with the ability to digest lactose sufficiently (2).

Primary lactase deficiency is attributable to relative or absolute absence of lactase that develops in childhood, and is the most common cause of lactose malabsorption and lactose intolerance (2).

Secondary lactase deficiency is one that results from small bowel injury, such as acute gastroenteritis, persistent diarrhea, or other causes that injure the small intestine mucosa, and can present at any age, but is more common in infancy. Treatment of secondary lactase deficiency and lactose malabsorption attributable to an underlying condition generally do not require elimination of lactose from the diet. Once the primary problem is resolved, lactose-containing products can be consumed normally. (2)

Congenital lactase deficiency is a rare disorder that has been reported in only a few infants. Affected newborn infants present with intractable diarrhea as soon as human milk or lactose-containing formula is introduced. (2)

Developmental lactase deficiency is the relative lactase deficiency observed among pre-term infants of less than 34 weeks gestation (2). One study in preterm infants reported benefit from the use of lactase-supplemented feedings or lactose-reduced formulas (3). The use of lactose-containing formulas and human milk does not seem to have any short- or long-term deleterious effects in preterm infants (2).

Lactose is found primarily in milk, milk-based formula and other dairy products, which provide a variety of nutrients essential to the WIC population (calcium,

vitamin D, protein). Lactose intolerance varies according to individuals. Some individuals may tolerate various quantities of lactose without discomfort, or tolerate it when consumed with other foods. Dairy products that are soured, or otherwise treated with bacteria that secrete lactase (e.g., Lactobacillus acidophilus), such as cheese and yogurt, are easier to digest in lactose-intolerant individuals because they contain relatively low levels of lactose. (4)

Many individuals diagnosed with lactose intolerance avoid dairy all together. Also, lactose intolerance has been shown to be associated with low bone mass and increased risk of fracture (5). Inadequate dairy intake increases the risk of metabolic syndrome, hypertension, preeclampsia, obesity and certain forms of cancer, especially colon cancer (6).

Implications for WIC Nutrition Services

It is important to assess participants individually for lactose tolerances and nutrient needs to determine the best plan of action. WIC can provide client-centered counseling to incorporate tolerated amounts of lactose-containing foods and/or other dietary sources of calcium, vitamin D and protein into participants' diets. WIC foods such as cheese, lactose-free milk, soy beverages, tofu and calcium fortified foods (like juice) can provide these nutrients to participants with lactose intolerance. Based on the needs and interests of the participant, WIC staff can, in addition, also offer the following strategies (as appropriate):

- **Except for infants with congenital lactase deficiency,** promote exclusive breastfeeding until six months of age and continue breastfeeding through the first year. For infants with congenital lactase deficiency, treatment is removal and substitution of lactose from the diet with a commercial lactose-free formula (2).
- Tailor food packages to substitute or remove lactose-containing foods.
- Educate participants on meeting nutritional needs in the absence of lactose-containing foods.
- Educate participants on planning lactose-free/lactose-reduced meals and snacks for outings, social gatherings, school and/or work.

Any WIC participant suspected to have lactose intolerance should be referred to a health care provider for evaluation and appropriate diagnosis (7), if needed (see Clarification for additional information on diagnosing Lactose intolerance).

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Lactose malabsorption can be diagnosed with a hydrogen breath test. The test involves having individuals ingest a standard dose of lactose after fasting. Elevated levels of breath hydrogen, which are produced by bacterial fermentation of undigested lactose in the colon, indicate the presence of lactose malabsorption (1). The hydrogen breath test is not routinely ordered, and instead, patients are frequently asked to assess symptoms while avoiding dairy products for a period of time followed by a lactose product challenge to

determine if they are lactose intolerant (7). The demonstration of lactose malabsorption does not necessarily indicate that an individual will be symptomatic.

References

1. National Institutes of Health Consensus Development Conference Statement: Lactose intolerance and health. February, 2010. Available at: http://consensus.nih.gov/2010/lactosestatement.htm. Accessed May 2012.
2. Heyman MB. Lactose intolerance in infants, children, and adolescents; Pediatrics 2006 September: 118 (#3) 1279-1286. http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/3/1279.pdf. Accessed May 2012.
3. Shulman RJ, Feste A, Ou C. Absorption of lactose, glucose polymers, or combination in premature infants. J Pediatr. 1995;127:626-631.
4. Ranciaro A, Tishoff SA. Population genetics: evolutionary history of lactose tolerance in Africa [abstract]. NIH Consensus Development Conference Lactose Intolerance and Health; February 2010; 43-47.
5. U.S. Department of Health and Human Services- Office of the Surgeon General. Bone health and osteoporosis: a report of the surgeon general. 2004.
6. Hearney RP. Consequences of excluding dairy or of avoiding milk in adults [abstract]. NIH Consensus Development Conference Lactose Intolerance and Health. February, 2010; 73-77.
7. Chang, Lin MD. Clinical Presentation: But what if it is not lactose intolerance? [abstract]. NIH Consensus Development Conference Lactose Intolerance and Health; February 2010; 39-42.

Additional Reference

1. National Dairy Council [Internet]. Lactose Intolerance Health Education Kit (2011). Available at: http://www.nationaldairycouncil.org/EDUCATIONMATERIALS/HEALTHPROFESSIONALSEDUCATIONKITS/Pages/LactoseIntoleranceHealthEducationKit.aspx. Accessed May 2012.

Nutrition Risk Criteria **356** **HYPOGLYCEMIA**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	1	-
CHILDREN	3	-

Definition

Presence of hypoglycemia diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Documentation in participant file of source of information (i.e. self-report of diagnosis by physician or written documentation by physician).

Justification

Hypoglycemia can occur as a complication of diabetes, as a condition in itself, in association with other disorders, or under certain conditions such as early pregnancy, prolonged fasting, or long periods of strenuous exercise (1).

Symptomatic hypoglycemia is a risk observed in a substantial proportion of newborns who are small for gestational age (SGA), but it is uncommon and of shorter duration in newborns who are of the appropriate size for gestational age (2).

WIC can provide nutrition management that concentrates on frequent feedings to support adequate growth for infants and children (2). WIC can also provide nutrition education to help manage hypoglycemia in women that includes consuming a balanced diet, low carbohydrate snacks and exercise (1).

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. National Institute of Diabetes, Digestive and Kidney Diseases. Hypoglycemia. National Diabetes Information Clearinghouse, 199. Available at: http://www.niddk.nih.gov/health/diabetes/pubs/hypo/hypo.htm.
2. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington D.C.; 1996. p.217-218.

Nutrition Risk Criteria **357 DRUG NUTRIENT INTERACTIONS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised.

Required Documentation

Justification

The drug treatment of a disease or medical condition may itself affect nutritional status. Drug induced nutritional deficiencies are usually slow to develop and occur most frequently in long-term drug treatment of chronic disease. Possible nutrition-related side effects of drugs include, but are not limited to, altered taste sensation, gastric irritation, appetite suppression, altered GI motility, and altered nutrient metabolism and function, including enzyme inhibition, vitamin antagonism, and increased urinary loss.

The marketplace of prescribed and over-the-counter drugs is a rapidly changing one. For knowledgeable information on the relationship of an individual's drug use to his/her nutritional status, it is important to refer to a current drug reference such as Physician's Desk Reference (PDR), a text such as Physician's Medication Interactions, drug inserts, or to speak with a pharmacist.

References

1. Allen, M: Food-Medication Interactions; 7th edition; Tempe, Arizona; 1991.
2. Physician’s Desk Reference, 51st edition; Montvale, New Jersey; Medical Economics Company, Inc.; 1997.
3. Diet and Drug Interactions. Daphne A. Roe, M.D., F.R.C.P.
4. Handbook on Drug and Nutrient Interactions: A Reference and Study Guide.
5. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 217-218.
6. Pronsky, ZM: Powers and Moore’s Food Medications Interactions; 10th edition; 1997.

Nutrition Risk Criteria **358 EATING DISORDERS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:

- self-induced vomiting
- purgative abuse
- alternating periods of starvation
- use of drugs such as appetite suppressants, thyroid preparations or diuretics
- self-induced marked weight loss

Presence of eating disorder(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders or evidence of such disorders documented by the CPA.

Required Documentation

Justification

Anorexia nervosa and bulimia are serious eating disorders that affect women in the childbearing years. These disorders result in general malnutrition and may cause life-threatening fluid and electrolyte imbalances. Women with eating disorders may begin pregnancy in a poor nutritional state. They are at risk of developing chemical and nutritional imbalances, deficiencies, or weight gain abnormalities during pregnancy if aberrant eating behaviors are not controlled. These eating disorders can seriously complicate any pregnancy since the nutritional status of the pregnant woman is an important factor in perinatal outcome.

Maternal undernutrition is associated with increased perinatal mortality and an increased risk of congenital malformation. While the majority of pregnant women studied reported a significant reduction in their eating disorder symptoms during pregnancy, a high percentage of these women regressed in the postpartum period. This regression in postpartum women is a serious concern for breastfeeding and non-breastfeeding postpartum women who are extremely preoccupied with rapid weight loss after delivery.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Worthington-Roberts, B., and Williams, SR: Nutrition in Pregnancy and Lactation; 5th ed.; Mosby Pub; St. Louis; pp.270-271.
2. Strober, M: International Journal of Eating Disorders; Vol. 8, No. 3; 1986; pp.285-295.
3. Institute of Medicine: Nutrition Services in Perinatal Care; 1992, p. 20.
4. Clinical Issues Perinatal Womens Health Nursing; 1992;3(4); pp. 695-700.
5. Krummel DA, and Kris-Etherton, PM: Nutrition in Women's Health, Aspen Pub; Gaithersburg, MD; pp. 58-102.

Nutrition Risk Criteria **359** **RECENT MAJOR SURGERY, TRAUMA, BURNS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status.

Any occurrence:

- within the past two (≤ 2) months may be self reported
- more than two (> 2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.

Required Documentation

Justification

The body's response to recent major surgery, trauma or burns may affect nutrient requirements needed for recovery and lead to malnutrition. There is a catabolic response to surgery; severe trauma or burns cause a hypermetabolic state. Injury causes alterations in glucose, protein and fat metabolism.

Metabolic and physiological responses vary according to the individual's age, previous state of health, preexisting disease, previous stress, and specific pathogens. Once individuals are discharged from a medical facility, a continued high nutrient intake may be needed to promote the completion of healing and return to optimal weight and nutrition status.

Reference

Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996. p. 188-9.

Nutrition Risk Criteria **360 OTHER MEDICAL CONDITIONS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but is not limited to:

- juvenile rheumatoid arthritis (JRA)
- lupus erythematosus
- cardiorespiratory diseases
- heart disease
- cystic fibrosis
- persistent asthma (moderate or severe) requiring daily medication

Presence of medical condition(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Justification

Juvenile rheumatoid arthritis (JRA) is the most common pediatric rheumatic disease and most common cause of chronic arthritis among children. JRA puts individuals at risk of anorexia, weight loss, failure to grow, and protein energy malnutrition.

Lupus erythematosus is an autoimmune disorder that affects multiple organ systems. Lupus erythematosus increases the risk of infections, malaise, anorexia, and weight loss. In pregnant women, there is increased risk of spontaneous abortion and late pregnancy losses (after 28 weeks gestation).

Cardiorespiratory diseases affect normal physiological processes and can be accompanied by failure to thrive and malnutrition. Cardiorespiratory diseases put individuals at risk for growth failure and malnutrition due to low calorie intake and hypermetabolism.

Cystic fibrosis (CF), a genetic disorder of children, adolescents, and young adults characterized by widespread dysfunction of the exocrine glands, is the most common lethal hereditary disease of the Caucasian race.

Many aspects of the disease of CF stress the nutritional status of the patient directly or indirectly by affecting the patient's appetite and subsequent intake. Gastrointestinal losses occur in spite of pancreatic enzyme replacement therapy. Also, catch-up growth requires additional calories. All of these factors contribute to a chronic energy deficit, which can lead to a marasmic type of malnutrition.

The primary goal of nutritional therapy is to overcome this energy deficit.

Studies have shown variable intakes in the CF population, but the intakes are usually less than adequate and are associated with a less than normal growth pattern.

Asthma is a chronic inflammatory disorder of the airways, which can cause recurrent episodes of wheezing, breathlessness, chest tightness, and coughing of variable severity. Persistent asthma requires daily use of medication, preferably inhaled anti-inflammatory agents. Severe forms of asthma may require long-term use of oral corticosteroids which can result in growth suppression in children, poor bone mineralization, high weight gain, and, in pregnancy, decreased birthweight of the infant. High doses of inhaled corticosteroids can result in growth suppression in children and poor bone mineralization. Untreated asthma is also associated with poor growth and bone mineralization and, in pregnant women, adverse birth outcomes such as low birth weight, prematurity, and cerebral palsy. Repeated asthma exacerbations ("attacks") can, in the short-term, interfere with eating, and in the long-term, cause irreversible lung damage that contributes to chronic pulmonary disease. Compliance with prescribed medications is considered to be poor. Elimination of environmental factors that can trigger asthma exacerbations (such as cockroach allergen or environmental tobacco smoke) is a major component of asthma treatment. WIC can help by providing foods high in calcium and vitamin D, in educating participants to consume appropriate foods and to reduce environmental triggers, and in supporting and encouraging compliance with the therapeutic regimen prescribed by the health care provider.

NOTE: This criterion will usually not be applicable to infants for the medical condition of asthma. In infants, asthma-like symptoms are usually diagnosed as bronchiolitis with wheezing which is covered under Criterion #352, Infectious Diseases.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis (“My doctor says that I have/my son or daughter has…”) Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp. 185-187, 190-191
2. Queen, Patricia and Lang, Carol: Handbook of Pediatric Nutrition; 1993; pp. 422-425.
3. National Heart, Lung, and Blood Institute: Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma; 1997; pp. 3, 20, 67-73.
4. National Heart, Lung, and Blood Institute: Management of Asthma During Pregnancy; 1992; pp. 7, 36-37.
5. JAMA: Asthma Information Center: Asthma Medications Misused, Underused in Inner City Residents; 1998, pp.1-2.

Nutrition Risk Criteria **361 DEPRESSION**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Presence of clinical depression, including postpartum depression.

Presence of condition diagnosed, documented, or reported by a physician, clinical psychologist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. See the **Clarification** section for more information about self-reporting a diagnosis.

Required Documentation

Document source of information (i.e. self-report of diagnosis by medical provider or written documentation by medical provider).

Justification

According to the National Institute of Mental Health (NIMH) nearly 10% of the U.S. population ages 18 and older suffers from depression each year, with 6.7% suffering from major depressive disorders (1). Although depression can occur at any age, the average onset is around age 30 (1, 2). Depression occurs twice as frequently in women as in men. Depression has a variety of symptoms, but the most common are deep feelings of sadness or a marked loss of interest in pleasure or activities. Other symptoms of depression include: appetite changes resulting in unintended weight losses or gains, insomnia or oversleeping, loss of energy or increased fatigue, restlessness or irritability, feelings of worthlessness or inappropriate guilt and difficulty thinking, concentrating or making decisions (1-3). Further, depression can increase the risk for some chronic diseases such as coronary heart disease, myocardial infarction, chronic pain syndromes, premature aging, and impaired wound healing. Therefore, untreated depression has the potential to impact long term health status (4). For information about children and depression, please see the **Clarification** section.

Pregnancy and Depression

Depression is common during pregnancy. Between 14% and 23% of pregnant women will experience depressive symptoms (5, 6). Several studies have found that depression risk is highest during the last trimester of pregnancy (4). Women who experience depression during pregnancy are found to be less likely to seek prenatal care (3). They may also suffer from episodes of nausea/vomiting or initiate/increase the use of drugs, alcohol and nicotine (4). Pregnant women with depression may be at risk for preeclampsia, preterm delivery or delivery of low birth weight infants and have higher perinatal mortality rates (5, 6).

Pregnant Adolescents

In the United States, 10% of women became pregnant during adolescence (7). The prevalence of teen pregnancy is highest among African and Native Americans, lower socioeconomic groups, and those living in stressful family environments. The prevalence rate of depression among pregnant adolescents is between 16% and 44%, which is almost twice as high as among their adult counterparts and non-pregnant adolescents (7). Adolescence is a stage of rapid

metabolic, hormonal, physiological and developmental changes. Depressive symptoms are likely to emerge when the physiologic and psychological changes that occur during pregnancy are superimposed upon normal developmental change. (8)

Teens who are under stress, lack social and/or family support, experience significant loss, or who have attention, learning or conduct disorders are at greater risk for developing clinical depression (9). Depression in young people often occurs with mental disorders, substance abuse disorders, or physical illnesses, such as diabetes (10). Pregnant adolescents with depressive symptoms are more likely to delay or refuse prenatal care and have subsequent, short interval pregnancies (within 24 months), both of which have shown to result in poor pregnancy outcomes (11, 12).

Antidepressant Use in Pregnancy

Negative consequences for the newborn such as fetal growth changes and shorter gestation periods have been associated with both depression symptoms and use of antidepressant medications during pregnancy. Although rare, some studies have linked fetal malformations, cardiac defects, pulmonary hypertension and reduced birth weight to antidepressant use during pregnancy, however, more research in this area is needed. (4, 6, 13) For more information about specific drug therapies used for treating depression, please see the Clarification section (14).

A fetus exposed to antidepressants throughout pregnancy or during the last trimester may, in rare instances, experience temporary withdrawal symptoms – such as jitters or irritability – at birth (15, 16). Some health care providers may suggest tapering dosages until after birth to minimize newborn withdrawal symptoms though it is unclear whether this method can reduce harmful effects. This strategy may also be unsafe for new mothers as they enter the postpartum period – a time of increased risk of mood swings and problems with anxiety. Therefore, it is imperative that prenatal women discuss the risks and benefits of antidepressant therapy with their health care provider.

Postpartum Depression and Related Mood Disorders

Postpartum depression was historically hypothesized to be caused by low estrogen and progesterone levels immediately following birth, however, this hypothesis has been found to have limited scientific support (17). Emerging studies have found that reproductive hormones have an indirect relationship on depression because of the influence on stress hormones, immune markers or sleep quality. The incidence of postpartum depression in new mothers can range from approximately 12% to 25%, to up to 35% or more in some high-risk groups. High risk groups include: women of low income, younger age, low education level and histories of stressful life events or traumatic experiences. Some studies have higher percentage rates for depression because they include both subjects with diagnosed major depression and those with depressive symptoms, thus accounting for the wide range in rates. (4)

Postpartum depression is distinguished from “baby blues” – a common reaction following delivery – both by its duration and the debilitating effects of the indifference the mother has about herself and her children (17). “Baby blues” are characterized by mild depressive symptoms, tearfulness (often for no discernible reason), anxiety, irritableness, mood fluctuations, increased sensitivity and fatigue. The “blues” typically peak four to five days after delivery, may last hours

to days and resolve by the 10th postnatal day (18).

Inflammation and Depression

Inflammation was once recognized as one of several risk factors for depression. New research has found that inflammation is not a risk factor – but rather it is the risk factor that underlies all others. This represents a shift in how inflammation contributes to depression. Emerging research has revealed that depression is associated with inflammation manifested by increased levels of proinflammatory cytokines. Common experiences of new motherhood; sleep disturbance, postpartum pain and past or current psychological trauma, act as stressors that cause proinflammatory cytokine levels to rise. This finding may explain why psychological trauma, act as stressors that cause proinflammatory cytokine levels to rise. This finding may explain why psychosocial, behavioral and physical risk factors increase the risk of depression (19). Additionally, inflammation levels normally rise during the last trimester of pregnancy, which may explain, as stated in the **Pregnancy and Depression** section above, the higher risk for experiencing depression during pregnancy (4).

Breastfeeding and Depression

Successful breastfeeding has a protective effect on maternal mental health because it attenuates stress and modulates the inflammatory response. Conversely, breastfeeding difficulties such as nipple pain can increase the risk of depression and should be addressed promptly. (19)

Implications for WIC Nutrition Services

Individuals diagnosed with depression can benefit from WIC nutrition services and supplemental foods. Through participant-centered counseling, WIC staff can, as necessary:

- Reinforce and support the treatments and therapies prescribed by the participant's health care provider.
- Make referrals to the primary health care provider and/or to other appropriate mental health and social service programs. A 2010 brief from the Urban Institute, recognized the WIC Program as a viable access point to identify and refer mothers with depressive symptoms (20). To learn more about mental health resources in your area please access the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's website. http://store.samhsa.gov/mhlocator or http://www.samhsa.gov/prevention/.
- Provide follow-up to ensure that the woman is receiving the necessary mental health treatment.
- Encourage food choices that promote nutritional well-being (to include good sources of Omega-3's for their anti-inflammatory properties).
- Educate about the increased risk of depressive symptoms during the third trimester of pregnancy as well as the prevalence, risks and signs of postpartum depression.
- Provide adequate breastfeeding education, assessment and support (e.g., peer counseling) to women with existing depression; both prenatally and in the postpartum period.

A supplement to this criterion was developed to provide WIC State and local

agencies with more information about the treatment of depression and WIC's role in providing nutrition services to women at risk of o diagnosed with depression: ***Guidance for Screening and Referring Women with or At Fisk for Depression.***

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Depression may be present in young children; however, it is generally not diagnosed until later in life. At this time, there is no evidenced-based research to support the diagnosis of depression as a risk criterion for WIC children participants. It is important to note, however, that a child's health may be at risk if the mother has a diagnosis of depression.

Nutrition Risk Criterion ***902 Woman of Infant/Child of Primary Caregiver with Limited ability to Make Feeding Decisions or Prepare Food***, is an appropriate risk criterion assignment for an infant or child of a WIC mother diagnosed with clinical depression.

There are three major classes of antidepressants. Of the three classes listed below, the first two, Tricyclic antidepressants (TCAs) and Selective serotonin reuptake inhibitors (SSRIs) are generally viewed as safe options for pregnant and breastfeeding women. MAOIs such as Nardil (Phenelzine) and Parnate (Tranylcypromine) are always contraindicated during pregnancy and breastfeeding as reproductive safety has not been established. (20)

- **Tricyclic antidepressants (TCAs)** are the oldest, least expensive and most studied of the antidepressants with a proven track record of effectiveness and include medications such as Amitriptyline (Elavil) and Desiprmine (Norpramin). Noted drawbacks are complex dosing, unpleasant side effects and risk of suicide.
- **Selective serotonin reuptake inhibitors (SSRIs)** are used most frequently in pregnant and breastfeeding mothers. Sertraline (Zoloft) are paroxetine (Paxil) are recommended first line treatments for breastfeeding women due to fewer side effects than other antidepressants and a once-a-day dosing schedule. Paroxetine (Paxil) is generally discouraged during pregnancy because it has been associated with fetal heart defects when taken during the first three months of pregnancy. Infants of mothers on these medications should be monitored for the following symptoms: sedation, agitation, irritability, poor feeding and GI distress.
- **Monoamine oxidase inhibitors (MAOIs)** work by inhibiting the enzyme monoamine oxidase to allow for more norepinephrine and serotonin to remain available in the brain. As stated above, these types of medications are always contraindicated during pregnancy and breastfeeding as reproductive safety has not been established. Furthermore, MAOIs have many drug and diet contraindications.

Nutrition Risk Criterion ***#357 Drug-Nutrient Interactions*** may be assigned, as appropriate, to women taking antidepressants.

Reference

1. National Institute of Mental Health [Internet]. Major depressive disorders among adults. Available at: http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml. Accessed June 2013.
2. American Psychiatric Association. Consumer Fact Sheet: Let's talk facts about depression. Available at: www.healthyminds.org. Accessed June 2013.
3. Institute of Medicine. WIC nutrition risk criteria: a scientific assessment. National Academy Press, Washington, D.C.; 1996.
4. Kendall-Tackett K. Depression in new mothers: causes, consequences and treatment alternatives, 2nd edition: 2010 pages 17-19, 8, 51-58.
5. Gaynes BN, Gavin N, Meltzer-Brody S, Lohr KN, Swinson T, Gartlehner G, Brody S, Miller WC. Perinatal depression: prevalence, screening accuracy, and screening outcomes. Evidence Report/Technology Assessment No. 119. (Prepared by the RTI-University of North Carolina Evidence-based Practice Center, under Contract No. 290-02-0016.) AHRQ Publication No. 05-E006-2. Rockville, MD: Agency for Healthcare Research and Quality. February 2005.
6. Yonkers KA, Wisner KL, Stewart DE, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists September/October 2009.
7. Szigethy EM, Ruiz, P. Depression among pregnant adolescents: an integrated treatment approach. Am J Psychiatry, 2001 Jan; 158(1):22-7.
8. McClanahan KK. Depression in pregnant adolescents: considerations for treatment. J Pediatr Adolesc Gyneco. Feb; 22(1):59-64. 2009.
9. Cash RE, P. N. (2204, February). Depression in children and adolescents: information for parents and educators. Available at: http://www.nasponline.org/resources/handouts/revisedPDFs/depression.pdf. Accessed June 2013.
10. National Institute of Mental Health. Depression in children and adolescents. (Fact Sheet for Physicians). Bethesda, MD: Author (NIH Publication No. 00-4744). August 2001.
11. American Academy of Child and Adolescent Psychiatry. Facts for families: when children have children. July, 2004 (No.31). Available at: www.aacap.org. Accessed June 2013.
12. Barnet B, Liu J, Devoe M. Double jeopardy: depressive symptoms and rapid subsequent pregnancy in adolescent mothers. Arch Pediatric Adolescent Medicine; 162(3), March 2008.
13. Kendall-Tackett K, Hale TW. Review: The use of antidepressants in pregnant and breastfeeding women: a review of recent studies. Hum Lact May 2010 26: 187-195, first published on August 3, 2009.
14. Mayo Clinic. Antidepressants: safe during pregnancy? Last updated 1/10/12. Available at: www.mayoclinic.com/health/antidepressants/DN00007/NSECTIONG. Accessed June 2013.
15. Sanz E, De-las-Cuevas C, Kiuru A, Bate A, Edwards R. Selective serotonin reuptake inhibitors in pregnant women and neonatal withdrawal syndrome: a database analysis. Lancet 2005, 365:451-4.
16. Hale TW, Kendall-Tackett K, Cong Z, Votta R, McCurdy F. Discontinuation syndrome in newborns whose mothers took antidepressants while pregnant or breastfeeding. Breastfeed Med. 2010 Dec;5(6):283-8. Epub 2010 Aug 31.
17. National Alliance on Mental Health Women and Depression Fact Sheet. Reviewed by Frank E, PhD; Novick D, Masalehdan A. November 2003;

Updated October 2009, Reviewed by Duckworth K, MD. October 2009. Available at: http://www.nami.org/Template.cfm?Section=Women_and_Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=89194. Accessed June 2013.

18. Epperson CN. Postpartum major depression: detection and treatment. American Family Physician. April 15, 1999. Available at: http://www.aafp.org/afp/990415ap/2247.html. Accessed June 2013.
19. Kendall-Tackett K. A new paradigm for depression in new mothers: the central role of inflammation and how breastfeeding and anti-inflammatory treatments protect mental health, International Breastfeeding Journal. March 2007.
20. Vericker T, Macomber J, Golden O. Infants of depressed mothers living in poverty: opportunities to identify and serve. Urban Institute, Brief 1, August 2010. Available at: http://www.urban.org/uploadedpdf/412199-infnats-of-depressed.pdf. Accessed June 2013.

Additional References

1. Healthwise.org [Internet]. Alcohol and drug problems. Available at: http://health.msn.com/health-topics/addiction/alcohol-and-drug-problems-61. Accessed June 2013.
2. U.S. Department of Health and Human Services. Health Resources and Services Administration, Maternal and Child Health Bureau. Depression during & after pregnancy: a resource for women, their families & friends. Avaialbe at: http://www.mchb.hrsa.gov/pregnancyandbeyond/depression/index.html. Accessed June 2013.

Nutrition Risk Criteria **362 DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD
INFANTS	1	RD
CHILDREN	3	RD

Definition

Developmental, sensory or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs. Disabilities include but are not limited to:

- minimal brain function
- feeding problems due to a developmental disability such as pervasive development disorder (PDD) which includes autism
- birth injury
- head trauma
- brain damage
- other disabilities

Required Documentation

Justification

Infants and children with developmental disabilities are at increased risk for nutritional problems. Education, referrals, and service coordination with WIC will aid in early intervention of these disabilities. Prenatal, lactating and non-lactating women with developmental, sensory or motor disabilities may: 1) have feeding problems associated with muscle coordination involving chewing or swallowing, thus restricting or limiting the ability to consume food and increasing the potential for malnutrition; or 2) require enteral feedings to supply complete nutritional needs which may potentially increase the risk for specific nutrient deficiencies.

Pervasive Developmental Disorder (PDD) is a category of developmental disorders with autism being the most severe. Young children may initially have a diagnosis of PDD with a more specific diagnosis of autism usually occurring at 2½ to 3 years of age or older. Children with PDD have very selective eating habits that go beyond the usual "picky eating" behavior and that may become increasingly selective over time, i.e., foods they used to eat will be refused. This picky behavior can be related to the color, shape, texture or temperature of a food. Common feeding concerns include:

- difficulty with transition to textures, especially during infancy;
- increased sensory sensitivity; restricted intake due to color, texture, and/or temperature of foods;
- decreased selection of foods over time;
- difficulty accepting new foods; difficulty with administration of multivitamin/mineral supplementation and difficulty with changes in mealtime

environment.

Nutrition education, referrals, and service coordination with WIC will assist the participant, parent or caregiver in making dietary changes/adaptations and finding assistance to assure she or her infant or child is consuming a nutritionally adequate diet.

References

1. Quinn, Heidi Puelzl; “Nutrition Concerns for Children With Pervasive Developmental Disorder/Autism” published in Nutrition Focus by the Center on Human Development and Disability; University of Washington, Seattle, Washington; September/October 1995.
2. Paper submitted by Betty Lucas, MPH, RD, CD to the Risk Identification and Selection Collaborative (RISC); November, 1999.
3. Zeman. Frances J.; Clinical Nutrition and Dietetics, 2nd Edition; 1991; pp.713-14, 721-22, 729-730.

Nutrition Risk Criteria **363 PRE-DIABETES**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

Impaired fasting glucose (IFG) and/or impaired glucose tolerance (IGT) are referred to as pre-diabetes. These conditions are characterized by hyperglycemia that does not meet the diagnostic criteria for diabetes mellitus (1). (See Clarification for more information.)

Presence of pre-diabetes diagnosed by a physician as self-reported by application/participant/caregiver, or as reported or documented by a physician or someone working under a physician's orders.

Required Documentation

Document in participant file source of information (i.e. self-report of diagnosis by physician).

Justification

An individual who is identified as having pre-diabetes is at relatively high risk for the development of Type 2 diabetes and cardiovascular disease (CVD).

The Expert Committee on the Diagnosis and Clarification of Diabetes Mellitus (2, 3) recognized a group of individuals whose glucose levels, although not meeting criteria for diabetes, are nevertheless too high to be considered normal. The blood tests used to measure plasma glucose and to diagnose pre-diabetes include a fasting plasma glucose test and a glucose tolerance test (see Clarification for more information). Individuals with a fasting plasma glucose level between 100-125 mg/dl are referred to as having impaired fasting glucose (IFG). Individuals with plasma glucose levels of 140-199 mg/dl after a 2-hour oral glucose tolerance test are referred to as having impaired glucose tolerance (IGT).

Many individuals with IGT are euglycemic and, along with those with IFG, may have normal or near normal glycosylated hemoglobin (HbA1c) levels. Oftentimes, individuals with IGT manifest hyperglycemia only when challenged with the oral glucose load used in standardized oral glucose tolerance tests.

The prevalence of IFG and IGT increases greatly between the ages of 20 and 49 years. In people who are > 45 years of age and overweight (BMI ≥ 25), the prevalence of IFG is 9.3% and 12.8% for IGT.

Screening for pre-diabetes is critically important in the prevention of Type 2 diabetes. The American Diabetes Association recommends (5) that testing to detect pre-diabetes should be considered in all asymptomatic adults who are overweight (BMI ≥ 25) or obese (BMI ≥ 30) and who have one or more additional risk factors (see Table 1 in Clarification).

IFG and IGT are not clinical entities in their own right, but rather risk factors for future diabetes as well as CVD. (Note: During pregnancy, IFG and IGT are diagnosed as gestational diabetes.) They can be observed as intermediate stages in many of the disease processes. IFG and IGT are associated with the metabolic syndromes, which include obesity (especially abdominal or visceral obesity), dyslipidemia (the high-triglyceride and/or low HDL type), and

hypertension. Dietary recommendations include monitoring of calories, reduced carbohydrate intake and high fiber consumption. Medical nutrition therapy (MNT) aimed and producing 5-10% loss of body weight and increased exercise have been variably demonstrated to prevent or delay the development of diabetes in people with IGT. However, the potential impact of such interventions to reduce cardiovascular risk has not been examined to date (2, 3).

WIC nutrition services can support and reinforce the MNT and physical activity recommendations that participants receive from their health care providers. In addition, WIC nutritionists can play an important role in providing women with counseling to help them achieve or maintain a healthy weight after delivery.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has...") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

Hyperglycemia is identified through a fasting blood glucose or an oral glucose tolerance test (1).

Impaired fasting glucose (IFG) is defined as fasting plasma glucose (FPG) ≥ 100 or ≥ 125 mg/dl (≥ 5.6 or ≥ 6.1 mmol/l), depending on study and guidelines (2).

Impaired glucose tolerance (IGT) is defined as a 75-g oral glucose tolerance test (OGTT) with 2-h plasma glucose values of 140-199 mg/dl (7.8-11.0 mmol/l).

The cumulative incidence of diabetes over 5-6 years was low (4-5%) in those individuals with normal fasting and normal 2-h OGTT values, intermediate (20-34%) in those with IFG and normal 2-h OGTT of IGT and a normal FPG, and highest (38-65%) in those with combined IFG and IGT (4).

Recommendations for testing for pre-diabetes and diabetes in asymptomatic, undiagnosed adults are in Table 1 below.

Table 1. Criteria and Methods for Testing for Pre-Diabetes and Diabetes in Asymptomatic Adults

1. Testing should be considered in all adults who are overweight (BMI ≥ 25*) and have additional risk factors:
    - physical inactivity
    - first-degree relative with diabetes
    - members of a high-risk ethnic population (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
    - women who delivered a baby weighing > 9 lbs or were diagnosed with gestational diabetes mellitus
    - hypertension (blood pressure ≥ 140/90 mmHg or on therapy for hypertension)
    - women with polycystic ovarian syndrome (PCOS)
    - IGT or IFG on previous testing
    - other clinical conditions associated with insulin resistance (e.g., severe obesity and acanthosis nigricans)
    - history of CVD

2. In the absence of the above criteria, testing for pre-diabetes should begin at age 45 years.

3. If results are normal, testing should be repeated at least at 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

4. To test for pre-diabetes or diabetes, either an FPG test or 2-hour glucose tolerance (OGTT; 75 g glucose load), or both, is appropriate.

5. An OGTT may be considered in patients with impaired fasting glucose (IFG) to better define the risk of diabetes.

6. In those identified with pre-diabetes, identify and if appropriate, treat other CVD risk factors.

* At-risk BMI may be lower in some ethnic groups.

Reference

1. American Diabetes Association. Clinical practice recommendations: Standards of medical care in diabetes. Diabetes Care. 2008 Jan: 31 Suppl 1:S12-54.
2. The Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Report of the expert committee on the diagnosis and classification of diabetes mellitus. Diabetes Care. 1997; 20:1183-1197.
3. The Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Follow-up report on the diagnosis of diabetes mellitus. Diabetes Care. 2003; 26:3160-3167.
4. American Diabetes Association National Institute of Diabetes and Digestive and Kidney Diseases. Position statement on prevention or delay of type 2 diabetes. Diabetes Care. 2004; 27:S47.
5. American Diabetes Association. Executive summary: Standards of medical care in diabetes. Diabetes Care. 2008 Jan; 31 Suppl 1:S5-11.

Nutrition Risk Criteria **371 MATERNAL SMOKING**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	-

Definition

Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigars.

Required Documentation

WIC Information System Program

Justification

Research has shown that smoking during pregnancy causes health problems and other adverse consequences for the mother, the unborn fetus and the newborn infant such as: pregnancy complications, premature birth, low-birth-weight, stillbirth, infant death, and risk for Sudden Infant Death Syndrome (SIDS) (1). Women who smoke are at risk for chronic and degenerative diseases such as: cancer, cardiovascular disease and chronic obstructive pulmonary disease. They are also at risk for other physiological effects such as loss of bone density (2).

Maternal smoking exposes the infant to nicotine and other comlbs, including cyanide and carbon monoxide, in-utero and via breastmilk (3). In-utero exposure to maternal smoking is associated with reduced lung function among infants (4). In addition, maternal smoking exposes infants and children to environmental tobacco smoke (ETS). (See #904, Environmental Tobacco Smoke.)

Because smoking increases oxidative stress and metabolic turnover of vitamin C, the requirement for this vitamin is higher for women who smoke (5). The WIC food package provides a good source of vitamin C. Women who participate in WIC may also benefit from counseling and referral to smoking cessation programs.

References

1. Manual of Clinical Dietetics 6th ed., American Dietetic Association. 2000.
2. Women and Smoking: A Report of the Surgeon General – 2001. www.cdc.gov/tobacco/data_statistics/sgr/sgr_2001/sgr_women_chapters.htm.
3. Breastfeeding Handbook for Physicians, American Academy of Pediatrics and American College of Obstetrics and Gynecologists. 2006
4. U.S. Department of Health and Human Services. *The Health Consequences of Smoking:* A Report of the Surgeon General—Executive Summary. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
5. *Dietary Reference Intakes for Vitamin C, Vitamin E, Selenium and Carotenoids* (2000). Institute of Medicine, the National Academy of Science.

Nutrition Risk Criteria **372 ALCOHOL AND ILLEGAL DRUG USE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD
BREASTFEEDING WOMEN	1	RD
NON-BREASTFEEDING WOMEN	6	RD

Definition

For Pregnant Women:

- Any alcohol use
- Any illegal drug use

For Breastfeeding and Non-breastfeeding Postpartum Women:

- Routine current use of ≥ 2 drinks per day (6). A serving or standard sized drink is 1 can of beer (12 fluid oz.); 5 oz wine; and 1½ fluid oz liquor (1 jigger gin, rum, vodka, whiskey (86 proof), vermouth, cordials or liqueurs)
- Binge drinking, i.e. drinks 5 or more (≥ 5) drinks on the same occasion on at least one day in the past 30 days
- Heavy drinking, i.e. drinks 5 or more (≥ 5) drinks on the same occasion on five or more days in the previous 30 days
- Any illegal drug use

Required Documentation

N/A

Justification

Drinking alcoholic beverages during pregnancy can damage the developing fetus. Excessive alcohol consumption may result in low birth weight, reduced growth rate, birth defects, and mental retardation. WIC can provide supplemental foods, nutrition education and referral to medical and social services which can monitor and provide assistance to the family.

“Fetal Alcohol Syndrome” is a name given to a condition sometimes seen in children of mothers who drank heavily during pregnancy. The child has a specific pattern of physical, mental, and behavioral abnormalities. Since there is no cure, prevention is the only answer.

The exact amount of alcoholic beverages pregnant women may drink without risk to the developing fetus is not known as well as the risk from periodic bouts of moderate or heavy drinking. Alcohol has the potential to damage the fetus at every stage of the pregnancy. Therefore, the recommendation is not to drink any alcoholic beverages during pregnancy.

Studies show that the more alcoholic beverages the mother drinks, the greater the risks are for her baby. In addition, studies indicate that factors such as cigarette smoking and poor dietary practices may also be involved. Studies show that the reduction of heavy drinking during pregnancy has benefits for both mother and newborns. Pregnancy is a special time in a woman's life and the majority of heavy drinkers will respond to supportive counseling.

Heavy drinkers themselves may develop nutritional deficiencies and more serious diseases, such as cirrhosis of the liver and certain types of cancer, particularly if they also smoke cigarettes. WIC can provide education and referral to medical and social services, including addiction treatment, which can help improve pregnancy outcome.

Pregnant women who smoke marijuana are frequently at higher risk of still birth, miscarriage, low birth weight babies and fetal abnormalities, especially of the nervous system. Heavy cocaine use has been associated with higher rates of miscarriage, premature onset of labor, IUGR, congenital anomalies, and developmental/behavioral abnormalities in the preschool years. Infants born to cocaine users often exhibit symptoms of cocaine intoxication at birth. Infants of women addicted to heroin, methadone, or other narcotics are more likely to be stillborn or to have low birth weights. These babies frequently must go through withdrawal soon after birth. Increased rates of congenital defects, growth retardation, and preterm delivery, have been observed in infants of women addicted to amphetamines.

Pregnant addicts often forget their own health care, adding to their unborn babies' risk. One study found that substance abusing women had lower hematocrit levels at the time of prenatal care registration, lower pregravid weights and gained less weight during the pregnancy. Since nutritional deficiencies can be expected among drug abusers, diet counseling and other efforts to improve food intake are recommended.

Heroin and cocaine are known to appear in human milk. Marijuana also appears in a poorly absorbed form but in quantities sufficient to cause lethargy, and decreased feeding after prolonged exposure.

References

1. USDA/DHHS Dietary Guidelines; 1995.
2. Lawrence Ruth: Maternal & Child Health Technical Information Bulletin: A Review of Medical Benefits and Contraindications to Breastfeeding in the United States; October 1997.
3. Weiner, L., Morse, B.A., and Garrido, P.: FAS/FAE Focusing Prevention on Women at Risk; International Journal of the Addictions; 1989; 24:385-395.
4. National Clearinghouse for Alcohol and Drug Information; Office for Substance Abuse Prevention; The fact is …alcohol and other drugs can harm an unborn baby; Rockville; 1989.
5. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
6. Jones, C. and Lopez, R.: Drug Abuse and Pregnancy; New Perspectives in Prenatal Care; 1990; pp. 273-318.
7. National Household Survey on Drug Abuse, Main Findings 1996; Office of Applied Studies, Substance Abuse and Mental Health services Administration. DHHS.

Nutrition Risk Criteria **381 ORAL HEALTH CONDITIONS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	RD/DENTAL
BREASTFEEDING WOMEN	1	DENTAL
NON-BREASTFEEDING WOMEN	6	DENTAL
INFANTS	1	DENTAL
CHILDREN	3	DENTAL

Definition

Oral health conditions include, but are not limited to:

- Dental caries, often referred to as “cavities” or “tooth decay”, is a common chronic, infectious, transmissible disease resulting from tooth-adherent specific bacteria, that metabolizes sugars to produce acid which, over time, demineralizes tooth structure (1).

- Periodontal diseases are infections that affect the tissues and bone that support the teeth. Periodontal diseases are classified according to the severity of the disease. The two major stages are gingivitis and periodontitis. Gingivitis is a milder and reversible form of periodontal disease that only affects the gums. Gingivitis may lead to more serious, destructive forms of periodontal disease called periodontitis. (2)

  More information on types of periodontal disease is available at: http://www.perio.org/consumer/2a.html.

- Tooth loss, ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality.

Presence of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician’s orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Required Documentation

Documentation of source of information (i.e. self-report of diagnosis by physician/dentist or written documentation by physician/dentist).

Justification

Oral health reflects and influences general health and well-being. Good oral health care and nutrition during pregnancy, infancy and childhood are often overlooked factors in the growth and development of the teeth and oral cavity.

Infants and Children

The Centers for Disease Control and Prevention (CDC) reports that dental caries may be the most prevalent infectious disease in U.S. children. More than 40% of children have tooth decay by the time they reach kindergarten. Infants that consume sugary foods, are of low socioeconomic status, and whose mothers have a low education level, are 32 times more likely to have caries at the age of 3 years than children who do not have those risk factors. Despite its high prevalence, early childhood caries (ECC) is a preventable disease. (3)

ECC may develop as soon as teeth erupt. Bacteria, predominantly mutans

streptococci (MS), metabolize simple sugars to produce acid that demineralizes teeth, resulting in cavities. The exact age at which MS colonization occurs in children is controversial, but it does not happen until teeth erupt. The earlier colonization occurs, the greater the risk of carries. MS typically originates in the mother and is transmitted to the child via saliva (often through cup and utensil sharing). Elevated maternal levels of MS, due to active or untreated caries and frequent sugar consumption, increase the risk of transmission. In addition, recent evidence suggests that exposure to environmental tobacco smoke increases the likelihood of MS colonization in children. (4)

Historically, ECC has been attributed to inappropriate and prolonged bottle use; formally called “baby bottle tooth decay.” However, recent studies indicate that the disease is multifactorial, which suggests any feeding practice that allows frequent sugar consumption in the presence of MS may result in caries formation: propped bottles containing sweetened liquids or formula, frequent consumption of juice or sweetened liquids from infant and “sippy” cups, and frequent snacking of high cariogenic foods. (4)

The frequency of sugar consumption is the main dietary variable in caries etiology. After bacteria metabolize sugar into acid, it takes 20-40 minutes for the acid to be neutralized or washed away by saliva. Therefore, if sugars are frequently consumed, the potential for demineralization is greater. Although MS can metabolize many different carbohydrates, they produce acid most efficiently from sugars, especially sucrose. Sugars within the cellular structure of food (such as fructose in whole fruit) are thought to be less cariogenic than sugars intentionally added to foods. (4) See **Table 1** for more information on the cariogenic potential of children’s foods and snacks.

Milk is widely consumed, especially by children, and thus the interaction between different kinds of milk consumed and caries development has been a research topic of interest. Lactose is one of the least cariogenic sugars because it is poorly metabolized by MS. Researchers have reported cows’ milk to be a protective, anticariogenic agent due to its high concentration of calcium and phosphate. The buffering activity of proteins present in cows’ milk also might allow the formation of very stable complexes of calcium phosphate. Other anticariogenic properties in cows’ milk include antibacterial enzymes, vitamin D and fluoride. (4, 5)

Infant formulas, on the other hand, have a high potential for inducing caries due to their high carbohydrate variability. The cariogenic potential of breast milk is inconclusive. Breast milk has been found to contain more lactose (8.3%) than cows’ milk (4.9%). A higher breast milk lactose concentration and the possibility that lactose fermentation of cows’ milk is slower than in breast milk, may make breast milk caries risk slightly higher. Some evidence indicates that breastfeeding for over 1 year during the night after tooth eruption might be associated with ECC, however other investigations showed no relationship between prevalence of caries and breastfeeding. Regardless of the type of milk consumed, sufficient dental care and cleaning after drinking milk/formula and breastfeeding can help prevent ECC. Avoiding inappropriate dietary practices, such as frequent juice consumption or snacking on highly cariogenic foods also remain important ECC preventive practices. (4, 5)

Table 1. Cariogenic Potential of Children's Foods and Snacks		
Noncariogenic	**Low Cariogenicity**	**High Cariogenicity**
Cheese Chicken Cottage cheese Eggs Flavored club soda Nuts and seeds* Plain cow's milk (unflavored) Plain yogurt Popcorn* Seltzer Vegetables	Flavored milk Fresh fruits Whole grain products	Breakfast bars Cake Candies** Cookies Doughnuts Fruit juice Granola bars Pretzels Dried fruits Soda crackers Sweetened beverages Sweetened dry cereals
*Not appropriate for infants and toddlers due to potential choking problems. **Sticky candy and/or slowly eaten candy are extremely cariogenic.		
Adapted from: Faine, MP. Nutrition and oral health. In: Proceedings of Promoting Oral Health of Children with Neurodevelopmental Disabilities and Other Special Health Care Needs. May 4-5, 2001. Seattle, WA.		

Women

Maternal periodontal disease and dental caries may impact pregnancy outcome, and the offspring's risk of developing early and severe dental caries. Periodontal disease and caries may also increase the women's risk of atherosclerosis, rheumatoid arthritis and diabetes. These oral health problems are highly prevalent in women of childbearing age, particularly among low-income women and members of racial and ethnic minority groups. Socioeconomic factors, lack of resources to pay for care, barriers to access care, lack of public understanding of the importance of oral health and effective self-care practices all represent underlying reasons cited for observed inadequacies in oral health. (6)

Maternal periodontal disease, a chronic infection of the gingiva (gums) and supporting tooth structures, has been associated with preterm birth, low birth weight and development of preeclampsia (6, 7). Studies indicate that periodontal infection can result in placental-fetal exposure and, when coupled with a fetal inflammatory response, can lead to preterm delivery (7). Additionally, in a cohort of 164 young, minority, pregnant and postpartum women, the preterm/low birth weight rate was 5.4% lower among women who received periodontal treatment than those who did not receive treatment (7). In a case-control study, researchers found that preeclamptic patients were 3.5 times more likely to have periodontal disease than normotensive patients (6). (See nutrition risk criterion ***304 History of Preeclampsia*** for more information.)

Fluoride and Fluorosis

Use of fluorides for the prevention and control of caries is documented to be both safe and highly effective. Fluoride, a naturally occurring substance, has several caries-protective mechanisms of action, including enamel remineralization and

altering bacterial metabolism to help prevent caries. Excessive intake of fluoride can cause dental fluorosis which is a change in the appearance of the tooth's enamel. In the U.S., fluorosis appears mostly in the very mild or mild form – as barely visible lacy white markings or spots. The severe form of dental fluorosis, staining and pitting of the tooth surface, is rare in the U.S. The CDC reports that 32% of American children have some form of dental fluorosis, with 2.45% of children having the moderate to severe stages. (8, 9, 10, 11)

Parents and caregivers may have questions and concerns about fluoride content in water supplies and in infant formula. Fluoridated water can be found in communities that supplement tap water with fluoride and it may also be found in well water. The CDC's *My Water's Fluoride* website: http://apps.nccd.cdc.gov/MWF/Index.asp, allows consumers in currently participating States to learn the fluoridation status of their water system.

All formula, including powdered, concentrate and ready-to-feed, contain fluoride, but most infant formula manufacturers ensure low levels of fluoride (8). WIC State and local agencies should refer caregivers of formula fed infants with questions regarding the use of fluoridated vs. non-fluoridated water to prepare infant formula to the infants' health care provider.

Dental Care and Anxiety

It is reported that 50% of the U.S. population does not seek regular dental care. Of the entire U.S. population, 8-15% has dental phobias. Dental fear can be directly learned from previous painful or negative experiences or indirectly learned from family, friends and the media. Negative portrayal of dentistry by these sources adds to an individual's anxiety. Anxiety and/or fear of dental procedures may prevent participants from seeking necessary dental care during high risk periods of the life cycle (e.g., pregnancy). Dental providers are learning to understand the causes of dental fear, have techniques to assess the level of fear and have modified treatments to accommodate patients with high anxiety levels. (12)

Oral Health Problems and Special Health Care Needs

The following special health care needs can increase the risk for oral health problems and can also make the overall effects of poor oral health more severe (13):

- **Prematurity and intrauterine malnutrition** – can have adverse effects on an individual's oral health. A study of infants who weighed <2000g at birth indicated more porous dental enamel and subsurface lesions. Infants with very low birth weights (<1500g) are more apt to have enamel defects of the primary teeth. Malnutrition in the first few months of life (when oral structures develop) can increase the risk for oral problems.
- **Gastroesophageal Reflux Disease (GERD)** – common among children with cerebral palsy, Down syndrome and other conditions. GERD can contribute to oral health problems. As acidic gastric contents are regurgitated, primary and permanent teeth can be eroded.
- **Failure to thrive and other problems with weight gain and growth** – frequent meals and snacks (which may contribute to caries development) may be needed to maintain an adequate energy intake, or if mealtime is longer than usual, the demineralization period may exceed remineralization. Delayed weaning and children sipping on a bottle

throughout the day, could also contribute to oral health problems.

- **Craniofacial malformations** – individuals with these malformations are at higher risk of developing oral problems. For example, children with cleft lip/palate disorders have more decayed, missing, and filed teeth than children without.
- **Compromised immune function** – individuals with AIDS or those who take immunosuppressive medications are more susceptible to oral infections such as candidiasis, viral infections, dental caries, and periodontal disease.
- **Down syndrome (Trisomy 21)** – individuals with Down syndrome often have delayed dental development*, may be missing permanent teeth, and may have under-developed teeth or teeth with thin enamel. In addition, the potential for eating problems and GERD make oral care for individuals with Down's especially important. (13)

*Delayed Tooth Eruption (DTE) is the emergence of a tooth into the oral cavity at a time that deviates significantly from norms established for different races, ethnicities, and sexes. Variation in the normal eruption of teeth is a common finding, but significant deviations from established norms should alert the clinician to further investigate the patient's health and development. Eruption depends on genetics, growth of the jaw, muscular action and other factors. DTE is seen in children with certain genetic disorders, particularly Down syndrome, and in children with general developmental delays that involve the oral musculature. Whenever DTE is generalized, the child should be examined for systemic diseases affecting eruption, such as endocrine disorders, organ failures, metabolic disorders, drugs and inherited disorders. (14) Additional information about tooth eruption is available at: http://www.ada.org/2930.aspx.

Dentate Status, Diet Quality and General Health

By the time individuals reach adulthood, the human mouth has progressed from 20 primary teeth to 32 permanent (adult) teeth (2). The extent to which tooth loss can adversely affect nutritional status is not completely known. However, diet quality tends to decline as the degree of dental impairment increases. Studies have shown that intake of vitamin A, fiber, calcium and other key nutrients decline as the number of teeth decline. In The Health Professionals study, participants without teeth had diets that contained fewer vegetables, less carotene and fiber, and more cholesterol, saturated fat, and calories than persons with 25 teeth or more (15). Despite the trend toward increased tooth retention throughout adult life in developed countries, 11% of adults aged 25 and older have lost all of their natural teeth. This number increases to 30% for people over age 65 and is even higher in those living in poverty. Loss of teeth is not a normal result of the aging process; the major cause of tooth loss is extractions resulting from dental caries and/or periodontal disease. (15)

To help prevent oral health problems from developing and ensure the best possible health and developmental outcomes, WIC staff can encourage participants and caregivers to:

Diet

- Breastfeed infants during the first year of life and beyond as mutually desired.
- Avoid having an infant/child sleep with a bottle. Any bottle taken to bed should contain only water. (See Risks 425.3 and 411.2)
- Gradually introduce a cup between 6 and 12 months of age, wean from

the bottle by 12 months of age.

- Drink/provide only water and milk between meals.
- Limit sugary foods and drinks (if sweets are eaten, it's best to restrict to mealtimes.)
- Avoid carbonated beverages and juice drinks. (See Risk 425.2)
- Limit the intake of 100% fruit juice to no more than 4-6 ounces per day.
- Establish eating patterns that are consistent with the Dietary Guidelines for Americans and the infant feeding practice guidelines of the American Academy of Pediatrics.
- Consume/provide a varied, balanced diet during gestation and throughout childhood to set the stage for optimal oral health. (1, 3, 4, 15)

Oral Hygiene

- Wipe the gums of even a very small infant with a soft washcloth or soft toothbrush, even prior to tooth eruption, to establish a daily oral hygiene routine (17, 18).
- Brush teeth (including an infant's, as soon as teeth erupt) thoroughly twice daily (morning and evening) and floss at least once every day.
- Minimize saliva sharing activities (i.e., sharing a drinking cup and utensils). (1, 3, 4, 15)

Fluoride

- Use fluoride toothpaste approved by the American Dental Association ("pea-size" for 2-5 year olds and, "smear" for under the age of two and at moderate or high caries risk). (1)
- Rinse every night with an alcohol-free over-the-counter mouth rinse with 0.05% sodium fluoride (guidance for woman participant and caregiver only). (3)
- Contact the infant's (if formula fed) health care provider with questions regarding the use of local drinking water or bottled water to prepare infant formula. (3)
- Talk to the dentist about fluoride supplements. These may be of benefit in reducing dental decay for children living in fluoride-deficient areas (See Risk 411.11).
- Check if the public water systems have added fluoride at: http://apps.nccd.cdc.gov/MWF/Index.asp
- Access the following website for more information about fluoride: http://www.cdc.gov/fluoridation/safety.htm.

Referrals

- Establish a dental home within 6 months of eruption of the first tooth and no later than 12 months of age. (3)
- See a dentist for examinations (every 6 months) and/or restoration of all active decay as soon as possible. (WIC staff should provide dental referrals as necessary.)

Oral Health Resources/Handouts

- Summary of Pediatric Oral Health Anticipatory Guidance: http://www.aafp.org/afp/2004/1201/p2113.html#afp20041201p2113-t2.
- Table: Oral health and dietary management for mothers and children (see page 3 of pdf.) http://www.sciencedirect.com/science/article/pii/S0002822398000443.
- Oral Health Care During Pregnancy: A National Consensus Statement: http://www.mchoralhealth.org/materials/consensus_statement.html.
- Your Baby's Teeth: http://www.aafp.org/afp/2004/1201/p2121.html.

- Two Healthy Smiles: Tips to Keep You and Your Baby Healthy: http://www.mchoralhealth.org/PDFs/pregnancybrochure.pdf.
- Tips for Good Oral Health Care During Pregnancy: http://www.mchoralhealth.org/PDFs/Oral HealthPregnancyHandout.pdf.
- A Healthy Smile for Your Baby (English): http://www.mchoralhealth.org/PDFs/babybrochure.pdf.
- A Healthy Smile for Your Baby (Spanish): http://www.mchoralhealth.org/PDFs/babybrochure_sp.pdf.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Policy on Early Childhood Caries (ECC): Classifications, consequences and preventive strategies. Am Academy of Pediatric Dentistry (2011) 47-49.
2. ADA Dental 101: Taking care of your teeth and gums. American Dental Association, 2008: 1-28.
3. American Academy of Pediatrics Policy Statement: Oral health risk assessment timing and establishment of the dental home. Pediatrics, (2003) Vol 11, No 5: 1113-1116.
4. Douglass BDS, et al. A practical guide to infant oral health. America Family Physician, (2004) Vol 70, No11: 2113-2120.
5. Rocha Peres RC, et al. Cariogenic potential of cows' human and infant formula milks and effect of fluoride supplementation. British Journal of Nutrition (2009), 101, 376-382.
6. Boggess K, Edelstein B. Oral health in women during preconception and pregnancy: implications for birth outcomes and infant oral health. Matern Child Health J. (2006) 10: S169-S174.
7. Bobetsis Y, et al. Exploring the relationship between periodontal disease and pregnancy complications. J Am Dent Assoc. Vol 137, Suppl 2, 7S-135, 2006.
8. Review Council, Guideline on Fluoride Therapy. American Academy of Pediatric Dentistry. Reference Manual 33/No6. 11/12 153-156.
9. J Berg, et al. Evidence-based clinical recommendations regarding fluoride intake from reconstituted infant formula and enamel fluorosis: a report of the American Dental Association Council on Scientific Affairs. JADA, Jan 2011 Vol 142 79-87.
10. Position of the Academy of Nutrition and Dietetics: the impact of fluoride on health. Journal of the Academy of Nutrition and Dietetics, Sept 2012, Vol 112, No. 9 1443-1453.
11. HHS Proposed Guidelines on Fluoride in Drinking Water, Commentary by Dr. Howard Koh, Jan 2011.
12. Krochak M, Rubin JG. An overview of the treatment of anxious and phobic dental patients. Compend Contin Educ Denta, Vol XIV, No 5: 604-614.
13. Ogata B, Trahms C. For children with special health care needs. Nutrition Focus Nov/Dec 2003 Vol 18, No 6.
14. Suri L, et al. Delayed Tooth Eruption: Pathogenesis, diagnosis, and treatment. A Literature Review Am J of Orthodontics, (Oct 2004) 432-445.
15. Palmer CA. Diet and nutrition in oral health, 2nd ed. Pearson Education Inc. 2007. Chapter 15, 315-330.

16. Policy Statement: Preventive oral health intervention for pediatricians. Pediatrics (2008). Vol 122, No 6: 1387-1394.
17. American Academy of Pediatrics. A Pediatric Guide to Oral Health Flip Chart and Reference Guide. 2011. Copyright 2012.
18. Holt K, et al. Bright Futures Nutrition, 3rd Edition. American Academy of Pediatrics, 2011.

Nutrition Risk Criteria **382 FETAL ALCOHOL SYNDROME**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD, SA
CHILDREN	3	RD, SA

Definition

Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.

Presence of FAS diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Required Documentation

Copy of physician diagnosis or RD confirmation of self-reported diagnosis must be documented in participant file.

Justification

FAS is a combination of permanent, irreversible birth defects attributable solely to alcohol consumption by the mother during pregnancy. There is no known cure; it can only be prevented. Symptoms of FAS may include failure to thrive, a pattern of poor growth throughout childhood and poor ability to suck (for infants). Babies with FAS are often irritable and have difficulty feeding and sleeping.

Lower levels of alcohol use may produce Fetal Alcohol Effects (FAE) or Alcohol Related Birth Defects (ARBD) that can include mental deficit, behavioral problems, and milder abnormal physiological manifestations. FAE and ARBD are generally less severe than FAS and their effects are widely variable. Therefore, FAE and ARBD in and of themselves are not considered risks, whereas the risk of FAS is unquestionable.

Identification of FAS is an opportunity to anticipate and act upon the nutritional and educational needs of the child. WIC can provide nutritional foods to help counter the continuing poor growth and undifferentiated malabsorption that appears to be present with FAS. WIC can help caregivers acknowledge that children with FAS often grow steadily but slower than their peers. WIC can also educate the caregiver on feeding, increased calorie needs and maintaining optimal nutritional status of the child.

Alcohol abuse is highly concentrated in some families. Drinking, particularly abusive drinking, is often found in families that suffer from a multitude of other social problems. A substantial number of FAS children come from families, either immediate or extended, where alcohol abuse is common, even normative. This frequently results in changes of caregivers or foster placements. New caregivers need to be educated on the special and continuing nutritional needs of the child.

The physical, social, and psychological stresses and the birth of a new baby, particularly one with special needs, places an extra burden upon the recovering woman. This puts the child at risk for poor nutrition and neglect (e.g., the caregiver may forget to prepare food or be unable to adequately provide all the foods necessary for the optimal growth and development of the infant or child.) WIC can provide supplemental foods, nutrition education and referral to medical and social services which can monitor and provide assistance to the family.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…" Should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.

References

1. Clarren, S.K., and Smith, D.W.: The Fatal Alcohol Syndrome; New England Journal of Medicine; May 11, 1978; 298:1063-1067.
2. Jones, K.L., Smith, D.W., Ulleland, C.N., and Streissguth, A.P.: Pattern of Malformation in Offspring of Chronic Alcoholic Mothers. Lancet; June 9, 1973; 815:1267-1271.
3. Masis B., M.D., May, A: A Comprehensive Local Program for the Prevention of Fetal Alcohol Syndrome, Public Health Reports; September-October 1991; 106: 5; pp. 484-489.
4. Lujan, C.C., BeBruyn, L., May, P.A., and Bird, M.E.: Profile of Abuse and Neglected Indian Children in the Southwest; Child Abuse Negligent; 1989; 34: 449-461.
5. Institute of Medicine: Fetal Alcohol Syndrome, Diagnosis, Epidemiology, Prevention and Treatment; 1996.
6. Weiner, L., Morse, B.A., and Garrido, P.: FAS/FAE Focusing Prevention on Women at Risk; International Journal of the Addictions; 1989; 24:385-395.

Nutrition Risk Criteria **401 FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-
CHILDREN ≥ 2 YEARS OF AGE	5	-

Definition

Women and children two years of age and older who meet the eligibility requirements of income, categorical, and residency status may be presumed to be at nutrition risk based on *failure to meet Dietary Guidelines for Americans [Dietary Guidelines]* (1). For this criterion, *failure to meet Dietary Guidelines* risk criterion is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans).

The *failure to meet Dietary Guidelines for Americans* risk criterion can only be assigned when a complete nutrition assessment has been completed and no other risk criteria have been identified. This includes assessing for for risk 425 Inappropriate Nutrition Practices for Children or risk 427 Inappropriate Nutrition Practices for Women.

Required Documentation

Complete nutrition assessment

Justification

The 1996 Institute of Medicine (IOM) report, *WIC Nutrition Risk Criteria: A Scientific Assessment* raised questions about the quality of traditional dietary assessment methods (e.g., 24-hour recall and food frequency questionnaires) and recommended further research in the development and validation of diet assessment methodologies (2). In response to the 1996 IOM report, the Food and Nutrition Service (FNS) commissioned the IOM to review the use of various dietary assessment tools and to make recommendations for assessing inadequate diet or inappropriate dietary patterns, especially in the category of *failure to meet Dietary Guidelines* (wee Clarification) (3).

The IOM Committee on Dietary Risk Assessment in the WIC Program approached this task by using the Food Guide Pyramid* recommended number of servings, based on energy needs, as cut-off points for each of the five basic food groups to determine if individuals were meeting the *Dietary Guidelines.* As a result of the review of the cut-off points for food groups and dietary assessment methods, the IOM published the 2002 report, *Dietary Risk Assessment in the WIC Program*. The IOM Committee's findings related to dietary risk, the summary evidence, and the Committee's concluding recommendation are provided below. (4)

IOM Committee Findings Related to Dietary Risk (4) (For more information, refer to the specific pages listed.)

- A dietary risk criterion that uses the WIC applicant's usual intake of the five basic Pyramid* food groups as the indicator and the recommended number of servings based on energy needs as the cut-off points is consistent with *failure to meet Dietary Guidelines.* (page 130)

- Nearly all U.S. women and children usually consume fewer than the recommended number of servings specified by the Food Guide Pyramid and, therefore, would be at dietary risk based on the criterion *failure to meet Dietary Guidelines*. (page 130)
- Even research-quality dietary assessment methods are not sufficiently accurate or precise to distinguish an individual's eligibility status using criteria based on the Food Guide Pyramid* or on nutrient intake. (page 131)

Summary Evidence Supporting a Presumed Dietary Risk Criterion (4) (For more information, refer to the specific page listed.)

- Less than 1 percent of all women meet recommendations for all five Pyramid* groups. (page 127)
- Less than 1 percent of children ages 2 to 5 years meet recommendations for all five Pyramid* groups. (page 127)
- The percentage of women consuming fruit during 3 days of intake increases with increasing income level. (page 127)
- Members of low-income households are less likely to meet recommendations than are more affluent households. (page 127)
- Food-insecure mothers are less likely to meet recommendations for fruit and vegetable intake than are food-secure mothers. (page 127)
- The percentage of children meeting recommendations for fat and saturated fat as a percentage of food energy increases with increasing income level. (page 127)
- Low-income individuals and African Americans have lower mean Healthy Eating Index scores than do other income and racial/ethnic groups. (page 127)

**The Food Guide Pyramid was the Dietary Guidelines icon at the time the 2002 IOM Committee on Dietary Risk Assessment in the WIC Program conducted the review. The Dietary Guidelines icon has been changed to MyPlate. Although the icon has changed, the Findings and the Supporting Research are still applicable to this criterion. Please see Clarification for more information.*

Summary Evidence Suggesting that Dietary Assessment Methods are Not Sufficient to Determine a WIC Applicant's Dietary Risk (4) (For more information, refer to the specific page listed.)

- 24-hour diet recalls and food records are not good measures of an individual's usual intake unless a number of independent days are observed. (page 61)
- On average, 24-hour diet recalls and food records tend to underestimate usual intake–energy intake in particular. (page 61)
- Food Frequency Questionnaires and diet histories tend to overestimate mean energy intakes. (page 61)

IOM Committee Concluding Recommendation (4) (For more information, refer to the specific page listed.)

"In summary, evidence exists to conclude that nearly all low-income women in the childbearing years and children ages 2 to 5 years are at dietary risk, are vulnerable to nutrition insults, and may benefit from WIC's services. Further, due to the complex nature of dietary patterns, it is unlikely that a tool will be developed to fulfill its intended purpose with WIC, i.e., to classify individuals

accurately with respect to their true dietary risk. Thus, any tools adopted would result in misclassification of the eligibility status of some, potentially many, individuals. By presuming that all who meet the Program's categorical and income eligibility requirements are at dietary risk, WIC retains its potential for preventing and correcting nutrition-related problems while avoiding serious misclassification errors that could lead to denial of services to eligible individuals." (page 135)

Implications for WIC Nutrition Services

As indicated in the 2002 IOM report, most Americans (including most WIC participants) fail to adhere to the *Dietary Guidelines*. Through participant-centered counseling, WIC staff can:

- Guide the participant in choosing healthy foods and age-appropriate physical activities as recommended in the *Dietary Guidelines.*
- Reinforce positive lifestyle behaviors that lead to positive health outcomes.
- Discuss nutrition-related topics of interest to the participant such as food shopping, meal preparation, feeding relationships, and family meals.
- Refer participants, as appropriate, to the Supplemental Nutrition Assistance Program (SNAP), community food banks and other available nutrition assistance programs.

Clarification

The recommendation and findings of the IOM Committee were developed using the *2000 Dietary Guidelines* as the standard for a healthy diet. Subsequent to the 2002 IOM report, the *Dietary Guidelines* have been updated with the release of the *2005* and *2010 Dietary Guidelines*. Although the subsequent editions of the *Dietary Guidelines* are different from the 2000 edition, there is no evidence to suggest that the 2002 IOM recommendation and findings are invalid or inaccurate. The fact remains that diet assessment methodologies may not reflect usual intakes and therefore are insufficient to determine an individual's eligibility status. In addition, future research will be necessary to determine if there is a change in the IOM finding that nearly all Americans fail to consume the number of servings from the basic food groups as recommended in the *Dietary Guidelines*.

References

1. United States Department of Agriculture and the United States Department of Health and Human Services. Dietary Guidelines for Americans, 7th Edition, 2010. Available at: www.usda.gov/cnpp.
2. Institute of Medicine (IOM); Committee on Scientific Evaluation of WIC Nutrition Risk Criteria. WIC nutrition risk criteria: A scientific assessment. Washington, DC: National Academy Press; 1996.
3. United States Department of Agriculture and the United States Department of Health and Human Services. Dietary Guidelines for Americans, 5th Edition, 2000. Available at: www.usda.gov/cnpp
4. Institute of Medicine (IOM); Committee on Dietary Risk Assessment in the WIC Program. Dietary risk assessment in the WIC program. Washington, DC: National Academy Press; 2002. Available at: http://www.iom.edu/Reports/2002/Dietary-Risk-Assessment-in-the-WIC-Program.aspx.

Nutrition Risk Criteria **411 INAPPROPRIATE NUTRITION PRACTICES (INFANTS)**

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	INFANTS	4	-

Definition

Routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below. Refer to "Justification and References" for this criterion.

411.1 Routinely using a substitute(s) for breast milk or for FDA approved iron-fortified formula as the primary nutrient source during the first year of life.

Examples of substitutes:

- Low iron formula without iron supplementation
- Cow's milk, goat's milk, or sheep's milk (whole, reduced fat, low-fat, skim), canned evaporated or sweetened condensed milk
- Imitation or substitute milks (such as rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions"

411.2 Routinely using nursing bottles or cups improperly.

- Using a bottle to feed fruit juice
- Feeding any sugar-containing fluids, such as soda/soft drinks, gelatin water, corn syrup solutions, sweetened tea
- Allowing the infant to fall asleep or be put to bed with a bottle at naps or bedtime
- Allowing the infant to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier
- Propping the bottle when feeding
- Allowing an infant to carry around and drink throughout the day from a covered or training cup
- Adding any food (cereal or other solid foods) to the infant's bottle

411.3 Routinely offering complementary foods* or other substances that are inappropriate in type or timing.

- Examples of inappropriate complementary foods:
- Adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier
- Introducing any food other than breast milk or iron-fortified infant formula before 4 months of age

*Complementary foods are any foods or beverages other than breast milk or infant formula.

411.4 Routinely using feeding practices that disregard the developmental needs or stage of the infant.

- Inability to recognize, insensitivity to, or disregarding the infant's cues for hunger and satiety (e.g., forcing an infant to eat a certain type and/or amount of food or beverage or ignoring an infant's hunger cues)
- Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking.
- Not supporting an infant's need for growing independence with self-feeding (e.g., solely spoon-feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils)
- Feeding an infant foods with inappropriate textures based on his/her developmental stage (e.g., feeding primarily pureed or liquid foods when the

infant is ready and capable of eating mashed, chopped or appropriate finger foods)

411.5 Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.

Examples of potentially harmful foods

- Unpasteurized fruit or vegetable juice
- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese
- Honey (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.)
- Raw or undercooked meat, fish, poultry, or eggs
- Raw vegetable sprouts (alfalfa, clover, bean, and radish)
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).

411.6 Routinely feeding inappropriately diluted formula.

- Failure to follow manufacturer's dilution instructions (to include stretching formula for household economic reasons)
- Failure to follow specific instructions accompanying a prescription

411.7 Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source of nutrients.

Examples of inappropriate frequency of nursing:

- Scheduled feedings instead of demand feedings
- Less than 8 feedings in 24 hours if less than 2 months of age
- Less than 6 feedings in 24 hours if between 2 and 6 months of age

411.8 Routinely feeding a diet very low in calories and/or essential nutrients.

Examples:

- Vegan diet
- Macrobiotic diet
- Other diets very low in calories and/or essential nutrients

411.9 Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breast milk or formula.

Limited or no access to a:

- Safe water supply (documented by appropriate officials e.g., municipal or health department authorities)
- Heat source for sterilization
- Refrigerator or freezer for storage

Failure to properly prepare, handle, and store bottles or storage containers or breast pumps properly; examples include:

Breast Milk

- Thawing in a microwave
- Refreezing
- Adding freshly expressed unrefrigerated breast milk to frozen breast milk
- Adding refrigerated breast milk to frozen breast milk in an amount that is greater than the amount of frozen breast milk
- Feeding thawed breast milk more than 24 hours after it was thawed
- Saving breast milk from a used bottled for another feeding
- Failure to clean breast pump per manufacturer's instruction

Formula

- Storing at room temperature for more than 1 hour

- Failure to store prepared formula per manufacturer's instructions
- Using formula in a bottle one hour after the start of a feeding
- Saving formula from a used bottle for another feeding
- Failure to clean baby bottle properly

411.10 Feeding dietary supplements with potentially harmful consequences.

Examples of dietary supplements, which when fed in excess of recommended dosage, may be toxic or have harmful consequences:

- Single or multi-vitamins
- Mineral supplements
- Herbal or botanical supplements/remedies/teas

411.11 Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements.

- Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride
- Infants who are exclusively breastfed, or who are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D

Required Documentation

Document which behaviors are present.

Justification

411.1 Routinely using a substitute(s) for breast milk or for FDA approved iron-fortified formula as the primary nutrient source during the first year of life.

During the first year of life, breastfeeding is the preferred method of infant feeding. The American Academy of Pediatrics (AAP) recommends breast milk for the first 12 months of life because of its acknowledged benefits to infant nutrition, gastrointestinal function, host defense, and psychological well-being (1). For infants fed infant formula, iron-fortified formula is generally recommended as a substitute for breastfeeding (1- 4). Rapid growth and increased physical activity significantly increase the need for iron and utilizes iron stores (1). Body stores are insufficient to meet the increased iron needs making it necessary for the infant to receive a dependable source of iron to prevent iron deficiency anemia (1). Iron deficiency anemia is associated with cognitive and psychomotor impairments that may be irreversible, and with decreased immune function, apathy, short attention span, and irritability (1, 5). Feeding of low-iron infant formula can compromise an infant's iron stores and lead to iron deficiency anemia. Cow's milk has insufficient and inappropriate amounts of nutrients and can cause occult blood loss that can lead to iron deficiency, stress on the kidneys from a high renal solute load, and allergic reactions (1, 3, 5-8). Sweetened condensed milk has an abundance of sugar that displaces other nutrients or causes over consumption of calories (9). Homemade formulas prepared with canned evaporated milk do not contain optimal kinds and amounts of nutrients infants need (1, 5, 8, 9). Goat's milk, sheep's milk, imitation milks, and substitute milks do not contain nutrients in amounts appropriate for infants (1, 3, 5**,** 10, 11).

411.2 Routinely using nursing bottles or cups improperly.

Dental caries is a major health problem in U.S. preschool children, especially in low-income populations (12). Eating and feeding habits that affect tooth decay and are started during infancy may continue into early childhood. Most implicated in this rampant disease process is prolonged use of baby bottles during the day or night, containing fermentable sugars, (e.g., fruit juice, soda, and other sweetened drinks), pacifiers dipped in sweet agents such as sugar, honey or syrups, or other high frequency sugar exposures (13). The AAP and the American Academy of Pedodontics recommended that juice should be offered to infants in a cup, not a bottle, and that infants not be put to bed with a bottle in their mouths (14, 15). While sleeping with a bottle in his or her mouth, an infant's swallowing and salivary flow decreases, thus creating a pooling of liquid around the teeth (16). The practice of allowing infants to carry or drink from a bottle or training cup of juice for periods throughout the day leads to excessive exposure of the teeth to carbohydrate, which promotes the development of dental caries (14).

Allowing infants to sleep with a nursing bottle containing fermentable carbohydrates or to use it unsupervised during waking hours provides an almost constant supply of carbohydrates and sugars (1). This leads to rapid demineralization of tooth enamel and an increase in the risk of dental caries due to prolonged contact between cariogenic bacteria on the susceptible tooth surface and the sugars in the consumed liquid (1, 17). The sugars in the liquid pool around the infant's teeth and gums feed the bacteria there and decay is the result (18). The process may start before the teeth are even fully erupted. Upper incisors (upper front teeth) are particularly vulnerable; the lower incisors are generally protected by the tongue (18). The damage begins as white lesions and progresses to brown or black discoloration typical of caries (18). When early childhood caries is severe, the decayed crowns may break off and the permanent teeth developing below may be damaged (18). Undiagnosed dental caries and other oral pain may contribute to feeding problems and failure to thrive in young children (18).

Unrestricted use of a bottle containing fermentable carbohydrates is a risk because the more times an infant consumes solid or liquid food, the higher the caries risk (1). Feeding behaviors such as unrestricted use of the bottle and frequent snacking can be habit forming in later infancy and may carry over into toddler-hood. Frequent cariogenic snacks eaten between meals place the toddler at high risk for caries development; this includes the habit of continually sipping from cups (or bottles) containing cariogenic liquids (juice, milk, soda, or sweetened liquid) (18). If inappropriate use of the bottle persists, the child is at risk of toothaches, costly dental treatment, loss of primary teeth, and developmental lags on eating and chewing. If this continues beyond the usual weaning period, there is a risk of decay to permanent teeth.

Propping the bottle deprives infants of vital human contact and nurturing which makes them feel secure. It can also cause ear infections because of fluid entering the middle ear and not draining properly; choking from liquid flowing into the lungs; and tooth decay from prolonged exposure to carbohydrate-containing liquids (19).

Adding solid food to a nursing bottle results in force-feeding, inappropriately increases the energy and nutrient composition of the formula, deprives the infant of experiences important in the development of feeding behavior, and could cause an infant to choke (1, 10, 20, 21).

411.3 Routinely offering complementary foods or other substances that are inappropriate in type of timing.

Infants, especially those living in poverty, are at high risk for developing early childhood carries (12). Most implicated in this disease process are: prolonged use of baby bottles containing fermentable sugars, (e.g., fruit juice, soda, and other sweetened drinks) during the day or night; pacifiers dipped in sweet agents such as sugar, honey or syrups, or other high frequency sugar exposures (13).

Feeding solid foods too early (i.e., before 4-6 months of age) by, for example, adding dilute cereal or other solid foods to bottles deprives infants of the opportunity to learn to feed themselves (3, 10, 20, 22). The major objection to the introduction of solids before age 4 months of age is based on the possibility that it may interfere with establishing sound eating habits and may contribute to overfeeding (5, 23). Before 4 months of age, the infant possesses an extrusion reflex that enables him/her to swallow only liquid foods (1, 12, 24). The extrusion reflex is toned down at four months (20). Breast milk or iron-fortified infant formula is all the infant needs. Gastric secretions, digestive capacity, renal capacity and enzymatic secretions are low, which makes digestion of solids inefficient and potentially harmful (5, 20, 23, 24). Furthermore, there is the potential for antigens to be developed against solid foods, due to the undigested proteins that may permeate the gut; however, the potential for developing allergic reactions may primarily be in infants with a strong family history of atopy (5, 23). If solid foods are introduced before the infant is developmentally ready, breast milk or iron-fortified formula necessary for optimum growth is displaced (1, 20, 24). Around 4 months of age, the infant is developmentally ready for solid foods when: the infant is better able to express certain feeding cues such as turning head to indicate satiation; oral and gross motor skills begin to develop that help the infant to take solid foods; the extrusion reflex disappears; and the infant begins to sit upright and maintain balance (1, 5, 20, 23, 24).

Offering juice before solid foods are introduced into the diet could risk having juice replace breast milk or infant formula in the diet (14). This can result in reduced intake of protein, fat, vitamins, and minerals such as iron, calcium, and zinc (25). It is prudent to give juice only to infants who can drink from a cup (14).

411.4 Routinely using feeding practices that disregard the developmental needs or stage of the infant.

Infants held to rigid feeding schedules are often underfed or overfed. Caregivers insensitive to signs of hunger and satiety, or who over-manage feeding may inappropriately restrict or encourage excessive intake. Findings show that these practices may promote negative or unpleasant associations with eating that may continue into later life, and may also contribute to obesity. Infrequent breastfeeding can result in lactation insufficiency and infant failure-to-thrive. Infants should be fed foods with a texture appropriate to their developmental level. (3, 5, 10, 12, 20, 22)

411.5 Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.

Only pasteurized juice is safe for infants, children, and adolescents (14). Pasteurized fruit juices are free of microorganisms (14). Unpasteurized juice may contain pathogens, such as Escherichia coli, Salmonella, and Cryptosporidium organisms (14, 26). These organisms can cause serious disease, such as hemolytic-uremic syndrome, and should never be fed to infants and children

(14). Unpasteurized juice must contain a warning on the label that the product may contain harmful bacteria (14, 27). Infants or young children should not eat raw or unpasteurized milk or cheeses (1)—unpasteurized dairy products could contain harmful bacteria, such as Brucella species, that could cause young children to contract a dangerous food borne illness. The AAP also recommends that young children should not eat soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese—these foods could contain Listeria bacteria (1). Hard cheeses, processed cheeses, cream cheese, cottage cheese, and yogurt need not be avoided (1).

Honey has been implicated as the primary food source of *Clostridium botulinum* during infancy. These spores are extremely resistant to heat, including pasteurization, and are not destroyed by present methods of processing honey. Botulism in infancy is caused by ingestion of the spores, which germinate into the toxin in the lumen of the bowel (9, 10, 20, 28, 29).

Infants or young children should not eat raw or undercooked meat or poultry, raw fish or shellfish, including oysters, clams, mussels, and scallops (1)—these foods may contain harmful bacteria or parasites that could cause children to contract a dangerous food borne illness.

According to the AAP, to prevent food borne illness, the foods listed below should not be fed to infants or young children (1). All of the foods have been implicated in selected outbreaks of food-borne illness, including in children. Background information regarding foods that could be contaminated with harmful microorganisms is also included below:

- Raw vegetable sprouts (alfalfa, clover, bean, and radish)--Sprouts can cause potentially dangerous Salmonella and E. coli O157 infection. Sprouts grown under clean conditions in the home also present a risk because bacteria may be present in seeds. Cook sprouts to significantly reduce the risk of illness (30).
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot) --These foods have been found to be contaminated with *Listeria monocytogenes*; if adequately cooked, this bacteria is destroyed.

411.6 Routinely feeding inappropriately diluted formula.

Over-dilution can result in water intoxication resulting in hyponatremia; irritability; coma; inadequate nutrient intake; failure to thrive; and/or poor growth (1, 3, 5, 10, 20, 31). Under-dilution of formula increases calories, protein, and solutes presented to the kidney for excretion, and can result in hypernatremia, tetany, and obesity (3, 5, 10, 20, 31).

Dehydration and metabolic acidosis can occur with under-dilution of formula (3, 5, 10, 31). Powdered formulas vary in density so manufacturers' scoops are formula-specific to assure correct dilution (5, 20). One clue for staff to identify incorrect formula preparation is to determine if the parent/caregiver is using the correct manufacturer's scoop to prepare the formula.

411.7 Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source of nutrients.

Exclusive breastfeeding provides ideal nutrition to an infant and is sufficient to support optimal growth and development in the first 6 months of life (4). Frequent breastfeeding is critical to the establishment and maintenance of an adequate milk supply for the infant (4, 32-36). Inadequate frequency of breastfeeding may

lead to lactation failure in the mother and dehydration, poor weight gain, diarrhea, and vomiting, illness, and malnourishment in the infant (4, 34, 37-42). Exclusive breastfeeding protects infants from early exposure to contaminated foods and liquids (40). In addition, infants, who receive breast milk more than infant formulas, have a lower risk of being overweight in childhood and adolescence (43, 44).

411.8 Routinely feeding a diet very low in calories and/or essential nutrients.

Highly restrictive diets prevent adequate intake of nutrients, interfere with growth and development, and may lead to other adverse physiological effects (3). Infants older than 6 months are potentially at the greatest risk for overt deficiency states related to inappropriate restrictions of the diet, although deficiencies of vitamins B12 and essential fatty acids may appear earlier (1, 45, 46). Infants are particularly vulnerable during the weaning period if fed a macrobiotic diet and may experience psychomotor delay in some instances (1, 47, 48). Well-balanced vegetarian diets with dairy products and eggs are generally associated with good health. However, strict vegan diets may be inadequate in calories, vitamin B12, vitamin D, calcium, iron, protein and essential amino acids needed for growth and development (49). The more limited the diet, the greater the health risk. Given the health and nutrition risks associated with highly restrictive diets, WIC can help the parent to assure that the infant consumes an adequate diet to optimize health during critical periods of growth as well as for the long term.

411.9 Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breast milk or formula.

Lack of sanitation in the preparation, handling and storage of expressed breast milk or formula may cause gastrointestinal infection. The water used to prepare concentrated or powdered infant formula and prepare bottles and nipples (for formula and breast milk) must be safe for consumption. Water contaminated with toxic substances (such as nitrates, lead, or pesticides) poses a hazard to an infant's health and should NOT be used (9). In addition, a heat source is necessary to sterilize bottles and other items used in the storage of both breast milk and formula. Adequate refrigeration (40 Degrees Fahrenheit or below) is necessary to safely store breast milk and prepared formula (9).

<u>Breast Milk</u>

Published guidelines on the handling and storage of breast milk may differ among pediatric nutrition authorities (1, 9, 50-53). However, there is consensus on the following breast milk feeding, handling, and storage practices that are considered inappropriate and unsafe (9, 50, 54-56):

- Thawing frozen breast milk in the microwave oven;
- Refreezing breast milk;
- Adding freshly expressed unrefrigerated breast milk to already frozen breast milk in a storage container*****
- Feeding previously frozen breast milk thawed in the refrigerator that has been refrigerated for more than 24 hours
- Saving breast milk from a used bottle for another use at another feeding
- Failure to clean a breast pump per manufacturer's instruction

*The appropriate and safe practice is to add chilled freshly expressed breast

milk, in an amount that is smaller than the milk that has been frozen for no longer than 24 hours.

As stated above, there are variations in breast milk storage guidelines among recognized entities, e.g., AAP and Academy of Breastfeeding Medicine (ABM) (1, 53). The ABM guidelines have longer refrigerated storage time than AAP and are cited for several organizations (1, 53). However, the ABM guidelines are for healthy term infants, and while they may be appropriate for a large percentage of the general population, the WIC population is considered an "at risk population". Therefore, it is not possible at this time to identify a clear cut-off to determine unsafe refrigeration limits for WIC risk determination.

Another consideration when recommending length of storage time is its effect on protective properties in breast milk. There is evidence that after 48 hours of refrigeration, breast milk significantly loses important antibacterial and antioxidant properties (57). These properties of breast milk are specifically important for the prevention of necrotizing enterocolitis, retinopathy, and bronchopulmonary dysplasia of premature infants (57). Although some properties may be reduced with longer refrigerated storage, this does not diminish the overall superiority of breast milk over formula, as formula does not contain these protective properties or many of the other benefits of breast milk.

Participant circumstances (e.g., adequate refrigeration, safe water, heat source) as well as health of the infant need to be considered when recommending the length of time breast milk may be stored in the refrigerator. Please see the WIC Works Resource System for handling and storage recommendations: http://www.nal.usda.gov/wicworks/WIC_Learning_Online/support/job_aids/safety.pdf. These recommendations are based on the AAP's guidelines for the safe handling and storage of breast milk.

If the breastfeeding mother uses a breast pump, it is essential for her to fully understand the importance of and the specific manufacturer's instructions for cleaning the breast pump. Improper cleaning of breast pumps and pump parts can increase the risk of expressed breast milk contamination (56).

Formula

Formula must be properly prepared in a sanitary manner to be safe for consumption. Furthermore, prepared infant formula is a perishable food, and must be handled and stored properly in order to be safe for consumption (3, 9, 20). Most babies who are hospitalized for vomiting and diarrhea are bottle fed. This has often been attributed to the improper handling of formula rather than sensitivities to the formula. During the manufacturing process, powdered formulas can become contaminated with harmful bacteria. In rare cases, the contaminated powdered formulas may cause infections in preterm or immune compromised infants. To reduce the risk of infection in infants it is important that formulas be carefully prepared and handled. Instructions for the sanitary preparation of formulas can be obtained from the WIC Works Resource System at: http://www.nal.usda.gov/wicworks/WIC_Learning_Online/support/job_aids/formula.pdf and from the World Health Organization at: http://www.who.int/foodsafety/publications/micro/pif_guidelines.pdf. It is generally recommended to boil the water used for infant formula preparation during the first 3 months of life (9). Caregivers should consider the safety of their water source and the health status of the infant in addition to consulting with their health care provider regarding whether to continue boiling the water when

preparing infant formula for the infant older than 3 months.

Manufacturers' instructions vary, depending on the product, in the length of time it is considered safe to store prepared infant formula without refrigeration before bacterial growth accelerated to an extent that the infant is placed at risk (1, 9, 20). Published guidelines on the handling and storage of infant formula indicated that it is unsafe to use prepared formula which (1, 9):

- Has been held at room temperature longer than 1 hour or longer than recommended by the manufacturer
- Has been held in the refrigerator longer than the safe storage time indicated by the manufacturer
- Remains in a bottle one hour after the start of feeding
- Remains in a bottle from an earlier feeding
- Is fed using improperly cleaned baby bottles

411.10 Feeding dietary supplements with potentially harmful consequences.

An infant consuming inappropriate or excessive amounts of single or multivitamin or mineral or herbal remedy not prescribed by a physician is at risk for a variety of adverse effects including harmful nutrient interactions, toxicity, and teratogenicity (1, 58). While some herbal teas may be safe, some have undesirable effects, particularly on infants who are fed herbal teas or who receive breast milk from mothers who have ingested herbal teas (59). Examples of teas with potentially harmful effects to infants and children include: licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, pokeroot or pokeweed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Matế, kola nut or gotu cola, and chamomile (59 -61). Like drugs, herbal or botanical preparations have chemical and biological activity, may have side effects, and may interact with certain medications--these interactions can cause problems and can even be dangerous (62). Botanical supplements are not necessarily safe because the safety of a botanical depends on many things, such as its chemical makeup, how it works in the body, how it is prepared, and the dose used (62).

411.11 Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements.

Depending on an infant's specific needs and environmental circumstances, certain dietary supplements may be recommended by the infant's health care provider to ensure health. For example, fluoride supplements may be of benefit in reducing dental decay for children living in fluoride-deficient areas (1, 63). To prevent rickets and vitamin D deficiency in healthy infants and children, the AA P recommends a supplement of 400 IU per day for the following (4, 64).

- All breastfed and partially breastfed infants unless they are weaned to at least 1 liter (or 1 quart) per day of vitamin D-fortified formula.
- All non-breastfed infants who are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula.

References

1. Committee on Nutrition, American Academy of Pediatrics. Pediatrics nutrition handbook. 6th Ed. Elk Grove Village, III: American Academy of Pediatrics, 2009.
2. American Academy of Pediatrics, Committee on Nutrition. Iron fortification of infant formula. Pediatrics 1999; 104:119-123.
3. Institute of Medicine. WIC nutrition risk criteria: a scientific assessment. National Academy Press, Washington D.C.; 1996.
4. American Academy of Pediatrics, Section on Breastfeeding: Breastfeeding and the use of human milk. Pediatrics 2005 Feb; 115(2):496-506.
5. Fomon SJ. Nutrition of normal infants. St. Louis: Mosby, 1993.
6. Whitney EN, Rolfes SR. Understanding nutrition. 9th Ed. Wadsworth: Thomson Learning, 2002: p. 241.
7. American Academy of Pediatrics, Committee on Nutrition. The use of whole cow's milk in infancy. Pediatrics 1992; 89(6):1105-1109.
8. Friel JK, et al. Eighteen-month follow-up of infants fed evaporated milk formula. Canadian Journal of Public Health. Revue Canadienne de Sante Publique, 90.4 (Jul-Aug 1999): 240-3. Abstract.
9. United States Department of Agriculture, Food and Nutrition Service. Infant nutrition and feeding, a guide for use in the WIC and CSF programs. Alexandria, VA: Special Supplemental Nutrition Programs, revised 2008. [FNS-288].
10. Trahms CM, Pipes PL, editors. Nutrition in Infancy and Childhood. WCB/McGraw-Hill; 1997.
11. Bellioni-Businco B, Paganelli R, Lucenti P, Giampietro PG, Perborn H, Businco L. Allergenicity of goat's milk in children with cow's milk allergy. J. Allergy Clin. Immunol. 1999; 103:1191-1194.
12. Tang J, Altman DS, Robertson D, O"Sullivan DM, Douglas JM, Tinanoff N. Dental caries prevalence and treatment levels in Arizona preschool children. Public Health Rep. 1997; 112:319-29.
13. Tinaoff N and Palmer CA. Dietary determinants of dental carries and dietary recommendations for preschool children. J. Public Health Dent. 2000; 60(3):197-206.
14. American Academy of Pediatrics, Committee on Nutrition. The use and misuse of fruit juice in pediatrics. Pediatrics 2001; 107:1210-1213.
15. American Academy of Pediatrics and American Academy of Pedodontics. Juice in ready-to-use bottles and nursing bottle carries. AAP News. 1978; 29(1):11.
16. Samour PQ, Helm KK, Lang CE. Handbook of pediatric nutrition. 2nd Ed. Gaithersburg, MD: Aspen Publishers, Inc.; 1999.
17. American Academy of Pediatric Dentistry. Baby Bottle Tooth Decay/Early Childhood Caries. Pediatr Dent 2000-2001 (revised May 1996); 2001 Mar-Apr; 23(2):18.
18. Fitzsimons D, Dwyer JT, Palmer C, Boyd LD. Nutrition and oral health guidelines for pregnant women, infants, and children. J. Am. Diet. Assoc. Feb 1998; 98(2):182-6.
19. Shelov SD. Caring for your baby and young child: birth to age 5. Elk Grove Village, IL: American Academy of Pediatrics; 1998.
20. Satter E. Child of mine: Feeding with love and good sense. Palo Alto (CA): Bull Publishing Company; 2000.
21. Tamborlane WV, editor. The Yale guide to children's nutrition. Connecticut: Yale University; 1997.
22. Williams CP, editor. Peidatric manual of clinical dietetics. Chicago: American Dietetic Association; 1998.

23. Fomon SJ. Feeding normal infants: rationale for recommendations. J. Am. Diet. Assoc. 2001; 101:1002-1005.
24. Rolfes, Debruyne, Whitney. Life span nutrition: conception through life; 1990; pp. 231-237.
25. Gibson SA. Non-milk extrinsic sugars in the diets of pre-school children: association with intakes of micronutrients, energy, fat and NSP. Br. J. Nutr. 1997; 78:367-378.
26. Parish ME. Public health and non-pasteurized fruit juices. Crit. Rev. Microbiol. 1997; 23:109-119.
27. Food Labeling. Warning and Notice Statement: Labeling of juice products; Final Rule. 63 Federal Register 37029-37056 (1998) (codified at 21 CFR §101, 120).
28. Botulism Fact Sheet [electronic file]. Atlanta (GA): Centers for Disease Control and Prevention; 1995.
29. Centers for Disease Control and Prevention (US). Botulism in the United States, 1899-1996. Atlanta (GA): Centers for Disease Control and Prevention; 1998.
30. Food and Drug Administration. Updates: Avoid raw sprouts to reduce food poisoning risk, agency advises. FDA Consumer magazine, September-October 1999. Available from: http://www.fda.gov/fdac/departs/1999/599_upd.html.
31. Fein SB, Falci CD. Infant formula preparation, handling, and related practices in the United States. J. Am. Diet. Assoc. 1999. 99:1234-1240.
32. Biancuzzo M. Breastfeeding the newborn: clinical strategies for nurses. St. Louis, MO; Morby, 1999, Pages 103-104.
33. Mochbracher N, Stock J. The Breastfeeding answer book (Revised edition). La Leche League International, 1997, Pages 20-23.
34. Eiger MS, Olds SW. The complete book of breastfeed. New York: Workman Publishing: 1999, p.88, 112-114.
35. Rosenthal MS. The breastfeeding sourcebook. Los Angeles: Lowell House; 1996, p. 157.
36. Sears M, Sears W. The breastfeeding book. Boston: Little, Brown and Company; 2000, p. 108-110.
37. Johnson DB. Nutrition in infancy:-evolving views on recommendations. Nutrition Today 1998; 32: 63-68.
38. Mark DH. Breastfeeding and infant illness: a dose-response relationship. J Amer Med Assoc 1990; 281: 1154.
39. Muztagh M. Optimal breastfeeding duration. J. Am. Diet. Assoc. 1997;97: 1252-1255.
40. Raiser J, Alexander C, O'Campo P. Breastfeeding and Infant Illness; a dose-response relationship? Am. J. Pub. Health 1999; 89: 25-30.
41. Scariest PD, Grummer-Strawn LM, Fein SB. A longitudinal analysis of infant mortality and the extent of breastfeeding in the United States. Pediatrics 1997; 99-6.
42. Story M, Hoyt K, Sofka D. Bright futures in practice. National Center for Education in Maternal and Child Health. Arlington: Georgetown University; 2000, p. 25.
43. Gilman MW, Rifas-Shiman SL, Camrgo CA Jr, Berkey CS, Frazier AL, Rockett HR, Field AE, Colditz GA. Risk of overweight among adolescents who were breastfed infants. J. Amer. Med. Assoc. 2001; 285(19): 2461-7.
44. Von Kries R, Koletzko B, Sauerwald T, von Mutius E, Barnert D, Grunert V, Von Voss H. Breastfeeding and obesity: cross-sectional study. Br. Med. J. 1999: 319(7203):147-50.
45. Sanders TA, Reddy S. Vegetarian diets and children. Am. J. Clin. Nutr. 1994; 59(suppl):1176S-1181S.

46. Sanders TA. Essential fatty acid requirements of vegetarians in pregnancy, lactation and infancy. Am. J. Clin. Nutr. 1999; 70:5555-5595.
47. Sanders TA. Vegetarian diets and children. Pediatric Clin. North Am. 1995; 42-955-965.
48. Dagnelie PC, Vergote FJ, van Staveren, WA, et al. High prevalence of rickets in infants on macrobiotic diets. Am. J. Clin. Nutr. 1990;51:202-208.
49. Duyff RL. American Dietetic Association. The American Dietetic Association's complete food and nutrition guide. Minneapolis, MN: Chronimed Pub; 1996.
50. American Academy of Pediatrics: A woman's guide to breastfeeding. 1999, pp. 13-14.
51. United States Department of Agriculture (USDA), Food and Nutrition Service. Breastfed Babies Welcome Here [Program Aid 1516]. Alexandria, VA: USDA, 1995, pp. 12-15.
52. Lawrence RA. Breastfeeding: a guide for the medical profession. 5th edition. St. Louis, MO: Mosby, 1999, pp. 677-710.
53. Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #8: human milk storage information for home use for full-term infants; Revision #1. Academy of Breastfeeding; March 2010. Available from: http://www.bfmed.org/Media/Files/Protocols/Protocol%208%20-%20English%20revised%202010.pdf.
54. Duke, CS. Common concerns when storing human milk. New Beginnings; July-August 1998; 15(4), p. 109.
55. Neifert, M. Dr. Mom's guide to breastfeeding. 1998; New York, NY: Plume, pp. 305-306.
56. Jones F, Tully, MR. Best practice for expressing, storing, and handling human milk in hospitals, homes and child care settings. Raleigh, NC: Human Milk Banking Association of North America Inc.; 2006.
57. Lee JW, Davis JM. Future applications of antioxidants in premature infants. Vurr Opin Pediatr. 2011 Apr; 23(2):161-6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21150443.
58. Anderson JV, Van Nierop MR. Basic nutrition facts a nutrition reference. Lansing, MI: Michigan Department of Public Health; 1989.
59. Lawrence RA. Breastfeeding: a guide for the medical profession. 5th edition. St. Louis, MO: Mosby, 1999, pp. 371-377.
60. Siegel RK. Herbal intoxication: psychoactive effects from herbal cigarettes, tea and capsules. JAMA 236:473, 1976.
61. Ridker PM. Toxic effects of herbal teas. Arch Environ Health 42(3):133-6, 1987.
62. Office of Dietary Supplements, National Institutes of Health (NIH). Botanical dietary supplements: background information. NIH web page, last updated 7/7/2004. Available from: http://ods.od.nih.gov/factsheets/BotanicalBackground.asp.
63. American Academy of Pediatric Dentistry. Fluoride. Pediatric Dent. 1999; 21:40.
64. American Academy of Pediatrics, Section on Breastfeeding and Committee on Nutrition. Prevention of rickets and vitamin D deficiency in infants, children, and adolescents. Pediatrics 2008; http://pediatrics.aappublications.org/content/122/5/1142.full.

Nutrition Risk Criteria **425 INAPPROPRIATE NUTRITION PRACTICES (CHILD)**

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	CHILDREN	5	-

Definition

FORMERLY QUESTIONABLE CHILD FEEDING

Routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below. Refer to "Justification and References" for this criterion.

425.1 Routinely feeding inappropriate beverages as the primary milk source.
Examples of inappropriate beverages as primary milk source:

- Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk
- Imitation or substitute milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."

425.2 Routinely feeding a child any sugar-containing fluids.
Examples of sugar-containing fluids:

- Soda/soft drinks
- Gelatin water
- Corn syrup solutions
- Sweetened tea

425.3 Routinely using nursing bottles, cups, or pacifiers improperly.

- Using a bottle to feed
  - fruit juice
  - diluted cereal or other solid foods
- Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime
- Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier
- Using a bottle for feeding or drinking beyond 14 months of age
- Using a pacifier dipped in sweet agents such as sugar, honey, or syrups
- Allowing a child to carry around and drink throughout the day from a covered or training cup

425.4 Routinely using feeding practices that disregard the developmental needs or stages of the child.

- Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's requests for appropriate foods)
- Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking
- Not supporting a child's need for growing independence with self-feeding (e.g., solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils)
- Feeding a child food with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily pureed or liquid food when the child is ready and capable of eating mashed, chopped or appropriate finger

foods)

425. 5 Feeding foods to a child that could be contaminated with harmful microorganisms.
Examples of potentially harmful foods for a child:

- Unpasteurized fruit or vegetable juice
- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese
- Raw or undercooked meat, fish, poultry, or eggs
- Raw vegetable sprouts (alfalfa, clover, bean, and radish)
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot)

425.6 Routinely feeding a diet very low in calories and/or essential nutrients.
Examples:

- Vegan diet
- Macrobiotic diet
- Other diets very low in calories and/or essential nutrients

425.7 Feeding dietary supplements with potentially harmful consequences.
Examples of dietary supplements which when fed in excess of recommended dosage may be toxic or have harmful consequences:

- Single or multi-vitamins
- Mineral supplements
- Herbal or botanical supplements/remedies/teas

425.8 Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.

- Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride
- Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride
- Not providing 400 IU of vitamin D if a child consumes less than 1 liter (or 1 quart, approximately 4 cups) of vitamin D-fortified milk or formula

425.9 Routine ingestion of nonfood items (pica).
Examples of inappropriate nonfood items:

- Ashes
- Carpet fibers
- Cigarettes or cigarette butts
- Clay
- Dust
- Foam rubber
- Paint chips
- Soil
- Starch (laundry and cornstarch)

Required Documentation

Document which of the behaviors are present in the participant file.

Justification

425.1 Routinely feeding inappropriate beverages as the primary milk source.

Goat's milk, sheep's milk, imitation milks and substitute milks (that are unfortified or inadequately fortified) do not contain nutrients in amounts appropriate as a primary milk source for children (1-4). Non-fat and reduced-fat milks are not recommended for use with children from 1 to 2 years of age because of the lower calorie density compared with whole-fat products (1, 5). The low-calorie, low-fat content of these milks requires that increased volume be consumed to satisfy caloric needs. Infants and children under two using reduced fat milks gain at a slower growth rate, lose body fat as evidenced by skin fold thickness, lose energy reserves, and are at risk of inadequate intake of essential fatty acids.

425.2 Routinely feeding a child any sugar-containing fluids.

Abundant epidemiologic evidence from groups who have consumed low quantities of sugar as well as from those who have consumed high quantities shows that sugar—especially sucrose—is the major dietary factor affecting dental caries prevalence and progression (6). Consumption of foods and beverages high in fermentable carbohydrates, such as sucrose, increases the risk of early childhood caries and tooth decay (6,7).

425.3 Routinely using nursing bottles, cups, or pacifiers improperly.

Dental caries is a major health problem in U. S. preschool children, especially in low-income populations (8). Most implicated in this rampant disease process is prolonged use of baby bottles during the day or night, containing fermentable sugars, (e.g., fruit juice, soda, and other sweetened drinks), pacifiers dipped in sweet agents such as sugar, honey or syrups, or other high frequency sugar exposures (6). Solid foods such as cereal should not be put into a bottle for feeding; this is a form of force-feeding (9) and does not encourage the child to eat the cereal in a more developmentally-appropriate way.
Additional justification for the examples include:

- The American Academy of Pediatrics (AAP) and the American Academy of Pedodontics recommend that children not be put to bed with a bottle in their mouth (10, 11). While sleeping with a bottle in his or her mouth, a child's swallowing and salivary flow decreases, thus creating a pooling of liquid around the teeth (12). Propping the bottle can cause: ear infections because of fluid entering the middle ear and not draining properly; choking from liquid flowing into the lungs; and tooth decay from prolonged exposure to carbohydrate-containing liquids (13).
- Pediatric dentists recommend that parents be encouraged to have infants drink from a cup as they approach their first birthday, and that infants are weaned from the bottle by 12-14 months of age (14).
- The practice of allowing children to carry or drink from a bottle or cup of juice for periods throughout the day leads to excessive exposure of the teeth to carbohydrate, which promotes the development of dental caries (10). Allowing toddlers to use a bottle or cup containing fermentable carbohydrates unsupervised during waking hours provides an almost constant supply of carbohydrates and sugars (1). This leads to rapid demineralization of tooth enamel and an increase in the risk of dental caries due to prolonged contact between cariogenic bacteria on the susceptible tooth surface and the sugars in the consumed liquid (1, 14). The sugars in the liquid pool around the child's teeth and gums feed the bacteria there and decay is the result (15). The process may start before the teeth are even fully erupted. Upper incisors (upper front teeth) are

particularly vulnerable; the lower incisors are generally protected by the tongue (15). The damage begins as white lesions and progresses to brown or black discoloration typical of caries (15). When early childhood caries are severe, the decayed crowns may break off and the permanent teeth developing below may be damaged (15). Undiagnosed dental caries and other oral pain may contribute to feeding problems and failure to thrive in young children (15). Use of a bottle or cup, containing fermentable carbohydrates, without restriction is a risk because the more times a child consumes solid or liquid food, the higher the caries risk (1). Cariogenic snacks eaten between meals place the toddler most at risk for caries development; this includes the habit of continually sipping from cups (or bottles) containing cariogenic liquids (juice, milk, soda, or sweetened liquid) (15). If inappropriate use of the bottle persists, the child is at risk of toothaches, costly dental treatment, loss of primary teeth, and developmental lags on eating and chewing. If this continues beyond the usual weaning period, there is a risk of decay to permanent teeth.

425.4 Routinely using feeding practices that disregard the developmental needs or stages of the child.

The interactions and communication between a caregiver and child during feeding and eating influence a child's ability to progress in eating skills and consume a nutritionally adequate diet. These interactions comprise the "feeding relationship" (9). A dysfunctional feeding relationship, which could be characterized by a caregiver misinterpreting, ignoring, or overruling a young child's innate capability to regulate food intake based on hunger, appetite and satiety, can result in poor dietary intake and impaired growth (16, 17). Parents who consistently attempt to control their children's food intake may give children few opportunities to learn to control their own food intake (18). This could result in inadequate or excessive food intake, future problems with food regulation, and problems with growth and nutritional status. Instead of using approaches such as bribery, rigid control, struggles, or short-order cooking to manage eating, a healthier approach is for parents to provide nutritious, safe foods at regular meals and snacks, allowing children to decide how much, if any, they eat (1, 17). Young children should be able to eat in a matter-of-fact way sufficient quantities of the foods that are given to them, just as they take care of other daily needs (3). Research indicates that restricting access to foods (i.e., high fat foods) may enhance the interest of 3- to 5-year-old children in those foods and increase their desire to obtain and consume those foods. Stringent parental controls on child eating have been found to potentiate children's preference for high-fat energy dense foods, limit children's acceptance of a variety of foods, and disrupt children's regulation of energy intake (19, 20). Forcing a child to clean his or her plate may lead to overeating or development of an aversion to certain foods (7). The toddler and preschooler are striving to be independent (7). Self-feeding is important even though physically they may not be able to handle feeding utensils or have good eye-hand coordination (7). Children should be able to manage the feeding process independently and with dispatch, without either unnecessary dawdling or hurried eating (3, 12). Self-feeding milestones include (1): During infancy, older infants progress from semisolid foods to thicker and lumpier foods to soft pieces to finger-feeding table food (9). By 15 months, children can manage a cup, although not without some spilling. At 16 to 17 months of age, well-defined wrist rotation develops, permitting the transfer of feed from the bowl to the child's mouth with less spilling. The ability to lift the elbow as the spoon is raised and to flex the wrist as the spoon reaches the mouth follows. At 18 to 24 months, they learn to tilt a cup by manipulation with the fingers. Despite these

new skills, 2-year-old children often prefer using their fingers to using the spoon. Preschool children learn to eat a wider variety of textures and kinds of food (3, 7). However, the foods offered should be modified so that the child can chew and swallow the food without difficulty (3).

425.5 Feeding foods to a child that could be contaminated with harmful microorganisms.

According to the AAP, to prevent food-borne illness, the foods listed below should not be fed to young children or infants (1). All of the foods have been implicated in selected outbreaks of food-borne illness, including in children. Background information regarding foods that could be contaminated with harmful microorganisms is also included below:

- Unpasteurized fruit or vegetable juice—Only pasteurized juice is safe for infants, children, and adolescents (10). Pasteurized fruit juices are free of microorganisms (10). Unpasteurized juice may contain pathogens, such as Escherichia coli, Salmonella, and Cryptosporidium organisms (10, 21). These organisms can cause serious disease, such as hemolytic-uremic syndrome, and should never be fed to infants and children (10). Unpasteurized juice must contain a warning on the label that the product may contain harmful bacteria (10, 22).
- Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese—Young children or infants should not eat raw or unpasteurized milk or cheeses (1). Unpasteurized dairy products could contain harmful bacteria, such as Brucella species, that could cause young children to contract a dangerous food borne illness. The American Academy of Pediatrics also recommends that young children should not eat soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese—these foods could contain Listeria bacteria (hard cheeses, processed cheeses, cream cheese, cottage cheese, and yogurt need not be avoided) (1).
- Raw or undercooked meat, fish, poultry, or eggs—Young children or infants should not eat raw or undercooked meat or poultry; or raw fish or shellfish, including oysters, clams, mussels, and scallops (1). These foods may contain harmful bacteria or parasites that could cause children to contract a dangerous foodborne illness.
- Raw vegetable sprouts (alfalfa, clover, bean, and radish)—Sprouts can cause potentially dangerous Salmonella and E. coli O157 infection. Sprouts grown under clean conditions in the home also present a risk because bacteria may be present in seed. Cook sprouts to significantly reduce the risk of illness (23).
- Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot)—These foods have been found to be contaminated with *Listeria monocytogenes*; if adequately cooked, this bacteria is destroyed.

425.6 Routinely feeding a diet very low in calories and/or essential nutrients.

Highly restrictive diets prevent adequate intake of nutrients, interfere with growth and development, and may lead to other adverse physiological effects (24). Well-balanced vegetarian diets with dairy products and eggs are generally associated with good health. However, strict vegan diets may be inadequate in calories, vitamin B12, vitamin D, calcium, iron, protein and essential amino acids needed for growth and development (25). The more limited the diet, the greater the health risk. Given the health and nutrition risks associated with highly

restrictive diets, WIC can help the parent to assure that the child consumes an adequate diet to optimize health during critical periods of growth as well as for the long term.

425.7 Feeding dietary supplements with potentially harmful consequences.

A child consuming inappropriate or excessive amounts of single or multivitamin or mineral or herbal remedy not prescribed by a physician is at risk for a variety of adverse effects including harmful nutrient interactions, toxicity, and teratogenicity (1, 26). Like drugs, herbal or botanical preparations have chemical and biological activity, may have side effects, and may interact with certain medications--these interactions can cause problems and can even be dangerous (27). Botanical supplements are not necessarily safe because the safety of a botanical depends on many things, such as its chemical makeup, how it works in the body, how it is prepared, and the dose used (27). While some herbal teas may be safe, some have undesirable effects, particularly on young children who are fed herbal teas or who receive breast milk from mothers who have ingested herbal teas (28). Examples of teas with potentially harmful effects to children include: licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, pokeroot or pokeweed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Maté, kola nut or gotu cola, and chamomile (28-30).

425.8 Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.

Depending on a child's specific needs and environmental circumstances, certain dietary supplements may be recommended by the child's health care provider to ensure health. For example, fluoride supplements may be of benefit in reducing dental decay for children living in fluoride-deficient areas (1, 31). In addition, the AAP recommends that children who are ingesting less than 1 liter (1 quart) per day of vitamin D-fortified formula or milk, should receive a vitamin D supplement of 400 IU/day (32). Since 1 quart of milk is in excess of the recommended 2 cups of milk per day for preschool children (33), most children will require a vitamin D supplement.

425.9 Routine ingestion by child of nonfood items (pica).

Pica is the compulsive eating of nonnutritive substances and can have serious medical implications (33). Pica is observed most commonly in areas of low socioeconomic status and is more common in women (especially pregnant women) and in children (30). Pica has also been seen in children with obsessive-compulsive disorders, mental retardation, sickle cell disease (34-36). Complications of this disorder include iron-deficiency anemia, lead poisoning, intestinal obstruction, acute toxicity from soil contaminants, and helminthic infestations (34, 37, 38).

References

1. Committee on Nutrition, American Academy of Pediatrics. Pediatric nutrition handbook. 6th ed. Elk Grove Village, Ill: American Academy of Pediatrics, 2009.
2. American Academy of Pediatrics, Committee on Nutrition: Iron fortification of infant formula. Pediatrics 1999; 104:119-123.
3. Trahms CM, Pipes PL, editors. Nutrition in Infancy and Childhood. WCB/McGraw-Hill; 1997.
4. Bellioni-Businco B, Paganelli R, Lucenti P, Giampietro PG, Perborn H, Businco L. Allergenicity of goat's milk in children with cow's milk allergy. J Allergy Clin Immunol 1999;103:1191-1194.
5. Tamborlane, WV, editor. The Yale guide to children's nutrition. Connecticut: Yale University; 1997.
6. Tinanoff N, Palmer CA. Dietary determinants of dental caries and dietary recommendations for preschool children. J Public Health Dent 2000;60(3):197-206.
7. Williams, CP, editor. Pediatric manual of clinical dietetics. Chicago: American Dietetic Association; 1998.
8. Tang J, Altman DS, Robertson D, O'Sullivan DM, Douglass JM, Tinanoff N. Dental caries prevalence and treatment levels in Arizona preschool children. Public Health Rep 1997;112:319-29.
9. Satter E. Child of mine: Feeding with love and good sense. Palo Alto (CA): Bull Publishing Company; 2000.
10. American Academy of Pediatrics Committee on Nutrition: The use and misuse of fruit juice in pediatrics. Pediatrics 2001;107:1210-1213.
11. American Academy of Pediatrics and American Academy of Pedodontics. Juice in ready-to-use bottles and nursing bottle carries. AAP News. 1978;29(1):11.
12. Samour PQ, Helm KK, Lang CE. Handbook of pediatric nutrition. 2nd ed. Gaithersburg, MD: Aspen Publishers, Inc.; 1999.
13. Shelov SD. Caring for your baby and young child: birth to age 5. Elk Grove Village, IL: American Academy of Pediatrics; 1998.
14. American Academy of Pediatric Dentistry. Baby Bottle Tooth Decay/Early Childhood Caries. Pediatr Dent 2000-2001 (revised May 1996); 2001 Mar-Apr;23(2):18
15. Fitzsimons D, Dwyer JT, Palmer C, Boyd LD. Nutrition and oral health guidelines for pregnant women, infants, and children. J Am Diet Assoc. Feb 1998;98(2):182-6.
16. Satter, E. Childhood feeding problems. Feelings and Their Medical Significance; Vol. 32, no. 2; Columbus, OH; Ross Laboratories; 1990.
17. Satter EM. The feeding relationship. J.Am.Diet.Assoc. 1986;86:352-6.
18. Johnson SL, Birch LL. Parents' and children's adiposity and eating style. Pediatrics 1994;94:653-61.
19. Olson RE. Is it wise to restrict fat in the diets of children? J Am Diet Assoc 2000 Jan;100(1):28-32.
20. Birch LL, Fisher JO. Development of eating behaviors among children and adolescents. Pediatrics 1998;101:539-549.
21. Parish ME. Public health and nonpasteurized fruit juices. Crit Rev Microbiol. 1997;23:109-119.
22. Food Labeling. Warning and Notice Statement: Labeling of Juice Products; Final Rule. 63 Federal Register 37029-37056 (1998) (codified at 21 CFR §101, 120).
23. Food and Drug Administration. Updates: Avoid Raw Sprouts to Reduce Food Poisoning Risk, Agency Advises. FDA Consumer magazine, September-October 1999 (see: http://www.fda.gov/fdac/departs/1999/599_upd.html)
24. Institute of Medicine. WIC nutrition risk criteria a scientific assessment.

National Academy Press, Washington, D.C.; 1996.
25. Duyff RL. American Dietetic Association. The American Dietetic Association's complete food and nutrition guide. Minneapolis, MN: Chronimed Pub; 1996.
26. Anderson JV, Van Nierop MR. Basic nutrition facts a nutrition reference. Lansing, MI: Michigan Department of Public Health; 1989.
27. Office of Dietary Supplements, National Institutes of Health (NIH). Botanical Dietary Supplements: Background Information. NIH web page, last updated 7/7/2004, see: http://ods.od.nih.gov/factsheets/BotanicalBackground.asp
28. Lawrence, RA. Breastfeeding: a guide for the medical profession. 5th edition. St. Louis, MO: Mosby, 1999, pp. 371-377.
29. Siegel RK. Herbal intoxication: psychoactive effects from herbal cigarettes, tea and capsules. JAMA 236:473, 1976.
30. Ridker PM. Toxic effects of herbal teas. Arch Environ Health 42(3):133-6, 1987.
31. American Academy of Pediatric Dentistry. Fluoride. Pediatr Dent. 1999;21:40.
32. American Academy of Pediatrics Section on Breastfeeding and Committee
33. On Nutrition, Prevention of rickets and vitamin D deficiency in infants, children, and adolescents. Pediatrics 2008; www.pediatrics.org/cgi/doi/10.1542/peds.2008-162. Accessed 2/09.
34. U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.
35. My Pyramid for Preschoolers. http://mypyramid.gov/preschoolers/index.html. Accessed 3/09.
36. Rose EA, Porcerelli JH, Neale AV. Pica: common but commonly missed. J Am Board Fam Pract. 2000;13(5):353-8.
37. LeBlanc LA, Piazza CC, Krug MA. Comparing methods for maintaining the safety of a child with pica. Res Dev Disabil. 1997; 18(3):215-20.
38. Ivascu NS, et al. Characterization of pica prevalence among patients with sickle cell disease. Arch Pediatr Adoles Med 2001; 155(11):1243-7.
39. Calabrese EJ, et al. Soil ingestion: a concern for acute toxicity in children. Environ Health Perspect. 1997; 105(12):1354-8.
40. Wang PY, Skarsgard ED, Baker RJ. Carpet bezoar obstruction of the small intestine. J Pediatr Surg. 1996; 31(12):1691-3.

Additional Related References:

Food Safety and Inspection Service. Food Safety Focus: Molds On Food: Are They Dangerous? Electronic Consumer Education and Information. April 2002 (see: http://www.nutrition.gov/framesets/search.php3?mw=moldy+food&Submit=Go&url=Select+A+Topic&db=www&mt=all)

Food Safety and Inspection Service. FOCUS ON: Food Product Dating. Electronic Consumer Education and Information. Updated June 2001 (see: http://www.nutrition.gov/framesets/search.php3?mw=moldy+food&Submit=Go&url=Select+A+Topic&db=www&mt=all)

Nutrition Risk Criteria **427 INAPPROPRIATE NUTRITION PRACTICES (WOMEN)**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-

Definition

FORMERLY QUESTIONABLE DIET FOR WOMEN

Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. These practices with examples are outlined below. Refer to "Justification and References" for this criterion.

427.1 Consuming dietary supplements with potentially harmful consequences.

Examples of dietary supplements which when ingested in excess of recommended dosages, may be toxic or have harmful consequences:

- Single or multiple vitamins
- Mineral supplements
- Herbal or botanical supplements/remedies/teas

427.2 Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.

- Strict vegan diet
- Low-carbohydrate, high-protein diet
- Macrobiotic diet
- Any other diet restricting calories and/or essential nutrients

427.3 Compulsively ingesting non-food items (pica).

Non-food items:

- Ashes
- Baking soda
- Burnt matches
- Carpet fibers
- Chalk
- Cigarettes
- Clay
- Dust
- Large quantities of ice and/or freezer frost
- Paint chips
- Soil
- Starch (laundry and cornstarch)

427.4 Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.

- Consumption of less than 27 mg of iron as a supplement daily by pregnant woman
- Consumption of less than 150 mcg of supplemental iodine per day by pregnant and breastfeeding women
- Consumption of less than 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant woman

427.5 Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.

Potentially harmful foods:

- Raw fish or shellfish, including oysters, clams, mussels, and scallops
- Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole
- Raw or undercooked meat or poultry
- Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot
- Refrigerated pâté or meat spreads
- Unpasteurized milk or foods containing unpasteurized milk
- Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as made with pasteurized milk
- Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog
- Raw sprouts (alfalfa, clover, and radish)
- Unpasteurized fruit or vegetable juices

Required Documentation

Document which of the above behavior(s) is present in the participant file.

Justification

427.1 Consuming dietary supplements with potentially harmful consequences.

Women taking inappropriate or excessive amounts of dietary supplements such as, single or multivitamins or minerals, or botanical (including herbal) remedies or teas, are at risk for adverse effects such as harmful nutrient interactions, toxicity and teratogenicity (1, 2). Pregnant and lactating women are at higher risk secondary to the potential transference of harmful substances to their infant.

Most nutrient toxicities occur through excessive supplementation of particular nutrients, such as, vitamins A, B-6 and niacin, iron and selenium (3). Large doses of vitamin A may be teratogenic (4). Because of this risk, the Institute of Medicine recommends avoiding preformed vitamin A supplementation during the first trimester of pregnancy (4). Besides nutrient toxicities, nutrient-nutrient and drug-nutrient interactions may adversely affect health.

Many herbal and botanical remedies have cultural implications and are related to beliefs about pregnancy and breastfeeding. The incidence of herbal use in pregnancy ranges from 7% to 55% with echinacea and ginger being the most common (1). Some botanical (including herbal) teas may be safe; however, others have undesirable effects during pregnancy and breastfeeding. Herbal supplements such as, blue cohash and pennyroyal stimulate uterine contractions, which may increase the risk of miscarriage or premature labor (1, 5). The March of Dimes and the American Academy of Pediatrics recommend cautious use of tea mixtures because of the lack of safety testing in pregnant women (6).

427.2 Consuming a diet very low in calories and /or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.

Women consuming highly restrictive diets are at risk for primary nutrient deficiencies, especially during critical developmental periods such as pregnancy. Pregnant women who restrict their diets may increase the risk of birth defects, suboptimal fetal development and chronic health problems in their children. Examples of nutrients associated with negative health outcomes are:

- Low iron intake and maternal anemia and increased risk of preterm birth or low
  birth weight (7, 8).
- Low maternal vitamin D status and depressed infant vitamin D status (9)
- Low folic acid and NTD (10, 11, 12)

Low calorie intake during pregnancy may lead to inadequate prenatal weight gain, which is associated with infant intrauterine growth restriction (IUGR) (13) and birth defects (10, 11, 14). The pregnant adolescent who restricts her diet is of particular concern since her additional growth needs compete with the developing fetus and the physiological changes of pregnancy (14).

Strict vegan diets may be highly restrictive and result in nutrient deficiencies. Nutrients of potential concern that may require supplementation are:

- Riboflavin (15, 16)
- Iron (15)
- Zinc (15, 17)
- Vitamin B12 (15, 16, 18)
- Vitamin D (15, 16, 18)
- Calcium (15, 16, 18, 19)
- Selenium (16)

The pregnant adolescent who consumes a vegan diet is at even greater risk due to her higher nutritional needs (16, 18). The breastfeeding woman who chooses a vegan or macrobiotic diet increases her risk and her baby's risk for vitamin B12 deficiency (18). Severe vitamin B12 deficiency resulting in neurological damage has been reported in infants of vegetarian mothers (18).

With the epidemic of obesity, treatment by gastric bypass surgery has increased more than 600% in the last ten years and has created nutritional deficiencies not typically seen in obstetric or pediatric medical practices (20). Gastrointestinal surgery promotes weight loss by restricting food intake and, in some operations, interrupting the digestive process. Operations that only reduce stomach size are known as "restrictive operations" because they restrict the amount of food the stomach can hold. Examples of restrictive operations are adjustable gastric banding and vertical banded gastroplasty. These types of operations do not interfere with the normal digestive process (21).

Some operations combine stomach restriction with a partial bypass of the small intestine, these are known as malabsorptive operations. Examples of malabsorptive operations are Roux-en-y gastric bypass (RGB) and Biliopancreatic diversion (BPD). Malabsorptive operations carry a greater risk for nutritional deficiencies because the procedure causes food to bypass the duodenum and jejunum, where most of the iron and calcium are absorbed. Menstruating women may develop anemia because not enough iron and vitamin B12 are absorbed. Decreased absorption of calcium may also contribute to osteoporosis and metabolic bone disease (21). A breastfeeding woman who has had gastric bypass surgery is at risk of vitamin B12 deficiency for herself and her

infant (22).

427.3 Compulsively ingesting non-food items (pica).

Pica, the compulsive ingestion of non-food substances over a sustained period of time, is linked to lead poisoning and exposure to other toxicants, anemia, excess calories or displacement of nutrients, gastric and small bowel obstruction, as well as, parasitic infection (23). It may also contribute to nutrient deficiencies by either inhibiting absorption or displacing nutrient dense foods in the diet.

Poor pregnancy outcomes associated with pica-induced lead poisoning, include lower maternal hemoglobin level at delivery (24) and a smaller head circumference in the infant (25). Maternal transfer of lead via breastfeeding has been documented in infants and can result in a neuro-developmental insult depending on the blood lead level and the compounded exposure for the infant during pregnancy and breastfeeding (26, 27, 28).

427.4 Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.

The Recommended Dietary Allowance (RDA) for pregnant women is 27 mg of iron per day (29). The Centers for Disease Control and Prevention recommends iron supplementation for all pregnant women to prevent iron deficiency (30); however, pregnant women should seek guidance from a qualified health care provider before taking dietary supplements (31).

During pregnancy and lactation the iodine requirement is sharply elevated. The RDA for iodine during pregnancy is 220 mcg and 290 mcg during lactation (29). Severe iodine deficiency during pregnancy can cause cretinism and adversely affect cognitive development in children (32). Even mild iodine deficiency may have adverse affects on the cognitive function of children (33). Since the 1970s, according to the 2001-2002 National Health and Nutrition Examination Surveys (NHANES), there has been a decrease of approximately 50% in adult urinary iodine values. For women of child bearing age, the median urinary iodine value decreased from 294 to 128 mcg per liter (34). The American Thyroid Association recommends that women receive prenatal vitamins containing 150 mcg of iodine daily during pregnancy and lactation (35). The iodine content of prenatal vitamins in the United States is not mandated, thus not all prenatal vitamins contain iodine (36). Pregnant and breastfeeding women should be advised to review the iodine content of their vitamins and discuss the adequacy of the iodine with their health care provider.

Non-pregnant women of childbearing age who do not consume adequate amounts of folic acid are at greater risk for functional folate deficiency, which has been proven to cause neural tube defects (NTDs), such as, spina bifida and anencephaly (37-40).

Folic acid consumed from fortified foods and/or a vitamin supplement in addition to folate found naturally in food reduces this risk (12). The terms “folic acid” and “folate” are used interchangeably, yet they have different meanings. Folic acid is the synthetic form used in vitamin supplements and fortified foods (12, 38, 39). Folate occurs naturally and is found in foods, such as dark green leafy vegetables, strawberries, and orange juice (12).

Studies show that consuming 400 mcg of folic acid daily interconceptionally can prevent 50 percent of neural tube defects (12). Because NTDs develop early in

pregnancy (between the 17th and 30th day) and many pregnancies are not planned, it is important to have adequate intakes before pregnancy and throughout the childbearing years (14). NTDs often occur before women know they are pregnant. It is recommended that all women capable of becoming pregnant consume a multivitamin containing 400 mcg of folic acid daily (39-41). It is important that breastfeeding and non-breastfeeding women participating in the WIC Program know about folic acid and foods that contain folate to encourage preconceptional preventive practices (38).

427.5 Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.

Foodborne illness is a serious public health problem (42). The causes include pathogenic microorganisms (bacteria, viruses, and parasites) and their toxins and chemical contamination. The symptoms are usually gastrointestinal in nature (vomiting, diarrhea, and abdominal pain), but neurological and "non-specific" symptoms may occur as well. Over the last 20 years, certain foods have been linked to outbreaks of food-borne illness. These foods include: milk (Campylobacter); shellfish (Norwalk-like viruses), unpasteurized apple cider (Escherichia coli O 157:H7); eggs (Salmonella); fish (ciguatera poisoning); raspberries (Cyclospora); strawberries (Hepatitis A virus); and ready-to-eat meats (Listeria monocytogenes).

Listeria monocytogenes can cause an illness called listeriosis. Listeriosis during pregnancy can result in premature delivery, miscarriage, fetal death, and severe illness or death of a newborn from the infection (43). Listeriosis can be transmitted to the fetus through the placenta even if the mother is not showing signs of illness.

Pregnant women are especially at risk for food-borne illness. For this reason, government agencies such as the Centers for Disease Control and Prevention, the USDA Food Safety and Inspection Service, and the Food and Drug Administration advise pregnant women and other high risk individuals not to eat foods as identified in the definition for this criterion (42, 43).

The CDC encourages health care professionals to provide anticipatory guidance, including the "four simple steps to food safety" of the Fight BAC campaign, to help reduce the incidence of food-borne illnesses.

References

1. Tiran D. The use of herbs by pregnant and childbearing women: a risk-benefit assessment. Complementary Therapies in Nursing and Midwifery. November 2003. 9(4):176-181.
2. Position of the American Dietetic Association: Nutrition and lifestyle for a healthy pregnancy outcome. J Am Diet Assoc. 2002 October;102(10):1479-1490.
3. Position of the American Dietetic Association: Food fortification and dietary supplements. J Am Diet Assoc. January 2001.
4. Langkamp-Henken B, Lukowski MJ, Turner RE, Voyles LM. High levels of retinol intake during the first trimester of pregnancy result from use of over-the-counter vitamin/mineral supplements. J Am Diet Assoc. September 2000.
5. March of Dimes (homepage on the Internet). New York: Herbal Supplements: heir Safety, a Concern for Health Care Providers. [cited May 26, 2004] Available from: http://www.marchofdimes.com
6. American Academy of Pediatrics, Committee on Nutrition. Pediatric Nutrition

Handbook. 5th ed. Kleinman, Ronald, editor. Washington DC: American Academy of Pediatrics; 2004.
7. Recommendations to prevent and control iron deficiency in the United States. MMWR [serial on the Internet]. 1998 April [cited 2004 March 12]. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/00051880.htm.
8. Rasmussen, K. M. Is there a causal relationship between iron deficiency or iron-deficiency anemia and weight at birth, length of gestation and perinatal mortality? American Society for Nutritional Sciences. 2001;590S-603S.
9. Scanlon KS, editor. Vitamin D expert panel meeting; October 11-12, 2001; Atlanta, Georgia. Available from: http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/Vitamin D Expert Panel Meeting.pdf.
10. Carmichael SL, Shaw GM, Schaffer DM, Selvin S. Diet quality and risk of neural tube defects. Medical Hypotheses. 2003;60(3):351-355.
11. Shaw GM, Todoroff K, Carmichael SL, Schaffer DM, Selvin S. Lowered weight gain during pregnancy and risk of neural tube defects among offspring. Int J Epidemiol. 2001; 30:60-65.
12. American Academy of Pediatrics, Committee on Genetics. Folic acid for the prevention of neural tube defects. Pediatrics.1999; 104(2):325-327.
13. Strauss RS, Dietz WH. Low maternal weight gain in the second and third trimester increases the risk for intrauterine growth retardation. American Society for Nutritional Sciences. 1999; 988-993.
14. Scholl TO, Hediger ML, Ances IG. Maternal growth during pregnancy and decreased infant birth weight. Am J Clin Nutr. 1990;51:790-793.
15. Position of the American Dietetic Association and Dietitians of Canada: Vegetarian diets. J Am Diet Assoc. 2003; 103(6):748-765.
16. Larsson CL, Johansson GK. Dietary intake and nutritional status of young vegans and omnivores in Sweden. Am J Clin Nutr. 2002; 76:100-106.
17. Bakan R, Birmingham CL, Aeberhardt L, Goldner EM. Dietary zinc intake of vegetarian and nonvegetarian patients with anorexia nervosa. International Journal of Eating Disorders. 1993;13(2):229-233.
18. Specker, Bonny L., Nutritional concerns of lactating women consuming vegetarian diets. Am J Clin Nutr. 1994:59(suppl):1182-1186.
19. Heaney RP, Dowell MS, Rafferty K, Bierman J. Bioavailability of the calcium in fortified soy imitation milk, with some observation on method. Am J Clin Nutr. 2000;71:1166-1169.
20. Steinbrook, R. Surgery for severe obesity. N Engl J Med. 2004; 350(11):1075-9.
21. National Institute of Diabetes and Digestive and Kidney Diseases. Gastrointestinal Surgery for Severe Obesity. [cited August 18, 2004] Available from: http://www.niddk.nih.gov/health/nutrit/pubs/gastric/gastricsurgery.htm
22. Grange DK, Finlay JL. Nutritional vitamin B12 deficiency in a breastfed infant following maternal gastric bypass. Pediatr Hematol Oncol. 1994; 11(3):311-8.
23. Corbett RW, Ryan C, Weinrich SP. Pica in pregnancy: does it affect pregnancy outcomes? American Journal of Maternal and Child Nursing. 2003;28(3):183-189.
24. Rainville AJ. Pica practices of pregnant women are associated with lower maternal hemoglobin level at delivery. J Am Diet Assoc. 1998;98(3): 293-6.
25. Institute of Medicine: WIC Nutrition Risk Criteria: A Scientific Assessment; 1996; pp.270-272.
26. Gulson, Brian L., et. al., Relationships of lead in breast milk to lead in blood, urine, and diet of infant and mother. Environmental Health Perspectives. 1998:106(10): 667-674.
27. Ping-Jian L, Ye-Zhou S, Qian-Ying W, Li-Ya G, Yi-Land W. Transfer of lead

via placenta and breast milk in human. Biomedical and Environmental Sciences. 2000; 13:85-89.
28. Canfield, RL, Henderson, C, Cory-Slecha, D, Cox, C, Jusko, T, Lanphear, B. Intellectual impairment in children with blood lead concentrations below 10 mcg per deciliter. N Engl J Med. 2003;348(16):1517-1526.
29. Institute of Medicine. Dietary reference intakes for vitamin A, vitamin K, arsenic, Boron, chromium, copper, iodine, iron, manganese, molybdenum, nickel, silicon, vanadium and zinc. Food and Nutrition Board, Washington, DC: National Academy Press; 2001.
30. Centers for Disease Control and Prevention. Recommendations to prevent and control iron deficiency in the United States. MMWR 1998:RR-3.
31. U.S. National Library of Medicine and National Institutes of Health. Drugs and supplements: iron. Medline Plus. http://www.nlm.nih.gov/medlineplus/druginfo/natural/patient-iron.html#Satety. Accessed May 2009.
32. Zimmerman MB. Iodine deficiency in pregnancy and effects of maternal iodine supplementation on the offspring: a review. Am J Clin Nutr 2009;8 (suppl:668S-72S).
33. de Escobar DM, Obregon MJ, del Rey FF. maternal thyroid hormones early in pregnancy and fetal brain development. Best Pract Res Clin Endoriconl Metab 2004;18:225-48.
34. Caldwell KL, Miller GA, Wang RY, Jain RB, Jones, RL. Iodine status of the U.S. population, National Health and Nutrition Examination Survey 2003-2004. Thyroid 2008;18:1207-14.
35. Becker DV, Braverman LE, Delange F, et al. Iodine supplementation for pregnancy and lactation – United States and Canada: recommendations of the American Thyroid Association. Thyroid 2006;16:949-51.
36. Leung AM, Pearce EN, Braverman, LE. Iodine content of prenatal vitamins in the United States. N Engl J Med 2009;360-9.
37. Centers for Disease Control and Prevention, Division of Birth Defects and Developmental Disabilities. Folic acid and the prevention of spina bifida and anencephaly: 10 years after the U.S. Public Health Service recommendation. MMWR 2002;51:(RR-13)1-3.
38. Centers for Disease Control and Prevention. National Center for Environmental Health, Division of Birth Defects and Developmental Disabilities. Preventing neural tube birth defects: a prevention model and resource guide. Atlanta: CDC, 1998.
39. Centers for Disease Control and Prevention. Recommendations for the use of folic acid to reduce the number of cases of spina bifida and other neural tube defects. MMWR 1992;41:RR-14.
40. Evans MI, Llurba E, Landsberger EJ, O'Brien JE, Harrison HH. Impact of folic acid fortification the Untied States: markedly diminish high maternal serum alpha-fetoprotein values. Am Col Obstetr Gynecol. 2004;103(3):447.
41. Chacko MR, Anding R, Kozinetz CA, Grover JL. Neural tube defects: knowledge and preconceptional prevention practices in minority young women. Pediatrics. 2003;112(3):536-542.
42. Centers for Disease Control and Prevention, Diagnosis and Management of Foodborne Illness, A Primer for Physicians. MMWR 2001;50:RR-2.
43. Food Safety and Inspection Service, USDA. Listeriosis and Pregnancy: What is Your Risk? [cited August 11, 2004] Available from: http://www.fsis.usda.gov.

Websites for additional information:

427.1 References - Supplements/Herbs

http://www.marchofdimes.com
http://www.dietary-supplements.info.nih.gov/
http://www.vm.cfsan.fda.gov/
http://www.herbalgram.org

427.2 References - Highly Restrictive Eating/ Nutrient Malabsorption
http://www.eatright.org
http://www.nimh.nih.gov
http://www.eatright.org/
http://www.llu.edu/llu/vegetarian/
http://www.nal.usda.gov/fnic/pubs/bibs/gen/vegetarian.htm
http://www.gastric-bypass-treatment.com/long-term-weight-loss-surgery-compications.aspx

427.3 References - Non-Food Ingestion
http://www.nieh.nih.gov/
http://www.epa.gov/

427.4 References - Folic Acid
http://www.cdc.gov/
http://www.aap.org/
http://www.iom.edu/

427.5 References - Listeriosis
http://www.cdc.gov/foodsafety
http://www.cdc.gov/ncidod/dbmd/diseaseinfo/listeriosis_g.htm
http://www.cfsan.fda.gov
http://www.foodsafety.gov
http://www.fightbac.org
http://www.ific.org

Nutrition Risk Criteria **428** **DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES**

Category, Priority and Referral

Category	Priority	Referral
INFANTS 4 TO 12 MONTHS	4	-
CHILDREN 12 THROUGH 23 MONTHS	5	-

Definition

An infant or child who has begun to or is expected to begin to 1) consume complementary foods and beverages, 2) eat independently, 3) be weaned from breast milk or infant formula, or 4) transition from a diet based on infant/toddler foods to one based on the *Dietary Guidelines for Americans*, is at risk of inappropriate complementary feeding.

A complete nutrition assessment, including for risk #46, Inappropriate Nutrition Practices for Infants, or #47, Inappropriate Nutrition Practices for Children, must be completed prior to assigning this risk.

Required Documentation

Complete Nutrition Assessment

Justification

Overview

Complementary feeding is the gradual addition of foods and beverages to the diet of the infant and young child. (1, 2) The process of adding complementary foods should reflect the physical, intellectual, and behavioral stages as well as the nutrient needs of the infant or child. Inappropriate complementary feeding practices are common and well documented in the literature. Caregivers often do not recognize signs of developmental readiness and, therefore, offer foods and beverages that may be inappropriate in type, amount, consistency, or texture. Furthermore, a lack of nationally accepted feeding guidelines for children under the age of two might lead caregivers to assume that all foods are suitable for this age range.

The 2000 WIC Participant and Program Characteristics study (PC 2000) shows greater percentages of anthropometric and biochemical risk factors in children ages 6 to 24 months than in children 24 to 60 months of age. (3)
These differences could reflect physical manifestations of inappropriate complementary feeding practices. Although PC 2000 shows a lower dietary risk in the 6 to 24 month age group, this risk is probably under-reported due to the high incidence of other higher priority nutrition risks.

AGE	ANTHOPOMETRIC RISK (%)	BIOCHEMICAL RISK (%)	DIETARY RISK (%)
6-11 MOS	40	16	55
1 YEAR	41	14	76
2 YEAR	37	12	80
3 YEAR	32	9	80
4 YEAR	35	7	79

The Institute of Medicine (IOM), in their report, *Summary of Proposed Criteria for Selecting the WIC Food Packages* identified specific nutrients with potential for inadequacy or excess for WIC participants. For breast-fed infants 6 through 11

months, the nutrients of concern for potential inadequacy are iron and zinc while those for children 12 through 23 months are iron, vitamin E, fiber and potassium. The nutrients of concern for excessive intake in children 12 through 23 months are zinc, preformed vitamin A, sodium and energy. (4)

To manage complementary feeding successfully, caregivers must make decisions about what, when, where, and how to offer foods according to the infant's or child's:

- Requirement for energy and nutrients;
- Fine, gross, and oral motor skills;
- Emerging independence and desire to learn to self-feed; and
- Need to learn healthy eating habits through exposure to a variety of nutritious foods. (1, 2, 5, 6, 7)

How WIC Can Help

The WIC Program plays a key role not only in the **prevention** of nutrition-related health problems, but also in the **promotion** of lifelong healthy eating behaviors. The process of introducing complementary foods provides a unique opportunity for WIC staff to assist caregivers in making appropriate feeding decisions for young children that may have lifelong implications.

Prevention of Nutrition-Related Health Problems

- Zinc deficiency: Zinc is critical for growth and immunity, as well as brain development and function. The concentration of zinc in breast milk declines to a level considered inadequate to meet the needs of infants 7 to 12 months of age. (8, 9) Complementary food sources of zinc, such as meats or zinc-fortified infant cereals, should be introduced to exclusively breastfed infants by 7 months.

- Iron deficiency: Hallberg states, "The weaning period in infants is especially critical because of the especially high iron requirements and the importance of adequate iron nutrition during this crucial period of development."(10) According to the Centers for Disease Control and Prevention (CDC), children less than 24 months of age, especially those between 9 and 18 months, have the highest rate of iron deficiency of any age group. (11) In the third National Health and Nutrition Examination Survey (NHANES III), children ages 1 to 2, along with adolescent girls, had the highest rates of overt anemia, while 9 % were iron deficient. (12) Meanwhile, the Pediatric Nutrition Surveillance 2003 Report noted anemia rates of 16.2 % in 6 to 11 month-old infants, 15.0 % in 12 to 17 month-olds, and 13.5 % in 18-23 month old children. (13)

  Picciano et al. reported that the intake of iron decreased from 98% of the recommended amount at 12 months to 76% at 18 months of age. (14) In WIC clinics, Kahn et al. found that the incidence of anemia was significantly more common in 6 to 23 month old children than in 23 to 59 month-olds. The 6 to 23 month-old was also more likely than the older child to develop anemia despite a normal hemoglobin test at WIC certification. (15)

Clarification

Feeding practices that may prevent iron deficiency include:

- Breastfeeding infants exclusively until 4 to 6 months of age;
- Feeding only iron-fortified infant formula as a substitute for or supplement to breast milk until age 1;
- Offering a supplemental food source of iron to infants, between 4 to 6 months or when developmentally ready;
- Avoiding cow's milk until age 12 months; and
- Limiting milk consumption to no more than 24 oz per day for children aged 1 to 5 years. (11)

- Obesity: Much of the literature on obesity indicates that learned behaviors and attitudes toward food consumption are major contributing factors. Proskitt states, "The main long term effect of weaning on nutritional status could be through attitudes toward food and meals learned by infants through the weaning process. This may be a truly critical area for the impact of feeding on later obesity." (16)

  Birch and Fisher state, "An enormous amount of learning about food and eating occurs during the transition from the exclusive milk diet of infancy to the omnivore's diet consumed by early childhood." The authors believe that parents have the greatest influence on assuring eating behaviors that help to prevent future overweight and obesity. (17)

  The American Academy of Pediatrics (AAP) states, "…prevention of overweight is critical, because long-term outcome data for successful treatment approaches are limited…" and, "Families should be educated and empowered through anticipatory guidance to recognize the impact they have on their children's development through lifelong habits of physical activity and nutritious eating." (1) Parents can be reminded that they are role models and teachers who help their children adopt healthful eating and lifestyle practices.

- Tooth decay: Children under the age of 2 are particularly susceptible to Early Childhood Caries (ECC), a serious public health problem. (18) In some communities, the incidence of ECC can range from 20% to 50%. (19) Children with ECC appear to be more susceptible to caries in permanent teeth at a later age. (1, 20)

  Dental caries can be caused by many factors, including prolonged use of a bottle and extensive use of sweet and sticky foods. (21)
  The Avon Longitudinal Study of Pregnancy and Childhood examined 1,026 children aged 18 months and found that baby bottles were used exclusively for drinking by 10 % of the children and for at least one feeding by 64% of the children. Lower income families were found to use the bottle more frequently for carbonated beverages than higher income families. (22)

  Complementary feeding practices that caregivers can use to prevent oral health problems include:
  - Avoiding concentrated sweet foods like lollipops, candy and sweetened cereals
  - Avoiding sweetened beverages. Introducing fruit juice after 6 months of age (1) and only feeding it in a cup; and limiting fruit juice to 4-6 oz/day
  - Weaning from a bottle to a cup by 12 to 14 months (23)

Promotion of Lifelong Healthy Eating Behaviors

- Timing of introduction of complementary foods:
  The AAP, Committee on Nutrition (CON) states that, "… complementary foods may be introduced between ages 4 and 6 months…" but cautions that actual timing of introduction of complementary foods for an individual infant may differ from this (population based) recommendation. Furthermore, the AAP-CON acknowledges a difference of opinion with the AAP, Section on Breastfeeding, which recommends exclusive breastfeeding for at least 6 months. (1)

  Early introduction of complementary foods before the infant is developmentally ready (i.e., before 4-6 months of age) is associated with increased respiratory illness, allergy in high-risk infants, and decreased breast milk production (7).

  Infants with a strong family history of food allergy should be breastfed for as long as possible and should not receive complementary foods until 6 months of age. The introduction of the major food allergens such as eggs, milk, wheat, soy, peanuts, tree nuts, fish and shellfish should be delayed until well after the first year of life as guided by the health care provider. (7, 24)

  Delayed introduction of complementary foods, on the other hand, is also associated with feeding difficulties. Northstone et al found that introduction of textured foods after 10 months of age resulted in more feeding difficulties later on, such as picky eating and/or refusal of many foods. To avoid these and other developmental problems, solid foods should be introduced no later than 7 months, and finger foods between 7 and 9 months of age. (25)

- Choosing Appropriate Complementary Foods and Beverages:
  Complementary foods should supply essential nutrients and be developmentally appropriate. (7) The WIC Infant Feeding Practices Study (WIC-IFPS) found that by 6 months of age, greater than 80% of mothers introduced inappropriate dairy foods (i.e., yogurt, cheese, ice cream and pudding), 60% introduced sweets/snack foods (defined as chips, pretzels, candy, cookies, jam and honey), and 90% introduced high protein foods (beans, eggs and peanut butter) to their infants. This study also found that, among the infants who received supplemental drinks by 5 months of age, three-quarters had never used a cup, concluding that most infants received supplemental drinks from the bottle. By one year of age, almost 90% of WIC infants received sweetened beverages and over 90% received sweet/snack foods. (26)

  The Feeding Infants and Toddlers Study (FITS) found that WIC infants and toddlers consumed excess energy but inadequate amounts of fruits and vegetables. In addition, WIC toddlers consumed more sweets, desserts and sweetened beverages than non-WIC toddlers. (27)

  Sixty-five percent of all food-related choking deaths occur in children under the age of 2. Children in this age group have not fully developed their oral-motor skills for chewing and swallowing. For this reason, they should be fed foods of an appropriate consistency, size, and shape. Foods commonly implicated in choking include hot dogs, hard, gooey or sticky candy, nuts and seeds, chewing gum, grapes, raisins, popcorn,
  peanut butter and hard pieces of raw fruits and vegetables and chunks of meat or cheese. (1, 28, 29)

- Introducing a cup: Teaching an infant to drink from a cup is part of the process of acquiring independent eating skills. A delay in the initiation of cup drinking prolongs the use of the nursing bottle that can lead to excess milk and juice intake and possible Early Childhood Caries (ECC). Weaning from a bottle to a cup should occur by 12 to14 months of age. (23)

- Helping the child establish lifelong healthy eating patterns:
  Lifelong eating practices may have their roots in the early years. Birch and Fisher state that food exposure and accessibility, the modeling behavior of parents and siblings, and the level of parental control over food consumption influence a child's food preferences. Inappropriate feeding practices may result in under- or over-feeding and may promote negative associations with eating that continue into later life.

  Normal eating behaviors such as spitting out or gagging on unfamiliar food or food with texture are often misinterpreted as dislikes or intolerances leading to a diminished variety of foods offered. Infants have an innate preference for sweet and salty tastes. Without guidance, an infant may develop a lifelong preference for highly sweetened or salty foods rather than for a varied diet. (17)

  A young child gradually moves from the limited infant/toddler diet to daily multiple servings from each of the basic food groups as described in the Dietary Guidelines. (30) The toddler stage (ages 1-2 years) may frustrate caregivers since many toddlers have constantly changing food preferences and erratic appetites. In addition, toddlers become skeptical about new foods and may need to experience a food 15-20 times before accepting it. (31)

  Caregivers can be guided and supported in managing common toddler feeding problems. Feeding practices that caregivers can use to facilitate a successful transition to a food group-based diet include:
  - Offering a variety of developmentally appropriate nutritious foods
  - Reducing exposure to foods and beverages containing high levels of salt and sugar
  - Preparing meals that are pleasing to the eye and include a variety of colors and textures, setting a good example by eating a variety of foods;
  - Offering only whole milk from age 1-2 (lower fat milk can be introduced after that age)
  - Providing structure by scheduling regular meal and snack times
  - Allowing the child to decide how much or whether to eat
  - Allowing the child to develop eating/self-feeding skills
  - Eating with the child in a pleasant mealtime environment without coercion

References

1. American Academy of Pediatrics. Committee on Nutrition. Kleinman RE, editor. Pediatric Nutrition Handbook. 5th ed. 2004.
2. Pelto GH, Levitt E, and Thairu L. Improving feeding practices: Current patterns, common constraints, and the design of interventions. Food and Nutrition Bulletin, 2003; 24(1): 45-82.
3. United States Department of Agriculture. Study of WIC participant and program characteristics. 2000.
4. Institute of Medicine. Food and Nutrition Board. Proposed criteria for selecting the WIC food packages. The National Academies Press, Washington DC, 2004.

5. Hervada AR, Hervada-Page M. Infant Nutrition: The first two years. In: Childhood Nutrition. Lifshitz F, editor. CRC Press; 1995.
6. Pipes PL, Trahms CM. Nutrient needs of infants and children. In: PipesPL, Trahms CM editors. Nutrition in infancy and childhood 5th ed. Mosby Publishing Co. 1993.
7. Hendricks KM, Weaning: Pathophysiology, practice and policy. In: Nutrition in Pediatrics, 3rd edition. B.C. Decker Inc, 2003.
8. Institute of Medicine. Food and Nutrition Board. Dietary reference intakes for vitamin A, vitamin K, arsenic, boron, chromium, copper, iodine, iron, manganese, molybdenum, nickel, silicon, vanadium and zinc. National Academies Press, Washington DC, 2001.
9. Clinical Nutrition Services; Warren Grant Magnuson Clinical Center, Office of Dietary Supplements. Facts about dietary supplements: zinc. National Institutes of Health. Bethesda Maryland; 2002.
10. Hallberg L. Perspectives on nutritional iron deficiency. Annu Rev Nutr. 2001; 21:1-21.
11. Centers for Disease Control and Prevention. Recommendations to prevent and control iron deficiency in the United States. MMWR. April 1998:18-21.
12. Looker AC, Dallman PR, Carroll MD, Gunter EW, Johnson CL. Prevalence of iron deficiency in the United States. JAMA. 1997; 277:973-6.
13. Centers for Disease Control and Prevention. Pediatric surveillance system 2003 annual report, Atlanta: U.S. Department of Health and Human Services, Center for Disease Control and Prevention, 2004. Available at http://www.cdc.gov/pednss (accessed 11/04).
14. Picciano MF, Smiciklas-Wright H, Birch LL, Mitchel DC, Murray-Kolb L, McConchy KL. Nutritional guidance is needed during dietary transition in early childhood. Ped. 2000; 106: 109-114.
15. Kahn JL, Binns HJ, Chen T, Tanz RR, Listernick R. Persistence and emergence of anemia in children during participation in the Special Supplemental Nutrition Program for Women, Infants, and Children. Arch Pediatr Adolesc Med. 2002; 156:1028-32.
16. Proskitt EM. Early feeding and obesity. In: Boulton J, Laron Z and Rey J, editors. Long-term consequences of early feeding. Nestle Nutrition Workshops Series; 1996, Nestle Ltd., Vevey/Lippincott-Raven Publishers, Philadelphia; Vol. 36.
17. Birch LL, Fisher JO. Development of eating behaviors among children and adolescents. Ped. 1998; 101:539-549.
18. Bertness J, Holt K, editors. Promoting awareness, preventing pain: Facts on early childhood caries (ECC) 2nd. Ed. [Fact Sheet on the Internet]. Washington (DC); National Maternal & Child Oral Health Resource Center; 2004. Available from: http://www.mchoralhealth.org.
19. American Academy of Pediatric Dentistry. Baby bottle tooth decay/early childhood caries. Pediatr Dent. 2001 Mar-Apr; 23 (2): 18.
20. al-Shalan TA, Erickson PR, Hardie NA. Primary incisor decay before age 4 as a risk factor for future dental caries. J Pediatr Dent. 1997 Jan-Feb; 9 (1): 37-41.
21. Casamassimo P ed. 1996. Bright futures in practice: oral health. Arlington, VA: National Center for Education in Maternal and Child Health.
22. Northstone K, Rogers I, Emmett P. Drinks consumed by 18-month-old children: Are current recommendations being followed? Eur J Clin Nutr. 2002; 56:236-44.
23. American Academy of Pediatric Dentistry. Policy on early childhood caries (EEC): Classifications, consequences, and prevention strategies. Pediatr Dent; Reference manual 2003-2004: 2004; 25(7):25
24. Butte N, Cobb K, Dwyer J, Graney L, Heird W, Rickard K. The start healthy feeding guidelines for infants and toddlers. J Am Diet Assoc, 2004; 104 (3)

442-454.
25. Northstone, K, Emmett P, Nethersole F. The effect of age of introduction to lumpy solids on foods eaten and reported difficulties at 6 and 15 months. J Hum Nutr Dietet. 2001; 14: 43-54.
26. Baydar N, McCann M, Williams R, Vesper E, McKinney P. WIC infant feeding practices study. USDA Office of Analysis and Evaluation. November 1997.
27. Ponza M, Devaney B, Ziegler P, Reidy K, and Squatrito C. Nutrient intake and food choices of infants and toddlers participating in WIC. J Am Diet Assoc 2004; 104: s71-s79.
28. Harris CS, Baker SP, Smith GA, Harris RM. Childhood asphyxiation by food: A national analysis and overview. JAMA. 1984; 251:2231-5.
29. Lucas B. Normal nutrition from infancy through adolescence. In: Handbook of pediatric nutrition. 2nd ed. Gaithersburg, Maryland: Aspen Publishers, Inc. 1999.
30. United States Department of Agriculture and the United States Department of Health and Human Services. Dietary guidelines for Americans, 5th ed. 2000. Available from:http://www.usda.gov.cnpp.
31. Story M, Holt K, Sofka D, editors. Bright futures in practice: nutrition. 2nd ed. Arlington, VA: National Center for Education in Maternal and Child Health; 2002.

Nutrition Risk Criteria **501 POSSIBILITY OF REGRESSION**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	1	
NON-BREASTFEEDING WOMEN	6	
INFANTS	1	
CHILDREN	3	

Definition

A participant who has previously been certified eligible for the Program may be considered to be at nutritional risk in the next certification period if the competent professional authority determines there is a possibility of regression in nutritional status without the benefits that the WIC Program provides.

***Possibility of Regression may not be used for consecutive certifications.**

***Use when no other risk can be identified. This code is the only code the participant has when used.**

Required Documentation

Document in participant file what previous risk code qualifies the applicant for regression risk use.

Justification

On occasion, a participant's nutritional status may be improved, to the point that s/he rises slightly above the cutoff of the initial risk condition by the end of the certification period. This occurs most frequently with those conditions that contain specific cutoffs or thresholds, such as anemia or inappropriate growth. Removal of such individuals from the Program can result in a "revolving-door" situation where the individual's recently improved nutritional status deteriorates quickly, so that s/he then re-enters the Program at equal or greater nutrition risk status than before. Therefore, WIC Program regulations permit State agencies to certify previously certified individuals who do not demonstrate a current nutrition risk condition against the possibility of their reverting to the prior existing risk condition if they do not continue to receive WIC benefits. This policy is consistent with the preventive nature of the WIC Program, and enables State and local agencies to ensure that their previous efforts to improve a participant's nutrition status, as well as to provide referrals to other health care, social service, and/or public assistance programs are not wasted.

Competent Professional Authorities and other certifying staff should keep in mind that every nutrition risk condition does not necessarily lead itself to the possibility of regression. For example, gestational diabetes or gingivitis of pregnancy are not conditions to which a new mother could regress, since they are directly associated with pregnancy, and the breastfeeding or non-breastfeeding women cannot regress to being pregnant if she is no longer receiving WIC benefits.

Clarification

After April 1, 1999, any certification for regression must be based on the new set of risk criteria. For example, a person deemed anemic under a State’s more inclusive criteria prior to April 1, 1999, may only be certified for regression after April 1, 1999, if his/her blood values would have met the revised CDC criteria for anemia published in the April 1998 MMWR tables.

Further, regression may only be used as a certifying nutrition risk when it

complies with the policies established by the State agency for its use, as set forth in the WIC Nutrition Services Standards issued by FNS in 1988. Such policies must include:

1. A requirement for a nutritional assessment to rule out the existence of another current risk factor before using eligibility on regression.
2. A requirement for written identification of the risk factor to which the participant may regress.
3. A list of risk factors and priority levels for which eligibility based regression may be applied; and
4. A limit on the number of times regression for a given risk factor may be consecutively applied.

References

WIC Program Regulations, Sect. 246.7(e)(1)(iii).

Nutrition Risk Criteria **502★ TRANSFER OF CERTIFICATION**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	as needed
BREASTFEEDING WOMEN	4	“
NON-BREASTFEEDING WOMEN	6	“
INFANTS	4	“
CHILDREN	5	“

Definition

Person with current valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants.

This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving State agency.

Required Documentation

VOC document from the certifying WIC clinic*

*See policy related to VOC transfers for more information

Justification

Local agencies must accept Verification of Certification (VOC) documents from participants. A person with a valid VOC document shall not be denied participation in the receiving State because the person does not meet that State’s particular eligibility criteria. Once a WIC participant has been certified by a local agency, the service delivery area into which s/he moves is obligated to honor that commitment.

References

1. FNS Instruction 803-11, Rev.1.
2. WIC Program Regulations; Section 246.7(k).

Nutrition Risk Criteria **601** **BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	1, 2, or 4* *Must be the same priority as at-risk infant.	-

Definition

A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk.

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Special attention should therefore be given to the health and nutritional status of the mother (5). Lactation requires an additional approximately 500 Kcal per day as increased protein, calcium, and other vitamins and minerals (3,1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1).

References

1. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.
2. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.
3. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.
4. WIC Program Regulations, Sect. 246.7(e)(1)(iii).
5. Worthington-Roberts BS, Williams SR. Nutrition in Pregnancy and Lactation. St. Louis: Mosby, 1993.

Nutrition Risk Criteria **602 BREASTFEEDING COMPLICATIONS (WOMEN)**

Category, Priority and Referral

Category	Priority	Referral
BREASTFEEDING WOMEN	4	RD/LC

Definition

A breastfeeding woman with any of the following complications or potential complications for breastfeeding:

- Severe breast engorgement
- Recurrent plugged ducts
- Mastitis (fever or flu-like symptoms with localized breast tenderness)
- Flat or inverted nipples
- Cracked, bleeding or severely sore nipples
- Age ≥ 40 years
- Failure of milk to come in by 4 days postpartum
- Tandem nursing (breastfeeding two siblings who are not twins)

Required Documentation

Justification

- Severe engorgement is often caused by infrequent nursing and/or ineffective removal of milk. This severe breast congestion causes the nipple-areola area to become flattened and tense, making it difficult for the baby to latch-on correctly. The result can be sore, damaged nipples and poor milk transfer during feeding attempts. This ultimately results in diminished milk supply. When the infant is unable to latch-on or nurse effectively, alternative methods of milk expression are necessary, such as using an electric breast pump.
- A clogged duct is a temporary back-up of milk that occurs when one or more of the lobes of the breast do not drain well. This usually results from incomplete emptying of milk. Counseling on feeding frequency or method or advising against wearing an overly tight bra or clothing can assist.
- Mastitis is a breast infection that causes a flu-like illness accompanied by an inflamed, painful area of the breast - putting both the health of the mother and successful breastfeeding at risk. The woman should be referred to her health care provider for antibiotic therapy.
- Infants may have difficulty latching-on correctly to nurse when nipples are flat or inverted. Appropriate interventions can improve nipple protractility and skilled help guiding a baby in proper breastfeeding technique can facilitate proper attachment.
- Severe nipple pain, discomfort lasting throughout feedings, or pain persisting beyond one week postpartum is atypical and suggests the baby is not positioned correctly at the breast. Improper infant latch-on not only causes sore nipples, but impairs milk flow and leads to diminished milk supply and inadequate infant intake. There are several other causes of severe or persistent nipple pain, including Candida or staph infection. Referrals for lactation counseling and/or examination by the woman's health care provider are indicated.
- Older women (over 40) are more likely to experience fertility problems and perinatal risk factors that could impact the initiation of breastfeeding. Because involutional breast changes can begin in the late 30s, older

mothers may have fewer functioning milk glands resulting in greater difficulty producing an abundant milk supply.

- Failure of milk to come in by 4 days postpartum may be a result of maternal illness or perinatal complications. This may place the infant at nutritional and/or medical risk, making temporary supplementation necessary until a normal breast milk supply is established.
- With tandem nursing the older baby may compete for nursing privileges, and care must be taken to assure that the younger baby has first access to the milk supply. The mother who chooses to tandem nurse will have increased nutritional requirements to assure her adequate milk production.

References

1. Alexander JM, Grant AM, Campbell MJ. Randomised controlled trial of breast shells and Hoffman's exercises for inverted and non-protractile nipples. BMJ 1992;304:1030-2.
2. Akre J. Infant Feeding. The physiological basis. Bull.World Health Organ 1989;67 Suppl:1-108.
3. Amier, L, Garland, SM, Dennerstein, L, et al.: Candida albicans: Is it associated with nipple pain in lactating women? Gynecol Obstetr Invest; 1996; 41:30-34.
4. De Coopman J. Breastfeeding after pituitary resection: support for a theory of autocrine control of milk supply? J.Hum.Lact. 1993;9:35-40.
5. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.
6. Livingstone VH, Willis CE, Berkowitz J. Staphylococcus aureus and sore nipples. Can.Fam.Physician 1996;42:654-9.
7. Mohrbacher N, Stock J, La LL, I. The breastfeeding answer book. Schaumburg, Ill: La Leche League International, 1997.
8. Neifert M. Early assessment of the breastfeeding infant. Contemporary Pediatr. 1996 Oct;13:142.
9. Neifert MR. The optimization of breast-feeding in the perinatal period. Clin.Perinatol. 1998;25:303-26.
10. Neifert MR, Seacat JM, Jobe WE. Lactation failure due to insufficient glandular development of the breast. Pediatrics 1985;76:823-8.
11. Riodan J, Auerbach KG. Breastfeeding and human lactation. Boston: Jones and Bartlett Publishers, 1993.
12. The Main Trial Collaborative Group: Preparing for breastfeeding: treatment of inverted and non-protractile nipples in pregnancy; Midwifery; 1994; 10:200.
13. Woolridge MW. Aetiology of sore nipples. Midwifery 1986; 2:172-6.

Nutrition Risk Criteria **603** **BREASTFEEDING COMPLICATIONS/POTENTIAL COMPLICATIONS (INFANTS)**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1	RD/LC

Definition

A breastfed infant with any of the following complications or potential complications for breastfeeding:

- jaundice
- weak or ineffective suck
- difficulty latching onto mother's breast
- inadequate stooling (for age, as determined by a physician or other health care professional), and/or less than 6 wet diapers per day

Required Documentation

Justification

- Jaundice occurs when bilirubin accumulates in the blood because red blood cells break down too quickly, the liver does not process bilirubin as efficiently as it should, or intestinal excretion of bilirubin is impaired. The slight degree of jaundice observed in many healthy newborns is considered physiologic. Jaundice is considered pathologic if it appears before 24 hours, lasts longer than a week or two, reaches an abnormally high level, or results from a medical problem such as rapid destruction of red blood cells, excessive bruising, liver disease, or other illness. When jaundice occurs in an otherwise healthy breastfed infant, it is important to distinguish "breastmilk jaundice" from "breastfeeding jaundice" and determine the appropriate treatment.

  In the condition known as "breastmilk jaundice," the onset of jaundice usually begins well after the infant has left the hospital, 5 to 10 days after birth, and can persist for weeks and even months. Early visits to the WIC clinic can help identify and refer these infants to their primary health care provider. Breastmilk jaundice is a normal physiologic phenomenon in the thriving breastfed baby and is due to a human milk factor that increases intestinal absorption of bilirubin. The stooling and voiding pattern is normal. If the bilirubin level approaches 18-20 mg%, the health care provider may choose to briefly interrupt breastfeeding for 24-36 hours which results in a dramatic decline in bilirubin level.

  - Resumption of breastfeeding usually results in cessation of the rapid fall in serum bilirubin concentration, and in many cases a small increase may be observed, followed by the usual gradual decline to normal.
  - "Breastfeeding jaundice", is an exaggeration of physiologic jaundice, which usually peaks between 3 and 5 days of life, though it can persist longer. This type of jaundice is a common marker for inadequate breastfeeding. An infant with breastfeeding jaundice is underfed and displays the following symptoms: infrequent or ineffective breastfeeding; failure to gain appropriate weight; infrequent stooling with delayed appearance of yellow stools (i.e., prolonged passage of meconium);

and scant dark urine with urate crystals. Improved nutrition usually results in a rapid decline in serum bilirubin concentration.

- A weak or ineffective suck may cause a baby to obtain inadequate milk with breastfeeding and result in a diminished milk supply and an underweight baby. Weak or ineffective suckling can be due to prematurity, low birth weight, a sleepy baby, or physical/medical problems such as heart disease, respiratory illness, or infection. Newborns who receive bottle feedings before beginning breastfeeding or who frequently use a pacifier may have trouble learning the proper tongue and jaw motions required for effective breastfeeding.

  Difficulty latching onto the mother's breast may be due to flat or inverted nipples, breast engorgement, or incorrect positioning and breastfeeding technique. Early exposure to bottle feedings can predispose infants to "nipple confusion" or difficulty learning to attach to the breast correctly and effectively extract milk. A referral for lactation counseling should be made.

- Inadequate stooling or less than 6 wet diapers are probable indicators that the breastfed infant is not receiving adequate milk. Not only is the baby at risk for failure to thrive, but the mother's milk is at risk for rapidly diminishing due to ineffective removal of milk. The breastfed infant with inadequate caloric intake must be identified early and the situation remedied promptly to avoid long-term consequences of dehydration or nutritional deprivation. Although failure to thrive can have many etiologies, the most common cause in the breastfed infant is insufficient milk intake as a result of infrequent or ineffective nursing. Inadequate breastfeeding can be due to infant difficulties with latching on or sustaining suckling, use of a nipple shield over the mother's nipple, impaired let down of milk, a non-demanding infant, excessive use of a pacifier, or numerous other breastfeeding problems.

  The literature regarding inadequate stooling varies widely in terms of quantification; this condition is best diagnosed by the pediatrician or other health care practitioner.

References

1. Auerbach KG, Gartner LM. Breastfeeding and human milk: their association with jaundice in the neonate. Clin.Perinatol. 1987;14:89-107.
2. Barros FC, Victora CG, Semer TC, Tonioli FS, Tomasi E, Weiderpass E. Use of pacifiers is associated with decreased breast-feeding duration. Pediatrics 1995;95:497-9.
3. Bocar DL. The lactation consultant: part of the health care team. NAACOGS.Clin.Issu.Perinat.Womens Health Nurs. 1992;3:731-7.
4. Cooper WO, Atherton HD, Kahana M, Kotagal UR. Increased incidence of severe breastfeeding malnutrition and hypernatremia in a metropolitan area. Pediatrics 1995;96:957-60.Neifert MR. The optimization of breast-feeding in the perinatal period. Clin.Perinatol. 1998;25:303-26.
5. De Carvalho M, Robertson S, Friedman A, Klaus M. Effect of frequent breast-feeding on early milk production and infant weight gain. Pediatrics 1983;72:307-11.
6. Kurinij N, Shiono PH. Early formula supplementation of breast-feeding. Pediatrics 1991;88:745-50.
7. Lawrence RA. Breastfeeding a guide for the medical profession. St. Louis: Mosby, 1994.
8. Maisels MJ, Newman TB. Kernicterus in otherwise healthy, breast-fed term newborns. Pediatrics 1995;96:730-3.

9. Meier PP, Engstrom JL, Fleming BA, Streeter PL, Lawrence PB. Estimating milk intake of hospitalized preterm infants who breastfeed. J.Hum.Lact. 1996;12:21-6.

Nutrition Risk Criteria **701** **BORN TO WIC MOM OR A POTENTIAL WIC MOM**

Category, Priority and Referral	**Category**	**Priority**	**Referral**
	INFANTS	2	-

Definition

An infant under six months age whose mother was a WIC participant during pregnancy or whose mother's medical records document that the woman was at nutritional risk during pregnancy because of detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions.

Required Documentation

N/A

Justification

Federal regulations designate these conditions for WIC eligibility (3).

WIC participation during pregnancy is associated with improved pregnancy outcomes. An infant whose nutritional status has been adequately maintained through WIC services during gestation and early infancy may decline in nutritional status if without these services and return to a state of elevated risk for nutrition related health problems. Infants whose mother was at medical/nutritional risk during pregnancy, but did not receive those services, may also be thought of as a group at elevated risk for morbidity and mortality in the infant period (1, 2).

WIC participation in infancy is associated with lower infant mortality, decreased anemia for infants and improvements in growth (head circumference, height and weight). Infants on WIC are more likely to consume iron-fortified formula and cereal and less likely to consume cow's milk before one year, thus lowering the risk of developing iron deficiency anemia (1, 2).

References

1. Disbrow DD. The costs and benefits of nutrition services: a literature review. J.Am.Diet.Assoc. 1989;89:S3-66.
2. Ryan AS, Martinez GA, Malec DJ. The effect of the WIC program on nutrient intakes of infants, 1984. Med.Anthropol. 1985;9153-72.
3. WIC Program Regulations; Section 246.7(e)(1)(ii).

Nutrition Risk Criteria **702** **BREASTFEEDING INFANT OF WOMAN AT NUTRITIONAL RISK**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	1, 2 or 4*	-

*Must be the same priority as at-risk mother.

Definition

Breastfeeding infant of a mother who is at nutritional risk.

The mother's nutrition risk must be documented on the infant's certification record/plan.

Required Documentation

Justification

A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Lactation requires the mother to consume an additional 500 Kcal per day (approximately) as well as increased protein, calcium, and other vitamins and minerals (2, 1). Inadequate maternal nutrition may result in decreased nutrient content of the milk (1). Special attention should therefore be given to the health and nutritional status of breastfed infants whose mothers are at nutritional risk (4).

References

1. Institute of Medicine. Nutrition During Lactation. National Academy Press, Washington, D.C.; 1991.
2. National Research Council (U.S.), Subcommittee on the Tenth Edition of the RDAs, National Institutes of Health, Committee on Dietary Allowances. Recommended dietary allowances. Washington, D.C.: National Academy Press, 1989.
3. WIC Program Regulations; Section 246.7(e)(1)(i).
4. Worthington-Roberts BS, Williams SR. Nutrition During Pregnancy and Lactation. St. Louis: Mosby, 1989.

Nutrition Risk Criteria **801★ HOMELESSNESS**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	4	-
CHILDREN	5	-

Definition

A woman, infant or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

- A supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations
- An institution that provides a temporary residence for individuals intended to be institutionalized
- A temporary accommodation of not more than 365 days in the residence of another individual
- A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings

Required Documentation

Justification

Homeless individuals comprise a very vulnerable population with many special needs. WIC program regulations specify homelessness as a predisposing nutrition risk condition. Today's homeless population contains a sizeable number of women and children – over one-third of the total homeless population in the U.S. Studies show 43% of today's homeless are families, and an increasing number of the "new homeless" include economically displaced individuals who have lost their jobs, exhausted their resources, have recently entered into the ranks of the homeless and consider their condition to be temporary.

Reference

WIC Program Regulations; Sect. 246.7(e)(2)(iv).

Nutrition Risk Criteria **802★ MIGRANCY**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	4	-
CHILDREN	5	-

Definition

Categorically eligible women, infants and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

Required Documentation

Justification

Data on the health and/or nutritional status of migrants indicate significantly higher rates or incidence of infant mortality, malnutrition, and parasitic disease (among migrant children) than among the general U.S. population. Therefore, migrancy has long been stipulated as a condition that predisposes persons to inadequate nutritional patterns or nutritionally related medical conditions.

Reference

WIC Program Regulations; Sect. 246.7(e)(2)(iv).

Nutrition Risk Criteria **902** **WOMAN OR INFANT/CHILD OF PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS/PREPARE FOOD**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	4	-
BREASTFEEDING WOMEN	4	-
NON-BREASTFEEDING WOMEN	6	-
INFANTS	4	-
CHILDREN	5	-

Definition

Woman (pregnant, breastfeeding, or non-breastfeeding), or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- ≤ 17 years of age;
- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist);
- physically disabled to a degree which restricts or limits food preparation abilities; or
- currently using or having a history of abusing alcohol or other drugs.

Required Documentation

Justification

The mother or caregiver ≤ 17 years of age generally has limited exposure and application of skills necessary to care for and feed a total dependent. Cognitive limitation in a parent or primary caregiver has been recognized as a risk factor for failure to thrive, as well as for abuse and neglect. The mentally handicapped caregiver may not exhibit the necessary parenting skills to promote beneficial feeding interactions with the infant. Maternal mental illnesses such as severe depression and maternal chemical dependency are also strongly associated with abuse and neglect. In 22 states, 90% of caregivers reported for child abuse are active substance abusers. Certain physical handicaps such as blindness, para- or quadriplegia, or physical anomalies restrict/limit the caregiver's ability to prepare and offer a variety of foods. Education, referrals and service coordination with WIC will aid the mother/caregiver in developing skills, knowledge and/or assistance to properly care for a total dependent.

References

1. Accardo PJ, Whitman BY. Children of mentally retarded parents. Am.J.Dis.Child 1990;144:69-70.
2. Grand RJ, Sutphen JL, Dietz WH. Pediatric nutrition theory and practice. Boston: Butterworths, 1987.
3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
4. Pollitt E, Wirtz S. Mother-infant feeding interaction and weight gain in the first month of life. J.Am.Diet.Assoc. 1981;78:596-601.
5. WIC Program regulations; Sect. 246.7(e)(2).

Nutrition Risk Criteria **903★ FOSTER CARE**

Category, Priority and Referral

Category	Priority	Referral
INFANTS	4	-
CHILDREN	5	-

Definition

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.

Required Documentation

Justification

"Foster children are among the most vulnerable individuals in the welfare system. As a group, they are sicker than homeless children and children living in the poorest sections of inner cities." This statement from a 1995 Government Accounting Office report on the health status of foster children confirms research findings that foster children have a high frequency of mental and physical problems, often the result of abuse and neglect suffered prior to entry into the foster care system. When compared to other Medicaid-eligible children, foster care children have higher rates of chronic conditions such as asthma, diabetes and seizure disorders. They are also more likely than children in the general population to have birth defects, inadequate nutrition and growth retardation including short stature.

Studies focusing on the health of foster children often point out the inadequacy of the foster care system in evaluating the health status and providing follow-up care for the children for whom the system is responsible. Because foster care children are wards of a system which lacks a comprehensive health component, the social and medical histories of foster children in transition, either entering the system or moving from one foster care home to another, are frequently unknown to the adults applying for WIC benefits for the children. For example, the adult accompanying a foster child to a WIC clinic for a first-time certification may have no knowledge of the child's eating patterns, special dietary needs, chronic illnesses or other factors which would qualify the child for WIC. Without any anthropometric history, failure to grow, often a problem for foster children, may not be diagnosed even by a single low cutoff percentile.

Since a high proportion of foster care children have suffered from neglect, abuse or abandonment and the health problems associated with these, entry into foster care or moving from one foster care home to another during the previous six months is a nutritional risk for certification in the WIC Program. Certifiers using this risk should be diligent in evaluating and documenting the health and nutritional status of the foster child to identify other risks as well as problems that may require follow-up or referral to other health care programs. This nutritional risk cannot be used for consecutive certifications while the child remains in the same foster home. It should be used as the sole risk criterion only if careful assessment of the applicant's nutritional status indicates that no other risks based on anthropometric, medical or nutritional risk criteria can be identified.

The nutrition education, referrals and service coordination provided by WIC will support the foster parent in developing the skills and knowledge to ensure that the foster child receives appropriate nutrition and health care. Since a foster

parent frequently has inadequate information about a new foster child's health needs, the WIC nutritionist can alert the foster parent to the nutritional risks that many foster care children have and suggest ways to improve the child's nutritional status.

References

1. American Medical News: America's Sickest Children; January 10, 1994; 15-19.
2. Chernoff R, Combs-Orme T, Risley-Curtiss C, Heisler A. Assessing the health status of children entering foster care. Pediatrics 1994;93:594-601.
3. DuRouseau PC, Moquette-Magee E, Disbrow D. Children in foster care: are they at nutritional risk? J.Am.Diet.Assoc. 1991 Jan;91(1):83-85.
4. Government Accounting Office. Foster care health needs of many young children are unknown and unmet: report to the ranking minority member, Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives. Washington D.C.: The Office; 1995 May. Report No.:GA 1.13:HEHS-95-114.
5. Halfon N, Mendonca A, Berkowitz G. Health status of children in foster care. The experience of the Center for the Vulnerable Child. Arch.Pediatr.Adolesc.Med. 1995;149:386-92.
6. Schor EL. The foster care system and health status of foster children. Pediatrics 1982;69:521-8.
7. Takayama JI, Wolfe E, Coulter KP. Relationship between reason for placement and medical findings among children in foster care. Pediatrics 1998;101:201-7.
8. Wyatt DT, Simms MD, Horwitz SM. Widespread growth retardation and variable growth recovery in foster children in the first year after initial placement. Arch.Pediatr.Adolesc.Med. 1997;151:813-6.

Nutrition Risk Criteria **904 EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE (ETS)**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-
BREASTFEEDING WOMEN	1	-
INFANTS	1	-
CHILDREN	3	-
NON-BREASTFEEDING WOMEN	6	-

Definition

Environmental tobacco smoke (ETS) exposure is defined (for WIC eligibility purposes) as exposure to smoke from tobacco products inside the home. *(1,2,3)
* See Clarification for background information.

Required Documentation

Justification

ETS is a mixture of the smoke given off by a burning cigarette, pipe, or cigar (sidestream smoke), and the smoke exhaled by smokers (mainstream smoke). ETS is a mixture of about 85% sidestream and 15% mainstream smoke (4) made up of over 4,000 chemicals, including Polycyclic Aromatic Hydrocarbons (PAHs) and carbon monoxide (5). Sidestream smoke has a different chemical make-up than main-stream smoke. Sidestream smoke contains higher levels of virtually all carcinogens, compared to mainstream smoke (6). Mainstream smoke has been more extensively researched than sidestream smoke, but they are both produced by the same fundamental processes.

ETS is qualitatively similar to mainstream smoke inhaled by the smoker. The 1986 Surgeon General's report: *The Health Consequences of Involuntary Smoking. A Report of the Surgeon General* concluded that ETS has a toxic and carcinogenic potential similar to that of the mainstream smoke (7). The more recent 2006 Surgeon General's report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General,* reaffirms and strengthens the findings of the 1986 report, and expands the list of diseases and adverse health effects caused by ETS (8).

ETS is a known human carcinogen (2). Women who are exposed to ETS are at risk for lung cancer and cardiovascular diseases (9). Prenatal or postnatal ETS exposure is related to numerous adverse health outcomes among infants and children, including sudden infant death syndrome (SIDS) (10, 11), upper respiratory infections (12), periodontal disease (13), increased severity of asthma/wheezing (12), metabolic syndrome (14), decreased cognitive function (15), lower birth weight and smaller head circumference (16). Infants born to women exposed to ETS during pregnancy have a small decrease in birth weight and a slightly increased risk of intrauterine growth retardation compared to infants of unexposed women (17).

Studies suggest that the health effects of ETS exposure at a young age could last into adulthood. These include cancer (18), specifically lung cancer (19, 20), and cardiovascular diseases (14, 21, 22,). There is strong evidence that ETS exposure to the fetus and/or infant results in permanent lung damage (23, 24, 25, 26).

ETS exposure increases inflammation and oxidative stress (27, 28, 29). Inflammation is associated with asthma (30), cardiovascular diseases (31, 32), cancer (33), chronic obstructive pulmonary disease (34), and metabolic syndrome (14, 35). PAHs are the major class of compounds that contribute to the ETS-related adverse health outcomes. These compounds possess potent carcinogenic and immunotoxic properties that aggravate inflammation.

Oxidative stress is a general term used to describe the steady state of oxidative damage caused by highly reactive molecules known as free radicals. The free radicals can be generated both during the normal metabolic process and from ETS and other environmental pollutants. When free radicals are not neutralized by antioxidants, they can cause oxidative damage to the cells. This damage has been implicated in the cause of certain diseases. ETS provokes oxidant damage similar to that of active smoking (36).

Antioxidants may modulate oxidative stress-induced lung damage among both smokers and non-smokers (22, 27-29, 37-40). Fruits and vegetables are the major food sources of antioxidants that may protect the lung from oxidative stress (1). Research indicates that consuming fruits and vegetables is more beneficial than taking antioxidant supplements (1). This suggests that other components of fruits and vegetables may be more relevant in protecting the lung from oxidative stress. Dietary fiber is also thought to contribute to the beneficial health effects of fruits and vegetables (1).

The Institute of Medicine (IOM) reports that an increased turnover in vitamin C has been observed in nonsmokers who are regularly exposed to tobacco smoke (41). The increased turnover results in lowered vitamin C pools in the body. Although there are insufficient data to estimate a special requirement for non-smokers regularly exposed to ETS, the IOM urges those individuals to ensure that they meet the Recommended Dietary Allowance for vitamin C (36, 41).

The WIC food package supplements the participant intake of vitamin C. In addition, many WIC State Agencies participate in the WIC Farmers' Market Nutrition Program, which provides coupons for participants to purchase fresh fruits and vegetables. WIC Program benefits also include counseling to increase fruit and vegetable consumption, and to promote a healthy lifestyle, such as protecting participants and their children from ETS exposure. WIC staff may also make appropriate referrals to participants, and/or their caregivers, to other health and social services, such as smoking cessation programs.

In a comprehensive scientific report, the Surgeon General concluded that there is no risk-free level of exposure to secondhand smoke (8). However, for the purpose of risk identification, the definition used for this risk criterion is based on the Centers for Disease Control and Prevention (CDC) Pediatric Nutrition Surveillance System (PedNSS) and the Pregnancy Nutrition Surveillance System (PNSS) questions to determine Environmental Tobacco Smoke (ETS) exposure:

1. Does anyone living in your household smoke inside the home? (infants, children)
2. Does anyone else living in your household smoke inside the home? (women)

Clarification

Because the definition used by other Federal agencies for ETS exposure is specific to “inside the home” and has been validated (3), the definition used for WIC eligibility must also be as specific. In addition, FNS encourages the use of the PedNSS and PNSS ETS exposure questions for WIC nutrition assessment.

There are other potential sources of ETS exposure, such as work and day care environments. However, no other validated questions/definitions could be found that were inclusive of other environments and applicable to WIC.

References

1. Lesley Butler, et al. RISC/WIC Report on Environmental Tobacco Smoke Exposure. February 2006. Unpublished.
2. Respiratory Health Effects of Passive Smoking (Also Known as Exposure to Secondhand Smoke or Environmental Tobacco Smoke ETS). U.S. Environmental Protection Agency, Office of Research and Development, Office of Health and Environmental Assessment, Washington, DC, EPA/600/6-90/006F, 1992. http://cfpub.epa.gov/ncea/cfm/recordisplay.cfm?deid=2835 Accessed March 2006.
3. Pirkle, JL, KM Flegal, DJ Brody, RA Etzel, and KR Maurer. Exposure of the U.S. Population to Environmental Tobacco Smoke. The Third National Health and Nutrition Examination Survey, 1988 to 1991. *JAMA;* 1996; 275,16; 1233-1240.
4. Witschi, H, JP Joad, and KE Pinkerton. The toxicology of environmental tobacco smoke. *Annu Rev Pharmacol Toxicol* 1997; 37: 29-52.
5. Seifert, JA, CA Ross, and JM Norris. Validation of a five-question survey to assess a child’s exposure to environmental tobacco smoke. *Ann Epidemiol* 2002; 12:273-277.
6. Adams, JD, KJ O’Mara-Adams, and D Hoffmann. Toxic and carcinogenic agents in undiluted main-stream smoke and sidestream smoke of different types of cigarettes. *Carcinogenesis* 1987-8:729-731.
7. U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Smoking: A Report of the Surgeon General.* Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, 1986. DHHS Publication No. (CDC) 87-8398.
8. U.S. Department of Health and Human Services*. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General—Executive Summary.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
9. National Cancer Institute. *Health Effects of Exposure to Environment Tobacco Smoke.* Smoking and Tobacco Control Monograph No. 10 (PDF - 71k). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 1999. NIH Pub. No. 99-4645. Accessed: March 2006.

WIC INCOME ELIGIBILITY GUIDELINES

July 1, 2014 through June 30, 2015

Number of Household Members	Maximum Annual Gross Household Income
1	$21,590
2	$29,101
3	$36,612
4	$44,123
5	$51,634
6	$59,145
7	$66,656
8	$74,167

For each additional individual, add $7,511/year
One pregnant woman counts as 2 household members

Prescreening Tool: wic.fns.usda.gov/wps/pages/start.jsf

These guidelines are to see if you *might* qualify for WIC. To make sure you qualify, please contact your local WIC office. To find your local WIC office, call the Idaho Careline at 211 or 1-800-926-2588, or visit www.wic.dhw.idaho.gov.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/ complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Application for the Idaho WIC Program

DATE APPLIED _____ APPT DATE: _____

SECTION A – Contact Information. Please complete all sections of the application.

Responsible Adult	FIRST	MI	LAST	MAIDEN NAME (if any)	DATE OF BIRTH (opt)

Physical Address	STREET	CITY	COUNTY	STATE	ZIP CODE

Mailing Address (if different)	STREET	CITY	COUNTY	STATE	ZIP CODE

Telephone	HOME	WORK OR MESSAGE

SECTION B – Applicant Information. Please answer the following questions.

1) How many people are living in your household (include unborn child/ren)? _____
2) Is anyone in your household receiving SNAP, TANF, Medicaid or CHIP? ❒ no ❒ yes
3) Is anyone in your household a migrant worker? ❒ no ❒ yes
4) What is the highest grade you have completed in school?_____

List all the individuals who are applying for WIC services. Include due date of unborn children in the space for name. (Ethnicity, sex and race data are for statistical purposes only. They are not used to determine eligibility. If you choose not to answer, WIC staff will select for you.)

FOR WIC USE

LEGAL NAME FIRST NAME MI LAST NAME	SEX	ETHNICITY	RACE (check all that apply)	ID NUMBERS F _____
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	

The WIC Program is an equal opportunity provider and employer.

IDENTITY:	RESIDENCY:	PREGNANCY PROOF:
❒ driver's license ❒ birth certificate ❒ government ID ❒ other _____ _____	❒ driver's license ❒ utility bill ❒ letter ❒ other _____ _____	❒ written ❒ visual

INCOME ELIGIBILITY:

❒ TANF MA FS CHIP
❒ check stub
❒ W-2
❒ unemployment
❒ other _____

MONTHLY INCOME CONVERSION **

Weekly	x 4.3
Bi-weekly (every 2 wks)	x 2.15
Semi-monthly (twice/mo)	x 2
Quarterly	÷ 3
Hourly	(Rate x hrs/wk) x 4.3

INCOME SOURCE (employer)	Amount	**	Subtotal
1. _____	$ _____	_____	$ _____
2. _____	$ _____	_____	$ _____
3. _____	$ _____	_____	$ _____

Household size: _____ Monthly gross income $ _____

Is there other income (overtime, tips, bonuses, child support, SSI)?

Staff Name: _____ Date: _____

FORMA NO: 101S (10/13)

Solicitud de Idaho Programa WIC

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

FECHA DE SOLICITUD: _____ FECHA DE CITA: _____

SECCIÓN A – Información de contacto. Por favor complete todas las secciones de la aplicación.

Adulto Responsable	PRIMER NOMBRE	SEGUNDO NOMBRE	APELLIDO	APELLIDO DE SOLTERA (si lo tiene)	FECHA DE NACIMIENTO (opc.)
Dirección Física	CALLE	CIUDAD	CONDADO	ESTADO	CÓDIGO POSTAL
Dirección de Correo (si es diferente)	CALLE	CIUDAD	CONDADO	ESTADO	CÓDIGO POSTAL
Teléfono	DE LA CASA		DEL TRABAJO O PARA DEJAR MENSAJES		

SECTION B – Información de la solicitud. Por favor, responda a las siguientes preguntas.

1) ¿Cuántas personas viven en su casa (incluya niños que están por nacer)? _____
2) ¿Hay alguien en su casa que está recibiendo Cupones de Alimentos, TANF, Medicaid o CHIP? ❒ no ❒ sí
3) ¿Hay alguien en su casa que es un trabajador campesino migrante? ❒ no ❒ sí
4) ¿Cuál es el grado más alto que completó en la escuela? _____

Anote a todas las personas que están solicitando los servicios de WIC. En el espacio para el nombre incluya las fechas de parto de niños por nacer. (La información sobre la etnicidad, el sexo y la raza se usan sólo para estadísticas. No se usan para determinar elegibilidad. Si prefiere no contestar, el personal de WIC lo elegirá por usted.)

PARA EL USO DE WIC

NOMBRE LEGAL PRIMER NOMBRE 2º. NOMBRE APELLIDO	SEXO	ETNICIDAD	RAZA (marque todas las que aplican)	NÚM. DE IDENT. F _____
_____ Fecha de Nacimiento _____	❒ Masculino ❒ Femenino	❒ Hispano/Latino ❒ No Hispano/No Latino	❒ Indio americano /Nativo de Alaska ❒ Asiático ❒ Negro o afro-americano ❒ Isleño del Pacífico/nativo de Hawai ❒ Blanco	
_____ Fecha de Nacimiento _____	❒ Masculino ❒ Femenino	❒ Hispano/Latino ❒ No Hispano/No Latino	❒ Indio americano /Nativo de Alaska ❒ Asiático ❒ Negro o afro-americano ❒ Isleño del Pacífico/nativo de Hawai ❒ Blanco	
_____ Fecha de Nacimiento _____	❒ Masculino ❒ Femenino	❒ Hispano/Latino ❒ No Hispano/No Latino	❒ Indio americano /Nativo de Alaska ❒ Asiático ❒ Negro o afro-americano ❒ Isleño del Pacífico/nativo de Hawai ❒ Blanco	
_____ Fecha de Nacimiento _____	❒ Masculino ❒ Femenino	❒ Hispano/Latino ❒ No Hispano/No Latino	❒ Indio americano /Nativo de Alaska ❒ Asiático ❒ Negro o afro-americano ❒ Isleño del Pacífico/nativo de Hawai ❒ Blanco	
_____ Fecha de Nacimiento _____	❒ Masculino ❒ Femenino	❒ Hispano/Latino ❒ No Hispano/No Latino	❒ Indio americano /Nativo de Alaska ❒ Asiático ❒ Negro o afro-americano ❒ Isleño del Pacífico/nativo de Hawai ❒ Blanco	

IDENTITY:	RESIDENCY:	PREGNANCY PROOF:
❒ driver's license ❒ birth certificate ❒ government ID ❒ other	❒ driver's license ❒ utility bill ❒ letter ❒ other	❒ written ❒ visual

INCOME ELIGIBILITY:

❒ TANF MA FS CHIP
❒ check stub
❒ W-2
❒ unemployment
❒ other

MONTHLY INCOME CONVERSION **

Weekly	x 4.3
Bi-weekly (every 2 wks)	x 2.15
Semi-monthly (twice/mo)	x 2
Quarterly	÷ 3
Hourly	(Rate x hrs/wk) x 4.3

INCOME SOURCE (employer)	Amount	**	Subtotal
1. _____	$ _____	_____	$
2. _____	$ _____	_____	$
3. _____	$ _____	_____	$

Household size: _____ Monthly gross income $

Is there other income (overtime, tips, bonuses, child support, SSI)?

Staff Name: _____ Date: _____

Appendix B
IDAHO WIC PROGRAM
Civil Money Penalty Procedure

WHEN TO OFFER A CIVIL MONEY PENALTY

A Civil Money Penalty may ONLY be offered to a vendor in lieu of disqualification when participant hardship would otherwise occur (see Participant Hardship). Participant hardship is not a static condition. Each time a vendor is disqualified, the potential of hardship must be re-evaluated. The determination of a participant hardship may require renewed review of the disqualification status of all vendors in the area.

If participant hardship occurs in an area where the only vendors are either serving a disqualification period or are in the disqualification process, the following criteria shall be used to determine which vendor is first offered a Civil Money Penalty.

First: The vendor whose sanction of disqualification was derived from the lowest point value. For example, 30 sanction points are better than 50 sanction points etc.

Second: If the first criteria results in a tie, the vendor with the least time remaining in the disqualification period will be the one offered the Civil Money Penalty.

If the best candidate for a Civil Money Penalty is a vendor already serving a disqualification, the option will be offered to that vendor to return to the program. This re-authorization shall occur only after the vendor submits a Contract packet which is approved by the State Agency, and receipt of the Civil Money Penalty for the amount established in this policy. The dollar amount of this payment will be determined as in all other cases.

As this should be an extremely rare occurrence, this is the only section of the Civil Money Penalty policy that will mention alternative choices of vendors. However, this section has been added to assure that the State Agency will not be required to offer a Civil Money Penalty to a vendor in the process of disqualification for major offenses while maintaining a disqualification of a vendor who had accumulated a number of minor offenses.

The State Agency will assure that a vendor who pays a Civil Money Penalty is one that the State Agency can successfully monitor.

WHEN A CIVIL MONEY PENALTY CANNOT BE OFFERED

Regardless of participant hardship, a Civil Money Penalty shall not be offered when the disqualification is based on federally mandated third or subsequent sanctions.

PROCEDURE FOR ASSESSING A CIVIL MONEY PENALTY

After determining that a participating WIC vendor should be disqualified from the program, the State Agency shall review the case to determine participant hardship. This review shall take place prior to the written notification of disqualification so that the vendor shall be made aware of its alternatives at the time of notification.

If the State Agency establishes participant hardship and determines that a Civil Money Penalty is an appropriate alternative, the State Agency shall contact the vendor to schedule a meeting.

Prior to or at the time the vendor is contacted to schedule a meeting; the vendor shall be sent a written notice of the disqualification action. This notice should include cause(s) for the disqualification, the effective date of the action, the vendor's right to appeal, and the procedures to be followed to file an appeal. This notice shall also notify the vendor that the State Agency has decided to offer a Civil Money Penalty in lieu of disqualification and that it will be contacted to schedule a meeting to discuss the Civil Money Penalty offer.

The meeting shall be used to offer the alternative of the Civil Money Penalty in lieu of the disqualification. The meeting shall cover the following:

a) The amount of the alternative Civil Money Penalty as determined by the following procedure for calculation Civil Money Penalties;

b) The method of payment of the Civil Money Penalty available to the vendor.

c) Discussion of all non-compliance issues, not just those that brought about the disqualification.

Also at the meeting, the vendor shall be advised of the following:

a) Acceptance/payment of the Civil Money Penalty settles all past non-compliance issues, but does not relieve the vendor of its obligation to stay in compliance with the Contract they signed with the State Agency or to protect the vendor from future sanctions or disqualification for continued non-compliance. The vendor must resolve to correct any and all problems identified;

b) The past violations settled by the Civil Money Penalty may be considered, at the discretion of the State Agency if additional violations of the same nature occur in the future;

c) The vendor has fifteen (15) calendar days after the meeting to accept the alternative Civil Money Penalty in writing, in lieu of disqualification;

d) The Civil Money Penalty settlement does not prohibit further WIC investigations.

Procedure for Calculating Money Payment

All Civil Money Penalties issued by the State Agency will be calculated using a standard formula for both federally mandated sanctions and State Agency sanctions. However, the penalty shall not exceed $11,000 per violation or $44,000 per single investigation, even if the formula indicates that a higher penalty is warranted. The formula is as follows:

Step I: Determine the vendor's average monthly redemptions for at least the six (6) month period ending with the month immediately proceeding the month during which the notice of administrative action is dated. (Unusual circumstances may warrant a modification of the formula, i.e. vendor on the program for only three (3) months, etc)

Step II: Multiply the average monthly redemptions figure by 10% (.10).

Step III: Multiply the product from Step II by the number of months the vendor would have been disqualified.

Note: Instances of other violations that have not yet reached disqualification action shall not be used to calculate the Civil Money Penalty. The calculation for the Civil Money Penalty shall be based solely on the disqualification period that brought about the action.

Example: The vendor is notified of a one-year disqualification starting October 20XX.
A Civil Money Penalty in lieu of disqualification would be calculated as follows:

Monthly redemption for at least the six (6) month period ending with the month immediately proceeding the month during which the notice of administrative action is dated:

September	$ 4,650
August	4,075
July	5,120
June	5,580
May	4,890
April	4,990

Step I = TOTAL $29,305. 6 = $4,884.17 monthly average

Step II = $4,884.17 x 10% = $488.42

Step II = $488.42 x 12 months = $5,861.04

If the calculation results in an amount greater than $11,000, the State Agency will impose the maximum amount of $11,000 for each violation up to $44,000 per *single investigation.

*A single investigation could result in several violations.

Payment of Civil Money Penalties

The payment of the Civil Money Penalty must be made by one (1) of the following methods as determined by the State Agency. All payments (either lump sum or installment) shall be made by certified check or money order payable to the Idaho Department of Health & Welfare WIC Program and must include the vendor's name and WIC Vendor number. Payments must be sent by certified mail to:

Department of Health & Welfare
Idaho WIC Program
450 West State Street, 4th Floor
P.O. Box 83720
Boise, ID 83720-0036

a) A lump sum payment of the Civil Money Penalty shall be received on or before the date the disqualification is to be effective or

b) Installment payments of equal amounts, the total number of which cannot exceed one half the numbers of months of the disqualification, shall be paid with interest authorized by State law.

The first installment must be received by the State Agency on or before the date the disqualification was to be effective. The subsequent payments must be received on the first day of the month for all subsequent months until final payment is received. If a vendor fails to make any scheduled installment payment by the due date, the State Agency shall notify the vendor that the balance of the Civil Money Penalty is due within twenty (20) calendar days or the State will disqualify the vendor for the length of the disqualification corresponding to the violation for which the CMP was assessed (for a period corresponding to the most serious violation in cases where a mandatory sanction included the imposition of multiple CMPs as a result of a single investigation).

PARTICIPANT HARDSHIP

Policy. Participant hardship shall be the determining factor in assessing a Civil Money Penalty. It shall also be a contributing factor in the vendor evaluation criteria established. Participant access is not a legitimate or acceptable issue for a vendor to raise when appealing a State Agency disqualification.

Procedure. To be considered participant hardship rather than just "participant inconvenience", one of the following conditions must be indicated:

1. The vendor serves ten (10) or more WIC participants whose specific nationality could not properly be served by another authorized vendor located within the geographic area (defined below) due to a language barrier;

2. To receive WIC benefits, twenty (20) or more WIC participants would be required to travel to an authorized vendor in another geographic area (defined below);

3. Physical barriers or conditions which would make impossible normal travel to another authorized WIC vendor (for example, an unabridged river, an expressway, an airport, frequent road closing due to bad weather);

4. The participant has a physical handicap that cannot be accommodated by alternative vendors, (for example, the vendor in question has a wheelchair ramp while other vendors in the area are not so equipped <u>and</u> a wheelchair bound participant regularly shops at that vendor). For this condition to apply, the handicapped participant must have done more than half of the WIC shopping in the previous six (6) months at the vendor's location.

DEFINITIONS

Geographic Area - The travel in excess of fifteen (15) miles in a rural area from the local agency clinic or the participant's residence or a ten (10) block radius of the local agency clinic or the participants' residence in an urban area to reach an authorized vendor.

FORM WIC 155
5/13

Idaho WIC Program
Fair Hearing Request

If the clinic takes any adverse action against you, you have the right to ask for an informal meeting or formal hearing. The adverse action may result in a claim against you for repayment of the cash value of improperly issued benefits or result in denial of participation or disqualification from the Program.

You may wish to contact a local legal service office to help you decide if you should ask for an informal meeting or a hearing. You may be able to receive free legal aid. Ask your local WIC clinic for referral information or dial Idaho's CareLine 211 for assistance.

When possible, you are encouraged to request an informal meeting with the local agency coordinator and/or clinic supervisor. This meeting is to try and resolve your concerns by reviewing the facts, regulations, and circumstances of the action taken. If the action taken by the local agency was wrong, it will be corrected as a result of this meeting. If you are not satisfied with the result of the informal meeting, you may proceed with the fair hearing request. An informal meeting is optional.

If the meeting with the local agency does not resolve your concerns or if you would like to proceed with a formal hearing, you must ask for the hearing within 60 days of the date the action was taken against you. Hearing requests may be made verbally or in writing and delivered or sent to the local agency or State WIC Office.*

Except for participants whose certification period has expired, participants who appeal the termination of benefits within 15 days of this action shall continue to receive Program benefits until the hearing officer reaches a decision or the certification period expires, whichever occurs first. Applicants who are denied benefits at initial certification may appeal the denial, but shall not receive benefits while awaiting the appeal process.

Return the Fair Hearing Request to:

Mail to: **Idaho WIC Program**
P.O. Box 83720
450 West State, 4th Floor
Boise, Idaho 83720-0036

Fax to: **(208) 332-7362**

*You are encouraged to keep a copy of the Fair Hearing Request for your records. You may ask the local WIC agency to make a copy for you.

The WIC Program is an equal opportunity provider and employer.

Fair Hearing Request

I disagree with the Idaho WIC Program decision concerning my application/participation as described below:

Mark the action you disagree with:

- ❒ Repayment of cash value of improperly issued benefits
- ❒ Disqualification
- ❒ Denied participation
- ❒ Other (explain):

_____

_____

_____

_____

I understand that if my certification is current and this request is made within 15 days from when the action in question is taken, I will continue to receive WIC benefits until the hearing officer reaches a decision or my certification period has expired, whichever occurs first.

Name	**Contact Phone Number**	
Street / Mailing Address	**City**	**Zip Code**
Signature	**Date**	

FOR OFFICE USE ONLY

Date Received in WIC	**Date Received at DHW Legal**	**Hearing Request Number**

The WIC Program is an equal opportunity provider and employer.

FORM WIC 155
5/13

Programa WIC de Idaho

Solicitud para una Audiencia Justa

Si la clínica toma una acción adversa en su contra, usted tiene el derecho de pedir una junta informal o una audiencia formal. La acción adversa puede resultar en un reclamo en su contra por reembolso del valor en efectivo de beneficios emitidos incorrectamente o puede resultar en la negación o la descalificación de su participación en el Programa.

Usted tal vez quiera contactar a la oficina local de servicio legal para ayudarle a decidir si debe pedir una junta informal o una audiencia. Tal vez pueda recibir ayuda legal gratis. Pida información en la clínica de WIC local o marque el 211 de Idaho CareLine para obtener ayuda.

Cuando sea posible, se le recomienda que pida una junta informal con el coordinador de la agencia local o con el supervisor de la clínica. Esta junta es para tratar de resolver sus preocupaciones revisando los hechos, las regulaciones y las circunstancias de la acción tomada. Si la acción tomada por la agencia local fue incorrecta, ésta será corregida como resultado de esta junta. Si usted no está satisfecho con el resultado de la junta informal, tal vez quiera proceder solicitando una audiencia justa. La junta informal es opcional.

Si la junta con la agencia local no resuelve sus preocupaciones o si le gustaría proceder con una audiencia formal, usted debe solicitar la audiencia dentro de 60 días de la fecha de la acción adversa en su contra. Las solicitudes para las audiencias pueden hacerse verbalmente o por escrito y son entregadas o enviadas a la agencia local o a la oficina estatal de WIC.*

Excepto por los participantes cuyo periodo de certificación ha expirado, los participantes que apelan la terminación de beneficios dentro de 15 días de esta acción continuarán recibiendo los beneficios del programa hasta que el oficial de audiencias llegue a una decisión o el período de certificación expire, cualquiera que ocurra primero. Los solicitantes con beneficios negados al inicio de la certificación pueden apelar la negación, pero no recibirán beneficios mientras esperan el proceso de apelación.

Regrese la Solicitud para una Audiencia Justa a:

Por Correo: **Idaho WIC Program**
P.O. Box 83720
450 West State, 4th Floor
Boise, Idaho 83720-0036

Por Fax: **(208) 332-7362**

*Se le recomienda que mantenga una copia para sus archivos de la Solicitud para una Audiencia Justa. Usted le puede pedir a la agencia local de WIC que le haga una copia.

El Programa WIC es un proveedor y empleador que ofrece igualdad de oportunidades.

Solicitud para una Audiencia Justa

Yo no estoy de acuerdo con la decisión del Programa WIC de Idaho con respecto a mi solicitud/participación como se describe abajo:

Marque la acción con la cual no está de acuerdo:

- ❒ Reembolso del valor en efectivo de beneficios emitidos incorrectamente
- ❒ Descalificación
- ❒ Participación negada
- ❒ Otro (explique):

_____

_____

_____

_____

Entiendo que si mi certificación está al día y esta solicitud es hecha dentro de 15 días de cuando la acción en cuestión fue tomada, continuaré recibiendo beneficios de WIC hasta que el oficial de audiencias llegue a una decisión o hasta cuando mi período de certificación expire, cualquiera que ocurra primero.

Nombre	**Número de Teléfono de Contacto**	
Calle/Dirección de Correo	**Ciudad**	**Código Postal**
Firma	**Fecha**	

.....

PARA EL USO DE OFICINA SOLAMENTE

Fecha recibida en WIC	**Fecha Recibida en DHW Legal**	**Número de la Solicitud de la Audiencia**

El Programa WIC es un proveedor y empleador que ofrece igualdad de oportunidades.

Table of Contents

16.05.03 - Rules Governing Contested Case Proceedings and Declaratory Rulings

000. Legal Authority. 3
001. Title And Scope. 3
002. Written Interpretations. 3
003. Administrative Appeals. 3
004. Incorporation By Reference. 3
005. Administrative Procedures Section. 3
006. Office -- Office Hours -- Mailing Address -- Street Address -- Telephone Number -- Internet Website. 3
007. Confidentiality Of Records And Public Records Requests. 4
008. -- 009. (Reserved). 4
010. Definitions And Abbreviations. 4
011. -- 039. (Reserved). 4
040. Petition For Adoption Of Rules. 4
041. -- 049. (Reserved). 4
050. Petition For Declaratory Ruling. 4
051. Contents Of Petition For Declaratory Ruling. 4
052. Disposition Of Petition For Declaratory Ruling. 4
053. -- 099. (Reserved). 5
100. Department Responsibility. 5
101. Filing Of Appeals. 5
102. Notice Of Hearing. 5
103. Prehearing Conference. 5
104. Subpoenas. 5
105. Disposition Of Case Without A Hearing. 5
106. Default. 6
107. Intervention. 6
108. -- 119. (Reserved). 6
120. Discovery. 6
121. Briefing Schedule. 6
122. Filing Of Documents In An Appeal. 6
123. Representation. 6
124. Representation Of Individuals With Developmental Disabilities. 6
125. Interpreters. 6
126. -- 129. (Reserved). 6
130. Open Hearings. 6
131. Authority Of Hearing Officer. 7
132. Burden Of Proof -- Individual Benefit Cases. 7
133. Burden Of Proof -- Provider Cases. 7
134. Evidence. 7
135. Discretionary Judicial Notice. 7
136. Mandatory Judicial Notice. 7
137. Hearing Record. 7
138. Decision And Order. 7
139. -- 149. (Reserved). 8

150. Review Of Preliminary Orders By Department. 8
151. Petition For Review By Board Of Health And Welfare. 8
152. Final Order. 8
153. Service Of Preliminary And Final Orders. 8
154. Maintenance Of Orders. 8
155. Effect Of Petition For Judicial Review. 8
156. -- 198. (Reserved). 8
199. Specific Contested Case Provisions. 8
200. Division Of Welfare Appeals. 8
201. Time For Filing Appeal. 9
202. Informal Conference. 9
203. Withdrawal Of An Appeal. 9
204. Time Limits For Completing Hearings. 9
205. Appeal Of Automatic Adjustments. 9
206. Consolidated Hearing. 9
207. Postponement Of Food Stamp Hearings. 9
208. -- 249. (Reserved). 9
250. Food Stamps Disqualification Hearings. 9
251. Combining Disqualification Hearing And Benefit Hearing. 9
252. Right Not To Testify. 9
253. Failure To Appear. 9
254. Standard For Determining Intentional Program Violations. 10
255. -- 299. (Reserved). 10
300. Division Of Medicaid - Request For Administrative Review. 10
301. Scope Of Hearing. 10
302. -- 399. (Reserved). 10
400. Division Of Health -- Laboratories. 10
401. Reportable Diseases. 10
402. Food Establishments. 10
403. -- 999. (Reserved). 10

Nutrition Risk Criteria **334 LACK OF OR INADEQUATE PRENATAL CARE**

Category, Priority and Referral

Category	Priority	Referral
PREGNANT WOMEN	1	-

Definition

Prenatal care beginning after the 1st trimester (after 13th week), or based on an Inadequate Prenatal Care Index published in a peer review articlesuch as the one by Kessner et al. (4).

First prenatal visit in the third trimester (7-9 months) or:

Weeks Gestation	Number of Prenatal Visits (2)
14-21	0 or unknown
22-29	1 or less
30-31	2 or less
32-33	3 or less
34 or more	4 or less

Required Documentation

Number of prenatal care visits (or no visits).

Justification

Women who do not receive early and adequate prenatal care are more likely to deliver premature, growth retarded, or low birth weight infants (3). The Kessner Index can be used to assess the adequacy of prenatal care for a woman with an uncomplicated pregnancy. Women with medical or obstetric problems, as well as younger adolescents, may need closer management; the frequency of prenatal visits should be determined by the severity of identified problems (1). Several studies have reported significant health and nutrition benefits for pregnant women enrolled in the WIC Program (3).

Clarification

The Centers for Disease Control and Prevention (CDC) defines a trimester as a term of three months in the prenatal gestation period with the specific trimesters defined as follows in weeks:

- First Trimester: 0-13 weeks
- Second Trimester: 14-26 weeks
- Third Trimester: 27-40 weeks

Further, CDC begins the calculation of weeks starting with the first day of the last menstrual period. If that date is not available, CDC estimates that date from the established date of confinement (EDC). This definition is used in interpreting CDC's Prenatal Nutrition Surveillance System data, comprised primarily of data on pregnant women participating in the WIC Program.

References

1. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. Washington, D.C.: AAP, ACOG; 1997.
2. Centers for Disease Control and Prevention. Prenatal Nutrition Surveillance System User's Manual. Atlanta: CDC, 1994.
3. Institute of Medicine. WIC nutrition risk criteria a scientific assessment. National Academy Press, Washington, D.C.; 1996.
4. Kessner DM, Singer J, Kalk CE, Schlesinger ER. Infant Death: An analysis by maternal risk and health care. Contrasts in Health Status; Vol. I. Washington, D.C.: Institute of Medicine, National Academy of Sciences; 1973.

IDAPA 16
TITLE 05
CHAPTER 03

16.05.03 - RULES GOVERNING CONTESTED CASE PROCEEDINGS AND DECLARATORY RULINGS

000. LEGAL AUTHORITY.
The Idaho Legislature has granted the Director of the Department of Health and Welfare and the Board of Health and Welfare the power and authority to conduct contested case proceedings and issue declaratory rulings, and to adopt rules governing such proceedings under Sections 16-107, 56-133, 56-135, 56-202, 56-203, 56-204A, 56-216, 56-1003, 56-1004, and 56-1005, Idaho Code. (4-11-06)

001. TITLE AND SCOPE.

01. Title. These rules are to be cited fully as Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-01)

02. Scope. These rules establish standards for petitions for rulemaking and declaratory rulings, and the conduct of contested cases. Contested cases include appeals from providers of medical assistance and other services, and appeals relating to individuals' benefits administered through the Division of Welfare, child support license suspension hearings, denial of a criminal history exemption, and tobacco citations pursuant to Sections 39-5705 and 39-5708, Idaho Code. (3-30-01)

002. WRITTEN INTERPRETATIONS.
There are none for this chapter of rules. (3-30-01)

003. ADMINISTRATIVE APPEALS.
All contested cases are governed by the provisions of this chapter. The Board of Health and Welfare and the Director of the Department of Health and Welfare find that the provisions of IDAPA 04.11.01.000, et seq., "Idaho Rules of Administrative Procedure of the Attorney General," are inapplicable for contested cases involving the programs administered by the Department, because of the specific requirements of federal and state law regarding hearing processes, and the complexity of the rules at IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General." (4-11-06)

004. INCORPORATION BY REFERENCE.
There are none in this chapter of rules. (3-30-01)

005. ADMINISTRATIVE PROCEDURES SECTION.
Petitions for adoption of rules, petitions for declaratory rulings, and appeals must be filed with: Administrative Procedures Section, 10th Floor, 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036. Phone: (208) 334-5564. FAX: 334-6558. (4-11-06)

006. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (4-11-06)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (4-11-06)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (4-11-06)

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (4-11-06)

05. Internet Website. The Department's internet website is found at http://www.healthandwelfare.idaho.gov. (4-11-06)

007. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.
Any use or disclosure of Department records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (4-11-06)

008. -- 009. (RESERVED).

010. DEFINITIONS AND ABBREVIATIONS.

01. Appellant. A person or entity who files an appeal of Department action or inaction. (3-30-01)

02. Board. The Idaho Board of Health and Welfare. (3-30-01)

03. Department. The Idaho Department of Health and Welfare. (3-30-01)

04. Director. The Director of the Department of Health and Welfare. (3-30-01)

05. Hearing Officer. The person designated to preside over a particular hearing and any related proceedings. (3-30-01)

06. IPV. Intentional program violation. (3-30-01)

07. Intervenor. Any person, other than an appellant or the Department, who requests to be admitted as a party in an appeal. (3-30-01)

08. Party. An appellant, the Department and an intervenor, if intervention is permitted. (3-30-01)

011. -- 039. (RESERVED).

040. PETITION FOR ADOPTION OF RULES.
Under Section 67-5230, Idaho Code, any person may file a written petition with the Administrative Procedures Section requesting the promulgation, amendment, or repeal of a rule. The petition must include a name, address and phone number to which the Department may respond; list the rule in question and explain the reasons for the petition; and include the suggested language of the rule. The Director will initiate rulemaking proceedings or deny the petition in writing within twenty-eight (28) days. (4-11-06)

041. -- 049. (RESERVED).

050. PETITION FOR DECLARATORY RULING.
Under Section 67-5232, Idaho Code, any person may file a written petition to the Director through the Administrative Procedures Section for a declaratory ruling as to the applicability of any statute or rule of the Department to an actual set of facts involving that person. (4-11-06)

051. CONTENTS OF PETITION FOR DECLARATORY RULING.
A petition for a declaratory ruling must identify that it is a request for a declaratory ruling under this section; the specific statute, or rule with respect to which the declaratory ruling is requested; a complete description of the situation for which the declaratory ruling is requested; and the specific ruling requested. The petition must include the date of the petition, the name, address and phone number of the petitioner and whether the petition is made on behalf of a corporation or organization. The petition must identify the manner by which the statute or rule interferes with, impairs, or threatens to interfere with or impair the legal rights, duties, licenses, immunities, interests or privileges of the petitioner. (4-11-06)

052. DISPOSITION OF PETITION FOR DECLARATORY RULING.
The Director will issue a final declaratory ruling in writing within seventy (70) days after receipt of the petition or within such additional time as may be required. The Director may decline to issue a declaratory ruling in the

following circumstances: (4-11-06)

01. **Incomplete**. When a petition fails to meet the requirements set forth in Section 051 of these rules; (3-30-01)

02. **Contested Case**. When the issue set forth in the petition would be more properly addressed as a contested case, such as where there is a reasonable dispute as to the relevant facts, or where witness credibility is an issue; (3-30-01)

03. **No Legal Interest**. When the petition fails to state a sufficient or cognizable legal interest to confer standing; (3-30-01)

04. **Others Affected**. When the issue presented would substantially affect the legal rights, license, privileges, immunities, or interests of parties other than petitioners; or (3-30-01)

05. **Beyond Authority**. When the ruling requested is beyond the authority of the Department. (3-30-01)

053. -- 099. (RESERVED).

100. DEPARTMENT RESPONSIBILITY.
When a decision is appealable, the Department will advise the individual or provider in writing of the right and method to appeal and the right to be represented. (4-11-06)

101. FILING OF APPEALS.
Appeals must be filed in writing and state the appellant's name, address and phone number, and the remedy requested, except that appeals of action relating to Division of Welfare programs listed in Section 200 of these rules may be made verbally to Department Staff by an individual or representative. Appeals should be accompanied by a copy of the decision that is the subject of the appeal. Unless otherwise provided by statute or these rules, individuals who are aggrieved by a Department decision have twenty-eight (28) days from the date the decision is mailed to file an appeal. An appeal is filed when it is received by the Department or postmarked within the time limits set forth in these rules. (4-11-06)

102. NOTICE OF HEARING.
All parties in an appeal will be notified of a hearing at least ten (10) days in advance, or within such time period as may be mandated by law. The hearing officer may provide a shorter advance notice upon request of a party or for good cause. The notice will identify the time, place and nature of the hearing; a statement of the legal authority under which the hearing is to be held; the particular sections of any statutes and rules involved; the issues involved; and the right to be represented. The notice must identify how and when documents for the hearing will be provided to all parties. (4-11-06)

103. PREHEARING CONFERENCE.
The hearing officer may, upon written or other sufficient notice to all interested parties, hold a prehearing conference to formulate or simplify the issues; obtain admissions or stipulations of fact and documents; identify whether there is any additional information that had not been presented to the Department with good cause; arrange for exchange of proposed exhibits or prepared expert testimony; limit the number of witnesses; determine the procedure at the hearing; and to determine any other matters which may expedite the orderly conduct and disposition of the proceeding. (3-30-01)

104. SUBPOENAS.
At the request of a party, the hearing officer may issue subpoenas for witnesses or documents, consistent with Sections 120 and 134 of these rules. (3-30-01)

105. DISPOSITION OF CASE WITHOUT A HEARING.
Any contested case may be resolved without a hearing on the merits of the appeal by stipulation, settlement, motion to dismiss, summary judgment, default, withdrawal, or for lack of jurisdiction. The hearing officer must dismiss an appeal that is not filed within the time limits set forth in these rules. (4-11-06)

106. DEFAULT.
If a party fails to appear at a scheduled hearing or at any stage of a contested case, the hearing officer must enter a proposed default order against that party. The default order must be set aside if, within fourteen (14) days of the date of mailing, that party submits a written explanation for not appearing, which the hearing officer finds substantial and reasonable. (4-11-06)

107. INTERVENTION.
Persons other than the original parties to an appeal who are directly and substantially affected by the proceeding may participate if they first secure an order from the hearing officer granting leave to intervene. The granting of leave to intervene is not to be construed as a finding or determination that the intervenor is or may be a party aggrieved by any ruling, order or decision of the Department for purposes of judicial review. (4-11-06)

108. -- 119. (RESERVED).

120. DISCOVERY.
Except for hearings involving Section 56-1005(5), Idaho Code, prehearing discovery is limited to obtaining the names of witnesses and copies of documents the opposing party intends to offer as exhibits. The hearing officer may order production of this information if a party refuses to comply after receiving a written request. The hearing officer will issue such other orders as are needed for the orderly conduct of the proceeding. Nothing in Section 120 limits the authority of the Director provided in Section 56-227C, Idaho Code. (4-11-06)

121. BRIEFING SCHEDULE.
A hearing officer may require briefs to be filed by the parties, and establish a reasonable briefing schedule. (3-30-01)

122. FILING OF DOCUMENTS IN AN APPEAL.
All documents intended to be used as exhibits must be filed with the hearing officer. Such documents will be provided to every party at the time they are filed with the hearing officer, in person or by first class mail. Service by mail is complete when the document, properly addressed and stamped, is deposited in the United States or Statehouse mail. A certificate showing delivery to all parties will accompany all documents when they are filed with the hearing officer. (4-11-06)

123. REPRESENTATION.
Any party in a contested case proceeding may be represented by legal counsel, at the party's own expense. An individual in an appeal involving benefits may also be represented by a non-attorney. (3-30-01)

124. REPRESENTATION OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.
Unless an individual, authorized representative or attorney provides a written declaration to the contrary, eligible individuals with developmental disabilities or mental illness are deemed to be represented by the state Protection and Advocacy System established under 42 USC 6041, et seq., and 42 USC 10801 et seq., and designated by the Governor. The protection and advocacy system has access to records of such individuals maintained by any program or institution of the Department if the individual is unable to authorize the system to have such access, or does not have a legal guardian, conservator or other legal representative. Service of documents will be made on the protection and advocacy system and the individual. Unless the protection and advocacy system provides written notification to the Department that it will not be representing the individual, the system is an authorized representative. (4-11-06)

125. INTERPRETERS.
If necessary, an interpreter will be provided by the Department. (4-11-06)

126. -- 129. (RESERVED).

130. OPEN HEARINGS.
All contested case hearings are open to the public, unless ordered closed in the discretion of the hearing officer due to the sensitive nature of the hearing. The hearing officer can order that individuals be identified by initials or an alias if necessary to protect their privacy. Witnesses may testify by telephone or other electronic means, provided the examination and responses are audible to all parties. (3-30-01)

131. AUTHORITY OF HEARING OFFICER.
The hearing officer will consider only information that was available to the Department at the time the decision was made. If appellant shows that there is additional relevant information that was not presented to the Department with good cause, the hearing officer will remand the case to the Department for consideration. No hearing officer has the jurisdiction or authority to invalidate any federal or state statute, rule, regulation, or court order. The hearing officer must defer to the Department's interpretation of statutes, rules, regulations or policy unless the hearing officer finds the interpretation to be contrary to statute or an abuse of discretion. The hearing officer will not retain jurisdiction on any matter after it has been remanded to the Department. (4-11-06)

132. BURDEN OF PROOF -- INDIVIDUAL BENEFIT CASES.
The Department has the burden of proof if the action being appealed is to limit, reduce or terminate services or benefits; establish an overpayment or disqualification; revoke or limit a license; or to contest a tobacco violation under Sections 39-5705 and 39-5708, Idaho Code. The appellant has the burden of proof on all other issues, including establishing eligibility for a program, service or license; seeking an exemption required due to criminal history or abuse registry information; or seeking to avoid license suspension for failure to pay child support. (4-11-06)

133. BURDEN OF PROOF -- PROVIDER CASES.
The Department has the burden of proof if the action being appealed is to revoke or limit a license, certification, or provider agreement; or to impose a penalty. The appellant has the burden of proof on all other issues, including establishing entitlement to payment. (3-30-01)

134. EVIDENCE.
Under Section 67-5251, Idaho Code, the hearing is informal and technical rules of evidence do not apply, except that irrelevant, immaterial, incompetent, unduly repetitious evidence, evidence excludable on constitutional or statutory grounds, or evidence protected by legal privilege is excluded. Hearsay evidence will be received if it is relevant to a matter in dispute and is sufficiently reliable that prudent persons would commonly rely on it in the conduct of their affairs, or corroborates competent evidence. Any part of the evidence may be received in written form if doing so will expedite the hearing without substantially prejudicing the interest of any party. Documentary evidence may be received in the form of copies or excerpts if the original is not readily available. Unless otherwise stated in statute, rule, or regulation, the evidentiary standard is proof by a preponderance of the evidence. (4-11-06)

135. DISCRETIONARY JUDICIAL NOTICE.
Notice may be taken of judicially cognizable facts by the hearing officer or authority on its own motion or on motion of a party. In addition, notice may be taken of generally recognized technical or scientific facts within the Department's specialized knowledge. Parties will be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material noticed including any staff memoranda or data, and the parties will be afforded an opportunity to contest the material so noticed. The Department's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence. (4-11-06)

136. MANDATORY JUDICIAL NOTICE.
The hearing officer will take judicial notice, on its own motion or on the motion of any party, of the following admissible, valid and enforceable materials: Rules of the Department and other state agencies; Federal regulations; State plans of the Department; The Constitutions and statutes of the United States and Idaho; Public records; and Such other materials that a court of law must judicially notice. (4-11-06)

137. HEARING RECORD.
The hearing officer must arrange for a record to be made of a hearing. The hearing must be recorded unless a party requests a stenographic recording by a certified court reporter, in writing, at least seven (7) days prior to the date of hearing. The record must be transcribed at the expense of the party requesting a transcript and prepayment or guarantee of payment may be required. Once a transcript is requested, any party may obtain a copy at the party's own expense. The Department must maintain the complete record of each contested case for a period of not less than six (6) months after the expiration of the last date for judicial review, unless otherwise provided by law. (4-11-06)

138. DECISION AND ORDER.
A preliminary order must be issued by the hearing officer not later than thirty (30) days after the case is submitted for decision. The order must include specific findings on all major facts at issue; a reasoned statement in support of the decision; all other findings and recommendations of the hearing officer; a preliminary decision affirming, reversing

or modifying the action or decision of the Department, or remanding the case for further proceedings; and the procedures and time limits for filing requests for review of the order. Unless otherwise provided by a statute governing a particular program, motions for reconsideration of a preliminary order will not be accepted. (4-11-06)

139. -- 149. (RESERVED).

150. REVIEW OF PRELIMINARY ORDERS BY DEPARTMENT.
In cases under the jurisdiction of the Department, either party may file a request for review with the Administrative Procedures Section not later than fourteen (14) days from the date the preliminary order was mailed. The request must identify all legal and factual bases of disagreement with the preliminary order. The Director or designee must allow for briefing by the parties and determines whether oral argument will be allowed. The Director or designee determines whether a transcript of the hearing is needed and if so, one will be provided by the party who requests review of the preliminary order. The Director or designee must exercise all of the decision-making power he would have had if he had presided over the hearing. (4-11-06)

151. PETITION FOR REVIEW BY BOARD OF HEALTH AND WELFARE.
In cases under the jurisdiction of the Board, either party may file a petition for review with the Administrative Procedures Section not later than twenty-eight (28) days from the date the preliminary order was mailed. The Administrative Procedures Section will establish a schedule for the submission of briefs and if allowed, oral argument. Appellant must provide a transcript of the hearing before the hearing officer unless the appeal involves only questions of law. The Board will exercise all of the decision-making power they would have had if they had presided over the hearing. (4-11-06)

152. FINAL ORDER.
The Board, Director or designee may affirm, modify, or reverse the order, or remand the matter to the hearing officer for further proceedings. The decision informs the parties of the procedure and time limits for filing appeals with the district court. Motions for reconsideration of a final order will not be accepted. (4-11-06)

153. SERVICE OF PRELIMINARY AND FINAL ORDERS.
Orders will be deemed to have been served when copies are mailed to all parties of record or their attorneys. (4-11-06)

154. MAINTENANCE OF ORDERS.
All final orders of the Board or the Director will be maintained by the Administrative Procedures Section and made available for public inspection for at least six (6) months, or until all appeals are concluded, whichever is later. (4-11-06)

155. EFFECT OF PETITION FOR JUDICIAL REVIEW.
The filing of a petition for judicial review will not stay compliance with a final order or suspend the effectiveness of the order, unless otherwise ordered or mandated by law. (4-11-06)

156. -- 198. (RESERVED).

199. SPECIFIC CONTESTED CASE PROVISIONS.
The following sections set forth special requirements of various Department programs, which supersede the general provisions of these rules insofar as they are different or inconsistent. Sections 200 through 254 pertain to the programs in the Division of Welfare; Sections 300 and 301 pertain to the Division of Medicaid; and Sections 400 through 402 pertain to the Division of Health. (3-30-01)

200. DIVISION OF WELFARE APPEALS.
The provisions of this section of rules govern the conduct of individual benefit hearings to determine eligibility for benefits or services in the Division of Welfare, including IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled," IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho," IDAPA 16.03.04, "Rules Governing the Food Stamp Program in Idaho," IDAPA 16.06.12, "Rules Governing Idaho Child Care Program," IDAPA 16.04.14, "Rules Governing the Low Income Energy Assistance Program," IDAPA 16.04.02, "Idaho Telecommunication Service Assistance Program Rules," IDAPA 16.04.12, "Rules Governing Individual and Family Grant Programs," and IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families

and Children." (3-30-01)

201. TIME FOR FILING APPEAL.
A decision issued by the Department in a Division of Welfare program will be final and effective unless an individual or representative appeals within thirty (30) days from the date the decision was mailed, except that a recipient or applicant for Food Stamps has ninety (90) days to appeal. An individual or representative may also appeal when the Department delays in making an eligibility decision or making payment beyond the limits specified in the particular program within thirty (30) days after the action would have been taken if the Department had acted in a timely manner. (4-11-06)

202. INFORMAL CONFERENCE.
An appellant or representative has the right to request an informal conference with the Department or Community Action Agency before the hearing date. This conference may be used to resolve the issue informally or to provide the appellant with information about the hearing or actions. The conference will not affect the appellant's right to a hearing or the time limits for the hearing. After the conference, the hearing will be held unless the appellant withdraws the appeal, or the Department withdraws the action contested by the appellant. (4-11-06)

203. WITHDRAWAL OF AN APPEAL.
An appellant or representative may withdraw an appeal upon written request to the hearing officer. (3-30-01)

204. TIME LIMITS FOR COMPLETING HEARINGS.
The Department must conduct the hearing relating to an individual's benefits and take action within ninety (90) days from the date the hearing request is received. When the hearing request concerns the computed amount of the Community Spouse Resource Allowance, the hearing will be held within thirty (30) days from the date the hearing request is received. The Department will expedite hearing requests from appellants such as migrant farm workers who are planning to move before the hearing decision would normally be reached. (4-11-06)

205. APPEAL OF AUTOMATIC ADJUSTMENTS.
An appeal will be dismissed if the hearing officer determines that the sole issue is an automatic grant adjustment, change in rule that affects benefit amount or eligibility, or reduction of Medicaid services under state or federal law. (4-11-06)

206. CONSOLIDATED HEARING.
When there are multiple appeals or a group appeal involving same change in law, rules, or policy, the hearing officer will hold a consolidated hearing. (4-11-06)

207. POSTPONEMENT OF FOOD STAMP HEARINGS.
An appellant may request, and be granted a postponement of a hearing, not to exceed thirty (30) days. The time limit for the Department's response shall be extended for as many days as the hearing is postponed. (4-11-06)

208. -- 249. (RESERVED).

250. FOOD STAMPS DISQUALIFICATION HEARINGS.
A disqualification hearing will be scheduled when the Department has evidence that an individual has allegedly committed one (1) or more acts of intentional program violations (IPV). (4-11-06)

251. COMBINING DISQUALIFICATION HEARING AND BENEFIT HEARING.
The hearing officer must consolidate a hearing regarding benefits or overpayment and a disqualification hearing if the issues are the same or related. The appellant must be notified that the hearings will be combined. (4-11-06)

252. RIGHT NOT TO TESTIFY.
The hearing officer must advise the appellant that he may refuse to answer questions during a disqualification hearing. (4-11-06)

253. FAILURE TO APPEAR.
If an appellant or representative fails to appear at a disqualification hearing or cannot be located, the hearing will be conducted in his absence. The Department must present proof that advance notice of the hearing was mailed to the

appellant's last known address. The hearing officer must consider the evidence and determine if an IPV occurred based solely on the information provided by the Department. The appellant has ten (10) days from the date of the scheduled hearing to show good cause for failure to appear. If an IPV had been established, but the hearing officer determines the appellant had good cause for not appearing, the previous decision will be void and a new hearing will be conducted. The previous hearing officer may conduct the new hearing. (4-11-06)

254. STANDARD FOR DETERMINING INTENTIONAL PROGRAM VIOLATIONS.
The determination that an intentional program violation has been committed must be established by clear and convincing evidence that the appellant committed or intended to commit an IPV. (4-11-06)

255. -- 299. (RESERVED).

300. DIVISION OF MEDICAID - REQUEST FOR ADMINISTRATIVE REVIEW.
An action relating to licensure or certification, billing or reimbursement is final and effective unless the provider or facility requests in writing an administrative review within twenty-eight (28) days after the notice is mailed. The request must be signed by the licensed administrator of the facility or by the provider, identify the challenged decision, and state specifically the grounds for its contention that the decision was erroneous. The parties must clarify and attempt to resolve the issues at the review conference. If the Department determines that additional documentation is needed to resolve the issues, a second session of the conference may be scheduled. A written decision by the Department will be furnished to the facility or provider. (4-11-06)

301. SCOPE OF HEARING.
If the Department's decision after the administrative review is appealed, only issues and documentation that were presented in the administrative review will be admissible in the appeal hearing. (4-11-06)

302. -- 399. (RESERVED).

400. DIVISION OF HEALTH -- LABORATORIES.
A notice of grounds for denial, suspension, revocation or renewal becomes final and effective unless the applicant or responsible party files a written appeal by registered or certified mail within fourteen (14) days of receipt of the notice. A hearing will be held not more than twenty-eight (28) days from receipt of the appeal. The applicant or responsible person will receive at least fourteen (14) days of notice of the hearing date. If the Department finds that the public health, safety or welfare imperatively requires emergency action, and incorporates the findings to that effect in its notice of denial, suspension or revocation, summary suspension of the approval may be ordered. (4-11-06)

401. REPORTABLE DISEASES.
An order or restriction as specified in IDAPA 16.02.10, Subsections 015.05 through 015.10, "Idaho Reportable Diseases," becomes final and effective unless an appeal is filed within five (5) working days after the effective date of the order or restriction. (4-11-06)

01. Conduct of Hearing. The Department may take whatever precautions and make whatever arrangements are necessary for the conduct of such hearing to insure that the health of participants and the public is not jeopardized. (3-30-01)

02. Review. Any person directly affected by an order or restriction may file exceptions to the Director's determination, which will be reviewed by the Board. The order or restriction remains effective unless rescinded by the Board. (4-11-06)

402. FOOD ESTABLISHMENTS.
Appeal procedures will be as provided in Section 861, IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." (4-11-06)

403. -- 999. (RESERVED).

Subject Index

A

Appeal Of Automatic Adjustments 9
Authority Of Hearing Officer 7

B

Beyond Authority, Disposition of Petition for Declaratory Ruling 5
Briefing Schedule 6
Burden Of Proof - Individual Benefit Cases 7

C

Combining Disqualification Hearing & Benefit Hearing 9
Consolidated Hearing 9
Contents Of Petition For Declaratory Ruling 4
Contested Case, Disposition of Petition for Declaratory Ruling 5
Criteria For Determining IPV 10

D

Decision & Order 7
Default 6
Definitions, IDAPA 16.05.03, Rules Governing Contested Case Proceedings & Declaratory Rulings 4
Department Responsibility 5
Discovery 6
Discretionary Judicial Notice 7
Disposition Of Case Without A Hearing 5
Disposition Of Petition For Declaratory Ruling 4
Division Of Health - Laboratories 10
Division Of Welfare Appeals 8

E

Effect Of Petition For Judicial Review 8

F

Failure To Appear 9
Filing Of Appeals 5
Filing Of Documents In An Appeal 6
Final Order 8
Food Establishments 10
Food Stamp's Disqualification Hearings 9

H

Hearing Record 7

I

Incomplete, Disposition of Petition for Declaratory Ruling 5
Intervention 6

M

Mandatory Judicial Notice 7

N

No Legal Interest, Disposition of Petition for Declaratory Ruling 5
Notice Of Hearing 5

O

Open Hearings 6

P

Petition For Adoption Of Rules 4
Petition For Declaratory Ruling 4
Petition For Review By Board Of Health & Welfare 8
Postponement Of Food Stamp Hearings 9
Prehearing Conference 5
Provider Cases, Burden Of Proof 7

R

Reportable Diseases 10
Representation 6
Representation Of Individuals With Developmental Disabilities 6
Request For Administrative Review 10
Review Of Preliminary Orders By Department 8

S

Service Of Preliminary & Final Orders 8
Specific Contested Cases Provisions 8

T

Time For Filing Appeal 9
Time Limits For Completing Hearings 9

W

Withdrawal Of An Appeal 9

IDAHO WIC POLICY MANUAL
INDEX OF CHANGES
October 2014

Location in Manual	Change
1-A-1	Updated organization chart
1-A-3 through 1-A-5	Updated State staff responsibilities
1-B-5	Removed Athol clinic and satellite office phone numbers
1-B-7	Updated District 3 clinic list
3-A-4 through 3-A-9	Updated priority tables to include new/revised NRC
4-D-2	Changed the paragraph for documentation of ineligibility at mid-certification to match documentation of ineligibility at certification
7-A and 7-B	Overhauled to include Final Rule changes (e.g., inclusion of Full Nutrition Benefit and Maximum Monthly Allowances, no Medical Documentation for soy, healthcare provider referral to LA RD for food package determination, milk standards, “nutritionals” replacing “medical foods”)
7-C	Replaced references to the Rights and Responsibilities form with Rights, Responsibilities and Consent form
9-A-3	Added section about ACH payments
9-B-1	Added section about above 50% vendors
9-B-2	Added section about SNAP authorization
Nutrition Risk Criteria	
334 Lack of or Inadequate Prenatal Care	New
361 Depression	Revised
381 Oral Health Conditions	Revised (formerly Dental Problems)
411 Inappropriate Nutrition Practices (Infants)	Revised
Forms and Attachments	
Check Audit form	Removed – posted on Staff section of WIC website
Computer Down Kit	Replaced Nutrition Assessment forms to reflect new/revised NRC (all categories)
Index of Changes	Updated
Medical Documentation form	Removed – posted on Staff and Health Care Provider sections of WIC website (new form)
Rights, Responsibilities and Consent (English and Spanish)	Removed – posted on WIC website homepage

myPay

View other LESs Submit

DEFENSE FINANCE AND ACCOUNTING SERVICE MILITARY LEAVE AND EARNINGS STATEMENT

ID	NAME (Last, First, MI)	SOC. SEC. NO.	GRADE	PAY DATE	YRS SVC	ETS	BRANCH	ADSN/DSSN	PERIOD COVERED
							ARNG		**CHK DT**

	ENTITLEMENTS Type	Amount	DEDUCTIONS Type	Amount	ALLOTMENTS Type	Amount	SUMMARY +Amt Fwd	
A	BASIC PAY	999	FED INC TAX				+Tot Ent	999
B	HARDSHIP DUTY		FICA TAX	100.00			-Tot Ded	
C	PAY		STATE INC TAX				-Tot Allt	
D	SUBSISTENCE ALWS		DEBT PAYMENT				=Net Amt	
E	BAH						-Cr Fwd	
F	FAM SEP ALWS						=EOM Pay	
G	WITHHELD TAX REF							
H	OTHER CREDITS							
I								
J								
K								
L								
M								
N								
O								
	TOTAL							

LEAVE	BF Bal	Ernd	Used	Cr Bal	ETS Bal	Lv Lost	Lv Paid	Use/Lose	FED TAXES	Wage Period	Wage YTD	M/S	Ex	Add'l Tax	Tax YTD
			0			**.0**	**.0**					**M**	**01**	**.00**	

FICA TAXES	Wage Period	Soc Wage YTD	Soc Tax YTD	Med Wage YTD	Med Tax YTD	STATE TAXES	St ID	Wage Period	Wage YTD	M/S	Ex	Tax YTD
										M	**01**	

PAY DATA	BAQ Type	BAQ Depn	VHA Zip	Rent Amt	Share	Stat	JFTR	Depns	2D JFTR	BAS Type	Charity YTD	TPC	PACIDN
	W DEP	**SPOUSE**										**A**	

THRIFT SAVINGS PLAN (TSP)	Base Pay Rate	Base Pay Current	Spec Pay Rate	Spec Pay Current	Inc Pay Rate	Inc Pay Current	Bonus Pay Rate	Bonus Pay Current
	0	**.00**	**0**	**.00**	**0**	**.00**	**0**	**.00**
		TSP YTD Deductions **.00**		Deferred **.00**		Exempt **.00**		

www.dfas.mil

DFAS Form 702, Jan 02

UNDERSTANDING YOUR DJMS LEAVE AND EARNINGS STATEMENT

DEFENSE FINANCE AND ACCOUNTING SERVICE MILITARY LEAVE AND EARNINGS STATEMENT

ID	NAME (LAST, FIRST, MI)	SOC. SEC. NO.	GRADE	PAY DATE	YRS SVC	ETS	BRANCH	ADSN/DSSN	PERIOD COVERED

ENTITLEMENTS		DEDUCTIONS		ALLOTMENTS		SUMMARY
TYPE	AMOUNT	TYPE	AMOUNT	TYPE	AMOUNT	+ AMT FWD
A						+ TOT ENT
B						- TOT DED
C						- TOT ALMT
D						= NET AMT
E						- CR FWD
F						= EOM PAY
G						
H						
I						
J						
K						
L						
M						
N						
O						
TOTAL						

LEAVE	BF BAL	ERND	USED	CR BAL	ETS BAL	LV LOST	LV PAID	USE\LOSE	FED TAXES	WAGE PERIOD	WAGE YTD	M/S	EX	ADD'L TAX	TAX YTD

FICA TAXES	WAGE PERIOD	SOC WAGE YTD	SOC TAX YTD	MED WAGE YTD	MED TAX YTD	STATE TAXES	ST	WAGE PERIOD	WAGE YTD	M/S	EX	TAX YTD

PAY DATA	BAQ TYPE	BAQ DEPN	VHA ZIP	RANT AMT	SHARE	STAT	JFTR	DEPNS	2D JFTR	BAS TYPE	CHARITY YTD	TPC	PACIDN

REMARKS YTD ENTITLE_____ YTD DEDUCT _____

DFAS Form 702, May 92

Defense Finance and Accounting Service
Cleveland Center
Code FFS
October 1997

Your pay is your responsibility. This publication is intended to be used as a guide to aid you in understanding the DJMS Leave and Earnings Statement (LES) DFAS Form 702. Every month you will receive an LES showing entitlements, deductions and allotments. Besides obvious format differences, there are also differences in the content of the LES. The Sea Service Counter will now be displayed in the remarks portion of the LES and the Other Pay Date (OPED) is no longer present on the LES. The LES will now be one page in length.

Verify and keep your LES each month. If your pay varies significantly and you don't understand why, or if you have any questions after reading this publication, consult with your disbursing office.

Fields 1 - 9 contain the identification portion of the LES.

DEFENSE FINANCE AND ACCOUNTING SERVICE MILITARY LEAVE AND EARNINGS STATEMENT									
ID	NAME (LAST, FIRST, MI) **1**	SOC. SEC. NO. **2**	GRADE **3**	PAY DATE **4**	YRS SVC **5**	ETS **6**	BRANCH **7**	ADSN/DSSN **8**	PERIOD COVERED **9**

Field 1 **NAME.** The member's name in last, first, middle initial format.
Field 2 **SOC. SEC. NO.** The member's Social Security Number.
Field 3 **GRADE.** The member's current pay grade.
Field 4 **PAY DATE.** The date the member entered active duty for pay purposes in YYMMDD format. This is synonymous with the Pay Entry Base Date (PEBD).
Field 5 **YRS SVC.** In two digits, the actual years of creditable service.
Field 6 **ETS.** The Expiration Term of Service in YYMMDD format. This is synonymous with the Expiration of Active Obligated Service (EAOS).
Field 7 **BRANCH.** The branch of service, i.e., Navy.
Field 8 **ADSN/DSSN.** The Disbursing Station Symbol Number used to identify each disbursing office.
Field 9 **PERIOD COVERED.** This is the period covered by the individual LES. Normally it will be for one calendar month. If this is a separation LES, the separation date will appear in this field.

Fields 10 through 22 contain the entitlements, deductions, allotments, their respective totals and a mathematical summary portion.

	ENTITLEMENTS		DEDUCTIONS		ALLOTMENTS		SUMMARY	
	TYPE	AMOUNT	TYPE	AMOUNT	TYPE	AMOUNT	+ AMT FWD	**13**
A B C D E F G H I J K L M N O	**10**		**11**		**12**		+ TOT ENT	**14**
							- TOT DED	**15**
							- TOT ALMT	**16**
							= NET AMT	**17**
							- CR FWD	**18**
							= EOM PAY	**19**
	TOTAL	**20**	**21**		**22**			

Field 10 **ENTITLEMENTS.** In columnar style the names of the entitlements and allowances being paid. Space is allocated for fifteen entitlements and/or allowances. If more than fifteen are present the overflow will be printed in the

remarks block. Any retroactive entitlements and/or allowances will be added to like entitlements and/or allowances.

Field 11 **DEDUCTIONS.** The description of the deductions are listed in columnar style. This includes items such as taxes, SGLI, Mid-month pay and dependent dental plan. Space is allocated for fifteen deductions. If more than fifteen are present the overflow will be printed in the remarks block. Any retroactive deductions will be added to like deductions.

Field 12 **ALLOTMENTS.** In columnar style the type of the actual allotments being deducted. This includes discretionary and nondiscretionary allotments for savings and/or checking accounts, insurance, bonds, etc. Space is allocated for fifteen allotments. If a member has more than one of the same type of allotment, the only differentiation may be that of the dollar amount.

Field 13 **+AMT FWD.** The amount of all unpaid pay and allowances due from the prior LES.

Field 14 **+ TOT ENT.** The figure from Field 20 that is the total of all entitlements and/or allowances listed.

Field 15 **- TOT DED.** The figure from Field 21 that is the total of all deductions.

Field 16 **- TOT ALMT.** The figure from Field 22 that is the total of all allotments.

Field 17 **= NET AMT.** The dollar value of all unpaid pay and allowances, plus total entitlements and/or allowances, minus deductions and allotments due on the current LES.

Field 18 **- CR FWD.** The dollar value of all unpaid pay and allowances due to reflect on the next LES as the +AMT FWD.

Field 19 **= EOM PAY.** The actual amount of the payment to be paid to the member on payday.

Fields 20 - 22 **TOTAL.** The total amounts for the entitlements and/or allowances, deductions and allotments respectively.

Fields 23 through 30 contain leave information.

LEAVE	BF BAL	ERND	USED	CR BAL	ETS BAL	LV LOST	LV PAID	USE\LOSE
	23	**24**	**25**	**26**	**27**	**28**	**29**	**30**

Field 23 **BF BAL.** The brought forward leave balance. Balance may be at the beginning of the fiscal year, or when active duty began, or the day after the member was paid Lump Sum Leave (LSL).

Field 24 **ERND.** The cumulative amount of leave earned in the current fiscal year or current term of enlistment if the member reenlisted/extended since the beginning of the fiscal year. Normally increases by 2.5 days each month.

Field 25 **USED.** The cumulative amount of leave used in the current fiscal year or curretn term of enlistment if member reenlisted/extended since the beginning of the fiscal year.

Field 26 **CR BAL.** The current leave balance as of the end of the period covered by the LES.

Field 27 **ETS BAL.** The projected leave balance to the member's Expiration Term of Service (ETS).

Field 28 **LV LOST.** The number of days of leave that has been lost.

Field 29 **LV PAID.** The number of days of leave paid to date.

Field 30 **USE/LOSE.** The projected number of days of leave that will be lost if not taken in the current fiscal year on a monthly basis. The number of days of leave in this block will decrease with any leave usage.

Fields 31 through 36 contain Federal Tax withholding information.

FED TAXES	WAGE PERIOD	WAGE YTD	M/S	EX	ADD'L TAX	TAX YTD
	31	**32**	**33**	**34**	**35**	**36**

Field 31 **WAGE PERIOD.** The amount of money earned this LES period that is subject to Federal Income Tax Withholding (FITW).
Field 32 **WAGE YTD.** The money earned year-to-date that is subject to FITW.
Field 33 **M/S.** The marital status used to compute the FITW.
Field 34 **EX.** The number of exemptions used to compute the FITW.
Field 35 **ADD'L TAX.** The member specified additional dollar amount to be withheld in addition to the amount computed by the Marital Status and Exemptions.
Field 36 **TAX YTD.** The cumulative total of FITW withheld throughout the calendar year.

Fields 37 through 41 contain Federal Insurance Contributions Act (FICA) information.

FICA TAXES	WAGE PERIOD	SOC WAGE YTD	SOC TAX YTD	MED WAGE YTD	MED TAX YTD
	37	**38**	**39**	**40**	**41**

Field 37 **WAGE PERIOD.** The amount of money earned this LES period that is subject to FICA.
Field 38 **SOC WAGE YTD.** The wages earned year-to-date that are subject to FICA.
Field 39 **SOC TAX YTD.** Cumulative total of FICA withheld throughout the calendar year.
Field 40 **MED WAGE YTD.** The wages earned year-to-date that are subject to Medicare.
Field 41 **MED TAX YTD.** Cumulative total of Medicare taxes paid year-to-date.

Fields 42 through 47 contain State Tax information.

STATE TAXES	ST	WAGE PERIOD	WAGE YTD	M/S	EX	TAX YTD
	42	**43**	**44**	**45**	**46**	**47**

Field 42 **ST.** The two digit postal abbreviation for the state the member elected.
Field 43 **WAGE PERIOD.** The amount of money earned this LES period that is subject to State Income Tax Withholding (SITW).
Field 44 **WAGE YTD.** The money earned year-to-date that is subject to SITW.
Field 45 **M/S.** The marital status used to compute the SITW.
Field 46 **EX.** The number of exemptions used to compute the SITW.
Field 47 **TAX YTD.** The cumulative total of SITW withheld throughout the calendar year.

Fields 48 through 60 contain additional Pay Data.

PAY DATA	BAQ TYPE	BAQ DEPN	VHA ZIP	RENT AMT	SHARE	STAT	JFTR	DEPNS	2D JFTR	BAS TYPE	CHARITY YTD	TPC	PACIDN
	48	**49**	**50**	**51**	**52**	**53**	**54**	**55**	**56**	**57**	**58**	**59**	**60**

Field 48 **BAQ TYPE.** The type of Basic Allowance for Quarters being paid.

Field 49 **BAQ DEPN.** A code that indicates the type of dependent.

I - Member married to member/own right
R - Own right
A - Spouse
C - Child
W - Member married to member, child under 21
G - Grandfathered
D - Parent
K - Ward of the court
L - Parents in Law
S - Student (age 21-22)
T - Handicapped child over age 21

Field 50 **VHA ZIP.** The zip code used in the computation of Variable Housing Allowance (VHA) if entitlement exists.

Field 51 **RENT AMT.** The amount of rent paid for housing if applicable.

Field 52 **SHARE.** The number of people with which the member shares housing costs.

Field 53 **STAT.** The VHA status; i.e., accompanied or unaccompanied.

Field 54 **JFTR.** The Joint Federal Travel Regulation (JFTR) code based on the location of the member for Cost of Living Allowance (COLA) purposes.

Field 55 **DEPNS.** The number of dependents the member has for VHA purposes.

Field 56 **2D JFTR.** The JFTR code based on the location of the member's dependents for COLA purposes.

Field 57 **BAS TYPE.** An alpha code that indicates the type of Basic Allowance for Subsistence (BAS) the member is receiving, if applicable. This field will be blank for officers.

B - Separate Rations
C - TDY/PCS/Proceed Time
H - Rations-in-kind not available
K - Rations under emergency conditions

Field 58 **CHARITY YTD.** The cumulative amount of charitable contributions for the calendar year.

Field 59 **TPC.** This field is not used by the Navy.

Field 60 **PACIDN.** The activity Unit Identification Code (UIC).

REMARKS	YTD ENTITLE_____	YTD DEDUCT _____
61	**62**	**63**

Field 61 **REMARKS.** Notices of starts, stops and changes to a member's pay items as well as general notices from varying levels of command may appear.

Field 62 **YTD ENTITLE.** The cumulative total of all entitlements for the calendar year.

Field 63 **YTD DEDUCT.** The cumulative total of all deductions for the calendar year.

Letter of Ineligibility for WIC Participation in Idaho

Date: _____

Thank you for applying for or participating in the Idaho WIC Program. If you have participated in the Idaho WIC Program, we hope that WIC helped you and/or your family. If this is your first visit to WIC and you do not qualify, please check back with us should your situation change related to reason(s) listed below.

_____ does not qualify or will no longer receive WIC benefits from this clinic for the following reason(s) marked below:

- ❒ You/your child is categorically ineligible for WIC.
- ❒ Your family income is over the income guidelines.
  Reported household size: _____ Reported income/frequency: _____
- ❒ You are six (6) months past delivery and are not breastfeeding.
- ❒ Your child is now five (5) years old.
- ❒ You have been/are breastfeeding an infant who is now 12 months old.
- ❒ You do not live within the service area served by this agency.
- ❒ You have asked to discontinue your participation in WIC.
- ❒ You/your child does not have an identified nutritional need.
- ❒ Other: _____

If you feel that this decision is not fair, you may request a Fair Hearing by contacting the State of Idaho WIC Program at 450 W. State St., 1st Fl., Boise, Idaho 83720 or the Civil Rights Coordinator at (907) 465-3100. You must request a Fair Hearing in writing within sixty (60) days from the date on this letter. If you wish to request a Fair Hearing, we will provide you with additional details.

Local WIC Agency Name: _____

Signature of WIC Participant/Applicant/Responsible Adult: _____

Signature of WIC Staff: _____

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/ complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Carta de Inelegibilidad para Participar en WIC en Idaho

Fecha: _____

Gracias por solicitar beneficios o por participar en el Programa WIC de Idaho. Si ha participado en el Programa WIC de Idaho, esperamos que WIC le haya sido de ayuda a usted y a su familia. Si esta es su primera visita a WIC y no califica, por favor regrese después si su situación cambia en lo que se refiere a las razones anotadas abajo.

_____ no califica o ya no recibe beneficios de WIC en esta clínica por las siguientes razones marcadas abajo:

- ❒ Usted/su hijo no es categóricamente elegible para WIC.
- ❒ El ingreso de la familia se sobrepasa de la guía de ingresos.
  El tamaño del hogar reportado: _____ El ingreso reportado/frecuencia: _____
- ❒ Ya pasaron seis (6) meses después del parto y no está amamantando.
- ❒ Su hijo ya tiene cinco (5) años de edad.
- ❒ Ha estado o está amamantando un bebé que ya tiene 12 meses de edad.
- ❒ Usted no vive dentro del área de servicio de esta agencia.
- ❒ Usted pidió no continuar participando en WIC.
- ❒ Usted/su hijo no tiene una necesidad de nutrición identificada.
- ❒ Otro: _____

Si siente que esta decisión no es justa, puede pedir una Audiencia Justa al contactar al Programa de WIC del Estado de Idaho, en 450 W. State St., 1st Fl., Boise, Idaho 83720 ó al Coordinador de Derechos Civiles al (907) 465-3100. Usted debe solicitar una audiencia justa por escrito dentro de sesenta (60) días de la fecha en esta carta. Si desea solicitar una Audiencia Justa, le daremos más detalles.

Nombre de la Agencia Local de WIC: _____

Firma del Participante/Solicitante/Adulto Responsable: _____

Firma del Personal de WIC: _____

El Departamento de Agricultura de los Estados Unidos (por sus siglas en inglés "USDA") prohíbe la discriminación contra sus clientes, empleados y solicitantes de empleo por raza, color, origen nacional, edad, discapacidad, sexo, identidad de género, religión, represalias y, según corresponda, convicciones políticas, estado civil, estado familiar or paternal, orientación sexual, o si los ingresos de una persona provienen en su totalidad o en parte de un programa de asistencia pública, o información genética protegida de empleo o de cualquier programa o actividad realizada o financiada por el Departamento. (No todos los criterios prohibidos se aplicarán a todos los programas y/o actividades laborales).

Si desea presentar una queja por discriminación del programa de Derechos Civiles, complete el USDA Program Discrimination Complaint Form (formulario de quejas por discriminación del programa del USDA), que puede encontrar en internet en http://www.ascr.usda.gov/complaint_filing_cust.html, o en cualquier oficina del USDA, o llame al (866) 632-9992 para solicitar el formulario. También puede escribir una carta con toda la información solicitada en el formulario. Envíenos su formulario de queja completo o carta por correo postal a U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, por fax al (202) 690-7442 o por correo electrónico a program.intake@usda.gov.

Las personas sordas, con dificultades auditivas, o con discapacidad del habla pueden contactar al USDA por medio del Federal Relay Service (servicio federal de transmisión) al (800) 877-8339 o (800) 845-6136 (en español).

El USDA es un proveedor y empleador que ofrece igualdad de oportunidades.

State Review Tool – Local Agency Chart Reviews

Agency: Choose an item.		Date(s): Click here to enter a date.Click here to enter a date.					
Clinic: Choose an item.		Reviewer(s): Choose an item. and Choose an item.					
1.	**Application**	**Chart** Choose an item.	**Chart** Choose an item.	**Chart** Choose an item.	**Chart** Choose an item.	**Chart** Choose an item.	**Comments**
	Family (client) No:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text.
	Participant Category:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Initial date of program inquiry served within timeframe	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Name, DOB accurate (match application)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Collection of racial/ethnic data done by participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Right and Responsibilities signed by participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Application signed by participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
2.	**Family Information**						**Comments**
	Documentation of Income (No proof Form)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text.
	Proof of Residency Documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Family history of homeless or migrant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
3.	**Participant Information**						**Comments**
	Client is a VOC or in Foster care	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text.
	Proof of ID Documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Proof of Pregnancy	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Immunization documented for infant/child	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
4.	**Nutrition Assessment/ Education**						**Comments**
	Health screening (age 5-7 months)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text.
	Risk codes assigned correctly	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Nutrition Education Documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Handouts documented (documented if given or not)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Low- risk care plan written by CPA	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	High-risk care plan written by RD (referral) or Note by RD (route)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Encouraged to breastfeed (pregnant)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Nutrition education contact (2 x 6 m, 4 x 1 yr)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

5.	Food Package Assignment						Comments
	Appropriateness of Food Package	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text.
	Prescriptions are obtained for special formulas, or Medical food pkg	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text. C:Click here to enter text. C:Click here to enter text. C:Click here to enter text.
6.	Follow-up						Comments
	Progress notes generally up to date	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text.
	High risk referral (if applicable)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text.
	Referrals documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text.
	Appointment schedule realistic	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	C:Click here to enter text. C:Click here to enter text.

Chart	Best Practices	Needs Improvement
Chart Choose an item.	Click here to enter text.	Click here to enter text.
Chart Choose an item.	Click here to enter text.	Click here to enter text.
Chart Choose an item.	Click here to enter text.	Click here to enter text.
Chart Choose an item.	Click here to enter text.	Click here to enter text.
Chart Choose an item.	Click here to enter text.	Click here to enter text.

Electronically Signed: Click here to enter text. Electronically Signed: Click here to enter text. Date: Click here to enter a date.

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

State Review Tool – Local Agency Clinic Observations

Agency: Choose an item.	Date(s): Click here to enter a date. Click here to enter a date.
Clinic: Choose an item.	Reviewer(s): Choose an item. and Choose an item.

Staff/Participant Information	OBS Choose an item.	OBS Choose an item.	OBS Choose an item.	OBS Choose an item.	OBS Choose an item.	Comments
Family (client) No:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text.
Participant Category:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
Staff Name (Certifier):	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	
Staff Name (Check distribution):	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	
Apt Type:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
1. **Determine WIC Eligibility**						**Comments**
Cordial Introduction	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text.
Participant confidentiality is maintained	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
Participant being certified is physically present for visit.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
Rights and Responsibilities are explained to the participant.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
Consent form signed *before* procedures.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
2. **Anthropometric Assessment**						**Comments**
Procedure is explained to applicant/participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text.
Height/Length and weight measurement technique	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
Sanitary technique and disposal used	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
3. **Hematologic Assessment**						**Comments**
Procedure explained to applicant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

	Hgb or hct technique	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Sanitary technique and disposal used	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Value explained to the applicant/participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
							O:Click here to enter text.
4.	**Health/Nutrition Information Questionnaire**						**Comments**
	Listened actively and allowed time for participant to talk.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Collected missing information from questionnaire in a non-judgmental manner.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Validated participants concerns while collecting information.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
							O:Click here to enter text.
5.	**Counseling and Education**						**Comments**
	Counseling and education occurs after assessment is completed.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Growth chart or prenatal weight gain grid is explained in a non-judgmental manner.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Hemoglobin is explained in non-judgmental manner	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Offered at most 1-2 nutrition related handouts.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Pregnant/Postpartum women were encouraged to breastfeed.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	O:Click here to enter text.
	Second nutrition education is offered/discussed with participant.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Appropriate referrals given both written and verbally.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
6.	**Participant Centered Services (PCS)**						**Comments**
	Elements of PCS are demonstrated: 1. Sets the agenda, opens the conversation 2. Establishes rapport 3. Asks open-ended & probing questions 4. Actively listens, supports participant talk time 5. Gives affirmations 6. Uses reflections 7. Summarizes, closes session x= Complete, done correctly	1.☐ 2.☐ 3.☐ 4.☐ 5.☐ 6.☐ 7.☐	1.☐ 2.☐ 3.☐ 4.☐ 5.☐ 6.☐ 7.☐	1.☐ 2.☐ 3.☐ 4.☐ 5.☐ 6.☐ 7.☐	1.☐ 2.☐ 3.☐ 4.☐ 5.☐ 6.☐ 7.☐	1.☐ 2.☐ 3.☐ 4.☐ 5.☐ 6.☐ 7.☐	O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text. O:Click here to enter text.

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

	Participant is actively involved in determining next steps (setting a goal) for improving health outcomes.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Tailored Nutr messages based upon participants interests/concerns, limited number of nutrition messages discussed	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Comments are made concerning progress of last visit	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
7.	**Food Instrument Issuance**						**Comments**
	Food Package is prescribed after nutrition assessment and tailored for participant (i.e. asked about preferences)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	**O:**Click here to enter text. **O:**Click here to enter text. **O:**Click here to enter text. **O:**Click here to enter text. **O:**Click here to enter text.
	Food package is issued correctly	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Elements of Food Instrument education are demonstrated: 1. Explains food package (why prescribed, supplemental nature, etc.) ☐ 2. How to use WIC checks/cash value vouchers is fully explained. ☐ 3. How to identify Authorized WIC vendor. ☐ 4. Authorized food list explained ☐ x= Complete, done correctly (If N/A selected since participant has a history of (H/O) WIC, still like to see staff ask participant if they have questions about these elements.)	1. ☐ 2. ☐ 3. ☐ 4. ☐ (or ☐ N/A for H/O WIC)	1.☐ 2.☐ 3.☐ 4.☐ (or ☐ N/A for H/O WIC)	1.☐ 2.☐ 3.☐ 4.☐ (or ☐ N/A for H/O WIC)	1.☐ 2.☐ 3.☐ 4.☐ (or ☐ N/A for H/O WIC)	1.☐ 2.☐ 3.☐ 4.☐ (or ☐ N/A for H/O WIC)	
	Separation of duties exists according to policy	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Check/CVV register is signed *after* checks/ CVV's are received.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
8.	**Documentation- Chart Review**						**Comments**
	Collection of racial/ethnic data done by participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	**O:**Click here to enter text. **O:**Click here to enter text. **O:**Click here to enter text. **O:**Click here to enter text. **O:**Click here to enter text.
	Right and Responsibilities signed by participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Application signed by participant	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Proof of ID (proof of pregnancy), Residency, Income	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Immunization documented for infant/child	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Risk codes assigned correctly	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	

	High risk referral (if applicable)	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Med Doc Form for special formulas or Medical food pkg	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Nutrition Education documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Handouts given documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Referrals documented	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	
	Care Plan written, Progress Notes up to date	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	

OBS	Best Practices	Needs Improvement
OBS Choose an item.	Click here to enter text.	Click here to enter text.
OBS Choose an item.	Click here to enter text.	Click here to enter text.
OBS Choose an item.	Click here to enter text.	Click here to enter text.
OBS Choose an item.	Click here to enter text.	Click here to enter text.
OBS Choose an item.	Click here to enter text.	Click here to enter text.

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

Electronically Signed: Click here to enter text. Electronically Signed: Click here to enter text. Date: Click here to enter a date.

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

State Review Tool – Local Agency Class Observations

Agency: Choose an item. Clinic: Choose an item.	Date(s): Click here to enter text.
Reviewer(s): Choose an item.	Staff Name: Click here to enter text.
Class: Click here to enter text.	Attendance: Click here to enter text.

1.	Facilitated Discussion	Result	Comments
	Class is facilitated by a qualified, trained staff member	Choose an item.	Click here to enter text.
	Class utilized a facilitated discussion model: 1. Interactive 2. Learners and facilitator share concerns, knowledge, and experiences 3. Supportive group leader style x= Complete, done correctly	1.☐ 2.☐ 3.☐	
	Class utilized relevant supportive training and education materials i.e. videos, handouts, visual aids	Choose an item.	
	Audiovisuals were properly used to reinforce information	Choose an item.	
	Room set-up was conducive to group learning	Choose an item.	
	Participants were scheduled for appropriate classes taking into account preferences, category, risk conditions, cultural identity, etc	Choose an item.	

Best Practices	Needs Improvement
Click here to enter text.	Click here to enter text.

Electronically Signed: Click here to enter text. Date: Click here to enter a date.

State Review Tool – Local Agency Clinic Site Review

Agency: Choose an item.	Date(s): Click here to enter a date. to Click here to enter a date.	Reviewer: Choose an item.

1.	Civil Rights	Clinic (Main): Choose an item.		Clinic (#2): Choose an item.		Clinic (#3): Choose an item.		Comments		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Building has easily visible "smoke-free" signage and no-smoking policy. [WRO 802-A/ASM 94-54]	Choose an item.		Choose an item.		Choose an item.		Click here to enter text.	Click here to enter text.	Click here to enter text.
	Civil Rights Poster ("And Justice for All") posted and clearly visible. [7 CFR 246.8, FNS Instruction 113-2, Rev. 1, ASM 98-90]	Choose an item.		Choose an item.		Choose an item.				
	Staff receives Civil Rights Training annually and is documented. [FNS Instruction 113-1]	Choose an item.								
	Clinic is accessible for persons with physical limitations. If not, what accommodations are made available? [7 CFR 246.8, FNS Instruction 113-2, Rev. 1]	Choose an item.		Choose an item.		Choose an item.				
	The civil rights (non-discrimination) statement is included, as appropriate, on all materials used. [7 CFR 246.8(a), 818-B]	Choose an item.		Choose an item.		Choose an item.				
	Civil Rights complaints received per State policy and retains file of complaints. [FNS Instruction 113-1; 7 CFR 246.8; IDHW – policy memo 04-05]	Choose an item.								
	Collection of racial/ethnic data from applicants/participants; allows participant to select as many racial categories as he/she chooses. [WRO Policy Memo 818-E; ASM 04-34]	Choose an item.		Choose an item.		Choose an item.				
	Follows policy for Limited English Proficiency (LEP) persons. [7 CFR 246.8(c), FNS Instruction 113-2, Rev 1, ASM 98-90]	Choose an item.		Choose an item.		Choose an item.				

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

2.	Customer Service	Clinic (Main):		Clinic (#2):		Clinic (#3):		Comments		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Clinic areas clean and free of hazards.	Choose an item.		Choose an item.		Choose an item.		Click here to enter text.	Click here to enter text.	Click here to enter text.
	Certification area provides confidentiality and privacy. [7 CFR 246.11(c)(7)(i)]	Choose an item.		Choose an item.		Choose an item.				
	Follows policy for release of participant information. [FNS Instruction 800-1]	Choose an item.		Choose an item.		Choose an item.				
	Follows policy for contacting prenatal applicants who miss the first certification appointment. [7 CFR 246.7 (b)(5)]	Choose an item.		Choose an item.		Choose an item.				
	Follows policy for processing VOC's. [FNS Instruction 803-11, Rev 1; 803-G; 803-AQ]	Choose an item.		Choose an item.		Choose an item.				
	Applicants are given certification appointments within specified time frames. [7CFR 246.7(f)(2); 803-15] Fill in date of next appointment:	Choose an item.	Click here to enter a date.	Choose an item.	Click here to enter a date.	Choose an item.	Click here to enter a date.			
3.	Breastfeeding Friendly	Clinic (Main):		Clinic (#2):		Clinic (#3):		Comments		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Formula and BF equipment storage is secure.	Choose an item.		Choose an item.		Choose an item.		Click here to enter text.	Click here to enter text.	Click here to enter text.
	Clinic environment is positive and endorses BF as the preferred method of infant feeding. [7 CFR 246.11(c)(7)(i)]	Choose an item.		Choose an item.		Choose an item.				
	Incorporates task-appropriate BF promotion and support training into orientation programs. [7 CFR 246.11(c)(7)(iii)]	Choose an item.								
	A person is designated as the BF coordinator for the agency/clinic [7 CFR 246.11 (c)(7)(ii)]	Choose an item.								
	Plans for prenatal and postpartum breastfeeding promotion and support are in use. {7 CFR 246.11(c)(7)(iv)	Choose an item.								

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

4.	Logs/Files	Clinic (Main):		Clinic (#2):		Clinic (#3):		Comments		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Calibration of scales/equipment schedule posted and current. (Quarterly)	Choose an item.	Click here to enter a date.	Choose an item.	Click here to enter a date.	Choose an item.	Click here to enter a date.	Click here to enter text.	Click here to enter text.	Click here to enter text.
	Waiting List log (verify minimum required information, # of people, oldest entry). [7 CFR 246.7(f)(1), 803-6]	Choose an item.		Choose an item.		Choose an item.				
	Non-Eligible Applicants file with written notification with reason. [7 CFR 246.7(j)(5)]	Choose an item.		Choose an item.		Choose an item.				
	Conflict of Interest Forms File [2-D-1; 7 CFR 246.4 (a)(26)(i-iii)]	Choose an item.								
	Semi-Annual Certification File [OMB A-87]	Choose an item.								
	Documentation of staff training [7 CFR 246.2]	Choose an item.								
	An annual NEP is available and in use. [7 CFR 246.11(d)(2)]	Choose an item.								
5.	Participant Abuse/ Complaints	Clinic (Main):		Clinic (#2):		Clinic (#3):		Comments		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Fair hearing request file. [7 CFR 246.8(b), IDHW Policy Memo 01-1]	Choose an item.						Click here to enter text.	Click here to enter text.	Click here to enter text.
	Address complaints (other) received against participants and/or vendors per state policy and retains a file of complaints. [chapter 2, section D]	Choose an item.		Choose an item.		Choose an item.				
6.	Food Instrument Issuance	Clinic (Main):		Clinic (#2):		Clinic (#3):		Comments		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Check/cash value voucher register done correctly.	Choose an item.		Choose an item.		Choose an item.		Click here to enter text.	Click here to enter text.	Click here to enter

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

	Follows policy for proxies and authorized signers. [7 CFR 246.2, 7 CFR 246.12(r)(1-4), 803-AI]	Choose an item.		Choose an item.		Choose an item.				text.
	Local agency does not allow applicants who are also agency staff, close friends with agency staff or immediate family members with agency staff to certify one's self or relatives or close friends. [7 CFR 246.4(a)(i)(ii); ASM 99-94] (Obtain a copy of procedure)	Choose an item.								
	Is there a list which indicates any relatives of staff, or staff working for the local clinic that are receiving WIC benefits?	Choose an item.								
	Ensures separation of benefit activities. (Procedure for clinic with one staff person) [7 CFR 246.4(25)(iii); ASM 99-94]	Choose an item.		Choose an item.		Choose an item.				
7.	**Clinic Environment**	**Clinic (Main):**		**Clinic (#2):**		**Clinic (#3):**		**Comments**		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	Measurement boards in good condition.	Choose an item.		Choose an item.		Choose an item.		Click here to enter text.	Click here to enter text.	Click here to enter text.
	Scales in good condition.	Choose an item.		Choose an item.		Choose an item.				
	Biohazard labeled containers for appropriate waste disposal.	Choose an item.		Choose an item.		Choose an item.				
	Work area is clean and sanitary procedures are followed.	Choose an item.		Choose an item.		Choose an item.				
	Correct policy manual used.	Choose an item.		Choose an item.		Choose an item.				
	Copy of current Certificate of Waiver from CLIA on file.	Choose an item.	Click here to enter a date.							

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

	Documentation of Idaho license for all RD's. [Idaho Statutes Title 54, Chapter 35-03]	Choose an item.								
	MOU(s) with other agencies/programs to ensure coordination of services and confidentiality. [7 CFR 246.6]	Choose an item.	List dates in comment box							
8.	**Certification**	**Clinic (Main):**		**Clinic (#2):**		**Clinic (#3):**		**Comments**		
		Observation Result	Up-to-Date?	Observation Result	Up-to-Date?	Observation Result	Up-to-Date?			
	During each six-month certification, at least 2 nutrition education contacts are made available to all. (2 contacts for each six months for certs longer than six months) [7 CFR 246.11(e)(2)(3)]	Choose an item.		Choose an item.		Choose an item.		Click here to enter text.	Click here to enter text.	Click here to enter text.
	Provide drug and other harmful substance abuse information to all clients. [7 CFR 246.11(a)(3)]	Choose an item.		Choose an item.		Choose an item.				
	Provide applicants/participants with referral(s) to: Medicaid, SNAP, CHIP, TANF, Immunizations, and others as needed. [7 CFR 246.7(b)]	Choose an item.		Choose an item.		Choose an item.				
	Children under the age of two are screened for immunization status using a documented record and referrals are provided to immunization services if needed. [WRO Policy Memo 803-AT]	Choose an item.		Choose an item.		Choose an item.				
	Does the agency conduct immunization screening and referral that goes beyond the minimum protocol outlined? [WRO policy Memo 803-AT]	Choose an item.								

Clinic	Best Practices	Needs Improvement
Clinic (Main): Click here to enter text.	Click here to enter text.	Click here to enter text.
Clinic (#2): Click here to enter text.	Click here to enter text.	Click here to enter text.
Clinic (#3): Click here to enter text.	Click here to enter text.	Click here to enter text.

Electronically Signed: Click here to enter text. Date: Click here to enter a date.

√ = Complete, done correctly N/A = Not Applicable X = Not done correctly

Local Agency Program Review Questionnaire

1. Please indicate the hours of operation for each clinic in your agency, make sure to include if any clinics are open for extended hours in the evening, weekends, or throughout the lunch period.

2. What is your agency most proud of in regards to participant centered services?

3. How are WIC participants scheduled for appointments? Please be specific if you have set aside days or times for specific appointment types such as classes, transfers or pregnant women. Also, what appointment types are scheduled during the time of our LA Review?

4. What has and has not worked well for adhering to processing standards? Please explain.

5. Please describe how 2nd Nutrition Education contacts are being scheduled; e.g. group classes, one-on-one, or by any other means, and list any challenges you may have in carrying out this nutrition education contact.

6. Please describe any innovative ways in which staff provides education, support and promotion of breastfeeding for both prenatal and postpartum women.

7. Are there any unique community partners you have for providing referrals?

8. What do you feel was your most successful outreach activity over the past year? Why?

9. What does your agency perceive as barriers in your efforts to best service WIC Participants? Explain any efforts or resources that have been helpful in addressing these barriers.

10. What areas would your agency like to focus on for growth and development? Describe any plans or progress toward these areas of focus.

11. Are there any questions, concerns, comments, technical assistance requests or recommendations you or your staff would like to address with us? If so, please provide a brief synopsis.

STATE FINANCIAL MANAGEMENT REVIEW FORM

Local Agency: Choose an item.
Site(s) Reviewed: Choose an item. Choose an item. Choose an item.
WIC Coordinator: Choose an item.
State Reviewer(s): Choose an item. Date: Click here to enter a date.

NOTE: Review items 1 through 10 at the State Office *prior to* on-site visit.

	REVIEW	YES	NO	N/A	COMMENTS
1.	Local Agency audit has been recently completed and forwarded to State Agency. [Contact State Legislative auditor for local agency health department copy. Contact Director of tribal associations for copy]				Fiscal year audited _____ Date of audit report _____
2.	Established claims for unallowable costs have been reconciled. If no, please explain in 'Comments'. [Review audit--follow-up with district/tribal association as needed. If a WIC finding is noted in audit, call the agency to find out what action is being taken; request documentation.]				
3.	There is documentation of corrective action plan(s) taken in response to WIC financial findings from recent audit report. [Review audit—follow-up with district/tribal association as needed.]				
4.	Local Agency has provided State Agency with line item budget and justifications during current fiscal year for its total WIC administrative grant. [Verify copy of budget is in contract file]				
5.	Local Agency incorporated budget modification(s) requested by State Agency as a result of the budget review. [Review budget and supporting correspondence]				

	REVIEW	YES	NO	N/A	COMMENTS
6.	Local Agency submits revised budget when additional allocations are made. [Review budget.]				
7.	Current budget does not deviate significantly from Local Agency's expenditure pattern. [Review current budget with previous 2-year closeout]				
8.	Twenty percent (20%) of the Local Agency administrative grant has been expended for nutrition education purposes. [Verify copy of budget in contract file]				
9.	Local Agency submits WIC monthly expenditure report by 30th day following the end of the month to State office.				
10.	Reported amounts in monthly regular expenditure reports reflect immediate cash needs (actual costs), rather than estimate costs, such as 1/12 of budget. [Reviewed monthly at State Office]				
11.	Claimed costs are allowable. [Ask to see 4-5 invoices. Verify that WIC appropriate expenditures are per WIC regulations. Check invoice against payment register (8230-type report). Ensure paid by correct department.] [OMB Circular A-87; 7 CFR 246.14]				
12.	Random sample of source documents can be traced to Local Agency's regular administrative expenditure reports. [Ask to see 4-5 invoices. Verify that WIC appropriate expenditures are per WIC regulations. Check invoice against payment register (8230-type report). Ensure paid by correct department.] [OMB Circular A-87; 7 CFR 246.14]				
13.	Local Agency allocates staff time appropriately between WIC and non-WIC related duties. [Check with WIC staff to see how time is reported; review with Coordinator.]				

	REVIEW	YES	NO	N/A	COMMENTS
14.	Local Agency allocates staff time appropriately within WIC categories for reporting: Nutrition Education, Breastfeeding Promotion, Client Services and General Administration. [Check with WIC staff to see how time is reported; review with Coordinator]				
15.	Review of Personnel timesheet(s) match payroll records. [Review 3+ records/timesheets]				
16.	Local Agency reports appropriate activities within WIC categories (i.e. breast pump issuance is listed under Breastfeeding Promotion rather than Nutrition Education).				
17.	WIC staff time, not paid by WIC, used to meet nutrition education or breastfeeding promotion expenditure requirements are reflected in 'in-kind' contributions. [Review payroll records/time sheets.]				
18.	Local Agency has copy of indirect cost rate agreement with Health and Welfare and a list of all services paid from indirect costs. [Local Agency submits to H & W financial department. Check to see that copy of agreed indirect rate is on file]				
19.	Local Agency is reimbursed by State Agency on a timely basis. [Document in 'Comments' the amount of time it takes from invoice to reimbursement]				
20.	Accounting controls ensure separation of nutrition education and breastfeeding promotion expenditures and expenditures are appropriate. [Ask WIC coordinator and/or finance manager how they ensure this.]				
21.	WIC and non-WIC programs have separate accounting codes. [Verify with finance manager]				

	REVIEW	YES	NO	N/A	COMMENTS
22.	Local Agency properly accounts for any program income (such as revenue from nutrition education materials). [Ask WIC coordinator and/or finance manager if they receive any income; if so, how is this accounted for]				
23.	Inventory records identify all items purchased with WIC funds and location. [Review current inventory list]				
24.	Local Agency conducts an annual equipment inventory.				Date of last inventory _____
25.	Documentation of approval is on file for equipment and computer purchases. [Review current inventory list. Randomly select items to physically locate; check for documentation related to purchase of items]				
26.	Local Agency has procedure(s) for replacing/disposing of equipment purchased with WIC funds; ordering supplies with WIC funds. [Attach copy, if available]				
27.	Valuable equipment is kept in secure locations; equipment is kept where specified; and a log is used if equipment must be removed from premises.				
28.	Effective controls prevent use of equipment and supplies purchased with WIC funds for non-WIC use. [If guidelines exist for sharing of items purchased with WIC funds, attach copy]				
29.	Local Agency has on file contracts that exist for any subcontracting services paid with WIC funds (i.e. clerical help, blood work services). [If yes, provide date of last monitoring of subcontractor invoices in 'Comments' section]				

Electronically Signed: Click here to enter text. Date: Click here to enter a date.

Electronically Signed: Click here to enter text. Date: Click here to enter a date.

The WIC Program is an equal opportunity provider and employer.

Idaho WIC Program
Bureau of Clinical and Preventive Services
Idaho Department of Health and Welfare
450 W. State St., 4th Floor
P.O. Box 83720
Boise, ID 83720-0036

IDAHO DEPARTMENT OF
HEALTH & WELFARE

State Review Tool – Local Agency Ineligible/Terminated Files

Agency: Choose an item. Reviewer(s): Choose an item. and Choose an item.

Date: Click here to enter a date. Clinic: Choose an item.

Family (Client) No:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Category:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Termination Reason:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Accurate Determination of Ineligibility:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Timely Notice of Ineligibility provided and on file (15 days):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
A minimum of 1 month of benefits provided from date of termination (If applicable):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Comments:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Family (Client) No:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Category:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Termination Reason:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Accurate Determination of Ineligibility:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Timely Notice of Ineligibility provided and on file (15 days):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
A minimum of 1 month of benefits provided from date of termination (If applicable):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Comments:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

BDAY: Childs 5th Birthday *BFYR: BF 1 Year Postpartum Catg B* *NBF: Not BF 6 Months Postpartum Catg N* *INEL: Women Categorically ineligible Catg P*
INC: Over income *PRGM: Program Misuse* *NSP: Not Serving Priority* *VWD: Voluntary Withdrawal*
D: Diseased *DISQ: Disqualified.*

State Review Tool – Local Agency Ineligible/Terminated Files

Date: Click here to enter a date. Clinic: Choose an item.

Family (Client) No:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Category:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Termination Reason:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Accurate Determination of Ineligibility:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Timely Notice of Ineligibility provided and on file (15 days):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
A minimum of 1 month of benefits provided from date of termination (If applicable):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Comments:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Date: Click here to enter a date. Clinic: Choose an item.

Family (Client) No:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Category:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Termination Reason:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Accurate Determination of Ineligibility:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Timely Notice of Ineligibility provided and on file (15 days):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
A minimum of 1 month of benefits provided from date of termination (If applicable):	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Comments:	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Electronically Signed: Click here to enter text. Date: Click here to enter a date.

BDAY: Childs 5th Birthday *BFYR: BF 1 Year Postpartum Catg B* *NBF: Not BF 6 Months Postpartum Catg N* *INEL: Women Categorically ineligible Catg P*
INC: Over income *PRGM: Program Misuse* *NSP: Not Serving Priority* *VWD: Voluntary Withdrawal*
D: Diseased *DISQ: Disqualified.*

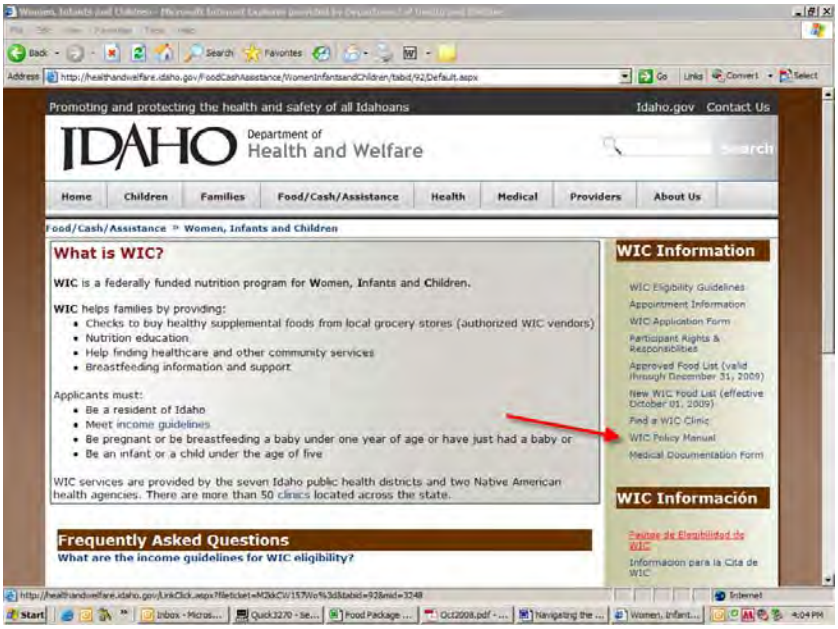
Navigating the Idaho WIC Program Policy Manual

- Click on Internet Explorer

- Go to www.healthandwelfare.idaho.gov and click on the W in the index

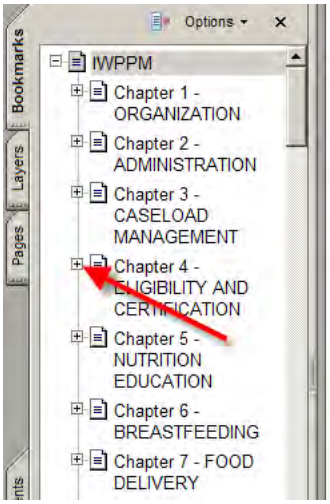
- Click on Women, Infants and Children

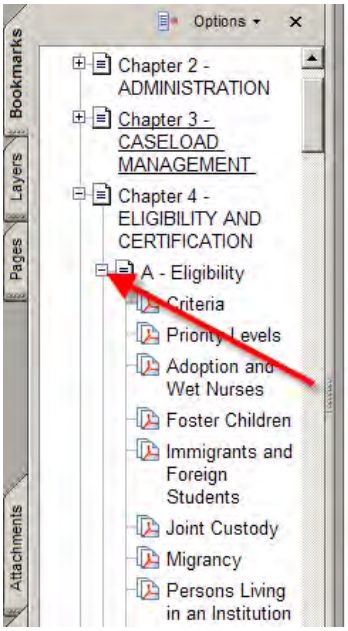
- On the menu to the right, click on the WIC Policy Manual link



- **Important:** Note the tabs to the left of the page. Click on the Bookmarks tab.

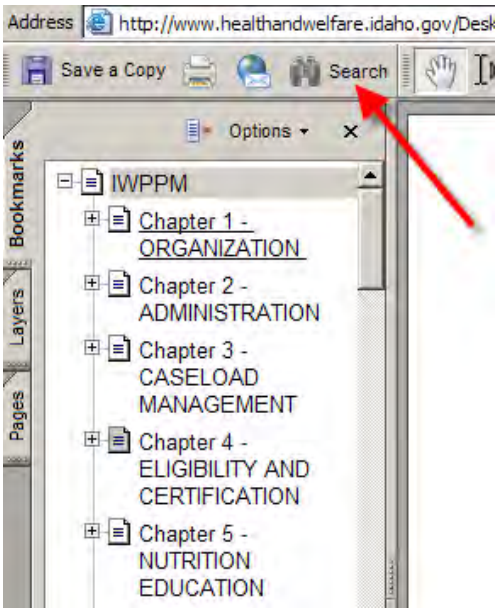
- The bookmarks are the table of contents. These are used to navigate through the document. You can expand each chapter and section by clicking on the plus sign in the box to the left. Note that the plus sign turns to a minus sign.



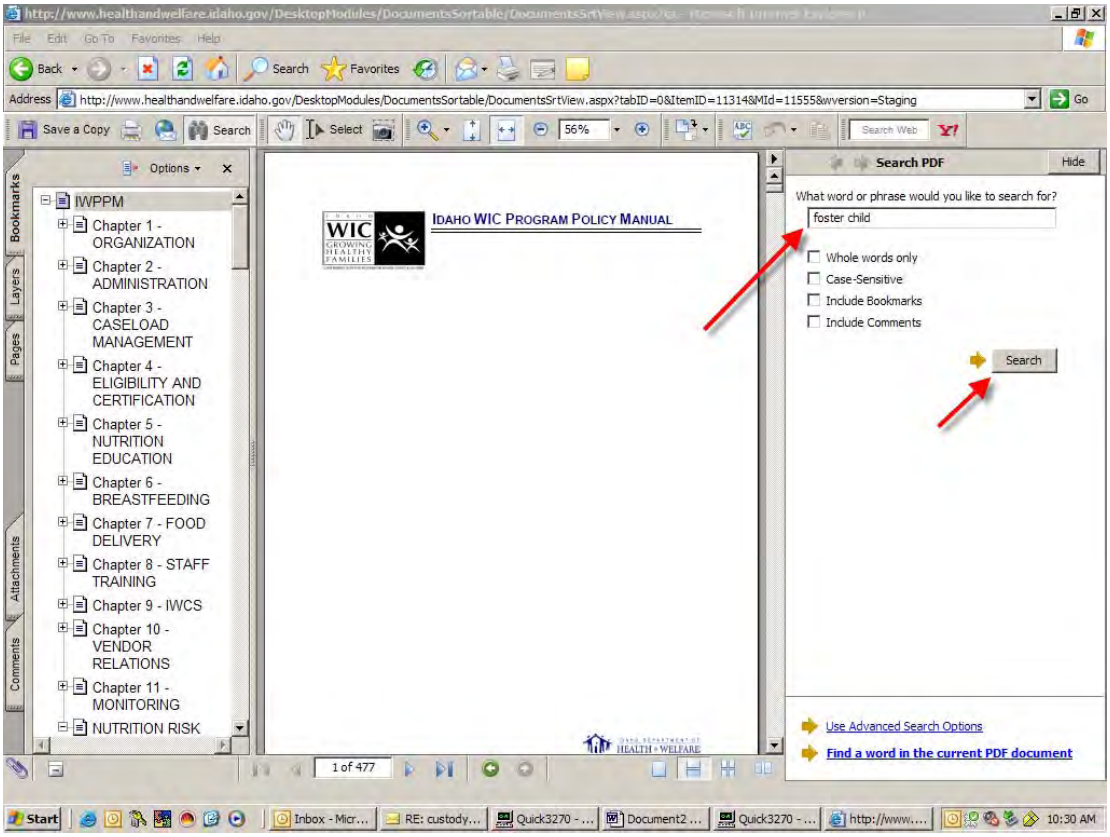


- Sections and chapters may also be collapsed by clicking on the minus signs.

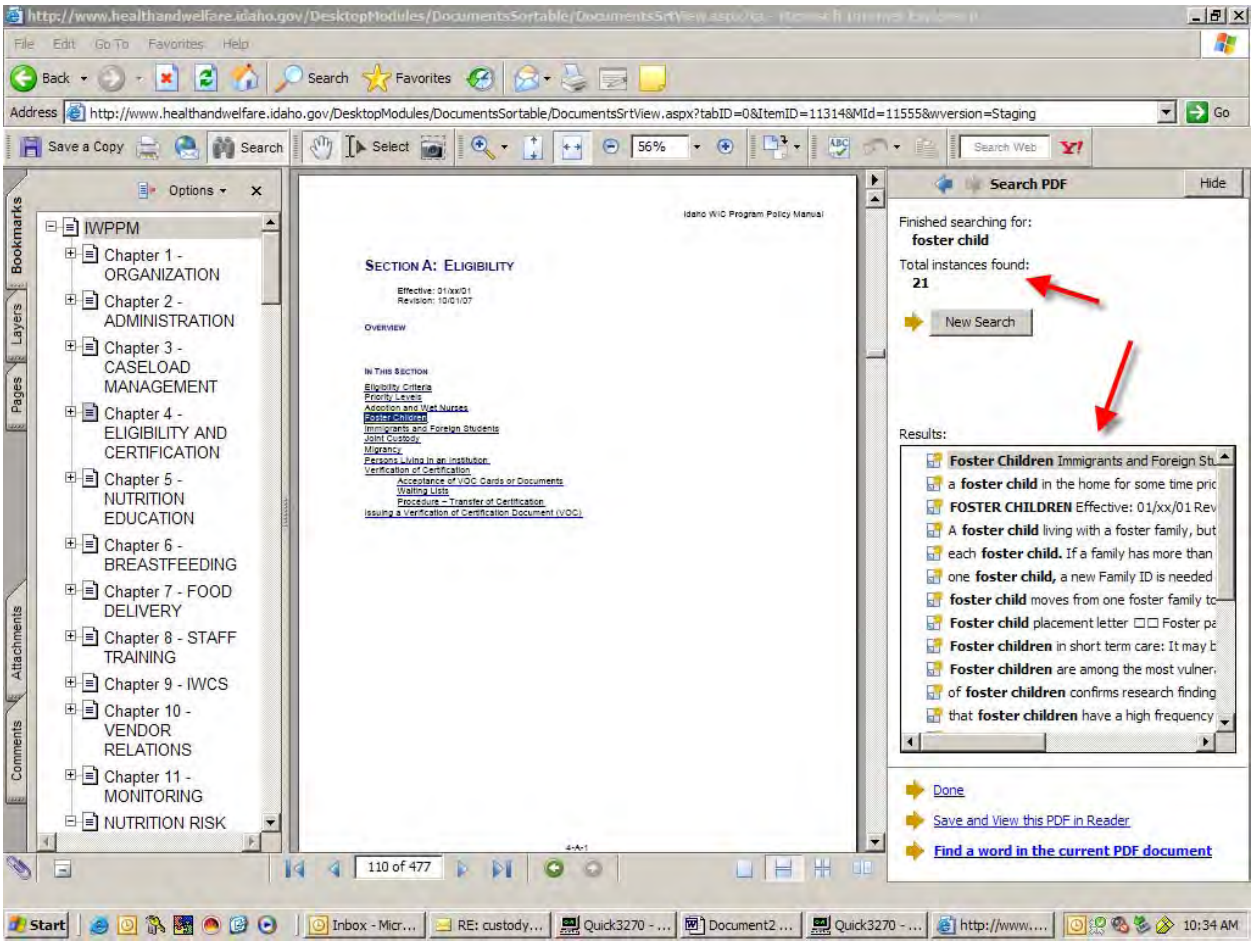
- Another option for navigation is to use the Search option found above the bookmarks.



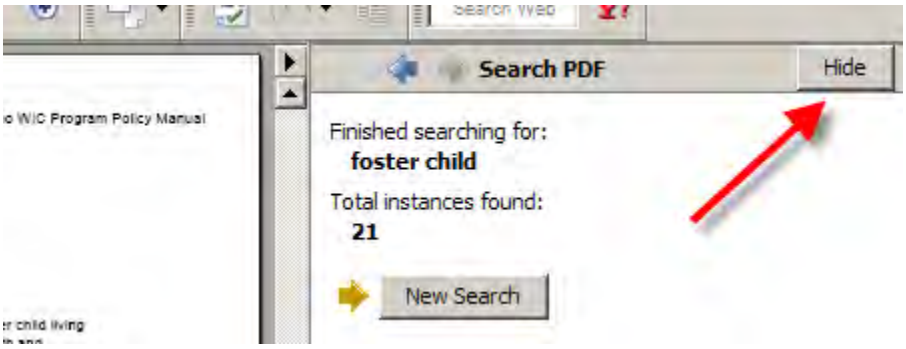
- A box will appear in which a keyword(s) may be typed. In this case, "foster child" has been entered.



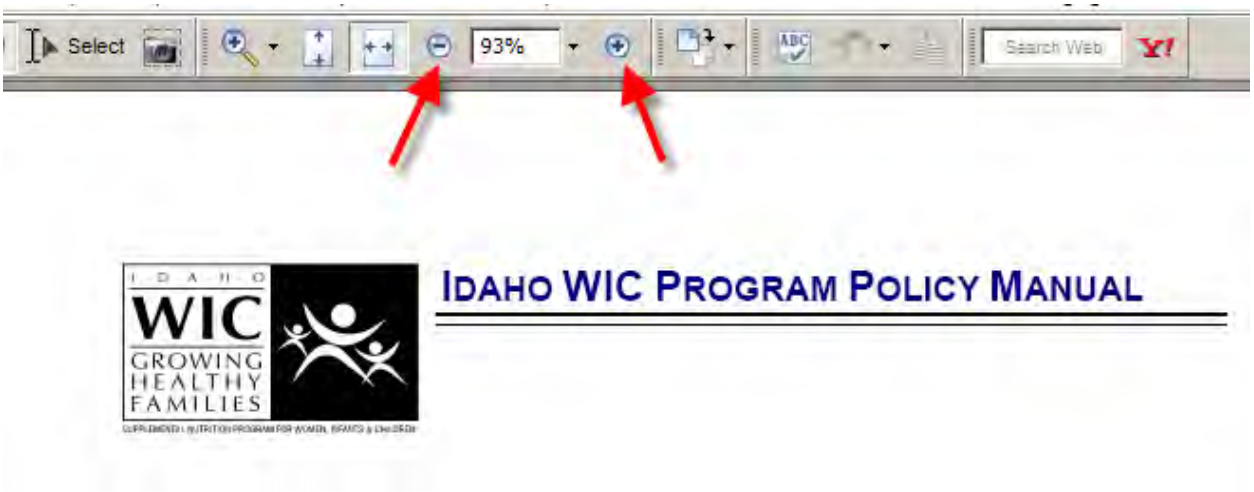
- The manual will be searched until the first instance of “foster child” is located, and you will be taken to that spot. The Search box includes the number of times “foster child” was found. The Results pane in the search box will give the contexts. A single click on a context will take you to that occurence in the manual.



- The Search box may be closed by clicking on the Hide button in the top righthand corner of the pane.



- For ease of reading, there is an magnification feature located on the toolbar just above the manual window. The plus (enlarge) or minus (reduce) buttons may be clicked to enhance your viewing pleasure.



- Forms and supporting documents that are referred to in the manual are included as the final chapter named Forms and Attachments. Where a link to a form occurs in the text of the manual, the form is not opened into a new window. Therefore, closing the window will close the entire manual. **Always use the green arrow at the bottom of the document to return to the previous screen.** This is a good rule of thumb whether you are using the blue underline links or Bookmarks.

Updates to the Idaho WIC Program Policy Manual are scheduled each October 1 and April 1.

For questions, please contact the State WIC Office at 334-5948, or toll free at 1-866-347-5484.

IDENTITY:	RESIDENCY:	PREGNANCY PROOF:
❒ driver's license ❒ birth certificate ❒ government ID ❒ other _____ _____	❒ driver's license ❒ utility bill ❒ letter ❒ other _____ _____	❒ written ❒ visual

INCOME ELIGIBILITY:

❒ TANF MA FS CHIP
❒ check stub
❒ W-2
❒ unemployment
❒ other _____

MONTHLY INCOME CONVERSION **

Weekly	x 4.3
Bi-weekly (every 2 wks)	x 2.15
Semi-monthly (twice/mo)	x 2
Quarterly	÷ 3
Hourly	(Rate x hrs/wk) x 4.3

INCOME SOURCE (employer)	Amount	**	Subtotal
1. _____	$ _____	_____	$ _____
2. _____	$ _____	_____	$ _____
3. _____	$ _____	_____	$ _____

Household size: _____ Monthly gross income $ _____

Is there other income (overtime, tips, bonuses, child support, SSI)?

Staff Name: _____ Date: _____

IDENTITY:	RESIDENCY:	PREGNANCY PROOF:
❒ driver's license ❒ birth certificate ❒ government ID ❒ other _____ _____	❒ driver's license ❒ utility bill ❒ letter ❒ other _____ _____	❒ written ❒ visual

INCOME ELIGIBILITY:

❒ TANF MA FS CHIP
❒ check stub
❒ W-2
❒ unemployment
❒ other _____

MONTHLY INCOME CONVERSION **

Weekly	x 4.3
Bi-weekly (every 2 wks)	x 2.15
Semi-monthly (twice/mo)	x 2
Quarterly	÷ 3
Hourly	(Rate x hrs/wk) x 4.3

INCOME SOURCE (employer)	Amount	**	Subtotal
1. _____	$ _____	_____	$ _____
2. _____	$ _____	_____	$ _____
3. _____	$ _____	_____	$ _____

Household size: _____ Monthly gross income $ _____

Is there other income (overtime, tips, bonuses, child support, SSI)?

Staff Name: _____ Date: _____

The Idaho WIC Program requires each applicant to provide proof of identification, residence (or address), and income when applying for WIC. If you cannot provide proof, please indicate which proof is missing by checking the correct box and completing the information

☐ **NO PROOF OF IDENTIFICATION**
The reason I have no proof of identification is: _____

_____

☐ **NO PROOF OF RESIDENCE OR ADDRESS**
The reason I have no proof of residence is: _____

_____

☐ **ZERO INCOME**
I declare the gross monthly income for myself and all the members of my family or household has been ZERO ($0.00) for the past 30 days. Our basic living needs for the past 30 days have been met by:

SHELTER: _____

FOOD: _____

Please read the following statement before signing the form.

The information I have written above is correct. I understand I may be prosecuted under law and have to pay back what I have received if I have intentionally lied or withheld the truth.

_____ _____
Date Responsible Adult Signature

_____ _____
Date WIC Program Representative Signature

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write to USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

El Programa de WIC de Idaho requiere que cada solicitante provea comprobante de su identificación, residencia (o dirección) e ingreso cuando esten solicitando beneficios de WIC. Si no puede proveer comprobantes, por favor indique qué comprobante le hace falta al marcar la cajilla apropiada y al completar la información

☐ **SIN COMPROBANTE DE IDENTIFICACION**
La razón por la cual no tengo comprobante de identificación es: _____

_____

☐ **SIN COMPROBANTE DE RESIDENCIA O DIRECCION**
La razón por la cual no tengo comprobante de residencia o dirección es: _____

_____

☐ **SIN INGRESO**
Yo afirmo que mi ingreso mensual y de todos los miembros de mi familia u hogar ha sido CERO ($0.00) por los últimos 30 días. Nuestras necesidades básicas para vivir han sido proveídas por los últimos 30 días por:

VIVIENDA: _____

COMIDA: _____

Por favor lea la declaración a continuación antes de firmar esta forma.

La información que he escrito anteriormente es correcta. Entiendo que puedo ser procesado por la ley y devolver los beneficios que he recibido si intencionalmente miento o no proveo toda la información necesaria.

_____ _____
Fecha Firma del Adulto Responsable

_____ _____
Fecha Firma del Representante del Programa WIC

De acuerdo con la ley federal y las políticas del Departamento de Agricultura de los EE.UU. (USDA, sigla en inglés), se le prohíbe a esta institución que discrimine por razón de raza, color, origen, sexo, edad, o discapacidad.

Para presentar una queja sobre discriminación, escriba a USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington DC 20250-9410, o llame gratis al (866) 632-9992 (voz). Personas con discapacidad auditiva o del habla pueden contactar con USDA por medio del Servicio Federal de Relevo (Federal Relay Service) al (800) 845-6136 (español) o (800) 877-8339 (inglés). USDA es un proveedor y empleador que ofrece oportunidad igual para todos.

IDAHO WIC PROGRAM

REFERRAL FOR NUTRITION COUNSELING—PRENATAL WOMEN

RD referral should be within timeframe indicated below or may be done during certification appointment.
Additional Referral: Any combination of four (or more) risk factors, route chart to RD.

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION
101★	UNDERWEIGHT WOMAN	X			ROUTE CHART TO RD
111★	OVERWEIGHT WOMAN	X			ROUTE CHART TO RD
131★	LOW MATERNAL WEIGHT GAIN			X	RD IN 1 MO
132★	MATERNAL WEIGHT LOSS IN PREGNANCY			X	RD IN 1 MO
133★	HIGH MATERNAL WEIGHT GAIN			X	RD IN 1 MO
201★	LOW HEMOGLOBIN		X		
	≤ 10.0 **or** decreases at recheck			X	RD IN 2 MOS
301	HYPEREMESIS GRAVIDARUM			X	REQUIRES MD DX, RD IN 1 MO
302	GESTATIONAL DIABETES			X	RD IN 1 MO
303	HX GESTATIONAL DIABETES	X			ROUTE CHART TO RD
304	HX OF PREECLAMPSIA	X			ROUTE CHART TO RD
311	HX PRETERM DELIVERY (≤ 37 weeks)	X			
312	HX LOW BIRTH WEIGHT	X			
321	HX FETAL OR NEONATAL LOSS	X			
331★	PREGNANCY – YOUNG AGE (<18 yrs)			X	RD IN 2 MOS (before EDC)
332★	CLOSELY SPACED PREGNANCY	X			
334	LACK OF OR INADEQUATE PRENATAL CARE	X			MEDICAL REFERRAL

★ - computer generated code

Key to abbreviations:

Dx – diagnosed by medical provider
Hx – history of
< – less than
> – greater than
≤ – less than or equal to
≥ – greater than or equal to

IDAHO WIC PROGRAM

REFERRAL FOR NUTRITION COUNSELING—PRENATAL WOMEN

RD referral should be within timeframe indicated below or may be done during certification appointment.
Additional Referral: Any combination of four (or more) risk factors, route chart to RD.

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION
335★	MULTIFETAL GESTATION			X	RD IN 2 MOS (before EDC)
336	FETAL GROWTH RESTRICTION			X	REQUIRES MD DX, RD IN 1 MO
337	HX BIRTH LGA INFANT	X			ROUTE CHART TO RD
338	PREGNANT & BREASTFEEDING			X	RD/BF COORDINATOR IN 1 MO
339	HX BIRTH W/ CONGENITAL DEFECT	X			
341	NUTRIENT DEFICIENCY DISEASES			X	REQUIRES MD DX, RD IN 1 MO
342	GASTRO-INTESTINAL DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
343	DIABETES MELLITUS			X	REQUIRES MD DX, RD IN 1 MO
344	THYROID DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
345	HYPERTENSION AND PREHYPERTENSION			X	REQUIRES MD DX, RD IN 1 MO
346	RENAL DISEASE			X	REQUIRES MD DX, RD IN 1 MO
347	CANCER			X	REQUIRES MD DX, RD IN 1 MO
348	CENTRAL NERVOUS SYSTEM DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
349	GENETIC AND CONGENITAL DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
351	INBORN ERRORS OF METABOLISM			X	REQUIRES MD DX, RD IN 1 MO
352	INFECTIOUS DISEASES			X	REQUIRES MD DX, RD IN 1 MO
353	FOOD ALLERGY	X			
354	CELIAC DISEASE			X	REQUIRES MD DX, RD IN 1 MO
355	LACTOSE INTOLERANCE	X			
356	HYPOGLYCEMIA	X			
357	DRUG NUTRIENT INTERACTIONS			X	RD IN 1 MO
358	EATING DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
359	RECENT MAJOR SURGERY, TRAUMA, BURNS			X	RD IN 1 MO
360	OTHER MEDICAL CONDITIONS			X	REQUIRES MD DX, RD IN 1 MO
361	DEPRESSION		X		APPROPRIATE REFERALS
362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT			X	RD IN 1 MO
371	MATERNAL SMOKING		X		SUBSTANCE ABUSE REFERRAL
372	ALCOHOL AND ILLEGAL DRUG USE			X	SUBSTANCE ABUSE REFERRAL, RD IN 1 MO
381	ORAL HEALTH CONDITIONS			X	RD IN 1 MO
401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS	X			
427	INAPPROPRIATE NUTRITION PRACTICES	X			
502★	TRANSFER OF CERTIFICATION (VOC)	X			ASSESS AND REFER AS NEEDED
801★	HOMELESS	X			APPROPRIATE REFERRALS
802★	MIGRANCY	X			
902	FEEDING SKILLS LIMITATION	X			ROUTE CHART AS NEEDED
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE	X			

★ - computer generated code

Summary – Charts to Route to RD:

101 Underweight Woman
111 Overweight Woman
303 Hx Gestational Diabetes
304 Hx of Preeclampsia
337 Hx Birth LGA Infant
902 Feeding Skills Limitation (route chart as needed)

Any combination of four (or more) risk factors (if not already scheduled for RD referral)

Revised 10/2014

IDAHO WIC PROGRAM

REFERRAL FOR NUTRITION COUNSELING—
BREASTFEEDING AND NON-BREASTFEEDING POSTPARTUM WOMEN

RD referrals should be within time frame indicated below or may be done during certification appointment.
Additional Referral: Any combination or four (or more) risk factors, route chart to RD.

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION
101★	UNDERWEIGHT WOMAN			X	BF WOMEN WITH RD IN 1 MO; NON-BF WOMEN WITH CA IN 3 MOS
111★	OVERWEIGHT WOMAN	X			
133★	HIGH MATERNAL WEIGHT GAIN	X			
201★	LOW HEMOGLOBIN		X		
	≤10.0 **or** decreases at recheck			X	RD IN 2 MOS
303	HX GESTATIONAL DIABETES	X			ROUTE CHART TO RD
304	HISTORY OF PREECLAMPSIA	X			
311	HX PRETERM DELIVERY (≤ 37 weeks)	X			
312	HX LOW BIRTH WEIGHT	X			
321	HX FETAL OR NEONATAL LOSS	X			REFER AS NEEDED
331★	PREGNANCY – YOUNG AGE (< 18 yrs)	X			
332★	CLOSELY SPACED PREGNANCY	X			
335	MULTIFETAL GESTATION			X	BF WOMEN WITH RD IN 1 MO; NON-BF WOMEN WITH CA IN 3 MOS
337	HX BIRTH LGA INFANT	X			
339	HX BIRTH WITH CONGENITAL DEFECT	X			
341	NUTRIENT DEFICIENCY DISEASES			X	REQUIRES MD DX, RD IN 1 TO 3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
342	GASTRO-INTESTINAL DISORDERS			X	(SEE ABOVE)

★ - computer generated code

Key to abbreviations:

Dx – diagnosed by medical provider
Hx – history of
< – less than
> – greater than
≤ – lesser than or equal to
≥ – greater than or equal to

IDAHO WIC PROGRAM

REFERRAL FOR NUTRITION COUNSELING— BREASTFEEDING AND NON-BREASTFEEDING POSTPARTUM WOMEN

RD referrals should be within time frame indicated below or may be done during certification appointment.
Additional Referral: Any combination of four (or more) risk factors, route chart to RD.

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION
343	DIABETES MELLITUS			X	REQUIRES MD DX, RD IN 1 MO
344	THYROID DISORDERS			X	REQUIRES MD DX, RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
345	HYPERTENSION AND PREHYPERTENSION			X	(SEE ABOVE)
346	RENAL DISEASE			X	(SEE ABOVE)
347	CANCER			X	(SEE ABOVE)
348	CENTRAL NERVOUS SYSTEM DISORDERS			X	(SEE ABOVE)
349	GENETIC AND CONGENITAL DISORDERS			X	(SEE ABOVE)
351	INBORN ERRORS OF METABOLISM			X	(SEE ABOVE)
352	INFECTIOUS DISEASES			X	(SEE ABOVE)
353	FOOD ALLERGY	X			
354	CELIAC DISEASE			X	REQUIRES MD DX, RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
355	LACTOSE INTOLERANCE	X			
356	HYPOGLYCEMIA	X			
357	DRUG NUTRIENT INTERACTIONS			X	RD IN 1 TO 3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF INTERACTIONS
358	EATING DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
359	RECENT MAJOR SURGERY, TRAUMA, BURNS			X	REQUIRES MD DX, RD IN 1 MO; EXCEPT WHERE C-SECTION IS ONLY REASON WITH CA IN 3 MOS
360	OTHER MEDICAL CONDITIONS			X	REQUIRES MD DX, RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
361	DEPRESSION		X		APPROPRIATE REFERRALS
362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH EATING			X	RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
363	PRE-DIABETES			X	REQUIRES MD DX, RD IN 1 MO
371	MATERNAL SMOKING	X			ROUTE CHART TO RD/LC FOR BF WOMEN
372	ALCOHOL OR ILLEGAL DRUG USE			X	SUBSTANCE ABUSE REFERRAL, RD IN 1 MO
381	ORAL HEALTH CONDITIONS	X			DENTAL REFERRAL
401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS	X			
427	INAPPROPRIATE NUTRITION PRACTICES	X			
501	POSSIBILITY OF REGRESSION	X			
502★	TRANSFER OF CERTIFICATION (VOC)	X			ASSESS AND REFER AS NEEDED
601	BF MOM OF INFANT AT NUTRITIONAL RISK	X			
602	BF COMPLICATION – WOMAN			X	IMMEDIATE REFERRAL TO LOCAL LACTATION EDUCATOR/BF COORDINATOR
801★	HOMELESS	X			APPROPRIATE REFERRALS
802★	MIGRANCY	X			
902	FEEDING SKILLS LIMITATION	X			ROUTE CHART AS NEEDED
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE	X			

★ - computer generated code

Summary – Codes to Route Chart to RD:

303 Hx Gestational Diabetes
371 Maternal Smoking (route chart for BF women)
902 Feeding Skills Limitation (route chart as needed)

Any combination of four (or more) risk factors (if not already scheduled for RD referral)

Revised 10/2014

IDAHO WIC PROGRAM

REFERRAL FOR NUTRITION COUNSELING—INFANTS

RD referrals should be within time frame indicated below or may be done during certification appointment.
Additional Referral Standard: Any combination of four (or more) risk factors, route chart to RD.

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION
103★	UNDERWEIGHT (Wt/Lgth ≤ 2.3%) OR AT RISK FOR UNDERWEIGHT (Wt/Lgth ≤ 5%)			X	RD IN 1 MO
115★	HIGH WEIGHT-FOR-LENGTH (Wt/Lgth ≥ 97.7%)		X		
121★	SHORT STATURE (Ht/Age ≤ 5%)	X			
134	FAILURE TO THRIVE			X	REQUIRES MD DX, RD IN 1 MO
135 ★	INADEQUATE GROWTH			X	RD IN 1 MO
141★	LOW BIRTH WEIGHT (< 5 lbs 8 oz)			X	RD IN 1 MO
142★	PREMATURITY (≤ 37 weeks)			X	RD IN 1 MO
153★	LARGE FOR GESTATIONAL AGE (≥ 9 lbs)		X		
201★	LOW HEMOGLOBIN		X		
	≤ 10.0 or no rise on re-check			X	RD IN 2 MOS
341	NUTRIENT DEFICIENCY DISEASES			X	REQUIRES MD DX, RD IN 1 MO
342	GASTRO-INTESTINAL DISORDER			X	REQUIRES MD DX, RD IN 1 MO
343	DIABETES MELLITUS			X	REQUIRES MD DX, RD IN 1 MO
344	THYROID DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
345	HYPERTENSION AND PREHYPERTENSION			X	REQUIRES MD DX, RD IN 1 MO
346	RENAL DISEASE			X	REQUIRES MD DX, RD IN 1 MO
347	CANCER			X	REQUIRES MD DX, RD IN 1 MO
348	CENTRAL NERVOUS SYSTEM DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
349	GENETIC AND CONGENITAL DISORDERS			X	REQUIRES MD DX, RD IN 1 MO
351	INBORN ERRORS OF METABOLISM			X	REQUIRES MD DX, RD IN 1 MO
352	INFECTIOUS DISEASES			X	REQUIRES MD DX, RD IN 1 MO
353	FOOD ALLERGY	X			REQUIRES MD DX, ROUTE CHART TO RD
354	CELIAC DISEASE			X	REQUIRES MD DX, RD IN 1 MO
355	LACTOSE INTOLERANCE	X			REQUIRES MD DX, ROUTE CHART TO RD
356	HYPOGLYCEMIA	X			
357	DRUG NUTRIENT INTERACTIONS			X	RD IN 1 MO
359	RECENT MAJOR SURGERY, TRAUMA, BURNS			X	RD IN 1 MO
360	OTHER MEDICAL CONDITIONS			X	REQUIRES MD DX, RD IN 1 MO
362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH EATING			X	RD IN 1 MO
381	ORAL HEALTH CONDITIONS	X			REFER TO DENTAL
382	FETAL ALCOHOL SYNDROME			X	REQUIRES MD DX, RD IN 1 MO
411	INAPPROPRIATE NUTRITION PRACTICES	X			
428	DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES	X			
501	POSSIBILITY OF REGRESSION	X			
502★	TRANSFER OF CERTIFICATION (VOC)	X			ASSESS AND REFER AS NEEDED
603	BF COMPLICATION – INFANT			X	IMMEDIATE REFERRAL TO LOCAL LACTATION EDUCATOR, IF AVAILABLE
701	BORN TO WIC MOM/POTENTIAL WIC MOM	X			

★ - computer generated code

Key to abbreviations:

Dx – diagnosed by medical provider
Hx – history of
< – less than
> – greater than
≤ – lesser than or equal to
≥ – greater than or equal to

IDAHO WIC PROGRAM

REFERRAL FOR NUTRITION COUNSELING—INFANTS

RD referrals should be within time frame indicated below or may be done during certification appointment.
Additional Referral Standard: Any combination of four (or more) risk factors, route chart to RD.

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION
702	BF INFANT OF MOM AT NUTRITIONAL RISK	X			
801★	HOMELESS	X			APPROPRIATE REFERRALS
802★	MIGRANCY	X			
902	FEEDING SKILLS LIMITATION	X			APPROPRIATE REFERRALS
903★	FOSTER CARE	X			
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE	X			

★ - computer generated code

Summary – Charts to Route to RD:

353 Food Allergy
355 Lactose Intolerance
Any combination of four (or more) risk codes (if not already scheduled for RD referral)

IDAHO WIC PROGRAM
REFERRAL FOR NUTRITION COUNSELING—CHILDREN

RD referrals should be within time frame indicated below or may be done during certification appointment.
Additional Referral Standard: Any combination of four (or more) risk factors, route to RD

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION NEEDED
103★	UNDERWEIGHT (BMI/Age ≤ 5%) OR AT RISK FOR UNDERWEIGHT (BMI/Age ≤ 10%); Under 24 months UNDERWEIGHT (Wt/Lgth ≤ 2.3%) OR AT RISK FOR UNDERWEIGHT (Wt/Lgth ≤ 5%)			X	RD IN 1 MO; IF GROWTH CONSISTENTLY PARALLELING CURVE, RD IN 3 MOS
113★	OBESE (BMI/Age ≥ 95%) - only for children ≥ 24 mos			X	RD IN 3 MOS
114★	OVERWEIGHT (BMI/Age ≥ 85%) - only for children ≥ 24 mos		X		
115★	HIGH WEIGHT-FOR-LENGTH (< 2 yrs; Wt/Lgth ≥ 97.7%)		X		
121★	SHORT STATURE (Ht/Age ≤ 5%) OR AT RISK OF SHORT STATURE (Ht/Age ≤ 10%); under age 2 SHORT STATURE (Lgth/Age ≤ 2.3%) OR AT RISK OF SHORT STATURE (Lgth/Age ≤ 5%)	X			
134	FAILURE TO THRIVE			X	REQUIRES MD DX, RD IN 1 MO
135★	INADEQUATE GROWTH		X		ROUTE CHART TO RD
141★	LOW BIRTH WEIGHT (< 2 yrs)		X		UP TO 24 MOS ROUTE CHART TO RD
142★	PREMATURITY (≤ 37 wks)		X		UP TO 24 MOS ROUTE CHART TO RD
201★	LOW HEMOGLOBIN		X		
	≤10.0 **or** decreases at re-check			X	RD IN 2 MOS
341	NUTRITION DEFICIENCY DISEASES			X	RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
342	GASTRO-INTESTINAL DISORDERS			X	(SEE ABOVE)
343	DIABETES MELLITUS			X	(SEE ABOVE)
344	THYROID DISORDERS			X	(SEE ABOVE)
345	HYPERTENSION AND PREHYPERTENSION			X	(SEE ABOVE)
346	RENAL DISEASE			X	(SEE ABOVE)
347	CANCER			X	(SEE ABOVE)
348	CENTRAL NERVOUS SYSTEM DISORDERS			X	(SEE ABOVE)
349	GENETIC AND CONGENITAL DISORDERS			X	(SEE ABOVE)
351	INBORN ERRORS OF METABOLISM			X	(SEE ABOVE)
352	INFECTIOUS DISEASES			X	(SEE ABOVE)
353	FOOD ALLERGY	X			REQUIRES MD DX, ROUTE CHART TO RD
354	CELIAC DISEASE			X	RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF CONDITION
355	LACTOSE INTOLERANCE	X			REQUIRES MD DX, ROUTE CHART TO RD
356	HYPOGLYCEMIA	X			
357	DRUG NUTRIENT INTERACTIONS			X	RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF INTERACTIONS

★ - computer generated code

Key to abbreviations:
Dx – diagnosed by medical provider
Hx – history of
< – less than
> – greater than
≤ – lesser than or equal to
≥ – greater than or equal to

IDAHO WIC PROGRAM
REFERRAL FOR NUTRITION COUNSELING—CHILDREN

RD referrals should be within time frame indicated below or may be done during certification appointment.
Additional Referral Standard: Any combination of four (or more) risk factors, route to RD

X = Appropriate Counselor

CODE	NUTRITIONAL RISK CRITERIA	CL	CA	RD	OTHER ACTION NEEDED
359	RECENT MAJOR SURGERY, TRAUMA, BURNS			X	RD IN 1 MO
360	OTHER MEDICAL CONDITIONS			X	RD IN 1-3 MOS DEPENDING ON MEDCIAL CARE & SEVERITY OF CONDITION
362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT			X	RD IN 1-3 MOS DEPENDING ON MEDICAL CARE & SEVERITY OF INTERACTIONS
381	ORAL HEALTH CONDITIONS	X			REFER TO DENTAL
382	FETAL ALCOHOL SYNDROME			X	REFER TO SUBSTANCE ABUSE PROGRAM, RD IN 1 MO
401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS	X			
425	INAPPROPRIATE NUTRITION PRACTICES	X			
428	DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES	X			
501	POSSIBILITY OF REGRESSION	X			
502★	TRANSFER OF CERTIFICATION (VOC)	X			ASSESS AND REFER AS NEEDED
801★	HOMELESS	X			APPROPRIATE REFERRALS
802★	MIGRANCY	X			
902	FEEDING SKILLS LIMITATION	X			APPROPRIATE REFERRALS
903★	FOSTER CARE	X			
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE	X			

★ - computer generated code

Summary – Codes to Route Chart to RD:

135 Inadequate Growth
141 Low Birth Weight (route chart up to 24 months age)
142 Prematurity (route chart up to 24 months age)
353 Food Allergy
355 Lactose Intolerance

Any combination of four (or more) risk factors (if not already scheduled for RD referral

MEMORANDUM OF UNDERSTANDING

SHARING WIC PARTICIPANT INFORMATION/DATA
between
(Name of your Agency) IDAHO WOMEN, INFANTS, AND CHILDREN PROGRAM; DIVISION OF HEALTH
and
Name of Agency you are working with

SAMPLE

PARTIES TO AGREEMENT:

This document is to serve as a Memorandum of Understanding (MOU) between the (your WIC agency name Women, Infants, and Children Program) (hereafter referred to as WIC) and (name of agency you are working with).

BACKGROUND:
Brief info on what is being shared and why (just need 2-3 sentences).

- Height, weight and/or hemoglobin for the purpose of program coordination

PURPOSE:
Summary of how information will be used.

- Information/data will be used to determine program eligibility; for program coordination

Summary of each party's responsibilities

- For example, Head Start program requesting participant data will be responsible for collecting a signed release of information from program participants giving permission for WIC to share participant data. The release will clearly state 'what' data is being requested. Head Start will provide WIC program with a copy of the signed release from participant(s). WIC program will provide requested data upon receipt of signed release.

The data will be used for the sole purpose of….

- Determining program eligibility and/or coordination of services for participant(s) within (specified programs involved in MOU).

Any use of the data not specified in this agreement is not authorized.

TERMS OF THE AGREEMENT:

The term of this agreement shall be (Dates MOU will be effective.)

Signed by:

Your Agency (WIC Coordinator or Director) Date

Agency you are working with Date

Date last checks issued _____

This document is a WIC Program Verification of Certification for the above named person.
See reverse side for Nutrition Risk Criteria.

Signature of Local Agency Official: _____

Printed Name of Local Agency Official: _____

Name and Address of Certifying Local Agency: (may be stamped)

Telephone Number: _____ Fax Number: _____

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/ complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

CODE	NUTRITION RISK CRITERIA	CODE	NUTRITION RISK CRITERIA
101 ★	UNDERWEIGHT WOMAN	348	CENTRAL NERVOUS SYSTEM DISORDERS
103 ★	UNDERWEIGHT/AT RISK – INFANTS/CHILDREN	349	GENETIC AND CONGENITAL DISORDERS
111 ★	OVERWEIGHT WOMAN	351	INBORN ERRORS OF METABOLISM
113 ★	OBESE – CHILDREN (2-5)	352	INFECTIOUS DISEASES
114 ★	OVERWEIGHT	353	FOOD ALLERGY
115 ★	HIGH WEIGHT-FOR-LENGTH	354	CELIAC DISEASE
121 ★	SHORT STATURE, AT RISK OF SHORT STATURE	355	LACTOSE INTOLERANCE
131 ★	LOW MATERNAL WEIGHT GAIN	356	HYPOGLYCEMIA
132 ★	MATERNAL WEIGHT LOSS IN PREGNANCY	357	DRUG NUTRIENT INTERACTIONS
133 ★	HIGH MATERNAL WEIGHT GAIN	358	EATING DISORDERS
134	FAILURE TO THRIVE	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
135 ★	INADEQUATE GROWTH	360	OTHER MEDICAL CONDITIONS
141 ★	LOW BIRTH WEIGHT	361	DEPRESSION
142 ★	PREMATURITY	362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT
153 ★	LARGE FOR GESTATIONAL AGE	363	PRE-DIABETES
201 ★	LOW HEMATOCRIT/HEMOGLOBIN	371	MATERNAL SMOKING
301	HYPEREMESIS GRAVIDARUM	372	ALCOHOL OR ILLEGAL DRUG USE
302	GESTATIONAL DIABETES	381	DENTAL PROBLEMS
303	HX GESTATIONAL DIABETES	382	FETAL ALCOHOL SYNDROME
304	HX PREECLAMPSIA	401	FAILURE TO MEET DIETARY GUIDELINES
311	HX PRETERM DELIVERY (≤ 37 WKS)	411	INAPPROPRIATE NUTRITION PRACTICES - INFANT
312	HX LOW BIRTH WEIGHT	425	INAPPROPRIATE NUTRITION PRACTICES - CHILD
321	HX FETAL OR NEONATAL LOSS	427	INAPPROPRIATE NUTRITION PRACTICES - WOMAN
331 ★	PREGNANCY – YOUNG AGE	428	DIET RISK ASSOC W/ COMP FEEDING PRACT
332 ★	CLOSELY SPACED PREGNANCY	501	POSSIBILITY OF REGRESSION
335 ★	MULTIFETAL GESTATION	502 ★	TRANSFER OF CERTIFICATION (VOC)
336	FETAL GROWTH RESTRICTION	601	BF MOM OF INFANT AT NUTRITIONAL RISK
337	HX BIRTH LGA INFANT	602	BREASTFEEDING COMPLICATION - WOMAN
338	PREGNANT AND BREASTFEEDING	603	BREASTFEEDING COMPLICATION – INFANT
339	HX BIRTH – CONGENITAL DEFECT	701	BORN TO WIC MOM/BORN TO POTENTIAL WIC MOM
341	NUTRIENT DEFICIENCY DISEASES	702	BF INFANT OF MOM AT NUTRITIONAL RISK
342	GASTROINTESTINAL DISORDER	801 ★	HOMELESSNESS
343	DIABETES MELLITUS	802 ★	MIGRANCY
344	THYROID DISORDERS	902	FEEDING SKILLS LIMITATION
345	HYPERTENSION AND PREHYPERTENSION	903 ★	FOSTER CARE
346	RENAL DISEASE	904	EXPOSURE TO ENVIRON TOBACCO SMOKE (ETS)
347	CANCER		

★ computer generated code

AGENCY WAITING LIST NOTIFICATION FORM

Applicant's name:

_____

First Last

Mailing address:

_____

Street

_____

City State Zip Code

Telephone number:

_____

Please check the appropriate box below regarding how the WIC program will contact you:

I ☐ do ☐ do not authorize the WIC program to leave voicemail messages at the phone number I provide to WIC.

I understand messages may contain information including but not limited to the WIC program name, applicant, participant and/or family name(s) and information related to appointments.

This section is for **CLINIC USE** only:

1. Date placed on waiting list: _____

2. Please circle one of the following options:

a. Potential / Actual Priority:

I II III IV V VI

b. Potential / Actual Category:

P B N I C

3. Complete a, b, or c as applicable:

a. P—EDC: _____

b. I/C—DOB: _____

c. N/B—Date pregnancy ended: _____

4. Referral to health and/or food/public assistance Program provided: _____

5. Date/time of appt for screening (if applicable):

_____

It has been determined that you may meet the criteria to participate in the Idaho WIC program. Unfortunately, at this time funding is not available to provide services to all the applicants who may qualify. You are being placed on a waiting list and will be notified when it is possible for you to apply for program benefits.

You may appeal this decision by requesting a Fair Hearing. The request for a Fair Hearing must be made in writing within 60 days of the date of this letter. You may contact the local agency WIC Coordinator to request a form (CFR 246.9 *Fair Hearing Procedures*).

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/ complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).USDA is an equal opportunity provider and employer.

X _____

Signature of Applicant and/or Responsible Adult **Date**

X _____

Signature and Title of Clinic Staff **Date**

COMPUTER DOWN KIT

Purpose

The computer down kit houses forms required to continue providing WIC services in the event WISPr is temporarily unavailable.

Procedures

If WISPr goes down temporarily, follow these steps once WISPr becomes available:

- Enter all documentation from the down time into WISPr.
    - Eligibility information, care plans, nutrition assessment (health information/questionnaire) and nutrition education etc.
- Shred relevant hard copies of documentation that have been entered into WISPr.
    - Each clinic may vary on the amount of documentation stored in WISPr verses the participant's hard copy chart.
- In Staff Notes (WISPr), document any information that would eliminate any gaps in the documentation during the time WISPr was down.
- Checks may be mailed to participants. The staff member responsible for mailing the check/CVVs needs to initial or sign his/her name (not the participant's) next to the group of checks/CVVs and indicate the date the checks/CVVs were mailed [IWPPM Chapter 7, Section C].

VOC

If a VOC is issued while WISPr is down, the following steps need to occur:

- Complete the VOC Transfer in WISPr.
- If a VOC is generated, shred the form.
- Document in Staff Notes (WISPr) that a VOC was issued when WISPr was down.

IDAHO WIC GROWING HEALTHY FAMILIES

SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

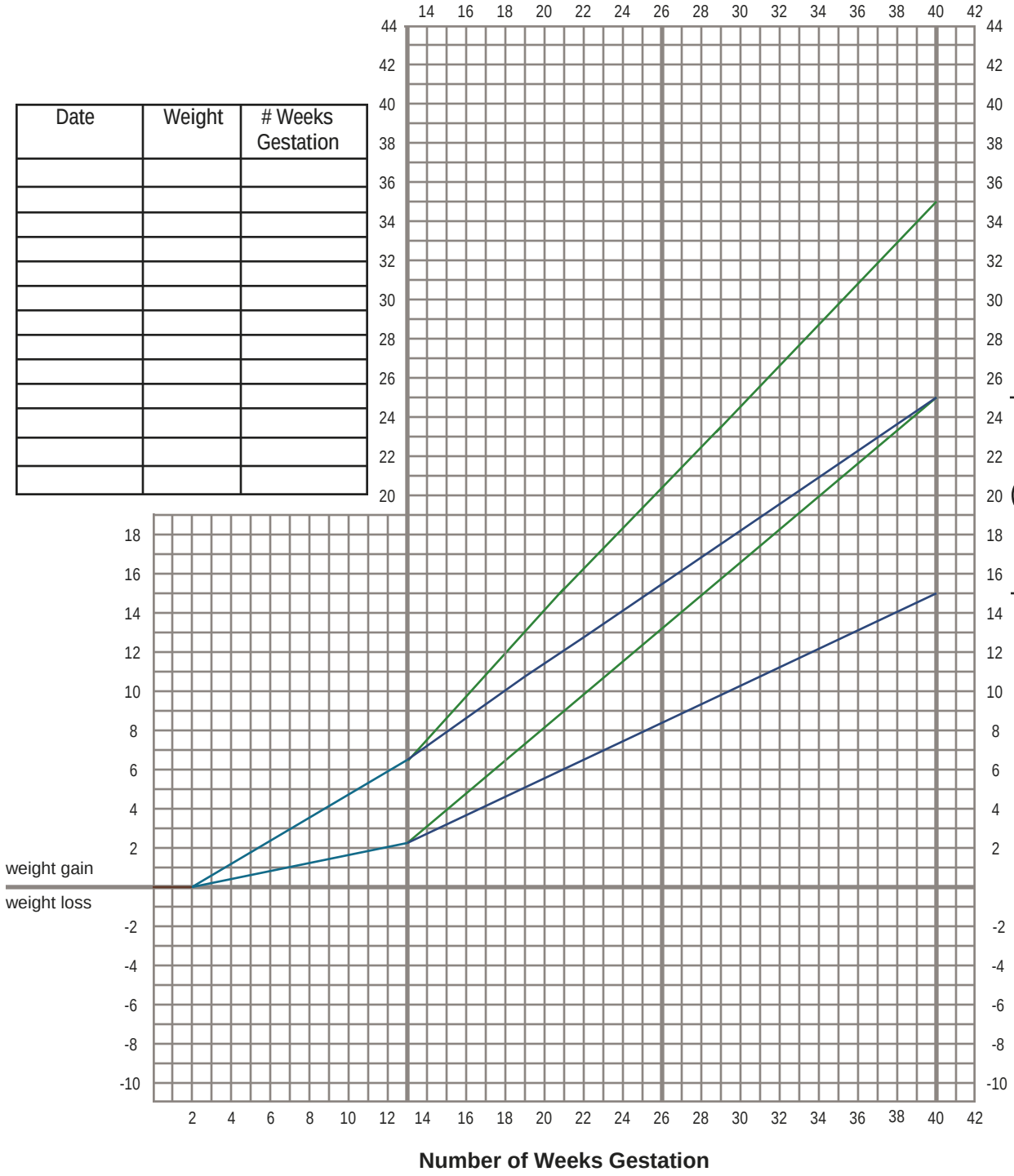
Prenatal Weight Gain—Single

Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.

Date	Weight	# Weeks Gestation



Weight Gain Recommendations

BMI 18.5 - 24.9
25-35 lbs total gain

1st Trimester
2.2 - 6.6 lbs

2nd Trimester
1 lb/week

3rd Trimester
1 lb/week

Nutrition Risk 17
BMI 25 - 29.9
15-25 lbs total gain

1st Trimester
2.2 - 6.6 lbs

2nd Trimester
.6 lb/week

3rd Trimester
.6 lb/week

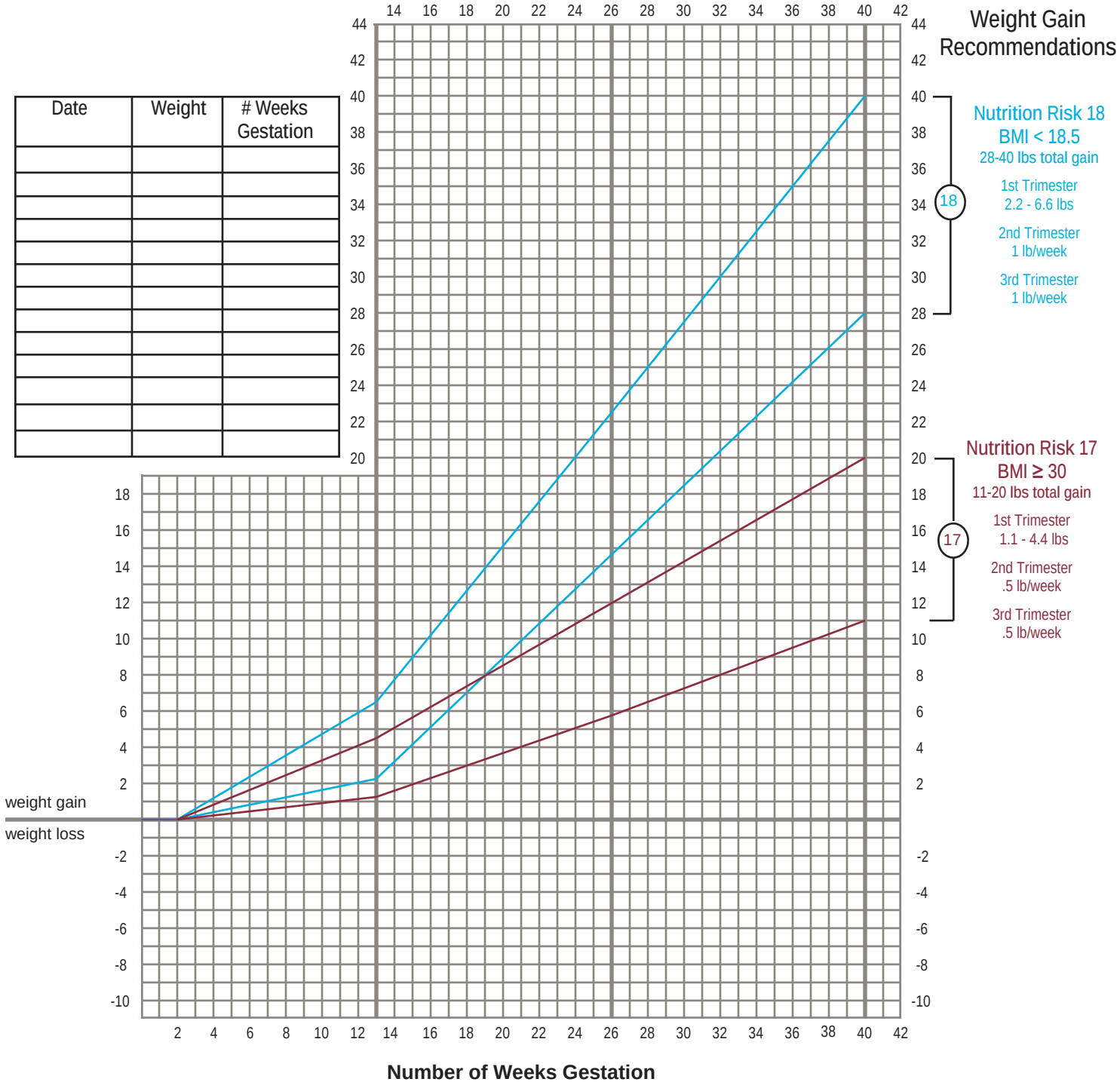
Prenatal Weight Gain—Single

Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.

Date	Weight	# Weeks Gestation



Prenatal Weight Gain—Multi

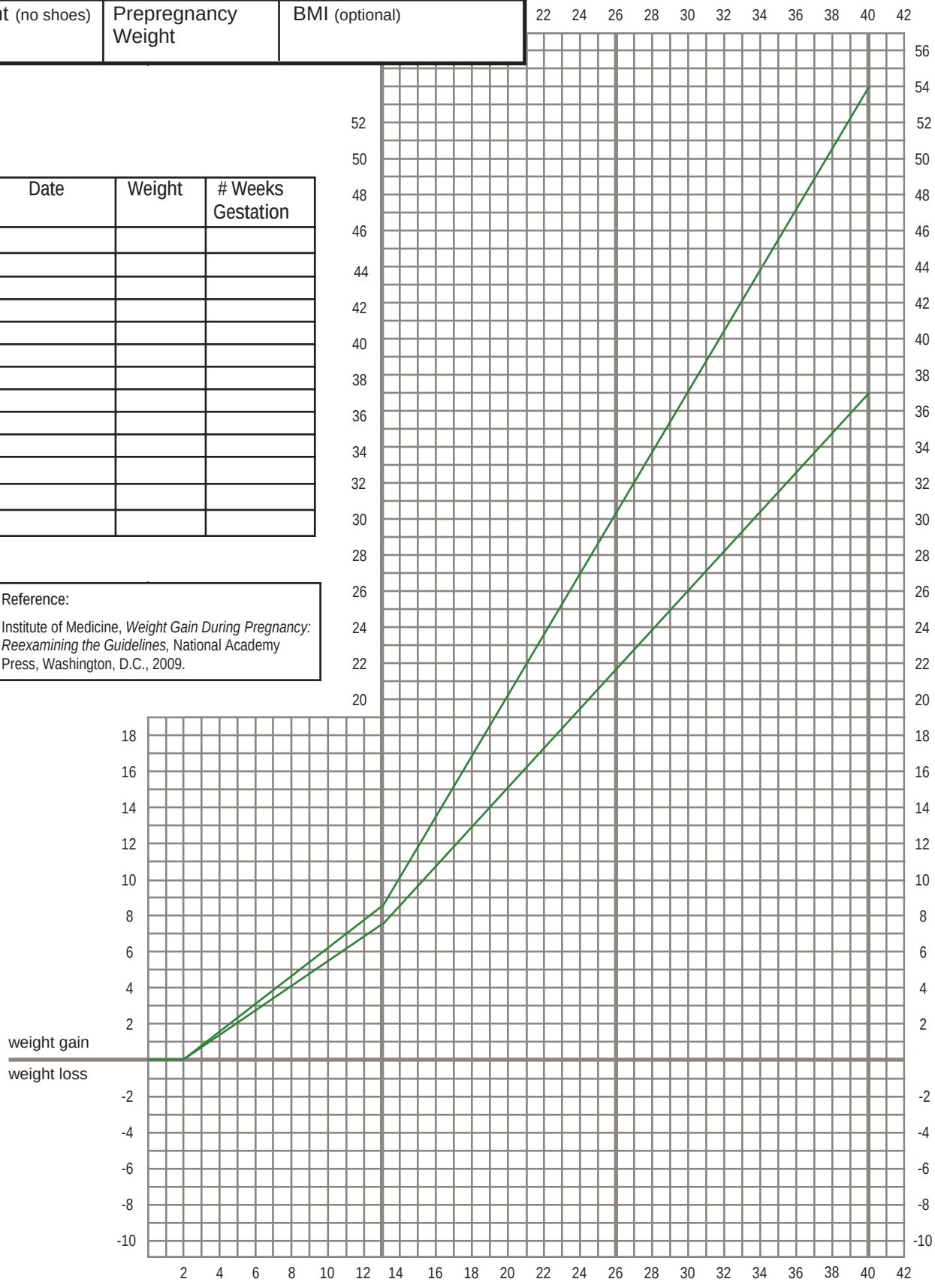
Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

Date	Weight	# Weeks Gestation

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.



Recommended Weight Gain

BMI 18.5 - 24.9
37-54 lbs total gain

1st Trimester
8-9 lbs

2nd Trimester
1.4 lbs/week

3rd Trimester
1.4 lbs/week

Prenatal Weight Gain—Multi

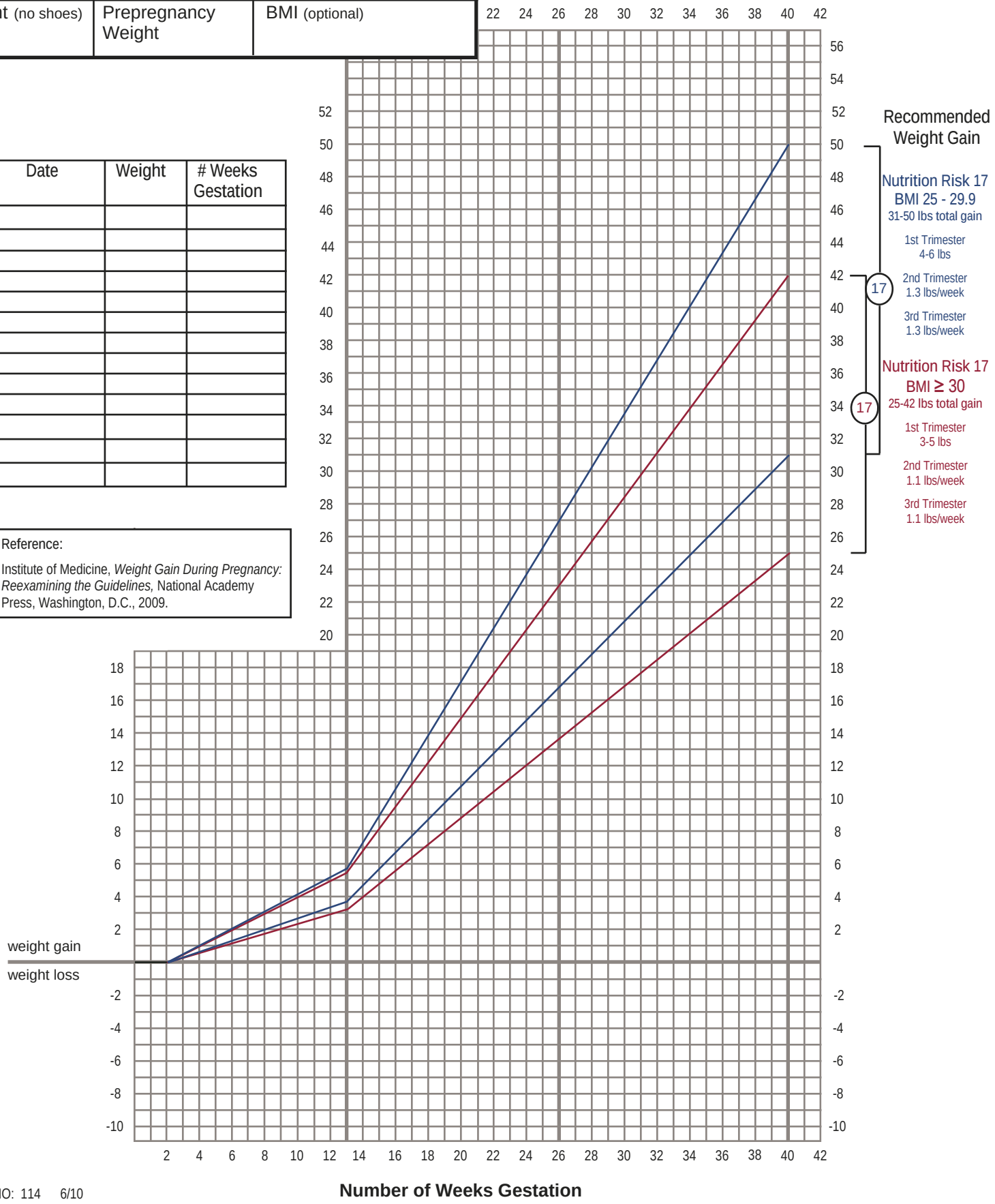
Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

Date	Weight	# Weeks Gestation

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.



PRENATAL

HEALTH ASSESSMENT

Estimated delivery date: _____ Multifetal gestation? ☐ No ☐ Yes

Previous pregnancy end: ☐ No previous pregnancy ☐ Date _____

NUTRITION ASSESSMENT

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How is your pregnancy going? _____
   Are you having any symptoms like nausea or vomiting?
   ☐ No
   ☐ Declined
   ☐ Yes [301]

2. Tell me about any health or medical concerns you are currently having.
   ☐ No concerns
   ☐ Concerns (describe) _____
   [201, 302, 336, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 356, 358, 359, 360, 361, 362, 381]

3. Is this your first pregnancy?
   ☐ Yes
   ☐ No Number of pregnancies: _____
   ☐ Declined

4. *(If first pregnancy, mark no complications and continue to next question)* Tell me about any complications or health problems you have had with any past pregnancies, such as gestational diabetes or high blood pressure.
   ☐ No complications
   ☐ Complications
   ☐ 303: Hx Gestational Diabetes ☐ 304: Hx of Preeclampsia ☐ 311: Hx Preterm Delivery (≤ 37 wks)
   ☐ 312: Hx Low Birth Weight ☐ 321: Fetal/Neonatal Loss ☐ 337: Hx Birth LGA Infant
   ☐ 339: Hx Birth-Congenital Defect ☐ Other: _____ [303, 304, 311, 312, 321, 337, 339]

5. Have you seen a medical provider for this pregnancy?
   ☐ No
   ☐ Declined
   ☐ Yes Clinic/Provider: _____Date of first appt _____Number of appts_____[334]

6. What medications are you currently taking?
   - ☐ None
   - ☐ List medications: _____ [357]

7. Do you have any dental problems that prevent you from eating some foods?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [381]

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. Do you currently smoke?
   - ☐ No
   - ☐ Declined
   - ☐ Yes # of cigarettes/day: ____ [371]

2. Did you smoke in the 3 months before you were pregnant?
   - ☐ No
   - ☐ Declined
   - ☐ Yes # of cigarettes/day: ____

3. Does anyone living in your house smoke *inside* the home?
   - ☐ No
   - ☐ Declined
   - ☐ Yes [904]

4. Did you drink alcohol in the 3 months before you were pregnant?
   - ☐ No
   - ☐ Declined
   - ☐ Yes # of drinks/week: _____

5. Have you had alcohol since becoming pregnant?
   - ☐ No
   - ☐ Declined
   - ☐ Yes How much do you drink? _____ How often? _____ [372]

6. Have you used street drugs since your pregnancy began?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [372]

7. What kind of activity or exercise do you like to do on most days?
   - ☐ Bike riding ☐ Dance ☐ Exercise class/gym ☐ Exercise DVD/video ☐ Jog/run
   - ☐ Play outdoors with children ☐ Swim ☐ Walk ☐ Yoga ☐ Declined to answer ☐ Other

   Frequency – times per week (opt.) _____ Length of time in minutes (opt.) _____

Nutrition/Health

I am going to ask you some questions about your diet. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. Tell me about any changes you have made to your diet since becoming pregnant. Experiencing any cravings?
   ☐ No changes ☐ Changes (list any reasons to assign NRC 427) _____ [427.02, 427.05]

2. How has your appetite been? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   ☐ Other (describe) _____ [427.02]

3. Are you avoiding food for any reason, including food allergies? (*If yes*) Tell me more.
   ☐ No
   ☐ Declined
   ☐ Yes (describe) _____ [353, 355, 358, 362, 427.02, 902]

4. What foods do you typically eat? _____
   _____ [427.02, 427.05, 902]

5. What do you drink most days?
   ☐ Coffee ☐ Juice ☐ Kool-Aid/punch ☐ Soda: diet ☐ Soda: regular ☐ Sports drinks ☐ Tea ☐ Water
   ☐ Milk (*circle:* whole lowfat skim lactose reduced/free goat raw soy) ☐ Other _____ [427.02, 427.05]

6. Do you regularly eat things other than food?
   ☐ No
   ☐ Declined
   ☐ Yes
   ☐ Dirt ☐ Clay ☐ Carpet fibers ☐ Dust ☐ Ashes ☐ Laundry starch
   ☐ Cigarette butts ☐ Paint chips ☐ Other [427.03]

7. Tell me about any vitamins, minerals, herbs or dietary supplements you are taking. (*If taking a prenatal vitamin*) What type of prenatal vitamin are you taking?
   ☐ None ☐ General vitamin/mineral supplement
   ☐ Children's vitamin/mineral supplement ☐ Iodine
   ☐ Folic acid supplement ☐ Iron
   ☐ Prenatal vitamin/mineral supplement, herb/dietary supplement or other: _____ [427.01, 427.04]

8. How do you plan to feed your baby?
   ☐ Breastfeeding ☐ Formula feeding ☐ Combination ☐ Other _____

9. Would you like to learn more about breastfeeding?
   ☐ No ☐ Declined ☐ Yes. Tell me more: _____

10. During the last 6 months, have you run out of money to buy food?
    ☐ No
    ☐ Declined
    ☐ Yes (describe) _____ [427.02]

11. Given all we have talked about, what nutrition or health questions do you have today?
    ☐ No questions/concerns
    ☐ Questions/concerns

    _____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
101	UNDERWEIGHT (WOMEN)	349	GENETIC AND CONGENITAL DISORDERS
111	OVERWEIGHT (WOMEN)	351	INBORN ERRORS OF METABOLISM
131	LOW MATERNAL WEIGHT GAIN	352	INFECTIOUS DISEASES
132	MATERNAL WEIGHT LOSS DURING PREGNANCY	353	FOOD ALLERGIES
133	HIGH MATERNAL WEIGHT GAIN	354	CELIAC DISEASE
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	355	LACTOSE INTOLERANCE
301	HYPEREMESIS GRAVIDARUM	356	HYPOGLYCEMIA
302	GESTATIONAL DIABETES	357	DRUG-NUTRIENT INTERACTIONS
303	HX OF GESTATIONAL DIABETES	358	EATING DISORDERS
304	HX OF PREECLAMPSIA	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
311	HX OF PRETERM DELIVERY	360	OTHER MEDICAL CONDITIONS
312	HX OF LOW BIRTH WEIGHT	361	DEPRESSION
321	HX OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
331	PREGNANCY AT A YOUNG AGE	371	MATERNAL SMOKING
332	CLOSELY SPACED PREGNANCIES	372	ALCOHOL AND ILLEGAL DRUG USE
334	LACK OF OR INADEQUATE PRENATAL CARE	381	ORAL HEALTH CONDITIONS
335	MULTIFETAL GESTATION	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS
336	FETAL GROWTH RESTRICTION	427	INAPPROPRIATE NUTRITION PRACTICES FOR WOMEN
337	HX OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT	427.01	DIETARY SUPPLEMENTS W/ POTENTIALLY HARMFUL CONSEQUENCES
338	PREGNANT WOMAN CURRENTLY BREASTFEEDING	427.02	CONSUMING DIET LOW IN CALORIES/NUTRIENTS
339	HX OF BIRTH W/ NUTRITION RELATED CONGENITAL/BIRTH DEFECT	427.03	COMPULSIVELY INGESTING NON-FOOD ITEMS (PICA)
341	NUTRIENT DEFICIENCY DISEASES	427.04	INADEQUATE VITAMIN/MINERAL SUPPLEMENTATION
342	GASTRO-INTESTINAL DISORDERS	427.05	INGESTING FOODS THAT COULD BE CONTAMINATED
343	DIABETES MELLITUS	502	TRANSFER OF CERTIFICATION
344	THYROID DISORDERS	801	HOMELESSNESS
345	HYPERTENSION (INCL CHRONIC/PREGNANCY INDUCED)	802	MIGRANCY
346	RENAL DISEASE	902	LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
347	CANCER	903	FOSTER CARE
348	CENTRAL NERVOUS SYSTEM DISORDERS	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

POSTPARTUM

HEALTH ASSESSMENT

Estimated delivery date: _____ Actual delivery date: _____ ☐ Multi-fetal gestation

Previous pregnancy end: ☐ No previous pregnancy ☐ Date _____ # infants delivered: _____

Delivery outcome(s): ☐ Alive ☐ Dead ☐ Miscarried ☐ Stillborn

NUTRITION ASSESSMENT

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How are you feeling now? _____

2. Are you having any medical problems that make it difficult to care for yourself or your baby?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (Describe) _____
   [201, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 356, 358, 359, 360, 361, 362, 363, 381]

3. What medications are you currently taking?
   - ☐ None
   - ☐ List medications: _____ [357]

4. Was this your first pregnancy? ☐ Yes ☐ No ☐ Declined Number of pregnancies: _____

5. Did you have any health or medical concerns with this last pregnancy, such as gestational diabetes?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [303, 304, 311, 312, 321, 335, 337, 339, 359]

6. Do you have any dental problems that prevent you from eating some foods?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [381]

7. *(Only ask this question if mom is being certified before the infant.)* How is your baby doing?

   _____

8. How much did your baby weigh at birth? _____ pounds _____ ounces [312, 337]

9. When was your first visit for prenatal care? Date: _____

10. It helps if we know where you go for medical care. Which medical clinic or provider do you go to?
    - ☐ No provider
    - ☐ Declined
    - ☐ Unknown
    - ☐ Provider: _____

11. How often do you go for medical care? _____

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. Do you smoke?
   ☐ No ☐ Declined ☐ Yes: # of cigarettes/day: _____ [371]

2. Did you smoke during the last 3 months of your pregnancy? ☐ No ☐ Declined ☐ Yes

3. Does anyone living in your house smoke *inside* the home?
   ☐ No ☐ Declined ☐ Yes [904]

4. Do you drink alcohol?
   ☐ No
   ☐ Declined
   ☐ Yes How many drinks at a time? _____ How often? _____ [372]

5. Did you drink alcohol in the last 3 months of your pregnancy?
   ☐ No ☐ Declined ☐ Yes # drinks/week _____

6. Have you used street drugs since the baby was born?
   ☐ No
   ☐ Declined
   ☐ Yes (describe) _____ [372]

7. What kind of activity or exercise do you like to do on most days?
   ☐ Bike riding ☐ Dance ☐ Exercise class/gym ☐ Exercise DVD/video ☐ Jog/run
   ☐ Play outdoors with children ☐ Swim ☐ Walk ☐ Yoga ☐ Declined to answer ☐ Other

   Frequency – times per week (opt.) _____ Length of time in minutes (opt.) _____

Nutrition/Health

I am going to ask you some questions about your health and nutrition. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. Tell me about feeding your new baby. How is it going?
   Method: ☐ Breastfeeding ☐ Combination feeding ☐ Formula feeding

   ☐ Other (describe) _____ [601, 602]

2. *(If any breastfeeding)* Would you like to learn more about or have help with breastfeeding?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____

3. How has your appetite been?
   - ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   - ☐ Other (describe) _____ [427.02]

4. Are there foods that you avoid for any reason, including food allergies?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [353, 355, 358, 362, 427.02, 902]

5. What foods do you typically eat? _____

   _____ [427.02, 427.05, 902]

6. What do you drink most days?
   ☐ Coffee ☐ Juice ☐ Kool-Aid/punch ☐ Soda: diet ☐ Soda: regular ☐ Sports drinks ☐ Tea ☐ Water
   ☐ Milk (*circle:* whole lowfat skim lactose reduced/free goat raw soy) ☐ Other _____ [427.02, 427.05]

7. Sometimes women experience unusual cravings after having a baby that may include non-food items like eating paper.. Do you regularly eat things other than food?
   - ☐ No
   - ☐ Declined
   - ☐ Yes
     - ☐ Dirt ☐ Clay ☐ Carpet fibers ☐ Dust ☐ Ashes ☐ Laundry starch
     - ☐ Cigarette butts ☐ Paint chips ☐ Other [427.03]

8. Tell me about any vitamins, minerals, herbs or dietary supplements you are taking. (*If taking a prenatal vitamin*) What type of prenatal vitamin are you taking?
   - ☐ None
   - ☐ Folic acid supplement
   - ☐ Iodine
   - ☐ Children's vitamin/mineral supplement
   - ☐ General vitamin/mineral supplement
   - ☐ Iron
   - ☐ Prenatal vitamin/mineral supplement, herb/dietary supplement or other: _____ [427.01, 427.04]

9. Did you take a multivitamin during pregnancy? (includes prenatals)
   ☐ No ☐ Declined ☐ Yes

10. Did you take a multivitamin before your pregnancy?
    ☐ No ☐ Declined ☐ Yes

11. During the last 6 months, have you run out of money to buy food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes (describe) _____ [427.02]

12. Given all we have talked about, what nutrition or health questions do you have today?
    - ☐ No questions/concerns
    - ☐ Questions/concerns _____

    _____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
101	UNDERWEIGHT (WOMEN)	356	HYPOGLYCEMIA
111	OVERWEIGHT (WOMEN)	357	DRUG-NUTRIENT INTERACTIONS
133	HIGH MATERNAL WEIGHT GAIN	358	EATING DISORDERS
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
303	HX OF GESTATIONAL DIABETES	360	OTHER MEDICAL CONDITIONS
304	HX OF PREECLAMPSIA	361	DEPRESSION
311	HX OF PRETERM DELIVERY	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
312	HX OF LOW BIRTH WEIGHT	363	PRE-DIABETES
321	HX OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS	371	MATERNAL SMOKING
331	PREGNANCY AT A YOUNG AGE	372	ALCOHOL AND ILLEGAL DRUG USE
332	CLOSELY SPACED PREGNANCIES	381	ORAL HEALTH CONDITIONS
335	MULTIFETAL GESTATION	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS
337	HX OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT	427	INAPPROPRIATE NUTRITION PRACTICES FOR WOMEN
339	HX OF BIRTH W/ NUTRITION RELATED CONGENITAL/BIRTH DEFECT	427.01	DIETARY SUPPLEMENTS W/ POTENTIALLY HARMFUL CONSEQUENCES
341	NUTRIENT DEFICIENCY DISEASES	427.02	CONSUMING DIET LOW IN CALORIES/NUTRIENTS
342	GASTRO-INTESTINAL DISORDERS	427.03	COMPULSIVELY INGESTING NON-FOOD ITEMS (PICA)
343	DIABETES MELLITUS	427.04	INADEQUATE VITAMIN/MINERAL SUPPLEMENTATION
344	THYROID DISORDERS	427.05	INGESTING FOODS THAT COULD BE CONTAMINATED
345	HYPERTENSION (INCL CHRONIC/PREGNANCY INDUCED)	501	POSSIBILITY OF REGRESSION
346	RENAL DISEASE	502	TRANSFER OF CERTIFICATION
347	CANCER	601	BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK
348	CENTRAL NERVOUS SYSTEM DISORDERS	602	BREASTFEEDING COMPLICATIONS
349	GENETIC AND CONGENITAL DISORDERS	801	HOMELESSNESS
351	INBORN ERRORS OF METABOLISM	802	MIGRANCY
352	INFECTIOUS DISEASES	902	LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
353	FOOD ALLERGIES	903	FOSTER CARE
354	CELIAC DISEASE	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE
355	LACTOSE INTOLERANCE		

INFANT

HEALTH ASSESSMENT

Was (infant's name) ever breastfed? ☐ Yes ☐ No ☐ Unknown

At what age did (infant's name) first have formula? _____ weeks (1-78) ☐ Not started ☐ Unknown

At what age did (infant's name) stop breastfeeding? _____ weeks (1-78) ☐ Not stopped ☐ Unknown

Why did (infant's name) stop or never start breastfeeding? ☐ Medical condition mom/infant

☐ Inadequate milk supply ☐ Breastfeeding management problem ☐ Mom returning to work/school

☐ Other (describe): _____

NUTRITION ASSESSMENT

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your baby's health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How is (infant's name) doing? _____

2. Has your doctor identified any health problems or medical conditions for (infant's name)?
   ☐ No concerns
   ☐ Concerns (describe) _____
   [134, 201, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 359, 360, 362, 381, 382]

3. Is (infant's name) currently taking any medications?
   ☐ No
   ☐ Unknown
   ☐ Yes (list medications): _____ [357]

4. How do you take care of (infant's name)'s teeth?

   _____ [381]

5. It helps if we know where you go for medical care. Where do you take (infant's name) for medical care?
   ☐ No provider
   ☐ Declined
   ☐ Unknown
   ☐ Provider: _____

6. How often do you take (infant's name) for medical care? _____

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. Does anyone living in your house smoke *inside* the home?
   - ☐ No
   - ☐ Unknown
   - ☐ Yes [904]

Nutrition/Health

I am going to ask you some questions about your baby's diet. Then we will come back and address any concerns or questions you may have. Is this all right with you?

1. How do you feed your baby?
   ☐ Breastfeeding ☐ Formula ☐ Combination ☐ Other _____ [411.01]

2. How do you know when (infant's name) is hungry or full?
   _____ [411.04]

3. *(If any breastfeeding)* How is breastfeeding going?
   - ☐ No concerns
   - ☐ Concerns (describe) _____ [603, 702]

4. *(If any breastfeeding)* Describe for me how often (infant's name) nurses and for how long?
   - ☐ Not breastfeeding
   - ☐ Description (how often/how long) _____ [411.07]

5. Do you use bottles to feed your baby?
   - ☐ No
   - ☐ Declined
   - ☐ Yes
     Do you put anything in the bottle other than breastmilk, formula or water?
     ☐ No ☐ Yes (contents of bottle): _____ [411.01, 411.02, 411.03, 411.05]

6. *(If putting breastmilk in a bottle)* Tell me more about how you prepare, store and give bottles with breastmilk.
   - ☐ Appropriately handles, stores and gives bottles
   - ☐ Fresh added to already frozen
   - ☐ Adding refrigerated to frozen in an amount greater than the amount of frozen
   - ☐ Failure to clean breast pump/bottles per manufacturer's instruction
   - ☐ Held from a used bottle to use at another feeding
   - ☐ Props bottle
   - ☐ Refreezing
   - ☐ Thawed held in refrigerator over 24 hours
   - ☐ Thawed in microwave [411.02, 411.03, 411.04, 411.09]

7. *(Ifusing any formula)* Tell me more about how you prepare, store and give (infant's name)'s bottles.

Formula brand/type: _____
Ounces/bottle: _____ Number of bottles in 24 hours: _____

- ☐ Appropriately prepares, stores and give bottles
- ☐ Held too long at room temperature
- ☐ Held in refrigerator longer than manufacturer's instruction
- ☐ Held in bottle from last feeding or over 1 hour from start of feeding
- ☐ Props bottles
- ☐ Using improperly cleaned bottles
- ☐ Unsafe water source [411.02, 411.03, 411.04, 411.06, 411.08, 411.09]

8. *(if any bottle feeding)* Does (infant's name) take a bottle to bed?
☐ No ☐ Declined ☐ Yes What is in the bottle? _____ [411.02]

9. Does (infant's name) drink from anything else other than breast or bottle?
- ☐ No
- ☐ Declined
- ☐ Yes
  - ☐ Sippy cup ☐ Sippy cup - bottle-type lid ☐ Cup without lid (contents: _____)
  - Other (describe): _____ [411.02]

10. What else, if anything, do you feed (infant's name)? ☐ No solids yet ☐ Baby food in jars
☐ Homemade baby food ☐ Table/family food ☐ Other (describe) _____

When did (infant's name) first have foods other than breastmilk or formula? Age in months: _____

☐ Cereal ☐ Other grains ☐ Fruit ☐ Vegetables ☐ Meat ☐ Yogurt ☐ Cheese
[411.03, 411.04, 411.05, 411.08, 902]

11. Tell me about how (infant's name) eats, like picking up pieces of food or holding a cup. ☐ Is not feeding self
☐ Reaches for food ☐ Picks up pieces of food ☐ Helps hold silverware ☐ Helps hold cup [411.04]

12. If you ever add anything to (infant's name)'s food or liquids, what do you add? ☐ Nothing ☐ Cereal
☐ Corn syrup ☐ Salt ☐ Sugar ☐ Honey ☐ Other (describe): _____ [411.02, 411.03]

13. Does (infant's name) take any vitamins, minerals, herbs or dietary supplements?
- ☐ No
- ☐ Declined
- ☐ Yes
  - ☐ Vitamin/mineral supplement ☐ Vitamin D ☐ Fluoride/fluoridated water ☐ Iron [411.10, 411.11]

14. During the last 6 months, have you run out of money to buy food?
☐ No ☐ Unknown ☐ Yes [411.08]

15. Given all we have talked about, what nutrition, health or feeding questions do you have today?
- ☐ No questions/concerns
- ☐ Questions/concerns

_____

_____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
103	UNDERWEIGHT OR AT RISK OF UNDERWEIGHT	360	OTHER MEDICAL CONDITIONS
114	OVERWEIGHT OR AT RISK OF BECOMING OVERWEIGHT	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
115	HIGH WEIGHT-FOR-LENGTH	381	ORAL HEALTH CONDITIONS
121	SHORT STATURE OR AT RISK OF SHORT STATURE	382	FETAL ALCOHOL SYNDROME
134	FAILURE TO THRIVE	411	INAPPROPRIATE NUTRITION PRACTICES FOR INFANTS
135	INADEQUATE GROWTH	411.01	ROUTINELY USING A SUB FOR BREASTMILK/FORMULA
141	LOW BIRTH WEIGHT	411.02	ROUTINELY USING BOTTLES OR CUPS IMPROPERLY
142	PREMATURITY	411.03	GIVING SOLID FOOD TOO SOON OR TOO CHUNKY
153	LARGE FOR GESTATIONAL AGE	411.04	FEEDING FOODS NOT APPROPRIATE TO DEVELOPMENTAL AGE
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	411.05	FEEDING FOODS THAT COULD BE CONTAMINATED
341	NUTRIENT DEFICIENCY DISEASES	411.06	ROUTINELY MIXING FORMULA INCORRECTLY
342	GASTRO-INTESTINAL DISORDERS	411.07	LIMITING BREASTFEEDING FOR FULLY BREASTFED
343	DIABETES MELLITUS	411.08	FEEDING A DIET BERY LOW IN CALORIES OR NUTRIENTS
344	THYROID DISORDERS	411.09	UNSAFE PREP/HANDLING/STORAGE OF BREASTMILK/FORMULA
345	HYPERTENSION	411.10	FEEDING POTENTIALLY HARMFUL DIETARY SUPPLEMENTS
346	RENAL DISEASE	411.11	NOT FEEDING RECOMMENDED DIETARY SUPPLEMENTS
347	CANCER	428	DIETARY RISK ASSOC W/ COMPLEMENTARY FEEDING PRACTICES
348	CENTRAL NERVOUS SYSTEM DISORDER	502	TRANSFER OF CERTIFICATION
349	GENETIC AND CONGENITAL DISORDERS	603	BREASTFEEDING COMPLICATIONS
351	INBORN ERRORS OF METABOLISM	701	INFANT UP TO 6 MO OF WIC MOTHER/WOMAN ELIGIBLE DURING PREGNANCY
352	INFECTIOUS DISEASES	702	BREASTFEEDING INFANT OF WOMEN AT NUTR RISK
353	FOOD ALLERGIES	801	HOMELESSNESS
354	CELIAC DISEASE	802	MIGRANCY
355	LACTOSE INTOLERANCE	902	LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
356	HYPOGLYCMIA	903	FOSTER CARE
357	DRUG-NUTRIENT INTERACTIONS	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE
359	RECENT MAJOR SURGERY, TRAUMA, BURNS		

CHILD

HEALTH ASSESSMENT (for children under age 2)

Was (child's name) ever breastfed? ☐ Yes ☐ No ☐ Unknown

At what age did (child's name) first have formula? _____ weeks (1-78) ☐ Not started ☐ Unknown

At what age did (child's name) stop breastfeeding? _____ weeks (1-78) ☐ Not stopped ☐ Unknown

Why did (child's name) stop or never start breastfeeding? ☐ Medical condition mom/infant

☐ Inadequate milk supply ☐ Breastfeeding management problem ☐ Mom returning to work/school

☐ Other (describe): _____

NUTRITION ASSESSMENT (all children)

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your child's health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How is (child's name) doing? _____

2. Has your doctor identified any health problems or medical conditions for (child's name)?
   ☐ No concerns
   ☐ Concerns (Describe) _____
   [134, 201, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 359, 360, 362, 381, 382]

3. Is (child's name) currently taking any medications?
   ☐ No
   ☐ Unknown
   ☐ Yes (list medications): _____ [357]

4. How do you feel about (child's name)'s growth?
   ☐ No concerns
   ☐ Concerns (Describe): _____

5. Has (child's name) had a blood lead test?
   ☐ No ☐ Declined ☐ Yes

6. How do you take care of (child's name)'s teeth?
   _____ [381]

7. It helps if we know where you go for medical care. Where do you take (child's name) for medical care?
   - ☐ No provider
   - ☐ Declined
   - ☐ Unknown
   - ☐ Provider: _____

8. How often do you take (child's name) for medical care?

   _____ Next appointment: _____

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. What kinds of play does (child's name) do most days? (Describe – examples: indoor games, ball, rides bike, exercise class, etc.)

   _____

   Frequency – times per week (opt.) _____ Length of time in minutes (opt.) _____

2. How many hours of screen time (TV, computer, video games, movies, videos, DVDs, Game Boy, etc.) does (child's name) get in a typical day?

   _____

3. Does anyone living in your house smoke *inside* the home?
   ☐ No ☐ Declined ☐ Yes [904]

Nutrition/Health

I am going to ask you some questions about your child's diet. Then we will come back and address any concerns or questions you may have. Is this all right with you?

1. How is (child's name)'s appetite?
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ Other (Tell me more) _____ [425.06]

2. What foods does (child's name) typically eat? _____

   _____ [425.04, 425.05, 425.06, 902]

3. How often does (child's name) usually eat?

   Number of meals _____ Number of snacks _____ Other: _____ [425.06, 902]

4. How do you help (child's name) with eating? _____

   _____

   What does (child's name) do to feed herself/himself? _____

   _____ [425.04]

5. Does (child's name) ever seem to choke or gag when eating?
   - ☐ No
   - ☐ Yes
     Tell me more: _____ [425.04]

6. How do you know when (child's name) is hungry or full? _____
   _____ [425.04]

7. Are there foods you limit or avoid feeding (child's name) for any reason, including food allergies?
   - ☐ No
   - ☐ Yes
     Tell me more:_____ [353, 355, 362, 425.06, 902]

8. Tell me what (child's name) drinks from, such as a cup or bottle.
   - ☐ Bottle
   - ☐ Breast
   - ☐ Cup
   - ☐ Sippy cup
   - ☐ Refused
   - ☐ Other: _____ [425.03]

9. Tell me what (child's name) routinely drinks most days: _____
   _____ [425.01, 425.02]

10. Does (child's name) regularly eat things other than food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes (Describe – example: dirt, clary, carpet, etc.) _____ [425.09]

11. Does (child's name) take any vitamins, minerals, herbs or dietary supplements?
    - ☐ No
    - ☐ Declined
    - ☐ Yes
      What and how much? _____ [425.07, 425.08]

12. Does (child's name) use pacifiers that have been dipped in liquids or food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes
      Tell me which liquids or foods are used to dip the pacifiers: _____ [425.03]

13. During the last 6 months, have you run out of money to buy food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes [425.06]

12. Given all we have talked about, what nutrition or health questions do you have today?
    - ☐ No questions/concerns
    - ☐ Questions/concerns

    _____

    _____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
103	UNDERWEIGHT OR AT RISK OF UNDERWEIGHT	357	DRUG-NUTRIENT INTERACTIONS
113	OBESE (CHILDREN 2-5 YEARS OF AGE)	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
114	OVERWEIGHT OR AT RISK OF BECOMING OVERWEIGHT	360	OTHER MEDICAL CONDITIONS
115	HIGH WEIGHT-FOR-LENGTH (CHILDREN < 24 MOS OF AGE)	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
121	SHORT STATURE OR AT RISK OF SHORT STATURE	381	ORAL HEALTH CONDITIONS
134	FAILURE TO THRIVE	382	FETAL ALCOHOL SYNDROME
135	INADEQUATE GROWTH	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS
141	LOW BIRTH WEIGHT	425	INAPPROPRIATE NUTRITION PRACTICES FOR CHILDREN
142	PREMATURITY	425.01	PRIMARY MILK SOURCE INAPPROPRIATE
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	425.02	SUGAR-CONTAINING BEVERAGES
341	NUTRIENT DEFICIENCY DISEASES	425.03	INAPPROPRIATE BOTTLE, CUP, PACIFIER USE
342	GASTO-INTESTINAL DISORDERS	425.04	DISREGARDING DEVELOPMENT
343	DIABETES MELLITUS	425.05	FEEDING POTENTIALLY HARMFUL FOODS
344	THYROID DISORDERS	425.06	DIET LOW IN CALORIES/NUTRIENTS
345	HYPERTENSION	425.07	DIETARY SUPPLEMENTS W/ POTENTIALLY HARMFUL CONSEQUENCES
346	RENAL DISEASE	425.08	NO DIETARY SUPPLEMENTS
347	CANCER	425.09	EATING NONFOOD ITEMS (PICA)
348	CENTRAL NERVOUS SYSTEM DISORDERS	428	DIETARY RISK – COMPLEMENTARY FEEDING PRACTICES
349	GENETIC AND CONGENTICAL DISORDERS	501	POSSIBILITY OF REGRESSION
351	INBORN ERRORS OF METABOLISM	502	TRANSFER OF CERTIFICATION
352	INFECTIOUS DISEASES	801	HOMELESSNESS
353	FOOD ALLERGIES	802	MIGRANCY
354	CELIAC DISEASE	902	CHILD OF PRIMARY CAREGIVER W/ LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
355	LACTOSE INTOLERANCE	903	FOSTER CARE
356	HYPOGLYCEMIA	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

The Idaho WIC Program requires each applicant to provide proof of identification, residence (or address), and income when applying for WIC. If you cannot provide proof, please indicate which proof is missing by checking the correct box and completing the information.

❒ **NO PROOF OF IDENTIFICATION**
The reason I have no proof of identification is: _____

_____

❒ **NO PROOF OF RESIDENCE OR ADDRESS**
The reason I have no proof of residence is: _____

_____

❒ **ZERO INCOME**
I declare the gross monthly income for myself and all the members of my family or household has been ZERO ($0.00) for the past 30 days. Our basic living needs for the past 30 days have been met by:

SHELTER: _____

FOOD: _____

Please read the following statement before signing the form.

The information I have written above is correct. I understand I may be prosecuted under law and have to pay back what I have received if I have intentionally lied or withheld the truth.

_____ _____
Date Responsible Adult Signature

_____ _____
Date WIC Program Representative Signature

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/ complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

El Programa de WIC de Idaho requiere que cada solicitante provea comprobante de su identificación, residencia (o dirección) e ingreso cuando esten solicitando beneficios de WIC. Si no puede proveer comprobantes, por favor indique qué comprobante le hace falta al marcar la cajilla apropiada y al completar la información.

❒ **SIN COMPROBANTE DE IDENTIFICACION**
La razón por la cual no tengo comprobante de identificación es: _____

_____

❒ **SIN COMPROBANTE DE RESIDENCIA O DIRECCION**
La razón por la cual no tengo comprobante de residencia o dirección es: _____

_____

❒ **SIN INGRESO**
Yo afirmo que mi ingreso mensual y de todos los miembros de mi familia u hogar ha sido CERO ($0.00) por los últimos 30 días. Nuestras necesidades básicas para vivir han sido proveídas por los últimos 30 días por:

VIVIENDA: _____

COMIDA: _____

Por favor lea la declaración a continuación antes de firmar esta forma.

La información que he escrito anteriormente es correcta. Entiendo que puedo ser procesado por la ley y devolver los beneficios que he recibido si intencionalmente miento o no proveo toda la información necesaria.

_____ _____
Fecha Firma del Adulto Responsable

_____ _____
Fecha Firma del Representante del Programa WIC

El Departamento de Agricultura de los Estados Unidos (por sus siglas en inglés "USDA") prohíbe la discriminación contra sus clientes, empleados y solicitantes de empleo por raza, color, origen nacional, edad, discapacidad, sexo, identidad de género, religión, represalias y, según corresponda, convicciones políticas, estado civil, estado familiar or paternal, orientación sexual, o si los ingresos de una persona provienen en su totalidad o en parte de un programa de asistencia pública, o información genética protegida de empleo o de cualquier programa o actividad realizada o financiada por el Departamento. (No todos los criterios prohibidos se aplicarán a todos los programas y/o actividades laborales).

Si desea presentar una queja por discriminación del programa de Derechos Civiles, complete el USDA Program Discrimination Complaint Form (formulario de quejas por discriminación del programa del USDA), que puede encontrar en internet en http://www.ascr.usda.gov/complaint_filing_cust.html, o en cualquier oficina del USDA, o llame al (866) 632-9992 para solicitar el formulario. También puede escribir una carta con toda la información solicitada en el formulario. Envíenos su formulario de queja completo o carta por correo postal a U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, por fax al (202) 690-7442 o por correo electrónico a program.intake@usda.gov.

Las personas sordas, con dificultades auditivas, o con discapacidad del habla pueden contactar al USDA por medio del Federal Relay Service (servicio federal de transmisión) al (800) 877-8339 o (800) 845-6136 (en español).

El USDA es un proveedor y empleador que ofrece igualdad de oportunidades.

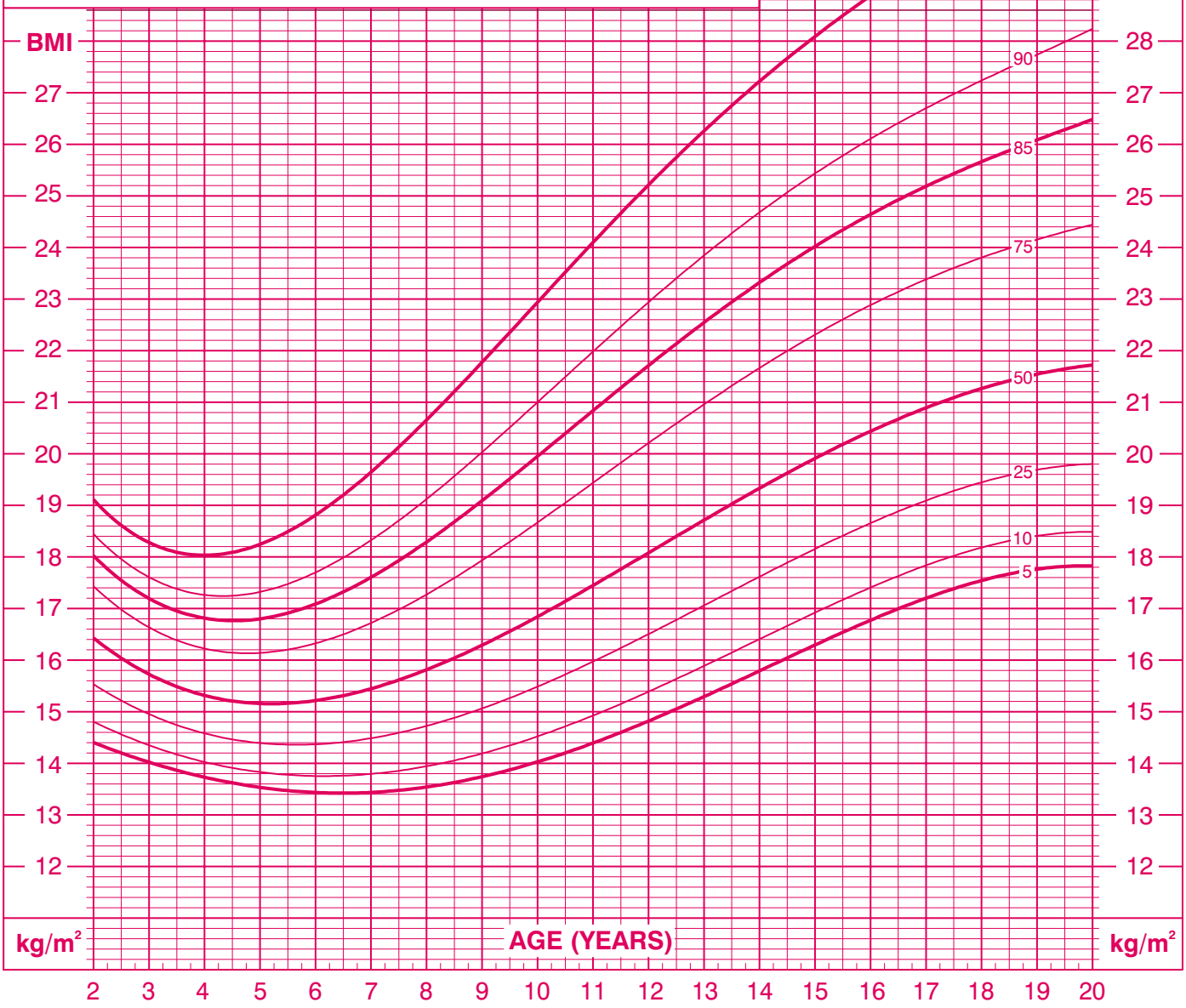
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

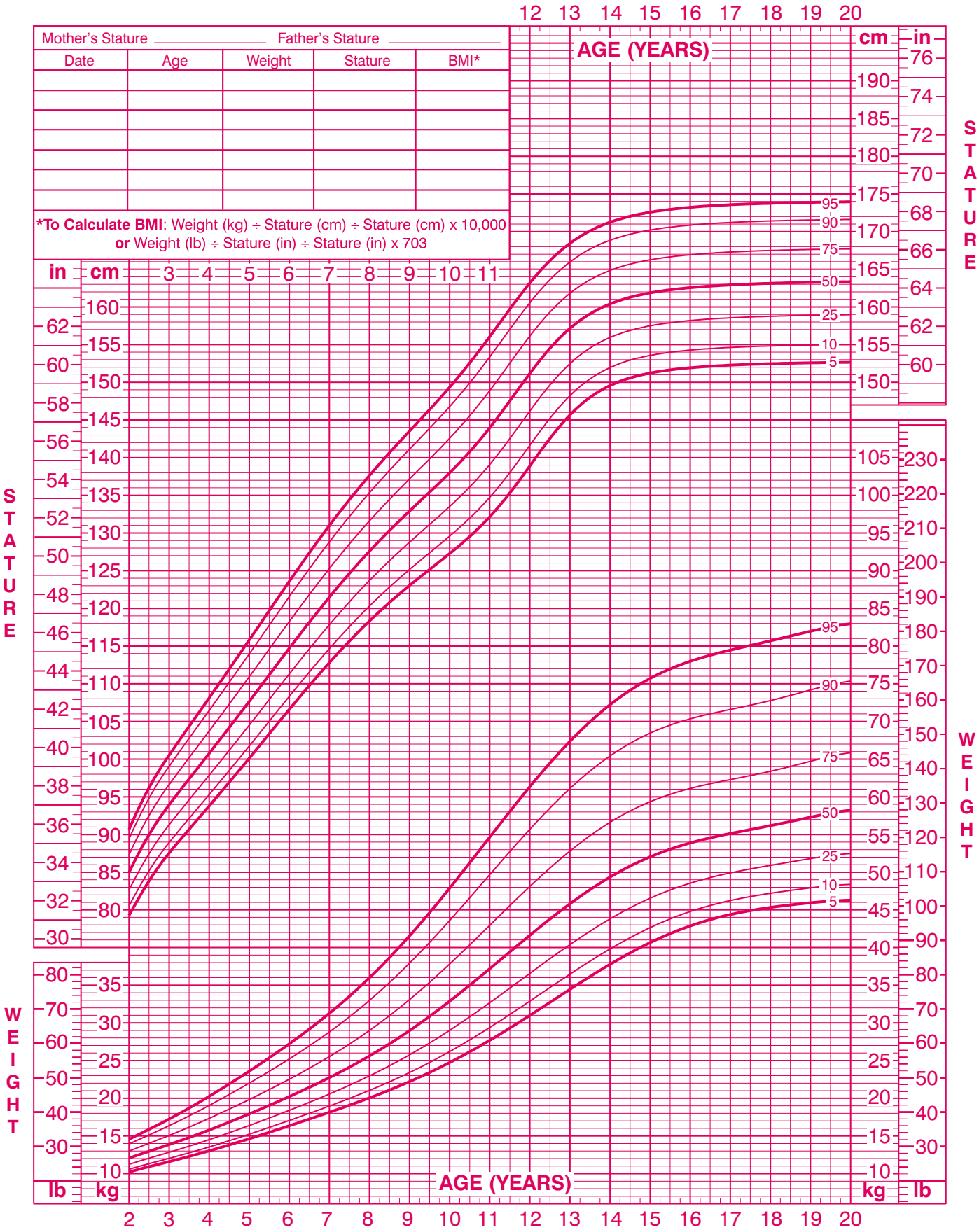
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



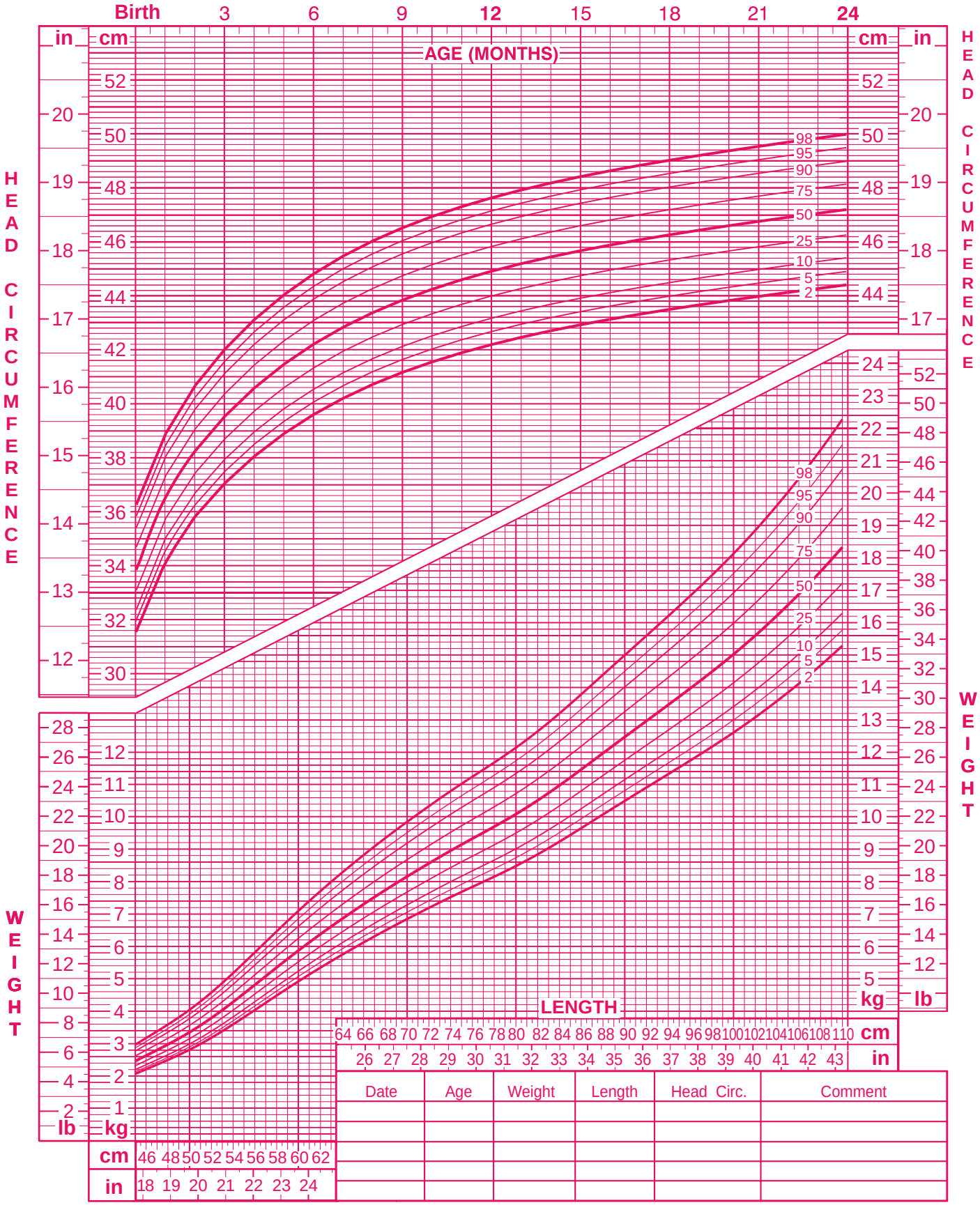
Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

Birth to 24 months: Girls
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



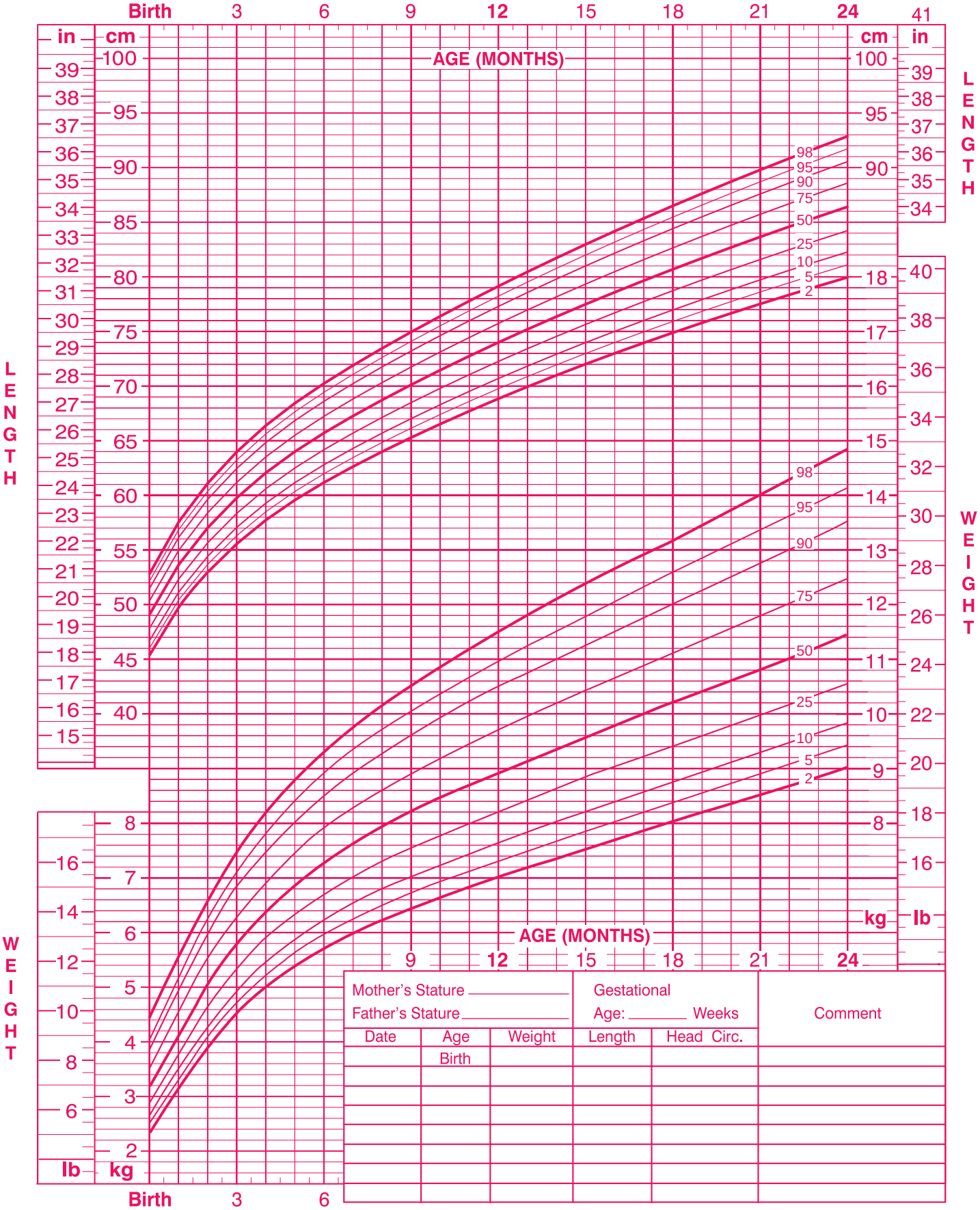
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

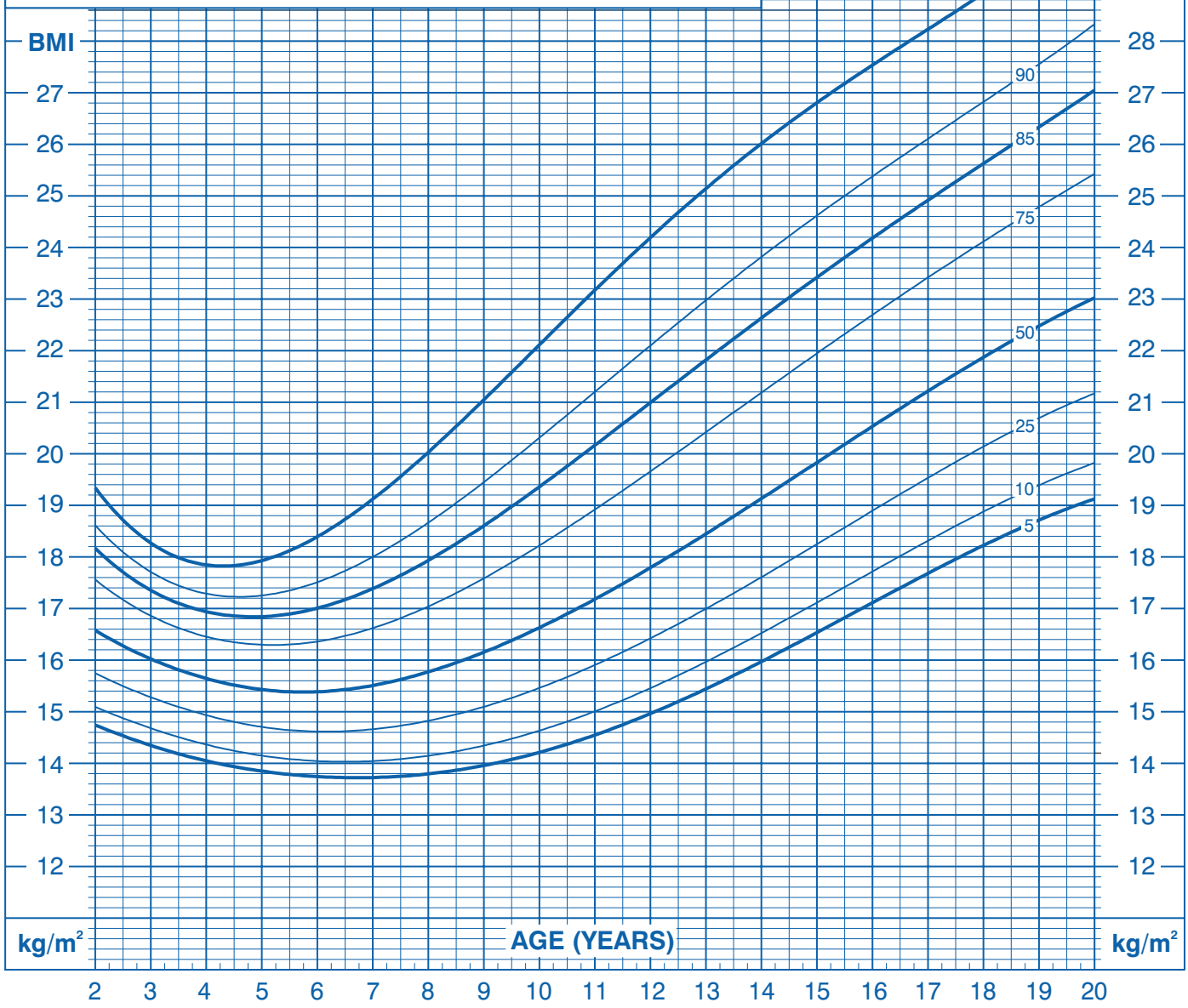
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

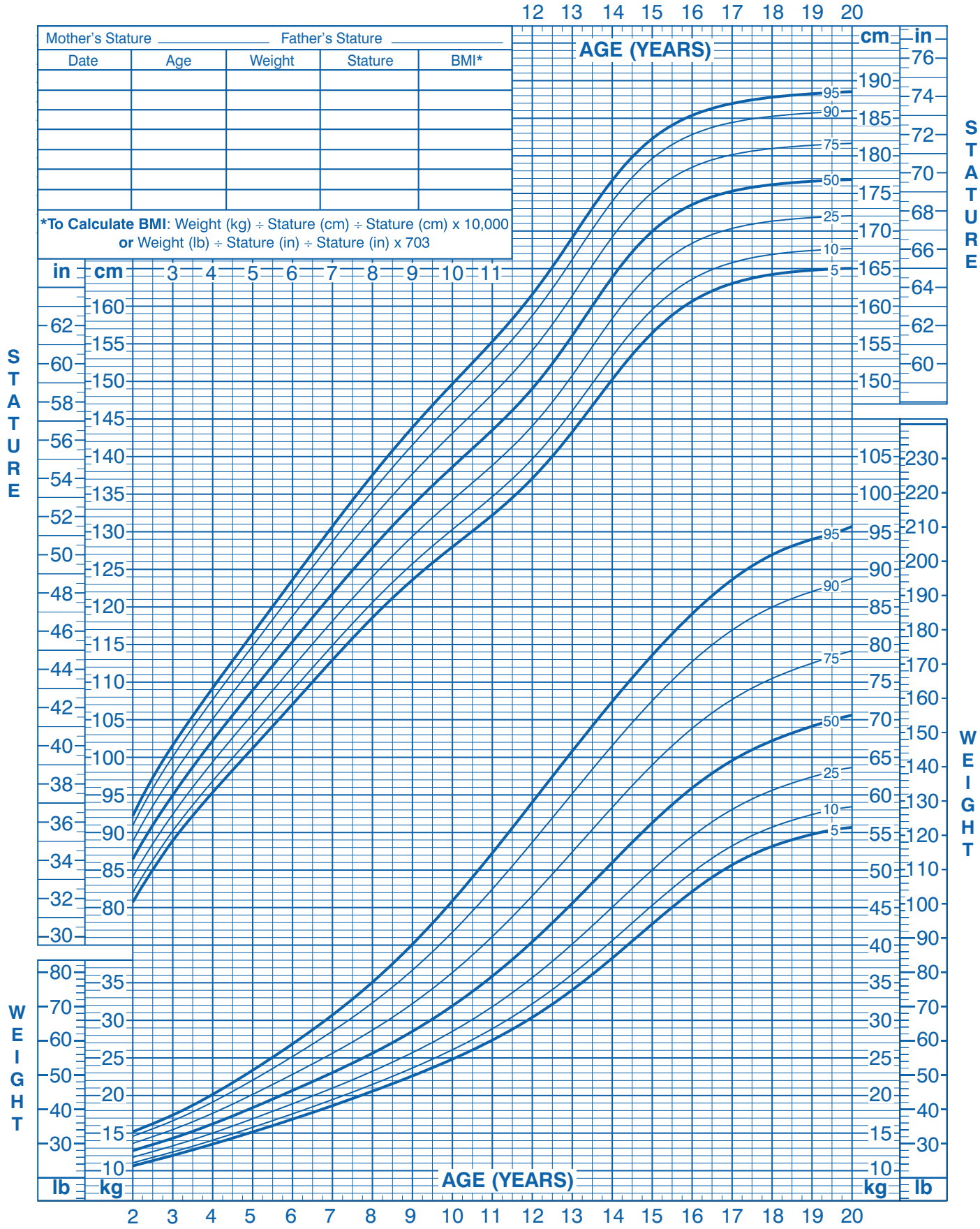
2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____

Mother's Stature _____		Father's Stature _____		
Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



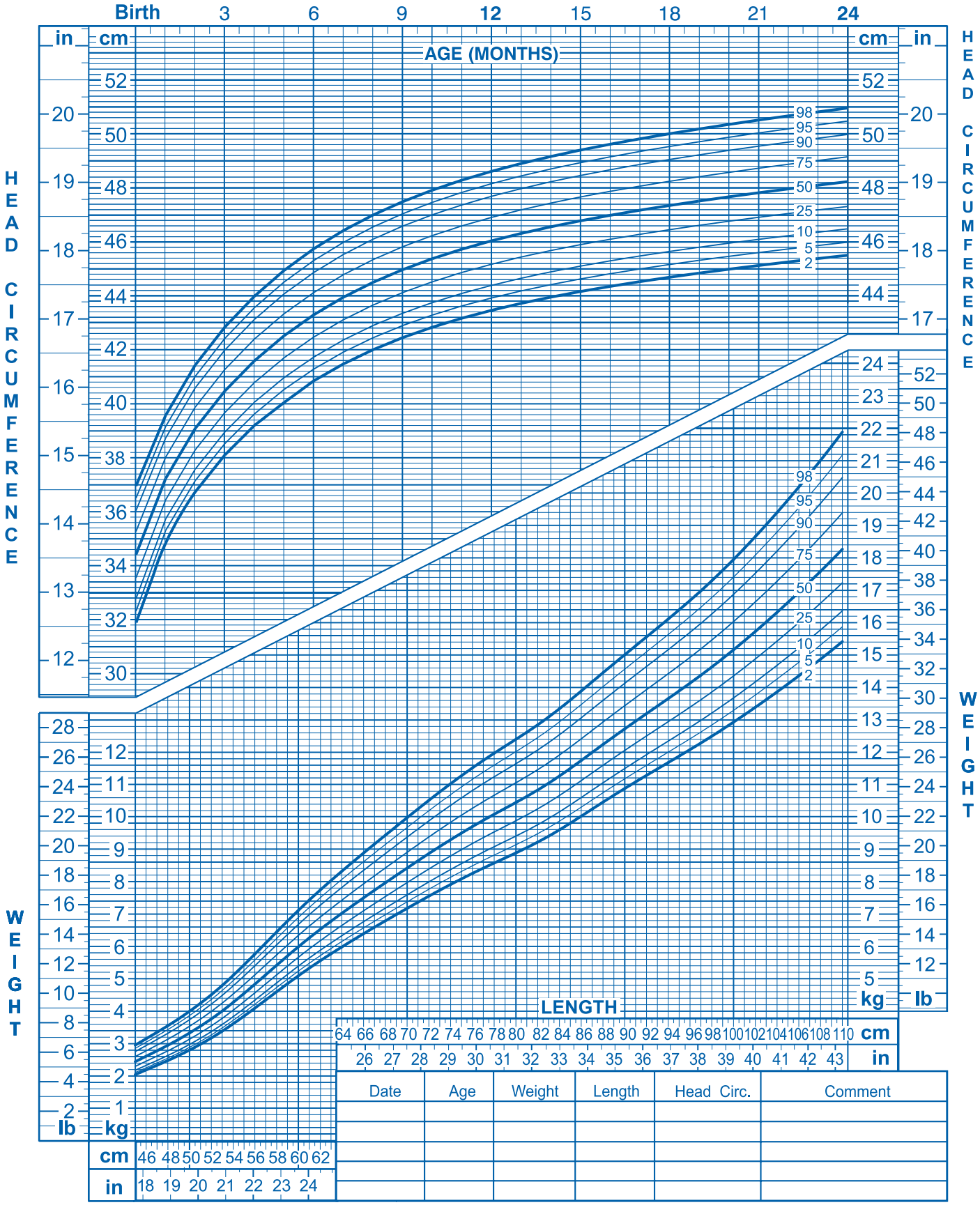
Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

SAFER • HEALTHIER • PEOPLE™

Birth to 24 months: Boys
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



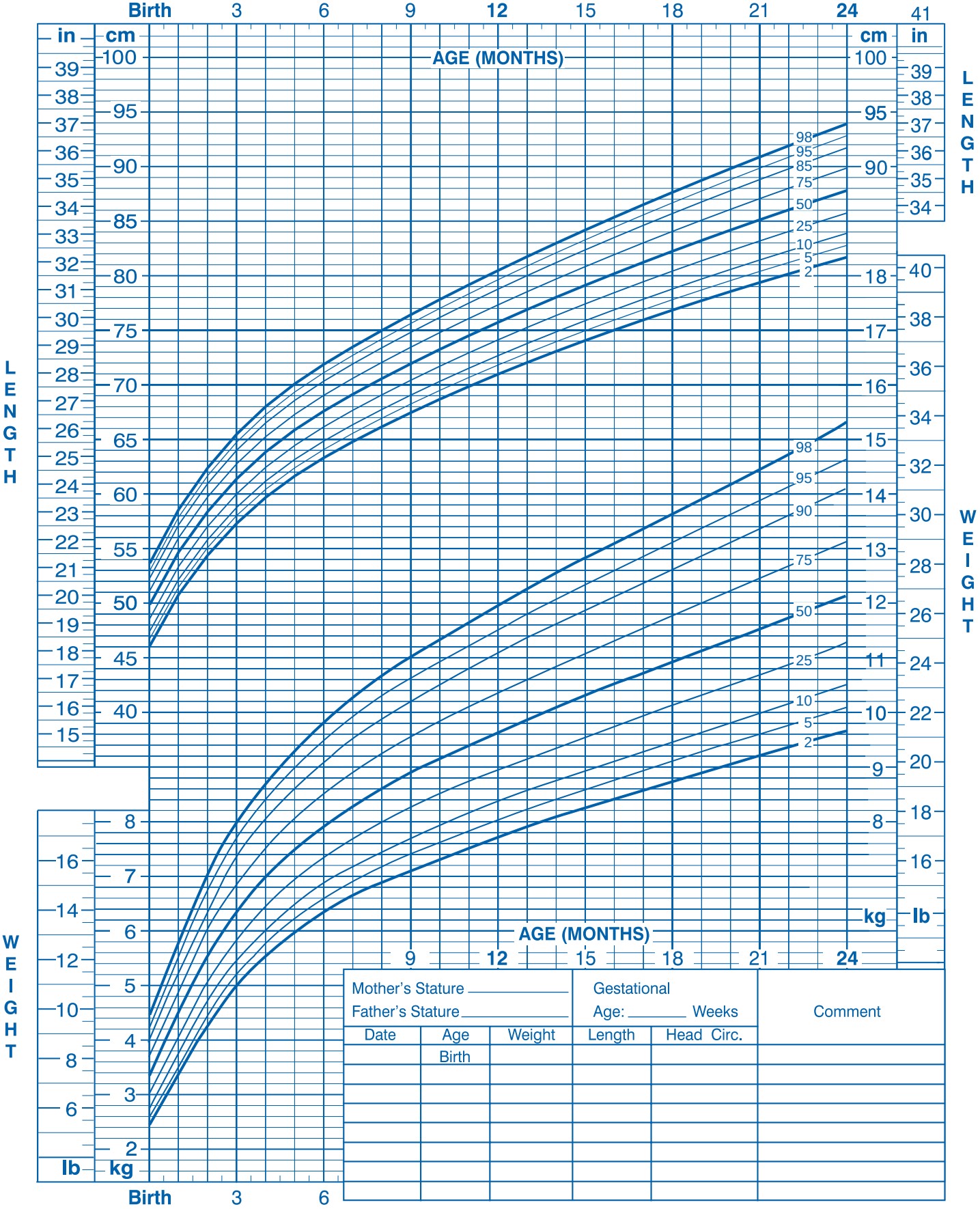
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

PARTICIPANT CARE PLAN

SUBJECTIVE:

_____

_____

OBJECTIVE:

Height: _____ Weight: _____ Hemoglobin/Hematocrit: _____

ASSESSMENT: _____

PLAN FOR FUTURE APPOINTMENTS:

❒ Schedule appt with RD ❒ Breastfeeding education ❒ Weight re-check ❒ 1 mo ❒ 2 mo ❒ 3 mo

❒ Schedule appt with LC ❒ Low risk nutrition education ❒ Hgb/hct re-check ❒ 2 mo ❒ 3 mo

❒ Route chart to RD ❒ _____ ❒ _____

REFERRALS: ❒ MA ❒ FS ❒ TANF ❒ SA ❒ MD ❒ Dental ❒ Other

_____

PARTICIPANT GOAL: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Done by: _____ Date: _____

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

A. LOCAL AGENCY WAITING LIST: Transferring Clients (VOC)

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Category (P B N I C)	Appt. date/time	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

B. LA WAITING LIST PRIORITY LEVEL I: Medical - P, B, and I

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size & income	Category/ Infant age/DOB and/or EDC	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

C. LA WAITING LIST PRIORITY LEVEL II: Infant of WIC Mom

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Infant age/DOB	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

The WIC Program is an equal opportunity provider and employer

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

4/2013

D. LA WAITING LIST PRIORITY LEVEL III: Medical - Children

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Child age/DOB	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

The WIC Program is an equal opportunity provider and employer

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

E. LA WAITING LIST PRIORITY LEVEL IV: Nutrition – Homeless (H), Migrant (M), P, B, and I

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Category/ Infant age/DOB and/or EDC	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

F. LA WAITING LIST PRIORITY LEVEL V: Nutrition – Homeless (H), Migrant (M) and C

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Child age/DOB	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

G. LA WAITING LIST PRIORITY LEVEL VI: Nutrition & Medical – Homeless (H), Migrant (M) and N

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Date pregnancy ended	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason