

Ohio WIC Policy and Procedure Manual

July 2015



July 1, 2015

Policy and Procedure Letter 183

TO: All WIC Project Directors
MAF

FROM: Michele A. Frizzell, RD, MBA, Chief, Bureau of Health Services

SUBJECT: Policy and Procedure Manual Updates

This letter explains revisions that have been made to the Ohio WIC Policy and Procedure Manual compact disk since July 2014. Please read the explanations of the changes as follows for each Chapter and Appendix and then review the specific manual sections. Note that effective dates on pages may vary because some of the policies and procedures were put into effect through All Projects Letters issued during the past year.

Chapter 100

Table of Contents

The Table of Contents has been updated to include the Chapter 100 changes.

Section 100 Introduction to Chapter 100 – Administrative Requirements

The Chapter 100 outline is updated to coordinate section content and titles.

Section 101 State WIC Organization, Functions and Responsibilities

This section updates descriptions of State WIC organization, functions, and responsibilities.

Section 102 State Directives

This section updates the location and title of the OGAPP Manual, updates descriptions of State WIC communication tools, adds information about the Cognos User Manual, removes references to paper All Projects Letters (APLs), and adds a requirement for a backup plan for sharing APLs when directors are absent. Section 102.8 is added for the annual WIC calendar.

Section 107 Additional WIC Operational Requirements

This section is updated to reflect the OGAPP definition of equipment to be items costing \$1000.00 or more.

Section 109 Record Retention Requirements

This section changes the reference from the Combined Programs Application (CPA) to the Ohio Department of Medicaid (ODM 07216) *Application for Health Coverage & Help Paying Costs* form received as a referral, and changes the reference about “closet formula” to “returned or donated formula.”

Section 113 Staff Recruitment, Job Responsibilities and Development Standards

This section updates the Health Professional training requirements by adding continuing education tracking responsibility to WIC directors or their designee; adding “Refer to 404.3 for Staffing Requirements and Responsibilities, and Appendix 100 for Sample Local WIC Breastfeeding Coordinator Job Description;” and adding “Refer to section 406.2: Guidelines for Hiring a Breastfeeding Peer Helper.”

Sections 115 Management Evaluations and 116 Local Agency Standards

Updates in these sections reflect the WIC Onsite Review Guide changes with references changed from coupon to food or WIC Nutrition Card (WNC) benefits, and references to the Ohio WIC Program Application.

Section 122.5 Notice of Information Sharing to Applicants and Participants

This section updates the name of the brochure, *Information Sharing in the WIC Program*, with assigned number HEA 4416.

Appendix 100

The 100 Appendix Table of Contents has been updated to include the Appendix 100 changes.

The *Department of Health Table of Organization* is updated to reflect organizational changes.

The *eQAR Instructions* are updated to include the Pump Inventory form changes.

eQAR Required Forms - The *Ohio WIC Program State Supplied Pump and Kit Issuance* form is updated with current information request.

The *Equipment Management System Spreadsheet Instructions* updates the equipment definition amount from \$300 to \$1,000.

Suggested Training Guidelines for WIC Health Professionals is renamed *Training Guidelines for WIC Health Professionals* and is updated to become required as well as to align it with the revised Nutrition Services Standards.

WIC Clinic Order Form Additions include:

- 362.23 FB-1 Feeding Your Baby – Newborns (Spanish)
- 363.23 FB-2 Feeding Your Baby – 0-4 Months (Spanish)
- 364.23 FB-3 Feeding Your Baby – Adding Solids (Spanish)
- 365.23 FB-4 Feeding Your Baby – 6-8 Months (Spanish)
- 376.23 FB-6 Feeding Your Baby – 8-9 Months (Spanish)
- 371.23 FB-7 Feeding Your Baby – 9-12 Months (Spanish)
- 372.23 FB-8 Power-packed Foods for Babies 9-12 Months Old Who Need Extra Calories (Spanish)
- 5165.23 TMF-1 Tips for Mothers and Fathers – Hunger Cues (Spanish)
- HEA 4502 Healthy Eating for Preschoolers (English and Spanish)
- HEA 4416 Information Sharing in the WIC Program

HEA 5527 Information Sharing in the WIC Program (Spanish)
0227.13 The pamphlet Switch to Skim or 1% Milk

WIC Clinic Order Form **Deletions** include:

- C-15 Nutrition Card – *When Your Child Refuses to Eat*
- The pamphlet *Skim and 1% Milk* in English and Spanish

The *WIC Equipment Request/Repair Approval Form* is amended to include information regarding whether the cost of equipment is currently budgeted or must be added to the budget before purchase.

Changes to *WIC Onsite Review Guide* include:

- Administration Requirement 4 (Pg. 5): The PPM section 413.1 (a) – (h) reference is updated to section 113.8 (a) – (h).
- System Administration Requirement 1 (Pg. 12): Reference to Voided and Reissued Coupons is changed to Voided and Reissued Benefits.
- Certification Requirement 1 (Pg. 13): References to the Combined Programs Application are updated to the WIC Program Application.
- Certification Requirement 2 (Pg. 14): Added the requirement: *Information Sharing in the WIC Program* brochure is provided at each certification and recertification appointment.
- Certification Requirement 3 (Pg. 15): Updated the requirement “Participant’s blood is collected and processed correctly” to “Hematological test must be performed correctly.”
- Certification Requirement 7 (Pg. 19): The requirement “A completed WIC ID card is issued and explained to each participant at initial certification appointment” is removed with transition to the WIC Nutrition Card. (entire page is deleted)
- Food Issuance Requirement 1 (Pg. 27): References to coupons are changed to the word benefits or WIC Nutrition Card.
- Food Issuance Requirement 2 (Pg. 28): References to Food Instruments are changed to WIC Nutrition Cards. The following requirements are removed:
 - Clinic staff must verify each time they print coupons that the preprinted coupon sequence number matches the computer generated sequence number.
 - Staff checks ID card for identity before participant/alternate signs for coupons.
 - Proper procedures are followed when mailing coupons.
- Food Issuance Requirement 5 (Pg. 31): The phrase “Sample formula distribution is monitored” is updated to “Returned formula distribution is monitored.” “Completed formula distribution logs are available with correct documentation including: date, amount, type, reason, and participant name concludes with the words “where formula is donated, and date formula is donated.”

Chapter 200

Table of Contents

The Table of Contents has been updated to include the Chapter 200 changes.

Section 200 Introduction to Chapter 200 - Certification and Program Requirements

The Section 200 overview has been updated to describe the current contents of Chapter 200.

Section 201 Ohio WIC Program Application Forms

Section 201 is revised based on replacement of the *Combined Programs Application* form and new procedures that were issued in All Projects Letter (APL) 2014-089.

Section 206 Residence Requirement

Deleted section 206.1 “Exception to Residency” and renumbered section 206.2 to 206.1.

Participants can be served in *any* county they desire as long as services are offered to them in the county of their residence.

References to “screens 101 and 102” were revised to current WIC System language. Removed reference to ID card and designating alternates. Changed words from “food” issuance to “benefit” issuance and “CPA” to “application.”

Sections 210-211 Income Requirement and Ohio WIC Program Income Guidelines

WIC income eligibility guidelines are updated effective July 1, 2015 based on increases in the federal poverty income guidelines.

Section 235 Immunization Coordination Requirement: Subsections 235.5 and 235.6

These subsections were revised to clarify that “grid views” may be mailed.

Section 263 Measurement Techniques for Height and Length

Updated verbiage that standing weight measurements are to be taken for children 24 months and older. Corrected sections about where to document (Health History or Nutrition Care Plan) exceptions to anthropometric measurements techniques as, currently, staff cannot document anything on the weight grids. All references to paper growth grids were deleted since all plotting is performed by the WIC System.

Section 264 Techniques for Determining Weight

Corrected sections about where to document (Health History or Nutrition Care Plan) exceptions to anthropometric measurements techniques as, currently, staff cannot document anything on the weight grids. All references to paper growth grids were deleted since all plotting is performed by the WIC System.

Section 267 Hematological Tests

The entire section has been revised to reflect the use of the Masimo Pronto-7 for hemoglobin testing as introduced in APL 2015-010. The Hemocue machine will be used for infants and children less than two years old and as a back-up method only.

Section 272 Eligible Applicants

As the WIC Nutrition Card (WNC) is rolled out, policy verbiage changes from “coupon” to “benefit.” In section 272.7, the rights and responsibilities have been updated with WNC references and no longer match the current coupon references in the WTW letter. The WTW letter will be updated to match this section after all coupons have been redeemed and processed. Section 272.7 was updated with the information from APL 2015-009, the instructions for completing and providing the *Information Sharing in the WIC Program* pamphlet. Section 272.9 regarding use and completion of the WIC ID Card was removed. Section 272.10, Issuing the Participant Master Record, becomes section 272.9.

Section 274 Changes in Categorical Status

The word “coupon” was changed to “benefits” with the use of the WNC.

Section 275 Terminations

Verbiage was revised to reflect use of WNC benefits.

Section 276 Transfers

This section was updated to reflect WNC and *WIC Information on Transferring Groups and Participants Using Statewide Search* document.

Section 281 Migrant Farmworkers

The entire section has been updated to help with certification of migrant farmworkers.

Section 283 Coordination and Integration of WIC and Other Health Care Services

Names of referral entities were updated and Mental Health Services (referrals for participants with depression) and Help Me Grow were added. The Referral Procedure section includes reference to the *Information Sharing in the WIC Program* pamphlet as implemented in APL 2015-009. With the replacement of the *Combined Programs Application* form, the referral procedures provided in All Projects Letter 2014-089 have been added to this section, including the addition of subsection 283.4 Referral on *Application for Health Coverage & Help Paying Costs Form*.

Appendix 200

The Table of Contents has been updated to include Appendix 200 changes.

Updates and Additions - Spanish:

Carta Bienvenida a WIC (Spanish HEA4472) WTW letter has been updated for use with the *Information Sharing in the WIC Program* (HEA 5527 Spanish) pamphlet.

Combinada De Programas (Combined Programs Application) ODJFS 07216-S revision 5/2011 is replaced with *Solicitud Combinada De Programas* Revision ODM 07216-SPA 7/2014 due to application changes by ODM.

WIC Interagency Referral and Follow-Up Form (Spanish- 4419) has been updated with the equal access statement and added “Email address” in the participant information section.

Updates and Additions - English:

Application for Health Coverage & Help Paying Costs [ODM 07216 (Rev. 7/2014)] is added for reference based on APL 2014-089.

Checklist for WIC Certification Appointments changed in format, revised “food issuance” to “benefit issuance,” and updated the area to correspond to use of the WNC. References to use of the ID folder and signing of coupon stubs were deleted.

Notice: The WIC Program Cannot Serve You letter (HEA 4462) has been updated with the newest version of the equal access statement.

Obtaining Blood Samples information was removed from Section 267 and placed into the Appendix since less blood samples will be used with the use of the Pronto-7 Analyzer.

Ohio WIC Program No Proof Form has been updated with the newest version of the equal access statement.

Private Physician/Hospital/Clinic Medical Services Memorandum of Agreement has minor changes in format to match the 2016 WIC Continuation Solicitation.

Welcome to WIC Letter (HEA 4435) has been updated for use with the *Information Sharing in the WIC Program* (HEA 4416) pamphlet.

WIC Authorized Representative Letter removes WIC ID as an example of identity and added that the authorized representative must bring in the WNC and know the PIN to receive benefits.

WIC Information on Transferring Groups and Participants Using Statewide Search was added.

WIC Interagency Referral and Follow-Up Form (English – HEA 4427) has been updated with the equal access statement and added “Email address” in the participant information section.

Deletions:

Combined Programs Application JFS 7216 (Rev. 5/2003) is removed due to form replacement by ODM.

Chapter 300

Chapter 300 Table of Contents

New section names were updated and Section 332 was changed to reserved.

Section 300 Introduction to Chapter 300 - Food Issuance

Coupon description removed; WNC description added.

Section 301 Authorized Foods

Links to the federal regulations and Final Food Package Rule were updated. Wording changes were made to reflect the change from coupons to EBT.

Section 302 Prescription of Supplemental Foods

Minor grammatical updates were made. Reference to expired section of policy (Health Professional Hiring Guidelines) was updated.

Section 303 Food Package Prescription for Women

Wording changes in the entire section were made to reflect the change from coupons to EBT. Also, the word “prescribe” was changed in several places to “authorize” to clarify policy.

303.5 Guidelines for Prescribing Food Packages to the Pregnant, Breastfeeding and Postpartum Woman

Section was updated to clarify that a woman who is breastfeeding while pregnant (singleton or multiples) may only receive a breastfeeding package if the infants are 12 months old or younger and not receiving formula from WIC.

Section was also updated to clarify the authorization of 2% milk is at the discretion of the health professional and warranted by a medical need. Soy milk and tofu may now be authorized by a health professional. It is at the discretion of the health professional to decide if more than 4 lbs. of tofu are to be substituted for milk.

Section 304 Food Package Prescription for Infants

Wording changes in the entire section were made to reflect the change from coupons to EBT.

304.2 Initial Certification of Breastfed Infants in the First Month of Life (Defined as an Infant Less Than 30 Days Old)

Breastfeeding guidance was updated.

304.4 Infant Formulas

Reference to the correct section of the *Ohio WIC Prescribed Formula and Food Request* form was updated.

304.6 Conversion of an Infant Food Package to a Child Food Package

Section was updated to clarify the authorization of 2% milk for children 24 months of age or older is at the discretion of the health professional and warranted by a medical condition.

Section 305.2 Guidelines for Prescribing Food Packages for Children

Section was updated to clarify the authorization of 2% milk for 1-year-old children (12 months to 2 years of age) for whom overweight or obesity is a concern, at the discretion of the health professional. Soy milk and tofu may now be authorized by the health professional.

Table 310A Authorized WIC Formulas

This table was updated to include information regarding the newly added formula – Carnation Breakfast Essentials. The section about PurAmino was also updated to reflect the new fat profile including 33% MCT oil. Enfamil Enfaport and Boost Kid Essentials (pharmacy) were removed.

Section 311 Iron-Fortified Formulas

Added additional clarification in Section 311.2 regarding RTF formulas being issued at the health professional's discretion if the participant has a medically relevant health condition.

Section 312.2 Prescriptions

Section was updated to reflect the new order of the revised *Ohio WIC Food and Formula Request Form*.

312.6 Food Packages with Special Formulas and 312.7 Food Packages with Soy Milk and Tofu

These sections were updated to clarify the authorization of 2% milk for children 24 months of age or older at the discretion of the health professional and warranted by a medical condition. Soy milk and tofu may now be authorized by a health professional. It is at the discretion of the health professional to decide if more than 4 lbs. of tofu are to be substituted for milk.

Section 318 Prescription of Special Formulas for Inborn Errors of Metabolism

Wording changes in the entire section were made to reflect the change from coupons to EBT. Website information was updated. Sections related to referral and benefit issuance were shortened and updated.

Section 322 Food Package Guide

Wording changes in the entire section were made to reflect the change from coupons to EBT.

Section 323 Food Package Changes

Wording changes in the entire section were made to reflect the change from coupons to EBT. Food/formula package change information moved here from EBT pilot policy section 330.

Section 330 Coupons and Fruit and Vegetable Vouchers (FVV)

Wording and policy changes in the entire section were made to reflect the change from coupons to EBT.

Section 331 Instructions for Coupon/FVV Use

Wording and policy changes in the entire section were made to reflect the change from coupons to EBT.

Section 332 Mailing Coupons/Fruit and Vegetable Vouchers

This section was deleted since WIC Nutrition Cards cannot be mailed.

Appendix 300

Appendix 300 Table of Contents

The Appendix 300 Table of Contents was updated with the Complaint form name change.

Bureau of Health Services Complaint Form

This form was updated for completing electronically and the bureau name was updated.

Container Sizes of Formula Provided by Ohio WIC The new formula, Carnation Breakfast Essentials, was added to the document, and Boost Kid Essentials (pharmacy) and Enfamil EnfaPort were removed.

Formula Guide

The new formula, Carnation Breakfast Essentials, was added to the document, and Boost Kid Essentials (pharmacy) and Enfamil EnfaPort were removed.

Metabolic Services Teams

This document is updated to match current information available online.

Ohio WIC Authorized Foods List (AFL)

Added new foods: Schwebel's 100% Whole Wheat Bread – 16 ounces and Healthy Life 100% Whole Wheat Sandwich Buns – 16 ounces effective January 2015; and fresh white potatoes effective July 1, 2015. The new formula, Carnation Breakfast Essentials, was added to the document, and Boost Kid Essentials (pharmacy) and Enfamil EnfaPort were removed.

The format of the paper AFL has been revised to help with readability and ease of use.

Ohio WIC Prescribed Formula and Food Request Form

- General changes in formatting were made for increased readability and understanding and to encourage more fully completed forms returning to the local clinics.
- The space for a contract formula trial has been added back.
- The new formula, Carnation Breakfast Essentials, was added to the document, and Boost Kid Essentials (pharmacy) and Enfamil EnfaPort were removed.
- The new section D simplifies the wording for supplemental food issuance. WIC health professionals will now issue age appropriate supplemental foods unless the healthcare provider indicates otherwise on the form.
- Instructions and clarifications of each section are now included on the back of the form. Some additional clarifications are on the front as well.

Special Child/Woman Food Package Tool

The unauthorized formula names have been removed.

MAF/NASrs/ PAP/pap

APPENDIX 200

APPENDIX**Table of Contents****PPL 183**

The Appendix consists of copies of forms used in the WIC program, reference guides, charts, and resource information. The material provided in the Appendix is arranged in alphabetical order. The material provided in the Appendix is separated into Hispanic Participant Materials and Appendix 200 Materials sections and arranged in alphabetical order.

Hispanic Participant Materials

Adenda de la Solicitud del Programa de WIC (WIC Application Addendum – HEA 4467)

Aviso: El Programa de WIC No le Puede Servirle (Notice: The WIC Program Cannot Serve You – HEA 4433)

Carta de Bienvenida a WIC (Welcome to WIC – HEA 4472)

Historial de Salud de WIC para Infantes (Health History – Infant – HEA 4491)

Historial de Salud de WIC para Mujeres Embarazadas (Health History – Pregnant – HEA 4494)

Historial de Salud de WIC para Mujeres Lactando/Amamantando y en Postparto (Health History – BF/PP – HEA 4492)

Historial de Salud de WIC para Niños De 1 hasta 5 Anos (Health History – Children – HEA 4493)

Solicitud Combinada De Programas ODM 07216-SPA 7/2014 (Combined Programs Application)

Solicitud del Programa de WIC (WIC Program Application – HEA 4473)

Tarjeta de identificacion del programa de WIC (WIC Program ID Card – HEA 4434)

WIC Interagency Referral and Follow-Up Form HEA 4419

Somali Participant Materials (not available for ordering)

Health History – Infant

Health History – Pregnant

Health History – Breastfeeding/Postpartum

Health History – Children

APPENDIX**Appendix 200 Materials**

Agency-Based Registration Voter Registration Transmission Form

A Designated Voter Registration Notice of Rights

Application for Health Coverage & Help Paying Costs ODM 07216 (Rev. 7/2014)

Appointment Reminder Card Instructions

Automated WIC Appointment Notice

Bilingual (English/Spanish) Voter Registration form

CDC Tables for Calculated BMI Values for Selected Heights and Weights for Ages 2-20

Checklist for WIC Certification Appointments

Codes for Public Assistance, Income Proof, and Referrals

Common Immunization Abbreviations

Department of Defense WIC Overseas Program Participant Profile Report/ Verification of Certification Card (VOC)

Growth Chart: Boys Birth-24 Months of Age

Growth Chart: Boys 2-5 Years of Age

Growth Chart: Girls Birth-24 Months of Age

Growth Chart: Girls 2-5 Years of Age

Identification Card HEA 4436

Impact SIIS: A Quick Guide for WIC Staff

Impact SIIS: Key Master Training Manual

Impact SIIS: User Training Manual

Notice: The WIC Program Cannot Serve You HEA 4462

Nutrition Care Plan

APPENDIX

Nutrition Practice Guide

ODH- Immunization Record Card, Parent's Copy

ODH - WIC Program Update Participant Immunization Data

Obtaining Blood Samples

Ohio WIC Program No Proof Form

Prenatal Weight Gain Chart - underweight

Prenatal Weight Gain Chart - normal weight

Prenatal Weight Gain Chart - overweight

Prenatal Weight Gain Chart - obese

Private Physician/Hospital/Clinic Medical Services Memorandum of Agreement

Recommended Immunization Schedule for Persons Aged 0-6 Years - United States, 2011

Risk Codes - Justifications and References

Sample Discussion Starters Using the WIC Food Package for All Categories

Sample WIC Health History Form for Fetal/Infant Loss

The WIC Program Can Now Serve You HEA 4457

Voter Registration Form

Welcome to WIC HEA 4435

WIC Application Addendum HEA 4466

WIC Authorized Representative Letter

WIC Health History for Children HEA 4450

WIC Health History for Infants HEA 4448

WIC Health History for Breastfeeding and Postpartum Women HEA 4449

APPENDIX

WIC Health History for Pregnant Women HEA 4455

WIC Information on Transferring Groups and Participants Using the Statewide Search

WIC Impact Report Instructions

WIC Interagency Referral and Follow-up Form HEA 4427

WIC Medical/Nutritional Risk Codes

WIC Program Application HEA 4460

Departamento de Salud de Ohio

Adenda de la Solicitud del Programa de WIC

Al firmar esta solicitud de WIC, yo estoy de acuerdo en presentar pruebas de elegibilidad para la información dada en esta solicitud y cualquier otra información pedida para llenar las reglas del programa.

Yo autorizo a cualquier persona que me suministre cuidados médicos o suministros médicos a que proporcione al Departamento de Medicaid de Ohio, al Departamento de Trabajo y Servicios a la Familia de Ohio o al Departamento de Salud de Ohio, cualquier

información relacionada con la magnitud, duración, y el propósito de los servicios proporcionados bajo Medicaid, WIC, y otros programas de asistencia médica.

Tambien autorizo al Departamento de Salud de Ohio, al Departamento de Medicaid de Ohio, y al Departamento de Trabajo y Servicios a la Familia de Ohio a que intercambien cualquier información que yo he proporcionado en esta solicitud para permitirles a los departamentos a que determinen mi elegibilidad.

Yo entiendo que esta solicitud es considerada sin tener en cuenta la raza, el color, el origen nacional, el sexo, la edad, o la incapacidad.

Al firmar a continuación, yo declaro bajo pena de perjurio que hasta donde llega mi conocimiento y creencia todas las respuestas en esta solicitud son ciertas y están completas. Yo entiendo que la ley determina una penalidad/multa o cárcel (o ambos) para cualquiera convicto de aceptar asistencia sin ser elegible.

Yo estoy pidiendo que mis servicios continuen.

Yo he revisado y actualizado la información desde mi última aplicación. ☐ **Sí** ☐ **No**

Firma del solicitante quien llenó esta solicitud	Fecha de firma
Firma del solicitante quien llenó esta solicitud	Fecha de firma

AGENCY USE ONLY

Pregnancy Verification

☐ Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephoned (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Medical chart location (office name)		

Income Verification

☐ Verification attached (county department of job and family services, employer, other agencies)

Check those that apply		Economic unit size	
<input type="checkbox"/> OWF <input type="checkbox"/> Disability Financial Assistance <input type="checkbox"/> Food Assistance <input type="checkbox"/> Medicaid <input type="checkbox"/> Refugee			
Card number		<input type="checkbox"/> Benefits Notice/Printout <input type="checkbox"/> Provider Information Line <input type="checkbox"/> MITS or EBT Portal	Effective date
Verification statement used (document/check stub/letter) <input type="checkbox"/> Yes <input type="checkbox"/> No	Statement date	Income amount \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly
Telephoned (name)	Agency/Business	Call date	
Confirmed or other information 			
Proof of Residence <input type="checkbox"/> Ohio License/ID <input type="checkbox"/> Utility/credit bill <input type="checkbox"/> WIC Reminder Card <input type="checkbox"/> Medical card/JFS document <input type="checkbox"/> Other _____			
WIC personnel signature			Date

Aviso: El Programa de WIC No Puede Servirle

Querido(a) _____,

El programa de WIC no puede servirle a partir de _____ debido a que usted no reúne las siguientes reglas marcadas:

☐ Usted no proporcionó la información que se necesita para determinar su elegibilidad de la siguiente manera:

☐ El ingreso de su hogar es mayor que la cantidad máxima permitida.

☐ El periodo de seis meses después de dar parto ha terminado y usted no está lactando o amamantando.

☐ Su bebé alimentado(a) con pecho cumple un año de edad en _____.

☐ Usted cumplirá cinco años de edad en _____.

☐ Usted se ha mudado fuera del área de servicio de WIC.

☐ Usted faltó a una cita de recertificación.

☐ Usted no recogió sus beneficios de alimentos por dos meses.

☐ Otro: _____

☐ Su nombre ha sido colocado en una lista de espera porque las casillas de servicios se encuentran llenas en este momento.

Si usted cree que estamos equivocados al no proporcionarle los servicios de WIC, usted tiene el derecho de solicitar una audiencia justa. Usted debe solicitar a nuestro personal la audiencia dentro de los 60 días a partir de la fecha de esta carta.

Firma del padre/madre, Guardián o Representante	Fecha	Firma del personal de WIC
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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, D.C. 20250-9410 o llame gratis al (866) 632-9992 (voz). Personas con discapacidad auditiva o del habla pueden contactar con.

Departamento de Salud de Ohio

Carta de Bienvenida a WIC

Querido(a) _____,

El programa de Mujeres, Infantes y Niños (WIC por sus siglas en inglés) es un programa de salud financiado por el Departamento de Agricultura de los Estados Unidos. WIC proporciona educación de nutrición, apoyo para amamantar o lactar, alimentos nutritivos y referencias a otras agencias de salud y servicios humanos. El propósito del programa es ayudar a mejorar la dieta durante tiempos críticos de crecimiento y desarrollo. Los alimentos suministrados por el programa son suplementarios y no se intenta proveer todos sus requisitos diarios de alimentos. Los alimentos de WIC son solamente para el participante.

El profesional de salud evaluará su salud e información de dieta y hablará de los factores de riesgos de nutrición que pueden afectar su salud y crecimiento. **Hoy, su riesgo nutricional es:**

--

Los profesionales de salud trabajarán con usted para desarrollar metas de nutrición para apoyar un embarazo, una lactancia, una experiencia de post-parto, y un crecimiento de los infantes y niños saludable.

Yo he hablado con el profesional de salud de WIC acerca de mi meta de nutrición. Yo estoy de acuerdo en tratar de:

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Fecha	Estatura	Largo	Peso	Hierro en la Sangre (Hemoglobina)

Los beneficios son para un tiempo específico, usualmente para 6 meses, es un periodo llamado certificación. Se le hará una cita para que usted recoja sus beneficios y también para su próxima cita de certificación. Estas citas se hacen antes de que su periodo de certificación se termine así usted no recibirá sus beneficios tarde.

Su próxima cita de WIC es:

Fecha para Educación de Nutrición y para Recoger los Beneficios	Fecha de la Próxima Visita de Certificación

Acuda a todas sus citas de WIC o sus beneficios terminarán.

Los alimentos terminarán en _____ debido ☐ el niño cumple 5 años de edad,
☐ el periodo de 6 meses después del parto terminarse, o
☐ a la elegibilidad de WIC para lactar amamantar terminarse.

Compartiendo Información en el Programa de WIC

El programa de WIC trabaja con muchos programas para satisfacer sus necesidades de servicio. El folleto *Information Sharing in the WIC Program* explica acerca de los programas que puede que reciban su información para divulgación; elegibilidad; y mejoramiento de salud, educación, y el bienestar de su familia.

Compartir información con los programas y los proveedores de servicios médicos los cuales no están enlistados en el folleto *Information Sharing in the WIC Program* requiere su consentimiento. A usted no se le requiere, pero usted puede marcar o añadir los programas o los proveedores de servicios médicos con quien(es) compartir su información.

☐ Head Start/Early Head Start ☐ Medicaid proveedor de bomba extractora de leche materna _____

☐ Otro _____

Yo he sido advertido de mis derechos y responsabilidades declaradas al dorso de esta carta. Yo recibí el folleto *Information Sharing in the WIC Program*. Yo certifico que la información que yo proporcioné es correcta según mi mejor conocimiento. La información de mi solicitud del programa WIC puede ser verificada. Yo entiendo que haciendo una declaración falsa o engañosa, o falsa representación, esconder, u ocultar hechos puede resultar en el pago del costo de los beneficios emitidos a mí y puede resultar en proceso legal bajo la ley estatal y federal.

Firma del participante o Guardián	Fecha efectiva del WIC	Firma del personal de WIC

Derechos y Responsabilidades del Participante

Derechos del Participante

1. Usted tiene el derecho de pedir una audiencia justa si esta agencia le suspende su participación en el programa de WIC. Usted debe solicitar una audiencia justa dentro de los 60 días apartir de la fecha en que se le ha notificado la suspensión. Al tiempo de la audiencia justa, usted puede ser representado y acompañado por un familiar, amigo(a), consejero legal u otro vocero.
2. Usted puede apelar cualquier decisión hecha por la agencia local acerca de su elegibilidad para el programa.
3. La agencia local hará disponibles a usted o a su guardián los servicios de lactar y de educación nutricional.

Responsabilidades del Participante

Yo entiendo que la falta de cumplir con mis responsabilidades puede resultar en descalificación. Yo y mi sustituto de compras tenemos que:

1. no vender, cambiar, o regalar los alimentos o la fórmula de WIC, los cupones, la bomba extractora de leche materna, o las tarjetas de transferencia de beneficios electrónicos (EBT por sus siglas en inglés). Ésto incluye usar las tiendas online como Craiglist o Ebay para vender o intercambiar beneficios de WIC;
2. no aceptar de las tiendas de alimentos dinero en efectivo, crédito, alimentos no autorizados, u otro artículo de valor por cupones de WIC o tarjeta de EBT;
3. no abusar físicamente, amenazar de abuso físico, o abusar verbalmente a alguien en la clínica de WIC o al personal de las tiendas;
4. notificar a la clínica si yo tengo dificultades comprando los alimentos de WIC en la tienda o si yo he sido tratado injustamente por el personal de la tienda;
5. no hacer declaraciones falsas o engañosas o engañe, esconda u oculte hechos para obtener beneficios;
6. no recibir beneficios de más de un programa de WIC a la vez;
7. usar los alimentos de WIC para el participante solamente. Mandar los cupones, la tarjeta de EBT o los beneficios de alimentos con los participantes si éstos se van de la casa;
8. asistir a las citas de WIC y recoger los beneficios durante los tiempos asignados y regularmente para evitar la terminación. Los beneficios de WIC paran cuando los cupones no se han recogidos por dos meses corridos;
9. notificar a la clínica de un cambio en ingreso, dirección, número de teléfono, tamaño de la familia y fecha de dar parto;
10. usar los cupones durante las fechas válidas;
11. mantener los cupones o tarjeta de EBT en un sitio seguro. Los cupones perdidos o robados no se pueden remplazar;
12. devolver la bomba extractora de leche materna prestada cuando se la pidan; y
13. traer de vuelta a la clínica de WIC exceso de fórmula y de alimentos de bebé que no se usó o abrió.

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 o 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](http://www.ascr.usda.gov/complaint_filing_cust.html) (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.

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
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Departamento de Salud de Ohio • Sección de Servicios de Nutrición

Historial de Salud de WIC para Infantes

Nombre del bebé			Fecha
Su nombre			Su relación al bebé (96)
Fecha de nacimiento	Fecha que se suponía que el bebé naciera (50)	Peso al nacer (51, 59)	Medida de largo al nacer (52)
Médico o clínica del bebé		Fecha de la última visita al médico o clínica	¿Participó en el programa de WIC durante este embarazo? <input type="checkbox"/> Sí <input type="checkbox"/> No (61)

Porfavor conteste las siguientes preguntas

Mi bebé amamanta Cada _____ horas o _____ veces al día y _____ veces en la noche <input type="checkbox"/> No amamanta (71, 75)	
Marque lo que aplique al bebé que amamanta <input type="checkbox"/> Debilidad chupando <input type="checkbox"/> Lenta ganancia de peso <input type="checkbox"/> Problemas al prederse del pezón <input type="checkbox"/> Mi bebé no tiene ningún problema <input type="checkbox"/> No amamanta <input type="checkbox"/> Otro _____ (56, 74)	
¿Ha lactado o amamantado al bebé alguna vez? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Sigue lactado o amamantado? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Porqué dejó de amamantar? _____ ¿Que edad tenía el bebé cuando dejó de amamantar? _____	
¿Nació el bebé tres o más semanas antes? <input type="checkbox"/> Sí ¿Cuántas semanas? _____ <input type="checkbox"/> No (50)	
Marque cualquier problema de salud que su bebé tenga. <input type="checkbox"/> Cólico <input type="checkbox"/> Reflujo <input type="checkbox"/> Dientes/encías <input type="checkbox"/> Defectos de nacimiento <input type="checkbox"/> Lenta ganancia de peso <input type="checkbox"/> Jaundice (condición con piel amarilla) <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (56, 68, 91, 93, 94)	
Liste las medicinas de su bebé <input type="checkbox"/> Ninguna (93)	
¿Tiene el bebé todas las vacunas? <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sé	
¿Examinó el médico el nivel de plomo en la sangre del bebé? <input type="checkbox"/> Sí Resultados _____ <input type="checkbox"/> No <input type="checkbox"/> No sé (21)	
¿Limpia las encías y los dientes de su bebé? <input type="checkbox"/> Sí <input type="checkbox"/> No	
Marque todo lo que consume el bebé. <input type="checkbox"/> Vitaminas (vitamina D) <input type="checkbox"/> Gotas de hierro <input type="checkbox"/> Gotas de fluoruro <input type="checkbox"/> Hierbas <input type="checkbox"/> Nada <input type="checkbox"/> Otro _____ (30)	
Liste las alergias a alimentos del bebé. <input type="checkbox"/> Ninguna (93)	
¿Cuántas veces al día está el pañal del bebé mojado o sucio? (74)	

¿Si le dá la botella a su bebé, qué hay en la botella? <input type="checkbox"/> Leche maternal <input type="checkbox"/> Fórmula <input type="checkbox"/> ¿Cuál fórmula? _____ <input type="checkbox"/> No uso la botella ¿Cuántas onzas cada vez que se alimenta? _____ ¿Cuán a menudo se alimenta? _____ (38)	
¿Si mezcla la fórmula, qué tipo de agua usa? <input type="checkbox"/> De pozo <input type="checkbox"/> De la ciudad <input type="checkbox"/> Destilada <input type="checkbox"/> Spring <input type="checkbox"/> Nursery <input type="checkbox"/> No mezclo la fórmula <input type="checkbox"/> Otro _____ (38)	
¿Tiene instrucciones especiales del doctor para mezclar la fórmula? <input type="checkbox"/> Sí <input type="checkbox"/> No (38)	
¿Tiene alguna pregunta acerca de como mezclar la fórmula de su bebé? <input type="checkbox"/> Sí <input type="checkbox"/> No (38)	
Si alimenta al bebé con botellas, marque lo que aplique. <input type="checkbox"/> Me lavo las manos antes de preparar la botella. <input type="checkbox"/> Reuso fórmula que quedó en la botella. <input type="checkbox"/> Yo esterilizo las botellas y el biberón o pezón de goma. <input type="checkbox"/> Lavo las botellas con agua bien caliente y jabón. <input type="checkbox"/> Yo uso el microonda para calentar las botellas. <input type="checkbox"/> Yo no uso botellas. (38)	
¿Además de leche maternal o fórmula, que más pone en la botella? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Jarabe de maíz (Karo® syrup)</div> <div style="width: 33%;"><input type="checkbox"/> Jugo</div> <div style="width: 33%;"><input type="checkbox"/> Ponche</div> <div style="width: 33%;"><input type="checkbox"/> Leche de vaca</div> <div style="width: 33%;"><input type="checkbox"/> Agua de gelatina (Jell-O®)</div> <div style="width: 33%;"><input type="checkbox"/> Azucar</div> <div style="width: 33%;"><input type="checkbox"/> Soda/cola</div> <div style="width: 33%;"><input type="checkbox"/> Leche de cabra</div> <div style="width: 33%;"><input type="checkbox"/> Té o café</div> <div style="width: 33%;"><input type="checkbox"/> Cereal</div> <div style="width: 33%;"><input type="checkbox"/> Miel</div> <div style="width: 33%;"><input type="checkbox"/> Agua</div> <div style="width: 33%;"><input type="checkbox"/> Gatorade®</div> <div style="width: 33%;"><input type="checkbox"/> Kool-Aid®</div> <div style="width: 33%;"><input type="checkbox"/> Alimento de bebé</div> <div style="width: 33%;"><input type="checkbox"/> Otro _____</div> <div style="width: 33%;"><input type="checkbox"/> Nada</div> </div> (36, 38)	
Marque todo lo que aplique. (36, 38) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> El bebé es alimentado con una cuchara</div> <div style="width: 50%;"><input type="checkbox"/> El bebé usa un "infant feeder"</div> <div style="width: 50%;"><input type="checkbox"/> El bebé toma de un vaso o taza</div> <div style="width: 50%;"><input type="checkbox"/> El bobo o chupete del bebé se sumerge en _____</div> <div style="width: 50%;"><input type="checkbox"/> El bebé se alimenta él mismo</div> <div style="width: 50%;"><input type="checkbox"/> El bebé se acuesta chupando el biberón/botella</div> <div style="width: 50%;"><input type="checkbox"/> La botella es sujeta con algo y el bebé chupa la botella solo</div> <div style="width: 50%;"><input type="checkbox"/> El bebé es usualmente alimentado en otro sitio, no en su casa</div> </div>	
Si su bebé ya empezó estos alimentos, a que edad empezó (38, 38) Cereal _____ Vegetales _____ Frutas _____ Jugo _____ Carnes _____ Dinners _____ Postres _____ Leche de vaca _____	
¿Tiene una estufa o microonda y refrigerador que trabaja en su casa? <input type="checkbox"/> Sí <input type="checkbox"/> No (38)	
¿Si alguien en su casa fuma, dónde fuman? <input type="checkbox"/> Adentro <input type="checkbox"/> Afuera <input type="checkbox"/> En el carro <input type="checkbox"/> Nadie fuma (46)	
¿Durante los últimos seis meses, ha sido su bebé físicamente, sexualmente o verbalmente abusado o abandonado? <input type="checkbox"/> Sí <input type="checkbox"/> No (67)	
¿Tiene preguntas o preocupaciones? _____	

Departamento de Salud de Ohio • Sección de Servicios de Nutrición

Historial de Salud de WIC para Mujeres Embarazadas

Nombre			Fecha	Edad (39,40)
Fecha de dar parto	Peso antes de quedar embarazada (12,13)	Cantidad de embarazos que ha tenido (39)	Cantidad de nacimientos vivos (45)	Fecha cuando el último embarazo terminó (43)
Médico o clínica prenatal			¿Cuántos meses de embarazada tenía durante su primera visita al doctor para este embarazo? (16)	

Si este no es su primer embarazo, llene la **sección número 1 y 2**. Solamente llene la **sección 2** si este es su primer embarazo.

Sección 1

¿Esta lactando o amamantando en estos momentos? <input type="checkbox"/> Sí <input type="checkbox"/> No (69)
¿Ha lactado o amamantado? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿ Si contestó sí, por qué dejó de lactar? _____ ¿Que edad tenía el bebé cuando paró? _____
¿Ha tenido problemas con embarazos en el pasado? <input type="checkbox"/> Sí <input type="checkbox"/> No Si contestó sí, liste _____ (44,45)
Marque si ha tenido un bebé que pesó lo siguiente al nacer. <input type="checkbox"/> 5 libras y 8 onzas o menos <input type="checkbox"/> 9 libras o más <input type="checkbox"/> Ninguno (22, 49)
¿Ha tenido un bebé que nació tres o más semanas antes de tiempo? <input type="checkbox"/> Sí ¿Cuántas semanas antes? _____ <input type="checkbox"/> No (49)
¿Ha tenido un bebé con algún problema de salud? <input type="checkbox"/> Sí <input type="checkbox"/> No Si contestó sí, explique _____ (23)

Sección 2

Marque cualquier problema(s) que esté teniendo con este embarazo. <input type="checkbox"/> Acidez <input type="checkbox"/> Poco apetito <input type="checkbox"/> Vómitos <input type="checkbox"/> Diarrea <input type="checkbox"/> Náusea <input type="checkbox"/> Estreñimiento <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (44)
Marque cualquier problema(s) de salud que usted tenga. <input type="checkbox"/> Diabetes <input type="checkbox"/> Depresión <input type="checkbox"/> Dental <input type="checkbox"/> Alta presión <input type="checkbox"/> Intolerancia de lactosa <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (44, 91, 93, 94)
¿Ha perdido peso durante este embarazo? <input type="checkbox"/> Sí ¿Cuánto? _____ <input type="checkbox"/> No (10)
Liste cualquier medicina que consume. <input type="checkbox"/> Ninguna (93)
Marque todos los suplementos que consume. <input type="checkbox"/> Vitaminas prenatales <input type="checkbox"/> Vitaminas <input type="checkbox"/> Hierro <input type="checkbox"/> Hierbas <input type="checkbox"/> Calcio <input type="checkbox"/> Ácido fólico <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (30)



¿Ha examinado su doctor el nivel de plomo en su sangre? <input type="checkbox"/> Sí <input type="checkbox"/> Resultados _____ <input type="checkbox"/> No <input type="checkbox"/> No sabe				(21)
¿Está en una dieta especial? <input type="checkbox"/> Sí, decisión suya <input type="checkbox"/> Sí, decisión del médico <input type="checkbox"/> No				(30, 35, 91, 93)
Liste sus alergias a alimentos _____				<input type="checkbox"/> Ninguna (93)
Marque cualquiera de estas cosas que come o anhela comer. <input type="checkbox"/> Cascaras de pintura <input type="checkbox"/> Hielo <input type="checkbox"/> Papel con tinta <input type="checkbox"/> Tierra o barro <input type="checkbox"/> Almidón <input type="checkbox"/> Borra o molinillo de café <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguna				(30)
Marque lo que aplique. <input type="checkbox"/> Otra persona compra los alimentos en mi casa. <input type="checkbox"/> Yo compró los alimentos. <input type="checkbox"/> Yo usualmente no como en casa. <input type="checkbox"/> Otra persona cocina en mi casa. <input type="checkbox"/> Yo usualmente cocino. <input type="checkbox"/> Yo vivo en un refugio (shelter), motel, o sitio temporero <input type="checkbox"/> Tengo una estufa o microonda y refrigerador que trabaja en mi casa <input type="checkbox"/> Me quedo sin dinero o estampillas para comprar alimentos.				(66, 95)
¿Qué piensa de sus hábitos de comer?				
Nombre una o dos cosas que hace como actividad física o ejercicio.				
¿Cuántos cigarillos, pipas, cigarros fuma o fumaba? Ahora _____ al día _____ en semana <input type="checkbox"/> ninguno Cualquier momento durante este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno Tres meses antes de este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno				(46)
¿Si alguien en su casa fuma, donde fuman? <input type="checkbox"/> Adentro <input type="checkbox"/> Afuera <input type="checkbox"/> En el carro <input type="checkbox"/> Nadie fuma				(46)
Marque todas las bebidas alcoholicas que toma. <input type="checkbox"/> Vino <input type="checkbox"/> Cerveza <input type="checkbox"/> Coolers <input type="checkbox"/> Licor Ahora _____ al día _____ en semana <input type="checkbox"/> ninguno Cualquier momento durante este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno Tres meses antes de este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno				(47, 66)
Marque todas las drogas que ha usado durante este embarazo. <input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroína <input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalantes <input type="checkbox"/> Drogas recetadas (mal uso) <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguna				(48, 66, 93)
¿Ha sido abusada físicamente, sexualmente o verbalmente en los últimos seis meses? <input type="checkbox"/> Sí <input type="checkbox"/> No				(67)
¿Tiene preguntas o preocupaciones? _____				

Departamento de Salud de Ohio • Sección de Servicios de Nutrición

Historial de Salud de WIC para Mujeres Lactando/Amamantando y en Postparto

Nombre		Fecha		Edad (39, 40)
Fecha en que este embarazo terminó	¿Cuál era su fecha de dar a luz o parto? (49)	Peso cuando se fue de parto	Peso antes de quedar embarazada (11)	
Marque <input type="checkbox"/> nacimiento vivo _____ libras _____ onzas		<input type="checkbox"/> parto muerto <input type="checkbox"/> malparto <input type="checkbox"/> aborto <input type="checkbox"/> muerte de infante (22, 45, 49)		
Número de embarazos en el pasado (39)	¿Cuántos embarazos terminaron en el nacimiento de un infante vivo? (42)	Fecha en que su embarazo anterior terminó (43)		
Médico o clínica prenatal	Fecha de la última visita médica			

Si esta amamantando, llene la **sección número 1** y **2**. Si **no** está amamantando, llene la **sección 2**.

Sección 1

Mi bebé amamanta Cada _____ horas o _____ veces al día y _____ veces en la noche	¿Cuántas veces en cada lado? _____ (70)
Si le dá la botella a su bebé ¿Que hay en la botella? _____	¿Cuán a menudo? _____
Tiene problemas con <input type="checkbox"/> Circulación de la leche materna <input type="checkbox"/> Senos calientes y duros <input type="checkbox"/> Bebé al prenderse del pezón (latch) <input type="checkbox"/> Senos dolorosos <input type="checkbox"/> Pezones dolorosos <input type="checkbox"/> Otros _____ <input type="checkbox"/> Ningún problema (74)	
¿Por cuánto tiempo quiere amamantar a su bebé?	
¿Piensa volver a trabajar o a la escuela? <input type="checkbox"/> Sí ¿Cuándo? _____ <input type="checkbox"/> No	
¿Qué tipo de apoyo para amamantar recibe en su casa?	
¿Le gustaría recibir mas ayuda para lactar/amamantar? <input type="checkbox"/> Sí <input type="checkbox"/> No	

Sección 2

¿Amamantó o lactó su niño alguna vez? <input type="checkbox"/> Sigue amamantando <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Porqué dejó de amamantar? _____ ¿Que edad tenía el bebé cuando dejó de amamantar? _____
¿Tuvo una cesárea? <input type="checkbox"/> Sí <input type="checkbox"/> No (93)
Liste cualquier problema que ha tenido. Con este embarazo _____ Con embarazos pasados _____ <input type="checkbox"/> Ninguno (44)
Marque cualquier problema de salud que tenga en estos momentos. <input type="checkbox"/> Diabetis <input type="checkbox"/> Depresión <input type="checkbox"/> Dental <input type="checkbox"/> Alta presión <input type="checkbox"/> Intolerancia de lactosa <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (91, 93, 94)
Liste cualquier medicina que toma. (93)

¿Ha examinado su doctor el nivel de plomo en su sangre? <input type="checkbox"/> Sí Resultados _____ <input type="checkbox"/> No <input type="checkbox"/> No sabe (21)			
¿Ha tenido un bebé que pesó 9 libras o más? <input type="checkbox"/> Sí <input type="checkbox"/> No (22, 49)			
¿Ha tenido un bebé que nació tres o más semanas antes de tiempo? <input type="checkbox"/> Sí ¿Cuántas semanas antes? _____ <input type="checkbox"/> No (49)			
¿Nació su bebé con algún problema de salud? <input type="checkbox"/> Sí <input type="checkbox"/> No Si contestó sí, explique. _____ (23)			
Marque todos los suplementos que consume. <input type="checkbox"/> Vitaminas prenatales/Vitaminas <input type="checkbox"/> Hierro <input type="checkbox"/> Hierbas <input type="checkbox"/> Calcio <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (30)			
¿Está en una dieta especial? <input type="checkbox"/> Sí, decisión suya <input type="checkbox"/> Sí, decisión del médico <input type="checkbox"/> No (30, 35, 91, 93)			
Liste sus alergias a alimentos <div style="text-align: right;"><input type="checkbox"/> Ninguno (93)</div>			
Marque cualquiera de estas cosas que come o anhela comer . <input type="checkbox"/> Cascaras de pintura <input type="checkbox"/> Hielo <input type="checkbox"/> Papel con tinta <input type="checkbox"/> Tierra o barro <input type="checkbox"/> Almidón <input type="checkbox"/> Borra o molinillo de café <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (30)			
Marque lo que aplique. <input type="checkbox"/> Otra persona compra los alimentos en mi casa. <input type="checkbox"/> Yo compré los alimentos. <input type="checkbox"/> Yo usualmente no como en casa. <input type="checkbox"/> Otra persona cocina en mi casa. <input type="checkbox"/> Yo usualmente cocino. <input type="checkbox"/> Yo vivo en un refugio (shelter), motel, o sitio temporero. <input type="checkbox"/> Tengo una estufa o microonda y refrigerador que trabaja en mi casa. <input type="checkbox"/> Me quedo sin dinero o estampillas para comprar alimentos. (66, 95)			
¿Qué piensa de sus hábitos de comer?			
Nombre una o dos cosas que hace como actividad física o ejercicio.			
¿Cuántos cigarillos, pipas, cigarros fuma o fumaba? Ahora _____ al día _____ en semana <input type="checkbox"/> ninguno Los últimos tres meses de este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno Tres meses antes de este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno (46)			
Si alguien en su casa fuma, donde fuman? <input type="checkbox"/> Adentro <input type="checkbox"/> Afuera <input type="checkbox"/> En el carro <input type="checkbox"/> Nadie fuma (46)			
Marque todas las bebidas alcoholicas que toma. <input type="checkbox"/> Vino <input type="checkbox"/> Cerveza <input type="checkbox"/> Coolers <input type="checkbox"/> Licor Ahora _____ al día _____ en semana <input type="checkbox"/> ninguno Los últimos tres meses de este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno Tres meses antes de este embarazo _____ al día _____ en semana <input type="checkbox"/> ninguno (47, 66)			
Marque todas las drogas que usa. <input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroína <input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalantes <input type="checkbox"/> Drogas recetadas (mal uso) <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguna (48, 66, 93)			
¿Ha sido abusada físicamente, sexualmente o verbalmente en los últimos seis meses? <input type="checkbox"/> Sí <input type="checkbox"/> No (67)			
¿Tiene preguntas o preocupaciones? _____			

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
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Departamento de Salud de Ohio • Sección de Servicios de Nutrición

Historial de Salud de WIC para Niños de 1 hasta 5 Años

Nombre del niño		Fecha
Su nombre		Su relación al niño (96)
Fecha de nacimiento del niño	Peso al nacer (51, 59)	Medida de largo al nacer
Médico del niño o clínica		Fecha del último médico o clínica visitada

Porfavor conteste las siguientes preguntas

¿Amamantó o lactó su niño alguna vez? <input type="checkbox"/> Sigue amamantando <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sabe ¿Porqué dejó de amamantar? _____ ¿Que edad tenía el niño cuando dejó de amamantar? _____	
¿Nació el niño tres o más semanas antes? <input type="checkbox"/> Sí ¿Cuántas semanas? _____ <input type="checkbox"/> No (50)	
Marque cualquier problema de salud que su niño tenga. <input type="checkbox"/> Asma <input type="checkbox"/> Depresión <input type="checkbox"/> Dientes/encías <input type="checkbox"/> Defectos de nacimiento <input type="checkbox"/> Intolerancia de lactosa <input type="checkbox"/> Otro _____ <input type="checkbox"/> Ninguno (68, 91, 93, 94)	
Liste las medicinas de su niño. <input type="checkbox"/> Ninguna (93)	
¿Tiene el niño todas las vacunas? <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No sé	
¿Examinó el médico el nivel de plomo en la sangre del niño? <input type="checkbox"/> Sí Resultados _____ <input type="checkbox"/> No <input type="checkbox"/> No sé (21)	
¿Ha visto el niño a un dentista? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Cepillan los dientes del niño? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿De donde coje agua? <input type="checkbox"/> Del pozo <input type="checkbox"/> De la ciudad <input type="checkbox"/> Comprada en tienda <input type="checkbox"/> Otro _____	
Marque todo lo que consume el niño. <input type="checkbox"/> Vitaminas <input type="checkbox"/> Hierbas <input type="checkbox"/> Hierro <input type="checkbox"/> Fluoruro <input type="checkbox"/> Otro _____ <input type="checkbox"/> Nada (30)	
Liste las alergias del niño a alimentos. <input type="checkbox"/> Ninguna (30)	
¿Está el niño en una dieta especial? <input type="checkbox"/> Sí, su decisión <input type="checkbox"/> Sí, decisión del médico <input type="checkbox"/> No (30, 35, 91, 93)	
¿Está el niño usando fórmula? <input type="checkbox"/> Sí ¿Cuál fórmula? _____ <input type="checkbox"/> No (91, 93)	



Marque todo lo que aplique a su niño. <div> <input type="checkbox"/> Toma de un vaso o taza <input type="checkbox"/> Toma de una botella <input type="checkbox"/> Se acuesta a dormir con la botella o “sippy cup” <input type="checkbox"/> Camina con la botella o “sippy cup” <input type="checkbox"/> Se alimenta por un tubo (feeding tube) </div>		(36, 94)
¿Qué alimentos se niega su niño comer? <div> <input type="checkbox"/> Ninguno </div>		(35)
Marque todas las cosas que su niño come. <div> <input type="checkbox"/> Papel con tinta <input type="checkbox"/> Cascaras de pintura <input type="checkbox"/> Tierra <input type="checkbox"/> Barro <input type="checkbox"/> Hielo <input type="checkbox"/> Ninguna <input type="checkbox"/> Otro _____ </div>		(30)
Marque lo que aplique. <div> <input type="checkbox"/> El niño se alimenta por si solo <input type="checkbox"/> Me quedo sin dinero o estampillas para comprar alimentos <input type="checkbox"/> El niño tiene problemas comiendo/masticando/tragando <input type="checkbox"/> Tengo una estufa o microonda y refrigerador que trabaja en mi casa <input type="checkbox"/> El niño usualmente no come en casa. <input type="checkbox"/> El niño vive en un refugio (shelter), motel, o sitio temporero </div>		(37, 66, 93, 95)
¿Qué piensa de los hábitos de comer de su niño?		
¿Cuántas horas por día es su niño activo físicamente? <div> <input type="checkbox"/> Menos de una hora <input type="checkbox"/> De una a dos horas <input type="checkbox"/> Tres horas o más </div>		
¿Si alguien en su casa fuma, donde fuman? <div> <input type="checkbox"/> Adentro <input type="checkbox"/> Afuera <input type="checkbox"/> En el carro <input type="checkbox"/> Nadie fuma </div>		(46)
¿Ha sido su niño físicamente, verbalmente o sexualmente abusado o abandonado en los últimos seis meses? <div> <input type="checkbox"/> Sí <input type="checkbox"/> No </div>		(67)
¿Tiene preguntas o preocupaciones? <div> _____ </div>		

SOLICITUD COMBINADA DE PROGRAMAS*La información y las instrucciones comienzan en la página 3.***SOLICITUD DE REGISTRO DE VOTANTE ADJUNTA - AYUDA DISPONIBLE**

Si no está registrado para votar donde vive ahora, ¿le gustaría aplicar para registrarse para votar?

☐ Sí, quiero registrarme para votar.☐ NO, no quiero registrarme para votar.**Si no marca ninguna casilla, se considerará que ha decidido no registrarse para votar en este momento.**

Sección A. ¿Para cuáles programas le gustaría aplicar? (Por favor indique cuáles.) Para obtener información acerca de estos programas, por favor vea la página 4. ☐ Comienzo Saludable y Familias Sanas (Medicaid) (Healthy Start and Healthy Families (Medicaid)) ☐ Servicios de Salud para Niños y Familias (Child & Family Health Services (CFHS)) ☐ Ayúdame a Crecer (Help Me Grow (HMG)) ☐ Programa Nutricional para Mujeres, Bebés y Niños (Nutritional Program for Women, Infants & Children (WIC)) ☐ Departamento de Niños con Discapacidades Médicas (Bureau for Children w/ Medical Handicaps (BCMh))

Sección B. ¿Le gustaría recibir información sobre alguno de los siguientes programas? (Por favor indique cuál.) El Departamento de Trabajo y Servicios a la Familia de su Condado (CDJFS) se comunicará con usted para ayudarle a aplicar. ☐ Cuidado de niños ☐ Manutención de menores

☐ Asistencia financiera ☐ Asistencia alimenticia

Sección C. ¿Alguna de las personas que están aplicando para Medicaid recibió atención médica en los últimos 3 meses?

☐ Sí ☐ No Si así es, incluya la verificación de ingresos y los gastos médicos de los últimos 3 meses.

Si es menor de 21 años, estaba bajo cuidado de crianza en su cumpleaños número 18? ☐ Sí ☐ No

Nombre de la persona que está aplicando		Inicial del segundo nombre		Apellido		Teléfono de la casa		Teléfono del trabajo	
Dirección (incluyendo número de apartamento)				Ciudad		Estado		Código postal	
								Condado	

Sección D. Por favor, ponga el nombre de cada persona que vive con usted. Para cada persona, responda el resto de las preguntas sólo si está solicitando cobertura médica para esa persona. Si está solicitando cobertura médica para usted, por favor ponga su nombre de primero.

1. Nombre completo (nombre, inicial, apellido)			Relación con usted		¿Hispano / Latino? <input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Indio americano / Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Negro/Afro-Americano <input type="checkbox"/> Nativo de Hawai / De otra Isla del Pacífico <input type="checkbox"/> Blanco	Idioma principal <input type="checkbox"/> Inglés <input type="checkbox"/> Otro (Por favor, especifique) _____	¿Es ciudadano de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Está discapacitado? <input type="checkbox"/> Sí <input type="checkbox"/> No	Si está embarazada: Cuántos bebés espera _____ Fecha prevista de nacimiento _____
Fecha de nacimiento	Número de seguro social	<input type="checkbox"/> Femenino <input type="checkbox"/> Masculino							
2. Nombre completo (nombre, inicial, apellido)			Relación con usted		¿Hispano / Latino? <input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Indio americano / Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Negro/Afro-Americano <input type="checkbox"/> Nativo de Hawai / De otra Isla del Pacífico <input type="checkbox"/> Blanco	Idioma principal <input type="checkbox"/> Inglés <input type="checkbox"/> Otro (Por favor, especifique) _____	¿Es ciudadano de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Está discapacitado? <input type="checkbox"/> Sí <input type="checkbox"/> No	Si está embarazada: Cuántos bebés espera _____ Fecha prevista de nacimiento _____
Fecha de nacimiento	Número de seguro social	<input type="checkbox"/> Femenino <input type="checkbox"/> Masculino							
3. Nombre completo (nombre, inicial, apellido)			Relación con usted		¿Hispano / Latino? <input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Indio americano / Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Negro/Afro-Americano <input type="checkbox"/> Nativo de Hawai / De otra Isla del Pacífico <input type="checkbox"/> Blanco	Idioma principal <input type="checkbox"/> Inglés <input type="checkbox"/> Otro (Por favor, especifique) _____	¿Es ciudadano de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Está discapacitado? <input type="checkbox"/> Sí <input type="checkbox"/> No	Si está embarazada: Cuántos bebés espera _____ Fecha prevista de nacimiento _____
Fecha de nacimiento	Número de seguro social	<input type="checkbox"/> Femenino <input type="checkbox"/> Masculino							
4. Nombre completo (nombre, inicial, apellido)			Relación con usted		¿Hispano / Latino? <input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Indio americano / Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Negro/Afro-Americano <input type="checkbox"/> Nativo de Hawai / De otra Isla del Pacífico <input type="checkbox"/> Blanco	Idioma principal <input type="checkbox"/> Inglés <input type="checkbox"/> Otro (Por favor, especifique) _____	¿Es ciudadano de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Está discapacitado? <input type="checkbox"/> Sí <input type="checkbox"/> No	Si está embarazada: Cuántos bebés espera _____ Fecha prevista de nacimiento _____
Fecha de nacimiento	Número de seguro social	<input type="checkbox"/> Femenino <input type="checkbox"/> Masculino							
5. Nombre completo (nombre, inicial, apellido)			Relación con usted		¿Hispano / Latino? <input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Indio americano / Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Negro/Afro-Americano <input type="checkbox"/> Nativo de Hawai / De otra Isla del Pacífico <input type="checkbox"/> Blanco	Idioma principal <input type="checkbox"/> Inglés <input type="checkbox"/> Otro (Por favor, especifique) _____	¿Es ciudadano de los Estados Unidos? <input type="checkbox"/> Sí <input type="checkbox"/> No ¿Está discapacitado? <input type="checkbox"/> Sí <input type="checkbox"/> No	Si está embarazada: Cuántos bebés espera _____ Fecha prevista de nacimiento _____
Fecha de nacimiento	Número de seguro social	<input type="checkbox"/> Femenino <input type="checkbox"/> Masculino							

Sección E. Para usted y cada persona que vive con usted (ya sea si está o no solicitando cobertura médica para esa persona), enumere todo tipo de ingreso, como: anualidades, salarios, trabajo por cuenta propia, seguro social, pensión veteranos (VA), compensación a trabajadores, pensión alimenticia, manutención de menores o manutención médica.

Nombre	Empleador o fuente de ingresos	Cantidad bruta	¿Con qué frecuencia recibe el ingreso?
		\$	
		\$	
		\$	
		\$	
		\$	

Sección F. ¿Alguien en su casa le paga a alguien para cuidar a sus hijos mientras usted está en el trabajo o la escuela?

☐ Sí ☐ No Si así es, ¿cuánto paga por niño a la semana? \$ _____

Sección G. ¿Alguien en su casa paga manutención de menores o manutención médica? ☐ Sí ☐ No

Si así es, ¿quién? _____ ¿Cuánto paga por semana? \$ _____

Sección H. Complete las líneas de abajo para cada póliza de seguro médico o la orden de manutención médica para una persona que vive con usted.

¿Quién está cubierto?	Compañía de seguros	Número de póliza	Prima mensual	Por favor, INDIQUE los servicios que cubre la póliza
			\$	<input type="checkbox"/> Hospitalización <input type="checkbox"/> Visitas al médico <input type="checkbox"/> Recetas médicas <input type="checkbox"/> Ambulancia <input type="checkbox"/> Dentales <input type="checkbox"/> Cuidado de la vista
			\$	<input type="checkbox"/> Hospitalización <input type="checkbox"/> Visitas al médico <input type="checkbox"/> Recetas médicas <input type="checkbox"/> Ambulancia <input type="checkbox"/> Dentales <input type="checkbox"/> Cuidado de la vista
			\$	<input type="checkbox"/> Hospitalización <input type="checkbox"/> Visitas al médico <input type="checkbox"/> Recetas médicas <input type="checkbox"/> Ambulancia <input type="checkbox"/> Dentales <input type="checkbox"/> Cuidado de la vista
			\$	<input type="checkbox"/> Hospitalización <input type="checkbox"/> Visitas al médico <input type="checkbox"/> Recetas médicas <input type="checkbox"/> Ambulancia <input type="checkbox"/> Dentales <input type="checkbox"/> Cuidado de la vista

AL FIRMAR ESTA SOLICITUD, ESTOY DE ACUERDO en entregar la documentación y la verificación de la información de esta solicitud. Entiendo que se me puede pedir que autorice a CDJFS para realizar los contactos necesarios para determinar mi elegibilidad. Al firmar una solicitud y recibir Medicaid, estoy asignando al Estado de Ohio todos los derechos a manutención médica y todos los derechos a los pagos por parte de un tercero responsable por la asistencia médica que se me debe a mí o alguna persona por la cual soy legalmente responsable durante el período de la elegibilidad de Medicaid.

Autorizo a cualquier persona que ofrezca cuidados médicos o suministros médicos para que proporcione al Departamento de Trabajo y Servicios a la Familia del Estado de Ohio o al Departamento de Salud de Ohio, cualquier información relacionada con la magnitud, la duración, y el alcance de los servicios ofrecidos bajo el programa Healthy Start, Healthy Families de Medicaid, WIC y otros programas de asistencia médica. También autorizo al Departamento de Salud de Ohio y al Departamento de Trabajo y Servicios a la Familia del Estado de Ohio para que intercambien cualquier información que yo haya proporcionado en este formulario, para permitirle a dichos departamentos determinar mi elegibilidad. Entiendo que esta solicitud será considerada sin distinción de raza, color, sexo, edad, incapacidades físicas o mentales, religión, origen nacional o creencias políticas.

NOTA: Su Número de Seguro Social (SSN, por sus siglas en inglés) no es necesario si sólo desea obtener los programas WIC, CFHS, HMG, o BCMH. Si usted proporciona el Número de Seguro Social en esta solicitud, éste será usado para comparar datos por computadora para verificar su elegibilidad y para la revisión de los programas. Estas revisiones le indican a la agencia si la participación y difusión del programa se están llevando a cabo.

Al firmar a continuación, afirmo que a mi mejor saber y entender las respuestas en esta solicitud son completas y correctas. Entiendo que la ley establece una pena de multas o prisión (o ambos) para toda persona declarada culpable de aceptar asistencia que él o ella no es elegible para recibir. Declaro bajo pena de perjurio que he revelado todas las anualidades y otros recursos financieros similares en los cuales yo o mi cónyuge tiene algún interés. **Declaro bajo pena de perjurio que toda la información en esta solicitud es verdadera y completa a lo mejor de mi conocimiento.**

Persona que está solicitando (Por favor escriba su nombre en letra de molde)	Firma	Fecha
Representante autorizado o persona que ayudó a completar este formulario	Firma	Fecha

Por favor envíe por correo la solicitud completa, el formulario firmado de los derechos y responsabilidades y copias de la información importante a su oficina local del Departamento de Trabajo y Servicios a la Familia de su Condado (CDJFS)
Para recibir ayuda para completar este formulario, llame al 1-800-324-8680 (TDD 1-800-292-3572 para personas con problemas de audición.)

No es necesario tener una entrevista en persona si está aplicando para Medicaid o BCMH.

Se requiere una solicitud diferente para la Asistencia Financiera o Asistencia Alimenticia. Para solicitar Asistencia Financiera a través de Ohio Trabaja Primero (Ohio Works First), Asistencia Alimenticia, o Medicaid para personas de la tercera edad, ciegas o discapacitadas, comuníquese con su oficina local del Departamento de Trabajo y Servicios a la Familia de su Condado.

INSTRUCCIONES

1. Llene la solicitud en las páginas 1 y 2. **FIRME y FECHE** la solicitud en la página 2.
2. Use sus propias hojas de papel si necesita más espacio para responder a las preguntas, incluso para enumerar a más integrantes de la familia en la sección D.
3. Cada persona que solicite cobertura médica a través de Medicaid debe proporcionar un número de seguro social O prueba de que ha presentado una solicitud para obtener un número de seguro social. Un número de seguro social NO es necesario si sólo desea WIC, HMG, CFHS, y /o BCMH.
4. Adjunte copias de documentos importantes. Incluso los que se indican a continuación en la "Lista de Verificación de la Solicitud".

¿Tiene preguntas? ¿Necesita ayuda para llenar este formulario?

Llame al 1-800-324-8680

TDD 1-800-292-3572

Si usted no ha recibido una copia de los formularios JFS 07236 "Sus Derechos y Responsabilidades como Consumidor de la Cobertura Médica de Medicaid" o JFS 07400 "Recuperación del Patrimonio de Medicaid de Ohio," por favor, pida estos formularios informativos en su oficina local de CDJFS, llame a la Línea Directa del Consumidor al **1-800-324-8680** o **TDD 1-800-292-3572**, o visite <http://www.odjfs.state.oh.us/forms/inter.asp>.

LISTA DE VERIFICACIÓN DE LA SOLICITUD

Con el fin de obtener servicios de atención médica, hay cierta información que usted debe proporcionar.

Prueba de ingresos, como:

- ☐ Una copia de un talón de pago reciente, O
- ☐ Si trabaja por cuenta propia, un formulario de impuestos 1040 del IRS con el anexo C o F; O
- ☐ Una carta de su empleador indicando la cantidad de su ingreso bruto mensual.

Si está embarazada, una declaración escrita de un médico o enfermera. Esta debe incluir la fecha prevista de nacimiento y cuántos bebés espera (Por ejemplo: gemelos = 2 bebés).

Usted tendrá que mostrar **prueba de ciudadanía de EE.UU. o estatus migratorio** para las personas que están solicitando Medicaid. Los documentos originales deben presentarse a su CDJFS; copias sólo pueden aceptarse si están certificadas por la agencia que emitió el documento.

Si usted o sus hijos tienen cobertura médica a través de algún otro plan de seguro médico, usted tendrá que enviar una copia de su tarjeta de seguro médico u otra prueba de cobertura. Por favor, asegúrese de copiar ambos lados de su tarjeta.

Envíe por correo su solicitud firmada, el formulario de derechos y responsabilidades firmado, y las copias de la información importante a su oficina local del Departamento de Trabajo y Servicios a la Familia de su Condado.

Si es aprobado para recibir Medicaid para usted o sus hijos, se le puede pedir que coopere con la agencia para el cumplimiento de la manutención de menores (CSEA) para establecer la paternidad (quién es el padre legal) o establecer y hacer cumplir una orden de manutención de menores que incluye manutención médica. Si usted está obligado a cooperar con la CSEA, se presentará una referencia a la CSEA a su favor. Si usted está obligado a cooperar, pero se niega a hacerlo, podría perder la cobertura para usted. Sus hijos seguirían cubiertos. Si usted no está obligado a cooperar con la CSEA, usted puede solicitar servicios de manutención de menores, completando el formulario JFS 07076 "Solicitud de Manutención de Menores".

PROGRAMAS DE COBERTURA MÉDICA

Ohio ofrece a las familias una variedad de opciones para obtener los servicios de atención médica. A continuación se muestra una breve descripción de los cinco programas financiados públicamente que están disponibles en todo Ohio. Las familias pueden solicitar uno o todos de los siguientes programas usando la solicitud adjunta.

Comienzo Sano y Familias Saludables (Healthy Start and Healthy Families)

Los Programas Comienzo Sano y Familias Saludables, ofrecen cobertura médica gratuita o a bajo costo a familias, mujeres embarazadas y niños (hasta los 19 años de edad). Algunos jóvenes adultos que cumplan determinados requisitos pueden ser cubiertos hasta los 21 años de edad. La cobertura incluye: visitas al médico, atención hospitalaria, servicios relacionados con el embarazo, recetas médicas, cuidado de la vista, servicios dentales, abuso de sustancias, servicios de la salud mental y ¡mucho más! Estos son servicios de atención médica importantes que su familia necesita para mantenerse sana y fuerte. Comienzo Saludable y Familias Sanas son programas de Medicaid administrados por el Departamento de Trabajo y Servicios a la Familia del Estado de Ohio. Para obtener más información, por favor llame al 1-800-324-8680 o visite www.jfs.ohio.gov/ohp/. Las familias que estén interesadas en recibir Asistencia Financiera a través del Programa Ohio Trabaja Primero (Ohio Works First), Asistencia Alimenticia (Food Assistance), o Medicaid para las personas de la tercera edad, ciegas o discapacitadas, deben comunicarse con la oficina local del Departamento de Trabajo y Servicios a la Familia de su Condado.

Mujeres, Bebés y Niños (WIC)

El Programa para Mujeres, Bebés y Niños (WIC, por sus siglas en inglés) le brinda alimentos nutritivos, información importante sobre la nutrición y educación sobre la lactancia materna y apoyo. También ayuda a las familias que son elegibles a encontrar atención médica u otros servicios que necesitan. Para ser elegible para WIC, usted debe ser una mujer que está embarazada o en período de lactancia o tener un bebé de menos de seis meses de edad. Los niños desde el nacimiento hasta los 5 años de edad también son elegibles. Las familias deben cumplir con los ingresos WIC y las normas de riesgo médico y nutricional. Para aplicar, llene la solicitud adjunta o visite su clínica local de WIC para más información. El programa WIC es administrado por el Departamento de Salud de Ohio (ODH).

Servicios de Salud para Niños y Familias (Child & Family Health Services (CFHS))

El Programa de Servicio de Salud para Niños y Familias (CFHS, por sus siglas en inglés) en su área puede ayudarle con uno o más de los siguientes servicios: atención médica para niños y adolescentes, cuidado prenatal y/o planificación del cuidado familiar. Las clínicas pueden ofrecer exámenes físicos de rutina para el niño, consejos de nutrición, exámenes de laboratorio, educación sobre la salud y podrían ayudarle a obtener otros cuidados médicos que usted necesite. Si usted no tiene ninguna otra manera de pagar por los servicios de una clínica CFHS como un seguro médico o cobertura de Medicaid, el costo de los servicios clínicos se basará en el tamaño de su familia y sus ingresos. A nadie se le pueden negar los servicios si no puede pagar. Para aplicar, llene la solicitud adjunta o visite su clínica local de Servicios de Salud para Niños y Familias. Este programa es administrado por ODH.

Departamento de Niños con Discapacidades Médicas (Bureau for Children with Medical Handicaps)

El Departamento de Niños con Discapacidades Médicas (BCMh, por sus siglas en inglés) es un programa de atención médica que ofrece servicios para niños con necesidades médicas especiales. Para recibir servicios BCMh un niño debe ser residente de Ohio, ser menor de 21 años de edad y estar bajo el cuidado de un médico aprobado por BCMh. Las familias también deben cumplir con algunos criterios de ingresos para ser elegibles. BCMh trabaja muy cerca con las enfermeras de salud pública en departamentos de salud locales para incrementar los servicios a los niños con discapacidades y sus familias. Para obtener más información sobre BCMh, las familias deben comunicarse con su departamento de salud local o llamar al 1-800-755-GROW (4769). Este programa es administrado por ODH.

Ayúdame a Crecer (Help Me Grow (HMG))

El objetivo del programa Ayúdame a Crecer (HMG, por sus siglas en inglés) es el de asegurar que los todos recién nacidos, niños y bebés en Ohio tengan el mejor comienzo posible en la vida. Los programas locales de Ayúdame a Crecer proporcionan servicios que:

- Identifican a los niños con o en riesgo de retrasos en el desarrollo o discapacidades;
- Proporcionan exámenes de salud, de audición, de la vista y del desarrollo;
- Proporcionan a los padres información sobre el desarrollo social y emocional de sus hijos para sentar las bases para el éxito escolar posterior;
- Aseguran que los padres tengan información sobre la importancia de las primeras vacunas de la infancia y la atención de la salud pediátrica de rutina; y
- Conectan a los niños en edades de tres años con los servicios apropiados.

Las personas que estén interesadas en recibir Asistencia Financiera a través de Ohio Trabaja Primero (Ohio Works First), Asistencia Alimenticia (Food Assistance), o Medicaid para personas de la tercera edad, ciegas o discapacitadas deben comunicarse con la oficina local del Departamento de Trabajo y Servicios a la Familia de su Condado.

Please read instructions carefully. Please type or print clearly with blue or black ink. For further information, you may consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

Por favor lea las instrucciones atentamente. Por favor escriba a máquina o con letra de molde clara con tinta azul o negra. Para más información puede consultar el Sitio web del Secretario de Estado en: www.OhioSecretaryofState.gov o llamar al 1-877-767-6446.

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be *received or postmarked* by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Numbers 1 and 2 below are required by law. You *must* answer **both** of the questions for your registration to be processed.

If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the *last four digits* of your Social Security number on line 10. If you have neither, please write "None."

If you register by mail and do not provide either a current Ohio driver's license number or the last four digits of your Social Security number, please enclose with your application a copy of one of the following forms of identification that shows your name and current address:

Current and valid photo identification, a military identification, or a current (within the last 12 months) utility bill, bank statement, paycheck, government check or government document (other than a notice of voter registration mailed by a board of elections) that shows your name and current address.

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

**Please see information on back of this form to learn how to
obtain an absentee ballot.**

**WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A
FELONY OF THE FIFTH DEGREE.**

1. Usted es ciudadano de los Estados Unidos.
2. Usted tendrá al menos 18 años de edad el día de las elecciones generales o antes de las mismas.
3. Usted habrá sido un residente de Ohio durante al menos los 30 días previos a las elecciones en las que quiere votar.
4. Usted no está encarcelado (en la cárcel o en prisión) por un delito grave.
5. Usted no ha sido declarado incompetente a fines de votación por un tribunal testamentario.
6. Usted no ha sido privado de sus derechos de forma permanente por violaciones de leyes electorales.

Use este formulario para registrarse para votar o para actualizar su registro actual en Ohio si ha cambiado de domicilio o nombre.

AVISO: Este formulario debe ser recibido o estar matasellado al menos 30 días antes de unas elecciones en las que usted tiene intención de votar. La junta electoral del condado le notificará el lugar donde usted vota. Si no recibe una notificación después de entregar su formulario a tiempo, por favor póngase en contacto con la junta electoral de su condado.

Números 1 y 2 del formulario a continuación son obligatorias por ley.
Debe contestar a **ambas** preguntas para que su registro pueda ser procesado.

Si usted tiene una licencia de conducir de Ohio válida, tiene que facilitar ese número en la línea 10. Si usted no tiene una licencia de conducir de Ohio, tiene que facilitar los cuatro últimos dígitos de su número del Seguro Social en la línea 10. Si no tiene ninguno de los dos, por favor escriba "Ninguno".

Si usted se registra por correo y no facilita un número de licencia de conducir de Ohio o los cuatro últimos dígitos de su número del Seguro Social, por favor incluya con su solicitud una copia de una de las siguientes formas de identificación que muestre su nombre y domicilio actual:

Actual y válida identificación con fotografía, identificación militar o un recibo o factura actual (no más de 12 meses de antigüedad) de servicios básicos, estado de cuentas bancarias, nómina, cheque del gobierno, o otro documento del gobierno (con excepción de una notificación de registro de votante enviado por la junta electoral) que muestre su nombre y domicilio actual.

Su domicilio de votar es el lugar que usted considera ser su domicilio permanente y no temporario. Su domicilio de votar es el lugar en lo que su habitación es fijada y el lugar a lo que, cuando usted esté ausente, tiene la intención de regresar. Si usted no tiene una habitación fijada, pero está habitante consistente y regular de un refugio o de otro lugar a lo que tiene la intención de regresar, se permite usar ese refugio como domicilio para su registro de votante. Si usted tiene preguntas sobre su circunstancia específica de domicilio, póngase en contacto con la junta electoral de su condado.

En la área debajo de la flecha en casilla 14, por favor firme en cursiva y por mano o ponga su marca, teniendo cuidado de no tocar las líneas o el texto que lo rodean para que cuando la junta electoral de su condado lo hacen una imagen digital, la pueden usar para identificar su firma.

Por favor consulte la información en el otro lado de este formulario para averiguar cómo obtener una boleta o papeleta de voto en ausencia.

AQUELLAS PERSONAS QUE COMETAN FRAUDE ELECTORAL SERÁN CULPABLES DE UN DELITO DE QUINTO GRADO.

I am: <input type="checkbox"/> Registering as an Ohio voter Quiero: <input type="checkbox"/> Registrarme para votar en Ohio	<input type="checkbox"/> Updating my address Actualizar mi domicilio	<input type="checkbox"/> Updating my name Actualizar mi nombre
--	---	---

1. Are you a U.S. citizen? / ¿Es usted ciudadano de los EE.UU.? ☐ Yes / Sí ☐ No / No

2. Will you be at least 18 years of age on or before the next general election? ☐ Yes / Sí ☐ No / No

¿Tendrá usted al menos 18 años de edad el día de las próximas elecciones generales o antes?
If you answered NO to either of the questions, do not complete this form.
Si respondió NO a cualquiera de las preguntas, no complete este formulario.

3. Last Name / Apellido	First Name / Nombre	Middle Name or Initial / Segundo Nombre o Inicial	Jr., II, etc.
4. House Number and Street (Enter new address if changed) / Número de Casa y Calle (Escriba la nueva dirección si ha cambiado)	Apt. or Lot # / Apt. o No. de Parcela	5. City or Post Office / Ciudad u Oficina de Correos	6. ZIP Code / Código Postal
7. Additional Mailing Address (if necessary) / Dirección Postal Adicional (si es necesario)		8. County (where you live) / Condado (donde vive)	
9. Birthdate (MO-DAY-YR) (required) / Fecha de Nacimiento (MES-DÍA-AÑO) (obligatorio)	10. Ohio Driver's License No. OR last four digits of Social Security No. (one form of ID required to be listed or provided) / No. de la licencia de conducir de Ohio o últimos cuatro dígitos del No. del Seguro Social (es necesario indicar o facilitar una forma de identificación)	11. Phone No. (voluntary) / No. Tfno. (voluntario)	

12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street / DOMICILIO ANTERIOR SI ESTÁ ACTUALIZANDO EL REGISTRO ACTUAL - Número de Casa y Calle Anterior

Previous City or Post Office / Ciudad u Oficina de Correos	County / Condado	State / Estado
---	-------------------------	-----------------------

13. CHANGE OF NAME ONLY Former Legal Name / SOLO CAMBIO DE NOMBRE Nombre Legal Anterior

Former Signature / Firma Anterior
--

14.

I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Declaro, so pena de fraude electoral, que soy ciudadano de los Estados Unidos, que habré vivido en este estado durante al menos los 30 días previos a las elecciones siguientes y que tendré al menos 18 años de edad en el momento de las elecciones generales.

Your Signature / Su firma **↓** **Date / Fecha** _____ / _____ / _____

MO	DAY	YR
MES	DÍA	AÑO

**FOR BOARD
USE ONLY**

SEC4010 (Rev. 6/14)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections. For your county board's address please visit www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (767-6446).

CÓMO CONSEGUIR UNA BOLETA O PAPELETA DE VOTO EN AUSENCIA

Usted tiene derecho a votar mediante una boleta o papeleta de voto en ausencia en Ohio sin tener que dar un motivo. Las solicitudes de boletas o papeletas de voto en ausencia se pueden obtener de la junta electoral de su condado o del Secretario de Estado en: www.OhioSecretaryofState.gov o llamando al 1-877-767-6446.

REQUISITOS DE IDENTIFICACIÓN PARA LOS VOTANTES DE OHIO

Los votantes deben traer identificación a los centros de votación para verificar su identidad. La identificación puede incluir actual y válida identificación con fotografía, identificación militar o una copia de un recibo o factura actual (no más de 12 meses de antigüedad) de servicios básicos, estado de cuentas bancarias, cheque del gobierno, nómina, o otro documento del gobierno (con excepción de notificaciones de las elecciones o notificaciones de registro de votante enviado por la junta electoral) que muestre su nombre y domicilio actual. Los votantes que no faciliten ninguno de estos documentos aún podrán votar facilitando los últimos cuatro dígitos del número de Seguro Social del votante y ejerciendo una papeleta provisional de conformidad con R.C. 3505.181. Para obtener más información acerca de los requisitos de identificación de los votantes, por favor consulte el Sitio web del Secretario de Estado en: www.OhioSecretaryofState.gov o llame al 1-877-767-6446.

AQUELLAS PERSONAS QUE COMETAN FRAUDE ELECTORAL SERÁN CULPABLES DE UN DELITO DE QUINTO GRADO.

Departamento de Salud de Ohio

Solicitud del Programa de WIC

Por favor conteste todas las preguntas en esta página.

A.

Padre, guardián, o nombre de solicitante		Teléfono <div><div><input type="checkbox"/> Casa</div><div><input type="checkbox"/> Celular</div></div> <div><div><input type="checkbox"/> Trabajo</div><div><input type="checkbox"/> Dejar mensaje</div></div>		
Dirección	Ciudad	Estado	Código postal	Condado
Dirección Postal (Si no es la misma dirección escrita arriba)		Ciudad	Estado	Código postal

B.

En la sección de abajo por favor liste todas las personas que viven en su casa.

1.

Nombre-primer, segundo, apellido		Relación con usted	<div><input type="checkbox"/> Femenino</div> <div><input type="checkbox"/> Masculino</div>	Día de Nacimiento
		Yo mismo		/ /
Hispanic/Latino	<div><input type="checkbox"/> Indio Americano/Nativo de Alaska</div> <div><input type="checkbox"/> Asiático</div> <div><input type="checkbox"/> Blanco</div> <div><input type="checkbox"/> Negro/Afro-Americano</div>	Si está embarazada: número de bebés sin haber nacido todavía		Día de dar parto
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Nativo de Hawaii/de otra Isla de Pacífico</div>			/ /

2.

Nombre-primer, segundo, apellido		Relación con usted	<div><input type="checkbox"/> Femenino</div> <div><input type="checkbox"/> Masculino</div>	Día de Nacimiento
				/ /
Hispanic/Latino	<div><input type="checkbox"/> Indio Americano/Nativo de Alaska</div> <div><input type="checkbox"/> Asiático</div> <div><input type="checkbox"/> Blanco</div> <div><input type="checkbox"/> Negro/Afro-Americano</div>	Si está embarazada: número de bebés sin haber nacido todavía		Día de dar parto
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Nativo de Hawaii/de otra Isla de Pacífico</div>			/ /

3.

Nombre-primer, segundo, apellido		Relación con usted	<div><input type="checkbox"/> Femenino</div> <div><input type="checkbox"/> Masculino</div>	Día de Nacimiento
				/ /
Hispanic/Latino	<div><input type="checkbox"/> Indio Americano/Nativo de Alaska</div> <div><input type="checkbox"/> Asiático</div> <div><input type="checkbox"/> Blanco</div> <div><input type="checkbox"/> Negro/Afro-Americano</div>	Si está embarazada: número de bebés sin haber nacido todavía		Día de dar parto
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Nativo de Hawaii/de otra Isla de Pacífico</div>			/ /

4.

Nombre-primer, segundo, apellido		Relación con usted	<div><input type="checkbox"/> Femenino</div> <div><input type="checkbox"/> Masculino</div>	Día de Nacimiento
				/ /
Hispanic/Latino	<div><input type="checkbox"/> Indio Americano/Nativo de Alaska</div> <div><input type="checkbox"/> Asiático</div> <div><input type="checkbox"/> Blanco</div> <div><input type="checkbox"/> Negro/Afro-Americano</div>	Si está embarazada: número de bebés sin haber nacido todavía		Día de dar parto
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Nativo de Hawaii/de otra Isla de Pacífico</div>			/ /

5.

Nombre-primer, segundo, apellido		Relación con usted	<div><input type="checkbox"/> Femenino</div> <div><input type="checkbox"/> Masculino</div>	Día de Nacimiento
				/ /
Hispanic/Latino	<div><input type="checkbox"/> Indio Americano/Nativo de Alaska</div> <div><input type="checkbox"/> Asiático</div> <div><input type="checkbox"/> Blanco</div> <div><input type="checkbox"/> Negro/Afro-Americano</div>	Si está embarazada: número de bebés sin haber nacido todavía		Día de dar parto
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Nativo de Hawaii/de otra Isla de Pacífico</div>			/ /

6.

Nombre-primer, segundo, apellido		Relación con usted	<div><input type="checkbox"/> Femenino</div> <div><input type="checkbox"/> Masculino</div>	Día de Nacimiento
				/ /
Hispanic/Latino	<div><input type="checkbox"/> Indio Americano/Nativo de Alaska</div> <div><input type="checkbox"/> Asiático</div> <div><input type="checkbox"/> Blanco</div> <div><input type="checkbox"/> Negro/Afro-Americano</div>	Si está embarazada: número de bebés sin haber nacido todavía		Día de dar parto
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	<div><input type="checkbox"/> Nativo de Hawaii/de otra Isla de Pacífico</div>			/ /

C.

¿Si alguien en su casa está embarazada, está ella bajo cuidado médico?	Si sí, ¿Cuál es el nombre del doctor?
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	

D.

¿Hay alguien en su casa que ha tenido un bebé en los últimos seis meses?	Si sí, ¿quién?
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	

E.

¿Hay alguien en su casa que está amamantando un bebé menor de 12 meses de edad?	Si sí, ¿quién?
<div><input type="checkbox"/> Sí</div> <div><input type="checkbox"/> No</div>	

F.

Por favor marque Sí o No si alguien en su casa recibe cualquiera de los siguientes:

Ohio Works First Cash <div><div><input type="checkbox"/> Sí</div><div><input type="checkbox"/> No</div></div> <div>Si sí, ¿quién?</div>	Medicaid <div><div><input type="checkbox"/> Sí</div><div><input type="checkbox"/> No</div></div> <div>Si sí, ¿quién?</div>	Food Assistance <div><div><input type="checkbox"/> Sí</div><div><input type="checkbox"/> No</div></div> <div>Si sí, ¿quién?</div>
---	--	---

Por favor llene las lineas de abajo para cada persona en su casa quien tenga cualquier ingreso como salario, trabaja para si mismo, desempleo, SSI, Seguro Social, pensión de VA, compensación de trabajador, sustento, sustento para niño(a), o paga de gran cantidad.

Nombre	Nombre de fuente del ingreso	Cantidad de ingreso bruto (sin descontar taxes o impuestos)	Cuán a menudo se recibe
		\$	
		\$	
		\$	

¡Importante! Usted tiene que firmar el otro lado de esta solicitud.
HEA 4473 (Rev. 10/13)

Al firmar esta solicitud de WIC, yo estoy de acuerdo en presentar pruebas de elegibilidad para la información dada en esta solicitud y cualquier otra información pedida para llenar las reglas del programa.

Yo autorizo a cualquier persona que me suministre cuidados médicos o suministros médicos a que proporcione al Departamento de Medicaid de Ohio, al Departamento de Trabajo y Servicios a la Familia de Ohio o al Departamento de Salud de Ohio, cualquier información relacionada con la magnitud, duración, y el propósito de los servicios proporcionados bajo Medicaid, WIC, y otros programas de asistencia médica.

Tambien autorizo al Departamento de Salud de Ohio, al Departamento de Medicaid de Ohio, y al Departamento de Trabajo y Servicios a la Familia de Ohio a que intercambien cualquier información que yo he proporcionado en esta solicitud para permitirles a los departamentos a que determinen mi elegibilidad.

Yo entiendo que esta solicitud es considerada sin tener en cuenta la raza, el color, el origen nacional, el sexo, la edad, o la incapacidad.

Al firmar a continuación, yo declaro bajo pena de perjurio que hasta donde llega mi conocimiento y creencia todas las respuestas en esta solicitud son ciertas y están completas. Yo entiendo que la ley determina una penalidad/multa o cárcel (o ambos) para cualquiera convicto de aceptar asistencia sin ser elegible.

Firma del solicitante quien llenó esta solicitud	Fecha de firma
Firma de la persona quien ayudó a llenar esta solicitud	Fecha de firma

AGENCY USE ONLY

Pregnancy Verification ☐ Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephoned (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Medical chart location (office name)		

Income Verification ☐ Verification attached (county department of job and family services, employer, other agencies)

Check those that apply <input type="checkbox"/> OWF <input type="checkbox"/> Disability Financial Assistance <input type="checkbox"/> Food Assistance <input type="checkbox"/> Medicaid <input type="checkbox"/> Refugee		Economic unit size
Card number <input type="checkbox"/> Benefits Notice/Printout <input type="checkbox"/> Provider Information Line <input type="checkbox"/> MITS or EBT Portal		Effective date
Verification statement used (document/check stub/letter) <input type="checkbox"/> Yes <input type="checkbox"/> No	Statement date	Income amount \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly
Telephoned (name)	Agency/Business	Call date
Confirmed or other information 		

Proof of Residence

<input type="checkbox"/> Ohio License/ID	<input type="checkbox"/> Utility/credit bill	<input type="checkbox"/> WIC Reminder Card	<input type="checkbox"/> Medical card/JFS document	<input type="checkbox"/> Other _____
WIC personnel signature				Date

Su clínica de WIC es:

Departamento de Salud de Ohio
Tarjeta de identificación
del programa de WIC

Por favor traiga esta tarjeta a cada cita de WIC.

Número de Clínica
Número de Grupo

Nombre y número de identificación de los participantes

Nombre y firma del participante/padre/guardián

Nombre
Firma

Nombres y firmas de compradores alternativos

Nombre
Firma

Nombre
Firma

HEA 4434 Rev. 07/12

*Amamante con pecho...para bebés
mamas, y comunidades saludables.*

Siempre traiga esta identificación (ID) a **todas sus citas de WIC** y a **las tiendas o colmados.**

Próxima Cita de WIC:

[illegible]

Usted tiene que volver a aplicar para WIC cada 6 meses. En otras citas, WIC le proveerá educación de nutrición y más cupones. Porfavor llame si necesita cambiar su cita.

[illegible]

Cuidado y uso de los cupones y la tarjeta de identificación de WIC



En la clínica
Cumpla con todas las citas programadas. Si usted falta a las citas, no recibirá sus cupones de WIC.

Solamente a usted o a su comprador alternativo se les permiten recoger y usar los cupones para usted o sus hijos. Los compradores alternativos deben de tener por lo menos 16 años de edad.

Las personas enlistadas en la tarjeta de identificación de WIC deben mostrar esta tarjeta de identificación para recoger los cupones en la clínica de WIC.

Se le pedirá firmar el talón de los cupones para verificar el recibo de éstos.

Dígale a su profesional de salud de WIC si usted no está usando todos los alimentos enlistados en sus cupones.

Déle al personal de WIC cualquier cupón que haya expirado.

Reporte cupones perdidos o robados a la clínica WIC inmediatamente, aunque **no** serán reemplazados.

Antes de comprar
No doble, rompa, o escriba en sus cupones de WIC.



Asegúrese de que la tienda donde usted compra acepte cupones de WIC.

Utilice sus cupones de WIC entre la primera y última fecha de uso.

Enseñe a su comprador alternativo a como leer y usar los cupones de WIC y la Lista de Alimentos Autorizados. Preste a su comprador alternativo la tarjeta de identificación de WIC y la lista de proveedores autorizados para comprar en la tienda por usted.

Use un cupón cada semana para ayudar a prevenir la descomposición de alimentos y para ayudar a que los alimentos duren todo el mes. Lleve con usted a la tienda solamente los cupones que planea usar.

No use todos los cupones de fórmula en una sola vez. Si su bebé tiene problemas con la fórmula, usted necesitará traer a la clínica los cupones sin usar para hacer un cambio.

Verifique que usted y su comprador alternativo hayan firmado la tarjeta de identificación de WIC.

Lleve la tarjeta de identificación de WIC a la tienda.

En la tienda
No haga ningún cambio en los cupones o en la tarjeta de identificación de WIC.



Compre los alimentos enlistados en los cupones y asegúrese de obtener la cantidad completa. No se le puede dar cambio, crédito, o vales por algo que usted no compra.

Compare precios entre los alimentos autorizados. Aproveche las ventas de liquidación y especiales cada semana. Use cupones de manufacturero y tiendas. Use su tarjeta de descuento de la tienda. Esto ayuda a WIC a servir a más personas.

Asegúrese que los alimentos que usted selecciona están enlistados en la Lista de Alimentos Autorizados. La sustitución de un artículo de alimento no autorizado no está permitida.

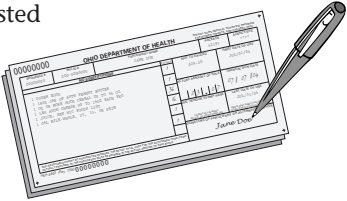
En la caja registradora
Separe sus alimentos de WIC de todos los otros alimentos. Muestre su tarjeta de identificación y dígame al(a) cajero(a) que usted tiene cupones de WIC.



Agrupe sus alimentos de WIC de acuerdo a como están enlistados en cada cupón que usted está utilizando.

Déle los cupones al(a) cajero(a). El(La) cajero(a) debe escribir la cantidad de los alimentos de WIC que usted compra, el costo total y la fecha. El (La) cajero(a) le dará los cupones a usted para que firme.

Firme los cupones en la esquina derecha inferior. Su firma muestra que usted ha recibido alimentos de WIC de igual valor al costo total escrito en los cupones.



Nota: La tienda debe cobrarle lo mismo que le cobran a otros clientes. Asegúrese que el total es correcto antes de firmar.

Dé los cupones firmados y su tarjeta de identificación al(a) cajero(a) para que pueda comparar las firmas.

Nota: El programa de WIC requiere que el(la) cajero(a) vea la tarjeta de identificación de WIC antes de aceptar los cupones. Las firmas en los cupones deben coincidir con las firmas en la tarjeta de identificación o el(la) cajero(a) negará la venta.

Cómo leer un cupón de WIC

Diagram illustrating the components of a WIC coupon form:

- El número de cupón (también número de secuencia):** 00000000
- Número de identificación del participante de WIC:** 000-0000000
- A quién es emitido:** PARTICIPANT NAME JANE DOE
- Para uso del estado solamente:** SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)
- Fecha en que el cupón fue utilizado:** JUL/01/04
- Una lista de los tipos de alimentos y las cantidades de cada alimento por las que el cupón puede ser utilizado:**

NO SUBSTITUTIONS	# of items
1 DOZEN EGGS	1
1 18OZ JAR OF AUTH PEANUT BUTTER	1
1 OZ OR MORE AUTH CEREAL UP TO 36 OZ	36
1 LBS AUTH CHEESE UP TO 16OZ EACH PKG	16
1 JUICE, SEE WIC FOODS LIST	1
1 GAL MILK-WHOLE, 2%, 1%, OR SKIM	1
- NOT TO EXCEED:** *****
- ACTUAL AMOUNT OF SALE:** 23.07
- TRANSACTION DATE:** 07/07/04
- WIC VENDOR STAMP HERE:** [Stamp area]
- PAYMENT WILL BE DENIED WITHOUT WIC VENDOR STAMP HERE**
- SIGNATURE OF PARTICIPANT OR ALTERNATE SHOPPER:** Jane Doe
- CUÁNTO SE GASTÓ (CAJERO(A) LLENA AQUÍ):** 00000000
- Identificación del vendedor:** [Stamp area]
- El(La) participante o comprador alternativo firma el cupón aquí cuando se esté usando el cupón. Debe ser firmado en presencia del(la) cajero(a).**

Ohio Department of Health
WIC Interagency Referral and Follow-Up Form

Date	Referred to	FAX
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Referring Agency Information

Name		Clinic
Agency		Phone
Address		FAX
City	State	ZIP

Información del Participante

Nombre del Participante		Día de Nacimiento
Padre/Guardián		EDC
Dirección		Número de Teléfono
Ciudad	Estado	Código Postal
Correo electrónico		

Hgb*	Hct*	Razón por ser referido y otra información médica
Altura*	Peso*	
BMI		

*Si es diferente que la fecha escrita arriba, indique la fecha cuando fué tomada.

Permiso para compartir la información

Usted no tiene que compartir la información que aparece arriba, pero para el bien suyo o de sus niños puede ser que lo deseé. Si usted decide no dar permiso, su rechazamiento no afectará de ninguna manera los servicios que recibe de WIC. Cualquier información que se comparta se mantendrá confidencial.

Su firma abajo indica que usted **da permiso** para compartir la información incluída en esta forma con la agencia "referida" listada arriba.

Firma del participante, padre, o guardián

Response from Physician, Health Clinic or Human Services Agency

Please complete, send one copy to the referring agency address, and retain one copy for your files.

Action taken	
Signed	Date

El USDA es un proveedor y empleador que ofrece igualdad de oportunidades.

Waaxda Caafimaadka ee Ohio • Qaybta Adeegga Nafaqada

Dumarka Ilmaha iyo Caruurta(WIC) Taariikhda Caafimaadka ee Ilmaha

Magaca Ilmaha			Taariikhda manta
Magacaaga			Waxaad ilmaha u tahay (96)
Taariikhda Dhalashadaada	Taariikhdii ilmaha la filaayay	Miisaankii Dhalashada	Dhererkii umulaadda (52)
Dhakhtarka Ilmaha? Ruqta		Booqashadii u dambaysay ee dhakhtarka/ ruqta	Ma ku jirtay WIC intaad uurka lahayd <input type="checkbox"/> Haa <input type="checkbox"/> Maya (61)

Fadlan ka jawaab su'aaladaha soo socda.

Ilmahaygu wuu i nuugaa _____ Saacadoodba ama _____ oo jeer maalintii iyo _____ jeer habeenkii <input type="checkbox"/> Naas ma nuugo (71,75)
Xarriiq wixii ku saabsan nuugidda ilmahaaga. <input type="checkbox"/> Nuugid liidata <input type="checkbox"/> Miisaan korodhkiisoo gaabinayaa <input type="checkbox"/> Dhibaatooyin ku saabsan nuugida <input type="checkbox"/> Ilmahayga dhibaato kama haysato nuugida <input type="checkbox"/> Ima nuugo <input type="checkbox"/> waxyaaba kale _____ (56,74)
Weligaa ilmahaaga ma nuujisay? <input type="checkbox"/> Haa <input type="checkbox"/> Maya Weli ma naaskaad u dhigtaa? <input type="checkbox"/> Haa <input type="checkbox"/> Maya Maxaad u joojisey? _____ Intee buu ilmahaagu jirey markaad ka joojisey _____
Ilmahaago sadex ama afar todobaad ma soo hormaray? <input type="checkbox"/> Haa intee todobaad? _____ <input type="checkbox"/> Maya (50)
Xarriiq wixii dhibaatooyin caafimaad oo ilmahaago lahaa. <input type="checkbox"/> Qabsinada <input type="checkbox"/> Cananaqsi <input type="checkbox"/> Ilko/Cirrid <input type="checkbox"/> Iin ku dhalasho <input type="checkbox"/> Miisaan korodh gaabiya <input type="checkbox"/> Cagaarshow <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Waxba (56,68,91,93,94)
Qor liis ilmaha dawadiisa ah. <input type="checkbox"/> Waxba (93)
Ilmahaaga tallaaladii maw dhanyihiin? <input type="checkbox"/> Haa <input type="checkbox"/> Maya <input type="checkbox"/> Ma Oggi
Dhakhtarku ilmahaaga ma ka qaaday dhiig lagaga baadhayo rasaas? <input type="checkbox"/> Haa Natiijooyinka _____ <input type="checkbox"/> Maya <input type="checkbox"/> Ma oogi (21)
Ma nadiifisaa Cirridka ama Ilkaha Ilmahaaga? <input type="checkbox"/> Haa <input type="checkbox"/> Maya
Xariiq wax allaaliyo waxa ilmahaagu Qaato. <input type="checkbox"/> Fiitamiinno (Fitamiin D) <input type="checkbox"/> Dhibco Xadiid ah <input type="checkbox"/> Dhibco Foloraydh ah <input type="checkbox"/> Xawaash <input type="checkbox"/> Wax yaaba kale _____ <input type="checkbox"/> Waxba (30)
Liisto ka samee Cuntada Ilmahaaga Xasaasiyada u Keenta <input type="checkbox"/> Waxba (93)
Imisa jeer buu ilmahaag dabageliska (dhaybarkiiisu) qoyan/ama qalalanyahay? (74)

Haddaad ilmahaaga siisid dhalooyin,maxaa ku jira dhalooyinka?

☐ Caano-naas ☐ Foormula Waa tee? ☐ Dhalooyin lama siiyo

imisa wiqiyadood halkii nuujinba? Intee jeer weeye nuujintu? (38)

Haddii aad isku qastid foormulada biya nooc ee ah baad isticmaashaa?

☐ Ceel ☐ Magaalo ☐ Biyo karsan ☐ Biyo durdur ☐ Biyaha caruurta ☐ Waxba iskuma qaso

☐ Wax yaaba kale (38)

Ma ka haysataa Dhakhtarkaaga amar gaar ah inaad u qastid ilmahaaga waxyaaba laysku daray?

☐ Haa ☐ Maya (38)

Miyaad wax suaala ah ka qabtaa ilmahaaga waxaad u qastid?

☐ Haa ☐ Maya (38)

Haddaad u adeegsatid Ilmaahaaga Dhalooyinka,xariiq wixii ku saabsan

☐ Waan fara xashaa intaan diyaarin dhalada ☐ Waxaan dib u isticmaalaa dhalooyin hore loo adeegsadey
☐ Waan kariyaa dhalooyinka iyo cinjirka/ibta ☐ Waxaan ku maydhaa dhalooyinka biyo kulul oo saabuun leh
☐ Waxaan adeegsadaa microwaveka si aan dhalooyinka u diiriyo. ☐ Dhalooyin wax kuma siiyo (38)

Waxaan ahayn Canaha naaska ama kuwa isku darka ah,maxaad kale oo aad ku riddaan dhalooyinka?

☐ Dareeraha Karo ☐ Juus ☐ Punch/Cabitaan khudrad macaan laga sameeyey ☐ Caana lo'aad ☐ Jell® Biyo
☐ Sonkor ☐ Biyo ☐ xumbo badan oon khamri ku jirin ☐ Caana idaad /riyaad ☐ Shaah/koofi
☐ Siirial ☐ Malab ☐ Gatorade® ☐ Kool Aid® ☐ Carruureed
☐ Waxyaabo kale ☐ Waxba (36,38)

Waxaad ku samaysaa calaamad inta ku hkusaysaa

☐ Ilmaha qaaddaa lagu siiyaa cuntada ☐ Ilmuhu wuxuu adeegsadaa mujuruc uu nuugo
☐ Ilmuhu koob buu wax ka cabaa ☐ Ilmaha cinjirka naaska maaweeladaa afka loo geliyaa
☐ Ilmuhu isagaa wax cuna ☐ Ilmuhu dhaluu sariirta ula baxaa
☐ Ilmaha dhaladaa afka loo geliyaa markuu wax cunaayo ☐ Ilmaha badanaa dibadaa wax lagu siiyaa (36,38)

Haddi ilmahaagu bilaabay cuntooyinka soo socda,intee jir buu ku bilaabay

Siiriyal_____ Khudrad_____ Khudrad macaan_____ Juice_____ Hilib_____ Cunto caadi ah_____
Macmacaanka cunta dabadeeda ah_____ Caana lo'aad_____ (36,38)

Aqalkiinu ma leeyahay shoolad shaqaynaysa ama maikarowaf iyo qaboojiso?

☐ Haa ☐ Maya (38)

Haddi cid sigaarka cabtaa ku nooshahay aqalkiina, halkee bay ku cabaan sigaarka?

☐ Gudaha ☐ Dibada ☐ Gaadhiga ☐ Cidina ma cabto (46)

Lixdii bilood ee u danbeeyey, ilmahaaga jidh, galmo ama hadal cidina maku bahastey ama ma la halleeyey?

☐ Haa ☐ Maya (67)

Wax suaalo ah ama walaacyo ah ma qabtaa?

Waaxda Caafimaadka ee Ohio • Qaybta Adeegga Nafaqada
Dimarka Ilmaha Caruurta (WIC) Taariikhda Caafimaadka ee Dumarka Uurka Leh

Magaca			Taariikhda Maanta		D'da (39,40)
Maalinta lagu	Miisaanka uurka (12,13)	Tirada uurarkii (39)	Inta ilma Noel (45)	Taariikhdiisii uurka ugu dambeeyay (43)	
Dkakhtarka ama Rugta			Intay qaadatay booqashadii ugu dambaysay (16)		

Haddaanay ahayn markii kuugu horreysay uurka, buuxi qaybta 1 iyo tan 2. Buuxi qaybta 2 hadduu yahay uurkii kuugu horreeyay.

Qaybta 1

Hadda ma nuujisa? <input type="checkbox"/> Haa <input type="checkbox"/> Maya (69)
Weligaa hore maw nuujisay? <input type="checkbox"/> Haa <input type="checkbox"/> Maya Haddad Haa tiri, maxaad u joojisay? _____ Imisuu jiray ilmahaagu markaad joojisay? _____
Wax dhibaata ah ma ku qabtay uurarkii hore? <input type="checkbox"/> Haa <input type="checkbox"/> Maya Haddaad haa, tiri, sheeg: _____ (44,45)
Xariiq haddaad dhashay ilma miisaankiisu yahay mid ka mida ah kuwan. <input type="checkbox"/> 5 Rodol iyo 8 wiiqyadood. <input type="checkbox"/> 9 iyo wixii ka badan <input type="checkbox"/> Midna (22,49)
Ma dhashay cunug ka hor maray wakhtigiisii saddex wiig ama ka badan? <input type="checkbox"/> Haa, Imisa wiig: _____ <input type="checkbox"/> Maya (49)
Ma dhashay ilme dhibaatooyin caafimaad qabay? <input type="checkbox"/> Haa <input type="checkbox"/> Maya Haddaad haa tiri, sharax: _____ (23)

Qaybta 2

Xariiq dhibaatooyinkaad kala kulantay uurkan. <input type="checkbox"/> Wadne kululaada <input type="checkbox"/> Cunta xumo <input type="checkbox"/> Mantag <input type="checkbox"/> Suban <input type="checkbox"/> Labalabo <input type="checkbox"/> Calooshoo taagan <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Midna (44)
Xariiq dhibaatooyinka kaa haysta xagga caafimaadka. <input type="checkbox"/> Sunkorow/kaadi macaan <input type="checkbox"/> Isku buuq <input type="checkbox"/> Ilkaha <input type="checkbox"/> Dhiig kar <input type="checkbox"/> Isaka xejin la'aan sonkorta caanaha ku jirta <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Midna (44,91,93,94)
Wax miisan ahe ma kaa dhinmay intaad uurka lahayd? <input type="checkbox"/> Haa Imisa? _____ <input type="checkbox"/> Maya. (10)
Qor daawooyinka aad qaadatid oo dhan (medicines) <input type="checkbox"/> Ma qaato. (93)
Xariiq waxyaabaha cuntada lagu kabo aad qaadatid. <input type="checkbox"/> Fiitamiinada dhalmaada ka hor <input type="checkbox"/> Fiitamiino caadi ah <input type="checkbox"/> Xadiid <input type="checkbox"/> Xawaashka dhirta <input type="checkbox"/> Kaalshiyam <input type="checkbox"/> Foolig aasid <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Waxba (30)

Takhtarku ma ka baadhay dhiiggaaga maadada rasaasta?			
<input type="checkbox"/> Haa	Natiijada _____	<input type="checkbox"/> Maya	<input type="checkbox"/> Ma oggi (21)
Cunta gaar ah miyaad qaadataa?			
<input type="checkbox"/> Haa, anaa doortay	<input type="checkbox"/> Haa dhakhtarkaygaa ii qoray	<input type="checkbox"/> Maya	(30,35,91,93)
Qor cuntada xasaasiyadda kugu samaysa			
			<input type="checkbox"/> Waxba (93)
Xariiq waxyaabaha aan cunto ahay ood cuntid ama u hungurootid			
<input type="checkbox"/> Waxa ka samaysan rinjiga	<input type="checkbox"/> Barafka	<input type="checkbox"/> Warqaadaha wax ku daabacan yihiin	<input type="checkbox"/> Wasakh/ciid
<input type="checkbox"/> Staarj(leh kaarboohydarayt)	<input type="checkbox"/> Koofiga qolofitiisa		
<input type="checkbox"/> Wax kale _____			<input type="checkbox"/> Waxba (30)
Xariiq inta kaa khusta oo dhan			
<input type="checkbox"/> Qof kale baa cuntada ii soo gada	<input type="checkbox"/> Anaa cuntadaydaa badanaa soo gata	<input type="checkbox"/> Inta badan guriga wax kama cuno.	
<input type="checkbox"/> Qof kale baa cuntada Karina	<input type="checkbox"/> Anaa cuntadayda badanaaba karsada		
<input type="checkbox"/> Waxaan ku noolahay, xarun dadka lagu hayo, huteel ama meel ku gaar.			
<input type="checkbox"/> Waxaan guriga ku haystaa kan cuntada lagu kariyo ama mykarooowayf iyo tallaajad			
<input type="checkbox"/> Lacag la'aan baa igu dhacda ama koobinta cunta qaadashadaa iga dhammaada oo Cuntaaan waayaa. (66,95)			
Maxaad ka qabtaa habka cunta qaadashadaada?			
Magacaw hal ama laba aad u samaysid jidh-dhis ama jimicsi.			
Imisa siggaar /beeb baad cabtaa/cabijirtay?			
Hadda	_____maalintii	_____wiigii	<input type="checkbox"/> Waxba
Saddexdii bilood ee ugu dambeeyay ee uurkan	_____maalintii	_____wiigii	<input type="checkbox"/> Waxba
Saddex bilood ee uurka ka hor	_____maalintii	_____wiigii	<input type="checkbox"/> Waxba (46)
Haddii cid guriga kugula nooli sigaar cabto, xaggay ku cabbaan?			
<input type="checkbox"/> Guriga gudihiisa	<input type="checkbox"/> Dibadiisa	<input type="checkbox"/> Baabuurka	<input type="checkbox"/> Cina ma cabto (46)
Calaamadee khamriga aad cabtid.			
<input type="checkbox"/> Wayn	<input type="checkbox"/> Beer	<input type="checkbox"/> Koolars	<input type="checkbox"/> Likar
Hadda	_____maalintii	_____wiigii	<input type="checkbox"/> Waxba
Intaan uurka yeeshay	_____maalintii	_____wiigii	<input type="checkbox"/> Waxba
Saddexdii bilood ee uurka ka hor	_____maalintii	_____wiigii	<input type="checkbox"/> Waxba (47,65)
Calaamadee daroogadaad qaadatay intaad uurka lahayd. (drug use)			
<input type="checkbox"/> Marjuwana	<input type="checkbox"/> Kraag	<input type="checkbox"/> Isbiidh	<input type="checkbox"/> LSD <input type="checkbox"/> Heroowiin
<input type="checkbox"/> Kiristal meth	<input type="checkbox"/> Inheelaantis	<input type="checkbox"/> Daawo laysu qoray oo khalad loo qaatay	
<input type="checkbox"/> Wax kale _____			<input type="checkbox"/> Waxba (48,66,93)
Lixdii bilood oo ugu dambaysay wax tacdi ah xoog la adeegsaday, galmo ama caytan ma lagu gaystay?			
<input type="checkbox"/> Haa	<input type="checkbox"/> Maya	(67)	
Wax su'aalada ah ama walaac ah ma qabtaa?			

Waaxda Caafimaadka ee Ohio • Qaybta Adeegga Nafaqada
WIC Taariikhda Caafimaadka Dumarka Nuujiya iyo Umulaha

Magaca		Taariikhda manta		Da'da (39,40)
Taariikhda uurkani dhamaaday	Marka la sugayay (49)	Miisaankaaga markaad dhalaysay	Miisaankaaga uurka ka hor (11)	
Mid xariiq <input type="checkbox"/> Dhalashada mid nool ____ rodol ____ wiiyadood <input type="checkbox"/> Dhalashad mid mayd ah <input type="checkbox"/> Dhicis <input type="checkbox"/> Laga soo saaray <input type="checkbox"/> Ilma dhinta (22,45,49)				
Inta jeer aad hore u uuraysatay (39)	Imisaa nolol ku dhashay (42)	Taariikhda uurkii ugu dambeeyay dhammaaday (43)		
Dhakhtarka ama Xarunta umulaha.		Taariikhdii ugu dambaysay ee booqashada dhakhtarka.		

Haddaad hadda nuujinaysid, buuxi qaybta 1 iyo 2, haddaanad nuujin buuxi qaybta labaad.

Qaybta 1

Cunuggaygu wuxuu jaqaa Hal mar ____ saacadoodaba ama ____ jeer maalintii iyo ____ jeer habeenkii Dhanwalba intee jeer? ____ (70)	
Haddii ilmahaaga dhalo wax lagu siiyo Maxaa ku jira dhalada? ____ Imisa jeer? ____	
Ma qabtaa dhibaatooyinkan? <input type="checkbox"/> Caana hibitaqa <input type="checkbox"/> Naasa adag oo kulul <input type="checkbox"/> Qabsashada <input type="checkbox"/> Xanuun naasaha ah <input type="checkbox"/> Barar ibta ah <input type="checkbox"/> Wax kale ____ <input type="checkbox"/> Wax dhibaato ah ma qabo (74)	
Ilaa goormaad rabtaa inaad ilmahaaga naaska ku wadid?	
Shaqo ama dugsi ma ku laabanaysaa? <input type="checkbox"/> Haa, Goorma? ____ <input type="checkbox"/> Maya	
Maxaa guriga kuu yaal oo ka caawiya nuujinta? Ma u baahan tahay caawimaad dheeraad ah? <input type="checkbox"/> Haa <input type="checkbox"/> Maya	

Qaybta 2

Weligaa ilmahaaga ma nuujisay? <input type="checkbox"/> Haddaan nuujinayaa <input type="checkbox"/> Haa <input type="checkbox"/> Maya Maxaad u joojisay? ____ Meequu jiray markaad ka joojisay? ____	
Ma lagugu soo qalay? <input type="checkbox"/> Haa <input type="checkbox"/> Maya (93)	
Sheeg dhibaatooyinkaad kala kulan tay Uuurkan ____ Uurarkii hore ____ <input type="checkbox"/> Waxba (44)	
Xariiq dhibaatooyinka kaa haysta xagga caafimaadka. <input type="checkbox"/> Sunkorow/kaadi macaan <input type="checkbox"/> Isku buuq <input type="checkbox"/> Ilkaha <input type="checkbox"/> Dhiig kar <input type="checkbox"/> Isaka xejin la'aan sonkorta caanaha la helo <input type="checkbox"/> Wax kale ____ <input type="checkbox"/> Midna (91,93,94)	
Qor waxaad daawooyin qaadatid (93)	

Takhtarku ma ka baadhay dhiiggaaga rasaasta?			(21)
<input type="checkbox"/> Haa natijada _____ <input type="checkbox"/> Maya <input type="checkbox"/> Ma ogi			
Weligaa ma dhashay ilme sagall rodol ama ka badan ah.			(22,49)
<input type="checkbox"/> Haa <input type="checkbox"/> Maya			
Cunugaagu saddex wiig ama ka badan ma ka soo horeeyay wakhtigiisii?			(49)
<input type="checkbox"/> Haa Imisa wiig? _____ <input type="checkbox"/> Maya			
Cunugaagu wax dhibaato caafimaad ah ma ku dhashay?			(23)
<input type="checkbox"/> Haa <input type="checkbox"/> Maya Haddaad haa tiri, sharax _____			
Xariiq waxa cuntada lagu kabo oo dhan aad qaadatid			(30)
<input type="checkbox"/> Fiitamiinada umulaha/fiitamiino <input type="checkbox"/> Xadiid <input type="checkbox"/> xawaash <input type="checkbox"/> Kaalshiyum <input type="checkbox"/> wax kale _____ <input type="checkbox"/> Waxba			
Ma cunto gaar ah baad qaadataa?			(30,35,91,93)
<input type="checkbox"/> Haa anaa doortay <input type="checkbox"/> Haa dhakgtarkaa ii qoray <input type="checkbox"/> Maya			
Qor cuntadaad ku leedahay xasaasiyad			(93)
<input type="checkbox"/> Midna			
Xariiq waxaa ka mid kuwan oo la cunin aad cuntid ama u hunurootid			(30)
<input type="checkbox"/> Waxyaabaha rinjiga <input type="checkbox"/> Barafka <input type="checkbox"/> Warqaadah daabacan <input type="checkbox"/> Wasakhda/ciida <input type="checkbox"/> Istaarjka <input type="checkbox"/> Qolofa kaafiga <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Midna			
Xariiq inta kaa hkusta.			(66,95)
<input type="checkbox"/> Qofkale baa cuntada ii soo gada <input type="checkbox"/> anaa cuntadayda soo gata <input type="checkbox"/> Badanaa anaa kariya <input type="checkbox"/> Badanaa guriga wax kama cuno <input type="checkbox"/> Qofkale baa cuntada Karina <input type="checkbox"/> waxaan ku noolahay shatar,huteel,meel ku gaadh <input type="checkbox"/> Guriga waxaa ii taal shoolad shaqaynaysaa ama mykroowayf iyo tallaajad. <input type="checkbox"/> Lacagta iyo koobinka cuntadu waa iga dhamaadan oo cunto la'aan baa igu dhacda			
Fikradee baad ka qabtaa habka cunta qaadashadaada?			
Sheeg mid ama laba jidh-dhis, ama jimicsi			
Imisa sigaar ah,beeb ah sigaarka weyn baad cabtaa/cabi jirtay?			(8,46)
Hadda _____ Maalintii _____ wiigii <input type="checkbox"/> Waxba Saddexdii bilood ee ugu dambeeyay uurkan _____ Maalintii _____ wiigii <input type="checkbox"/> Waxba Saddexdii bilood ee ka horeyaya uurkan _____ Maalintii _____ wiigii <input type="checkbox"/> Waxba			
Haddii cid kula nooli sigaar cabto,xaggay ku cabbaan?			(46)
<input type="checkbox"/> Gudaha <input type="checkbox"/> dibada <input type="checkbox"/> baaruurka <input type="checkbox"/> Cidna ma cabto			
Xariiq alkohoolkaad cabtid			(47,66)
<input type="checkbox"/> Wayn <input type="checkbox"/> Biir <input type="checkbox"/> Kuulars <input type="checkbox"/> Likar Hadda _____ maalintii _____ wiigii <input type="checkbox"/> Waxba Saddexdii bilood ee ugu dambeeyay uurkan _____ maalintii _____ wiigii <input type="checkbox"/> Waxba Saddexdii bilood ee ka horeyaya uurkan _____ maalintii _____ wiigii <input type="checkbox"/> Waxba			
Xariiq daroogooyinkaad qaadatid			(48,66,93)
<input type="checkbox"/> Marijuwana <input type="checkbox"/> Kraak <input type="checkbox"/> Isbiidh <input type="checkbox"/> LSD <input type="checkbox"/> heroowin <input type="checkbox"/> Kiristal Meth <input type="checkbox"/> Inhaylars <input type="checkbox"/> Dawooyin layso qoro(khalad loo isticmaalay) <input type="checkbox"/> Waxkale _____ <input type="checkbox"/> Waxba			
Saddexdii bilood ee ugu dambaysay cidi tacadi ma kugu samaysay xag xoog,galmo ama af.			(67)
<input type="checkbox"/> Haa <input type="checkbox"/> Maya			
Ma qabtaa wax su'aale ah ama walaacya ah?			

Waaxda Caafimaadka ee Ohio • Agaasinka adeegyada Nafaqada
Dumarka ilmaha iyo Caruurta(WIC) Taariikhda Caafimaadka ee Caruurta 1-5 Jirta

Magaca ilmaha		Taariikhda manta
Mgacaaga		Waxaad isu tihiin (96)
Taariikhda ilmuhu dhashay	Miisaankuu ahaa (51,59)	Dhererkuu ahaa
Dhakhtarka ilmaha ama rugta Caafimaadka		Booqashadii ugu dambaysay dhakhtarka

Fadlan ka jawaab su'aaladaha soo socda.

Cunugaaga weli naas ma jaqay? <input type="checkbox"/> Weli wuu jaqayaa <input type="checkbox"/> Haa <input type="checkbox"/> Maya <input type="checkbox"/> Ma oggi Maxaad uga joojisay? _____ Meequu jiray markaad ka joojisay? _____	
Cunugaagu ma saddex wiig ama ka badan ka hor buu dhashay? <input type="checkbox"/> Haa imisa wiig? _____ <input type="checkbox"/> Maya (50)	
Fadlan xariiq dhibaatooyinka caafimaadka ilmahaaga oo dhan. <input type="checkbox"/> Xiiq(Neef) <input type="checkbox"/> Isku buuq <input type="checkbox"/> Ilkaha/Ciridaka <input type="checkbox"/> kala dhantaanaan uu ku dhashay <input type="checkbox"/> Sonkorta caanaha aanu u adkaysan <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Waxba (68,91,93,94)	
Qor daawooyinka cunugu qaato. <div style="text-align: right;"><input type="checkbox"/> Waxba (93)</div>	
Tallaalada si wakhtiyaysan ma u qaatay? <input type="checkbox"/> Haa <input type="checkbox"/> Maya <input type="checkbox"/> Ma oggi	
Dhakhtarku dhiigga ilmaha maadada rasaasta ma ka baadhay? <input type="checkbox"/> Haa <input type="checkbox"/> Natijada _____ <input type="checkbox"/> Maya <input type="checkbox"/> Ma oggi (21)	
Ilmahaaga dhakhtarka ilkuhu ma arkay? <input type="checkbox"/> Haa <input type="checkbox"/> Maya	
Cunugga ma loo rumeeyaa? <input type="checkbox"/> Haa <input type="checkbox"/> Maya	
Xaggaad biyaha ka qaadataa? <input type="checkbox"/> Ceel <input type="checkbox"/> Magaalada <input type="checkbox"/> Dukaan baan ka gataa <input type="checkbox"/> Meel kale _____	
Xariiq waxa cunuggu qaato oo dhan <input type="checkbox"/> Fiitamiino <input type="checkbox"/> Xawaash <input type="checkbox"/> Xadiid <input type="checkbox"/> Foloraydh <input type="checkbox"/> Wax kale _____ <input type="checkbox"/> Waxba (30)	
Qor waxa cunuggaagu ka qabo xasaasiyad <div style="text-align: right;"><input type="checkbox"/> Waxba (93)</div>	
Cunuggaaga ma cunta gaar ah baa la siiyaa? <input type="checkbox"/> Haa, anaa u dooray <input type="checkbox"/> Haa, Dhakhtarkaa u qoray <input type="checkbox"/> Maya (30,35,91,93)	
Cunuggaaga ma foormulaa la siiyaa? <input type="checkbox"/> Haa Tee? _____ <input type="checkbox"/> Maya (91,93)	

Xariiq inta ka khusta cunuggaaga.

☐ Koob buu ka cabbaa

☐ Dhaluu ka cabbaa

☐ Sariirtuu taga isagoo dhalo ama koob wata

☐ Wuxuu socdaa isgoo dhalo ama koob wata

☐ Tuubaa lagu quudiya.

(36,94)

Cuntadee buu diidaa cunuggaagu?

☐ Waxba

(35)

Fadlan xariiq waxaan cunto ahayn oo cunuggaagu cuno.

☐ Warqaadha daabacan

☐ Alaabta rinjiga

☐ Wasakhda

☐ Ciidda

☐ Barafka

☐ Wax kale

☐ Waxba

(30)

Xariiq waxa khusa

☐ Cunuggu iskiis buu wax u cunaa

☐ Cunuggu badanaaba wax kama cuno guriga

☐ Lacgata iyo koobinka cuntada baa iga madhata oo cuntaan waayaa

☐ Cunuggu wuxuu ku noolyahay meel dad badani ku nool yihiin,huteel ama meel ku gaadh meel ah.

☐ Cunuggu wuxuu qabaa dhibaatooyin cunid/calaalin/leqid.

☐ Waxaan guriga ku haystaa wax wax lagu kariyo oo shaqaynaya ama mykroowayf iyo Tallaajad.

(37,66,94,95)

Sidaad u aragtaa cunta qaadashada cunuggaaga?

Imisa saacadood buu cunuggaagu firfircoon yahay?

☐ Wax saacad ka yar

☐ Hal ilaa laba saacadood

☐ Saddex ama ka badan

Haddii cid guriga kugula nooli cabto sigaarka, halkay ku cabbaan?

☐ Gudaha guriga

☐ Dibedda

☐ Gaariga

☐ Cidna ma cabto

(46)

Lixdii bilood ee ugu dambaysay cidi aflagaado,gacan ka hadal iyo galmo ma u gaysatay?

☐ Haa

☐ Maya

(67)

Wax su.aalado ama walaac ah ma qabtaa?

**AGENCY – BASED REGISTRATION
VOTER REGISTRATION TRANSMISSION FORM**

Agency Name: _____

Agency Address: _____
(local address) _____

Transmission Date: _____

Number of Registration Forms: _____

For Board Use
Only / Duplicates

Agency Designee Signature: _____

Title: _____

Phone Number: _____

COMMENTS: _____

A Designated Voter Registration Agency Notice of Rights

Agency Name

To Our Participants:

- 1. You have been provided with a voter registration application.
Do you want to register or update your current voter registration? ___ Yes or ___ No

If you do not check either box, you will be considered to have decided not to register to vote at this time.

- 2. Applying to register or declining to register to vote will not affect the amount of assistance or the extent of the service that you will be provided by this agency.
- 3. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours.
- 4. If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register, or in applying to register to vote, you may file a complaint with:

(name of county prosecutor)

Ohio Secretary of State
180 E. Broad St., 15th floor
Columbus, OH 43215
614-466-2585

(address of county prosecutor)

(telephone number of county prosecutor)

5. If you have not received any verification of your voter registration from the county board of elections where you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections at this phone number: _____.
-

Application for Health Coverage & Help Paying Costs

ODM 07216 (7/2014)

THINGS TO KNOW



Use this application to see what you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)



Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



Apply faster online

Apply faster online at HealthCare.gov or benefits.Ohio.gov.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, visit: <http://medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/NoticeofPrivacyPractices.aspx>



What happens next?

Send your complete, signed application to your local County Department of Job & Family Services office. Find your county office here: jfs.ohio.gov/County/County_Directory.pdf
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call **(800) 324-8680**. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- **Online:** HealthCare.gov or benefits.Ohio.gov
- **Phone:** Call the Medicaid Consumer Hotline at **(800) 324-8680**.
- **In person:** Contact your local County Department of Job & Family Services office.
- **En Español:** Llame a nuestro centro de ayuda gratis al **(800) 324-8680**.



NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or benefits.Ohio.gov or call us at **(800) 324-8680**. Para obtener una copia de este formulario en Español, llame **(800) 324-8680**. If you need help in a language other than English, call **(800) 324-8680** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **(800) 292-3572**.

THIS PAGE INTENTIONALLY LEFT BLANK.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number () -		15. Other phone number () -	
16. Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address: _____			
17. What is your preferred spoken or written language (if not English)?			

18. VOTER REGISTRATION APPLICATION ATTACHED - ASSISTANCE AVAILABLE

If you are not registered to vote where you live now, would you like to apply to register to vote today?

☐ YES, I want to register. ☐ NO, I do not want to register to vote.

If you do not check either box, you will be considered to have decided not to register to vote at this time.

19. For which programs would you like to apply? (Please check). For information about these programs, please see Appendix D.

- | | |
|--|--|
| <input type="checkbox"/> Healthy Start & Healthy Families (Medicaid) | <input type="checkbox"/> Nutritional Program for Women, Infants & Children (WIC) |
| <input type="checkbox"/> Child & Family Health Services (CFHS) | <input type="checkbox"/> Bureau for Children with Medical Handicaps (BCMH) |
| <input type="checkbox"/> Help Me Grow | |

STEP 2 Tell us about your family.

Who do you need to include on this application? Tell us about them.

If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you
- Anyone else who lives with you but is temporarily absent and there is a definite plan for their return.

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage, unless you have a common child who lives with you.
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix	2. Relationship to you? SELF
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

5. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES.** If yes, please answer questions a-c. ☐ **NO.** If no, skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No


If yes, please list the name of the tax filer: _____


How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. If yes, how many babies are expected during this pregnancy? _____

What is your expected due date? _____

8. Do you want health coverage? Even if you have insurance, there might be a program with better coverage or lower costs.

☐ **YES.** If yes, answer all the questions below. 

☐ **NO.** If no, SKIP to the income questions on page 3. 
Leave the rest of this page blank.

9. Do you have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. If you aren't a U.S. citizen or U.S. national, but you have immigration documents, please provide the following:

a. Alien number _____

b. Document type _____ c. Document ID number _____

d. Have you lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

e. Are you, your spouse, or your parent a veteran or an active duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. If you live with at least one child under the age of 19, are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
				<input type="checkbox"/> Other _____

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**

If you're currently employed, tell us about your income. Start with question 18.

☐ **Self-employed**

Skip to question 27.

☐ **Not employed**

Skip to question 28.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number

() -

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number

() -

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

25. Average hours worked each WEEK

26. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits, once business expenses are paid) from this self-employment will you get this month?

\$

28. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often you receive it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment \$ How often?

☐ Pensions \$ How often?

☐ Social Security \$ How often?

☐ Retirement accounts \$ How often?

☐ Alimony received \$ How often?

☐ Net farming/fishing \$ How often?

☐ Net rental/royalty \$ How often?

☐ Other income \$ How often?

Type:

29. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often you receive it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid \$ How often?

☐ Student loan interest \$ How often?

☐ Other deductions \$ How often?

Type:

30. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person. ➡

Your total income this year

\$

Your total income next year (if you think it will be different)

\$

THANKS! Please complete STEP 2: Person 2 for anyone else listed in the "Do Include" column on Page 1.

STEP 2: PERSON 2

If you have more than two people to include, use copies of Appendix E to provide information about additional people for this application.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you																				
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female																					
5. Social Security number (SSN) ____ - ____ - ____ We need this if you want health coverage and have an SSN.																						
6. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: _____																						
7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.) <input type="checkbox"/> YES. If yes, please answer questions a-c. <input type="checkbox"/> NO. If no, skip to question c. a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ b. Will PERSON 2 claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s) of dependents: _____ c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____																						
8. Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, how many babies are expected during this pregnancy? _____ What is your expected due date? _____																						
9. Does PERSON 2 want health coverage? Even if they have insurance, there might be a program with better coverage or lower costs. <input type="checkbox"/> YES. If yes, answer all the questions below. <input type="checkbox"/> NO. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.																						
10. Does PERSON 2 have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No																						
11. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No																						
12. If PERSON 2 isn't a U.S. citizen or U.S. national, but has immigration documents, please provide the following: a. Alien number _____ b. Document type _____ c. Document ID number _____ d. Has PERSON 2 lived in the U.S. since August 22, 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Is PERSON 2, their spouse, or their parent a veteran or an active duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No																						
13. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. If PERSON 2 lives with at least one child under the age of 19, are they the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Was PERSON 2 in foster care at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Please answer the following questions if PERSON 2 is 22 or younger:																						
16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, end date: _____ b. Reason the insurance ended: _____																						
17. Is PERSON 2 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No																						
18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____																						
19. Race (OPTIONAL—check all that apply.) <table style="width: 100%;"><tr><td><input type="checkbox"/> White</td><td><input type="checkbox"/> American Indian or Alaska Native</td><td><input type="checkbox"/> Filipino</td><td><input type="checkbox"/> Vietnamese</td><td><input type="checkbox"/> Guamanian or Chamorro</td></tr><tr><td><input type="checkbox"/> Black or African American</td><td><input type="checkbox"/> Asian Indian</td><td><input type="checkbox"/> Japanese</td><td><input type="checkbox"/> Other Asian</td><td><input type="checkbox"/> Samoan</td></tr><tr><td></td><td><input type="checkbox"/> Chinese</td><td><input type="checkbox"/> Korean</td><td><input type="checkbox"/> Native Hawaiian</td><td><input type="checkbox"/> Other Pacific Islander</td></tr><tr><td></td><td></td><td></td><td></td><td><input type="checkbox"/> Other _____</td></tr></table>			<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan		<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander					<input type="checkbox"/> Other _____
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro																		
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan																		
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander																		
				<input type="checkbox"/> Other _____																		

Now, tell us about any income from PERSON 2 on the back.

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**

If you're currently employed, tell us about your income. Start with question 20.

☐ **Self-employed**

Skip to question 29.

☐ **Not employed**

Skip to question 30.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

() - -

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

() - -

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

27. Average hours worked each WEEK

28. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$

30. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often you receive it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment \$ How often?

☐ Pensions \$ How often?

☐ Social Security \$ How often?

☐ Retirement accounts \$ How often?

☐ Alimony received \$ How often?

☐ Net farming/fishing \$ How often?

☐ Net rental/royalty \$ How often?

☐ Other income \$ How often?

Type:

31. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often PERSON 2 receives it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid \$ How often?

☐ Student loan interest \$ How often?

☐ Other deductions \$ How often?

Type:

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income this year

\$

PERSON 2's total income next year (if you think it will be different)

\$

THANKS! This is all we need to know about PERSON 2.

STEP 3 American Indian or Alaska Native family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

- ☐ If No, skip to Step 4.
- ☐ Yes. If yes, please also complete Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

☐ YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

- | | |
|--|---|
| <input type="checkbox"/> Medicaid _____ | <input type="checkbox"/> Employer insurance: _____ |
| <input type="checkbox"/> CHIP _____ | Name of health insurance: _____ |
| <input type="checkbox"/> Medicare _____ | Policy number: _____ |
| <input type="checkbox"/> TRICARE (Don't check if you have direct care or Line of Duty) _____ | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> VA health care programs _____ | <input type="checkbox"/> Other |
| <input type="checkbox"/> Peace Corps _____ | Name of health insurance: _____ |
| | Policy number: _____ |
| | Is this a limited-benefit plan (like a school accident policy)? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse (including a parent or spouse not included on this application).

- ☐ YES. If yes, you'll need to complete and include Appendix A.
- ☐ NO. If no, continue to Step 5.

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Ohio Department of Medicaid if anything changes (and is different than) what I wrote on this application. I can call 1-800-324-8680 to report any changes within 10 days. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

Check one of the following:

- ☐ I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).
- ☐ _____ is incarcerated (detained or jailed).
(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

STEP 5

Read & sign this application: continued

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Ohio Department of Medicaid or Marketplace to use income data, including information from tax returns.

The Ohio Department of Medicaid or the Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my/our eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I authorize any person who furnishes health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Healthy Start, Healthy Families Medicaid program, WIC, and medical assistance programs. I also authorize the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, and the Ohio Department of Health to exchange any information I have provided on this form, to enable the departments to determine my eligibility.

My right to appeal

If I think the Ohio Department of Medicaid or the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Ohio Department of Medicaid or the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Ohio Department of Medicaid at 1-800-324-8680. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature

Date (mm/dd/yyyy)

STEP 6

Mail completed application.

Mail your complete, signed application to your local County Department of Job & Family Services office.

 Find your local office by visiting this link: jfs.ohio.gov/County/County_Directory.pdf

You can complete the voter registration form attached to this application.

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Health Coverage from Jobs

You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last, Suffix)	2. Employee Social Security number _____ - _____ - _____
--	---

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____	
5. Employer address		6. Employer phone number (_____) _____ - _____	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) (_____) _____ - _____		12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).



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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last, Suffix)

2. Social Security Number

____ - ____ - ____



EMPLOYER Information

Ask the employer for this information.

3. Employer name

4. Employer Identification Number (EIN)

____ - ____ - ____

5. Employer address (the Marketplace will send notices to this address)

6. Employer phone number

() -

7. City

8. State

9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)

12. Email address

() -

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

APPENDIX B

Ohio Department of Medicaid
ODM 07216 - B (7/2014)

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	<div>First Middle</div> <div>Last</div>	<div>First Middle</div> <div>Last</div>
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	<div>\$ _____</div> <div>How often? _____</div>	<div>\$ _____</div> <div>How often? _____</div>



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Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local County Department of Job and Family Services. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name, Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)



HEALTH COVERAGE PROGRAMS

Ohio offers families a variety of options for getting health care services. Below is a brief description of four publicly funded programs that are available throughout Ohio. Families can apply for one or all of the following programs by using the attached application.

Healthy Start and Healthy Families

The Healthy Start and Healthy Families programs offer free or low-cost health coverage to families, children (up to age 19) and pregnant women. Certain young adults meeting specific criteria may be covered up to age 21.

Coverage includes: doctor visits, hospital care, pregnancy-related services, prescriptions, vision, dental, substance abuse treatment, mental health services and much more! These are important health care services that your family needs to stay healthy and strong. Healthy Start and Healthy Families are Medicaid programs administered by the Ohio Department of Medicaid. For more information, please call 1-800-324-8680 or visit medicaid.ohio.gov.

Women, Infants & Children (WIC)

The Women, Infants, and Children (WIC) program provides nutritious foods, important nutrition information, and breastfeeding education and support. It also helps eligible families find health care or other services they need. To be eligible for WIC, you must be a woman who is pregnant or breastfeeding or have a baby less than six months old. Children from birth to age 5 also qualify. Families must meet WIC income and medical or nutritional risk guidelines. To apply, complete the attached application or visit your local WIC clinic. The WIC program is administered by the Ohio Department of Health.

Child & Family Health Services (CFHS)

The Child and Family Health Services (CFHS) program in your area may provide one or more of the following services: child and adolescent health care and prenatal care. Clinics offer physicals, nutrition counseling, social services, laboratory tests, health education and more. The cost of the clinic services is based on your family size and income but no one is turned away from services if they cannot pay. To apply, please complete the attached application or visit your local CFHS. This program is administered by the Ohio Department of Health.

Children with Medical Handicaps (BCMh)

The Children with Medical Handicaps program (BCMh) is a health care program providing services for children with special health care needs. To receive BCMh services, a child must be an Ohio resident younger than age 21 and be under the care of a BCMh-approved doctor. Families must also meet income eligibility criteria. BCMh works closely with public health nurses in local health departments to identify and coordinate services for children with medically handicapping conditions and their families. For more information, families can contact their local health department or call (800) 755 - GROW (4769). This program is administered by the Ohio Department of Health.

Help Me Grow (HMG)

The Help Me Grow Home Visiting program provides parenting education for pregnant women and first time mothers. The program helps families with young children connect with resources so that children start school healthy and ready to learn. The Help Me Grow Early Intervention program provides services to families with children birth to age three with developmental disabilities. Services are coordinated and families are connected to services which build the parent's ability to enhance their child's development so that children with disabilities or delays in development start school healthy and ready to learn.



Those who are interested in getting cash assistance through Ohio Works First or getting Food Assistance should contact their local County Department of Job & Family Services.



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APPENDIX E

Ohio Department of Medicaid
ODM 07216 - E (7/2014)

STEP 2

ADDITIONAL PERSON _____ (give this person a number)

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security number (SSN) _____ We need this if you want health coverage and have an SSN.		
6. Does this person live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: _____		
7. Does this person plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don't file a federal income tax return.) <input type="checkbox"/> YES. If yes, please answer questions a-c. <input type="checkbox"/> NO. If no, skip to question c. a. Will this person file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ b. Will this person claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s) of dependents: _____ c. Will this person be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ How is this person related to the tax filer? _____		
8. Is this person pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, how many babies are expected during this pregnancy? _____ What is the expected due date? _____		
9. Does this person want health coverage? Even if they have insurance, there might be a program with better coverage or lower costs. <input type="checkbox"/> YES. If yes, answer all the questions below. <input type="checkbox"/> NO. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.		
10. Does this person have any physical, mental, or emotional health condition(s) that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Is this person a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. If this person isn't a U.S. citizen or U.S. national, but has immigration documents, please provide the following: a. Alien number _____ b. Document type _____ c. Document ID number _____ d. Has this person lived in the U.S. since August 22, 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Is this person, their spouse, or their parent a veteran or an active duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Does this person want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. If this person lives with at least one child under the age of 19, are they the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Was this person in foster care at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please answer the following questions if this person is 22 or younger:		
16. Did this person have insurance through a job and lose it within the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, end date: _____ b. Reason the insurance ended: _____		
17. Is PERSON 2 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____		
19. Race (OPTIONAL—check all that apply.) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> White</div> <div style="width: 33%;"><input type="checkbox"/> American Indian or Alaska Native</div> <div style="width: 33%;"><input type="checkbox"/> Filipino</div> <div style="width: 33%;"><input type="checkbox"/> Vietnamese</div> <div style="width: 33%;"><input type="checkbox"/> Guamanian or Chamorro</div> <div style="width: 33%;"><input type="checkbox"/> Black or African American</div> <div style="width: 33%;"><input type="checkbox"/> Asian Indian</div> <div style="width: 33%;"><input type="checkbox"/> Japanese</div> <div style="width: 33%;"><input type="checkbox"/> Other Asian</div> <div style="width: 33%;"><input type="checkbox"/> Samoan</div> <div style="width: 33%;"><input type="checkbox"/> Chinese</div> <div style="width: 33%;"><input type="checkbox"/> Korean</div> <div style="width: 33%;"><input type="checkbox"/> Native Hawaiian</div> <div style="width: 33%;"><input type="checkbox"/> Other Pacific Islander</div> <div style="width: 33%;"><input type="checkbox"/> Other _____</div> </div>		

Now, tell us about any income from ADDITIONAL PERSON _____ on the back.



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STEP 2**ADDITIONAL PERSON****Current Job & Income Information**☐ **Employed**

If this person is currently employed, tell us about their income. Start with question 20.

☐ **Self-employed**

Skip to question 29.

☐ **Not employed**

Skip to question 30.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

() - -

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

23. Average hours worked each WEEK

CURRENT JOB 2: (If this person has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

() - -

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

\$

27. Average hours worked each WEEK

28. In the past year, did this person: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will this person get from this self-employment this month?

\$

30. **OTHER INCOME THIS MONTH:** Check all that apply. Tell us the amount and how often this person receives it.**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).☐ None☐ Unemployment \$ How often?☐ Pensions \$ How often?☐ Social Security \$ How often?☐ Retirement accounts \$ How often?☐ Alimony received \$ How often?☐ Net farming/fishing \$ How often?☐ Net rental/royalty \$ How often?☐ Other income \$ How often?

Type:

31. **DEDUCTIONS:** Check all that apply. Tell us the amount and how often this person receives it.

If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

☐ Alimony paid \$ How often?☐ Student loan interest \$ How often?☐ Other deductions \$ How often?

Type:

32. **YEARLY INCOME:** Complete only if this person's income changes from month to month.

If you don't expect changes to this person's monthly income, add another person or skip to the next section.

This person's total income this year:

\$

This person's total income next year (if you think it will be different):

\$

THANKS! This is all we need to know about this ADDITIONAL PERSON.

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Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.

For further information, you may consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Numbers 1 and 2 below are required by law. You must answer **both** of the questions for your registration to be processed.

Registering in Person

If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Registering by Mail

If you register by mail and do not provide either an Ohio driver's license number or the last four digits of your Social Security number, you must enclose with your application a copy of one of the following forms of identification:

Current and valid photo identification, a military identification, or a current (within the last 12 months) utility bill, bank statement, paycheck, government check or government document (other than a notice of voter registration mailed by a board of elections) that shows your name and current address.

Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

Please see information on back of this form to learn how to obtain an absentee ballot.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

FOLD HERE

I am: ☐ Registering as an Ohio voter

☐ Updating my address

☐ Updating my name

1. Are you a U.S. citizen? ☐ Yes ☐ No

2. Will you be at least 18 years of age on or before the next general election? ☐ Yes ☐ No

If you answered NO to either of the questions, do not complete this form.

3. Last Name First Name Middle Name or Initial Jr., II, etc.

4. House Number and Street (Enter new address if changed) Apt. or Lot # 5. City or Post Office 6. ZIP Code

7. Additional Mailing Address or P.O. Box (if necessary) 8. County (where you live)

9. Birthdate (MO-DAY-YR) (required) 10. Ohio Driver's License No. OR Last Four Digits of Social Security no. (one form of ID required to be listed or provided) 11. Phone No. (voluntary)

12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street

Previous City or Post Office County State

13. CHANGE OF NAME ONLY Former Legal Name Former Signature

14.

I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Your Signature ↓

Date ____ / ____ / ____
MO DAY YR

FOR BOARD
USE ONLY
SEC4010 (Rev. 6/14)
City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections. For your county board's address please visit www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

**WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY
OF A FELONY OF THE FIFTH DEGREE.**

Appointment Reminder Card Instructions

A. Setting Up the Clinic information for the Appointment Reminder Cards:

(Please note: Step A only needs to be followed when setting up the clinic information for the first time or when the clinic information needs to be changed. Otherwise, start with Step B.)

1. Click on “Admin” from the top menu bar in the WIC Certification System.
2. Click on “Clinic Maintenance.”

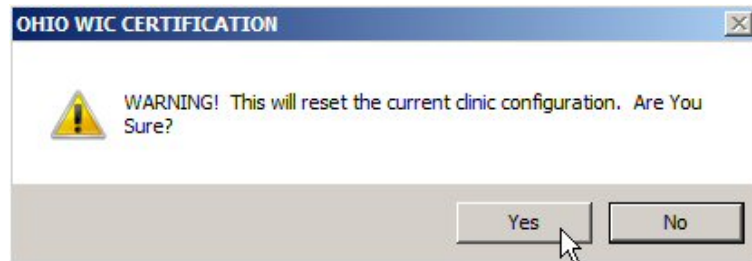
The screenshot shows the 'WIC Main Screen - User STATE logged on'. The 'Admin' menu is open, and 'Clinic Maintenance' is highlighted. Other menu options include 'Begin OF Day', 'End of Day', 'Reprint BOD/EOD Reports', 'Data Transfer Client', 'Browse/Correct FI Sequence', 'Lock/Unlock Participant', 'Mass Upload', 'Dual App Resolution', 'User ID Maintenance', 'FI Rebuild', 'Inquire on FI Stock Range', 'Purge Process', 'Auto Terminate', and 'Create Sys Report Tables'. The main screen also displays fields for Group ID, Name (L,F,M), Address, City, Part ID, Name (L,F,M), Category, Address, City, Status, and various date and time fields.

3. The “Clinic Maintenance” window will appear:

The 'Clinic Maintenance' window displays fields for Clinic ID (09999), Region (1), Clinic Name (WIC CLINIC), Contact Person (WIC STAFF), Clinic Phone Number ((555)555-5555), Clinic Fax Number ((555)555-5550), Send ARS Report To, E-Mail Address (wicclinic@odh.ohio.gov), Hours of Operation (8 am - 5 pm), Days of Operation (Mon-Fri), Mailing Address (123 Anywhere Street, Anytown, OH, 55555), and Physical Address (123 Anywhere Street, Anytown, OH, 55555). A checkbox labeled 'Check if Mailing address is same as the Physical address' is checked. Buttons at the bottom include 'Set Current', 'Add New', 'Delete', and 'Close'.

- Complete the fields in the “Clinic Maintenance” window. (Please note: If the Clinic Name, Clinic Phone Number and Mailing Address fields are not completed, the Appointment Reminder Cards menu option will not be available to you.)

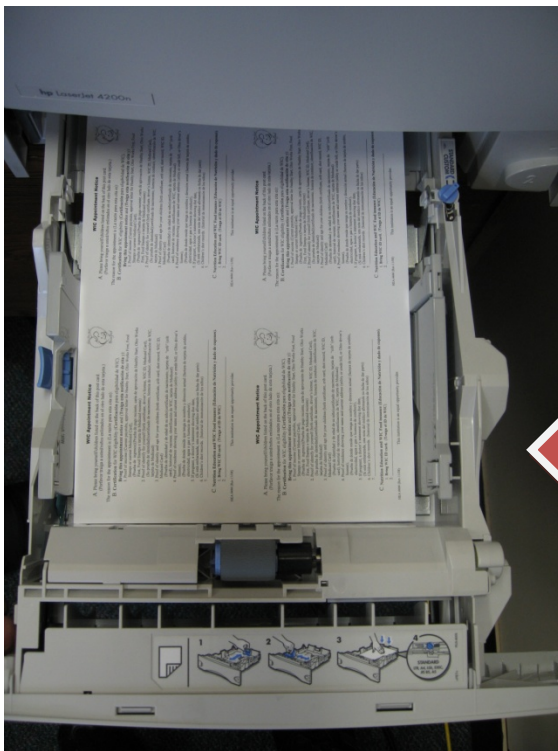
4. Click the “Set Current” button at the bottom of the Clinic Maintenance window.
 - A box will appear with the warning “This will reset the current clinic configuration. Are You Sure?”:



- Click the “Yes” button.

B. Loading The Appointment Reminder Cardstock:

Load the appointment reminder cardstock PRE-PRINTED SIDE UP, with the heading “WIC Appointment Notice” aligned on the left side of the printer paper tray.



WIC Appointment Notice

A. Please bring yourself/children listed on the back of this post card.
(Por favor traiga a usted/miembros enlistados en el otro lado de esta tarjeta.)

This notice is an equal opportunity provider.

B. Certification for WIC eligibility (Certificación para elegibilidad de WIC)

Bring this appointment notice and (Traiga esta notificación de cita y):

1. Proof of income (Prueba de ingresos)
2. Proof of identity for yourself/yourself (Prueba de identidad para usted/miembros)
3. Proof of residence (Prueba de residencia)
4. Proof of current Medicaid Card (Prueba de su tarjeta de Medicaid actual)
5. Proof of current WIC card (Prueba de su tarjeta de WIC actual)
6. Proof of current WIC card (Prueba de su tarjeta de WIC actual)
7. Proof of current WIC card (Prueba de su tarjeta de WIC actual)

C. Nutrition Education and WIC Food Insecurity (Educación de Nutrición y falta de ingresos)

1. Bring WIC ID card (Traiga su ID de WIC)
2. Bring WIC ID card (Traiga su ID de WIC)

WIC Appointment Notice

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C. Nutrition Education and WIC Food Insecurity (Educación de Nutrición y falta de ingresos)

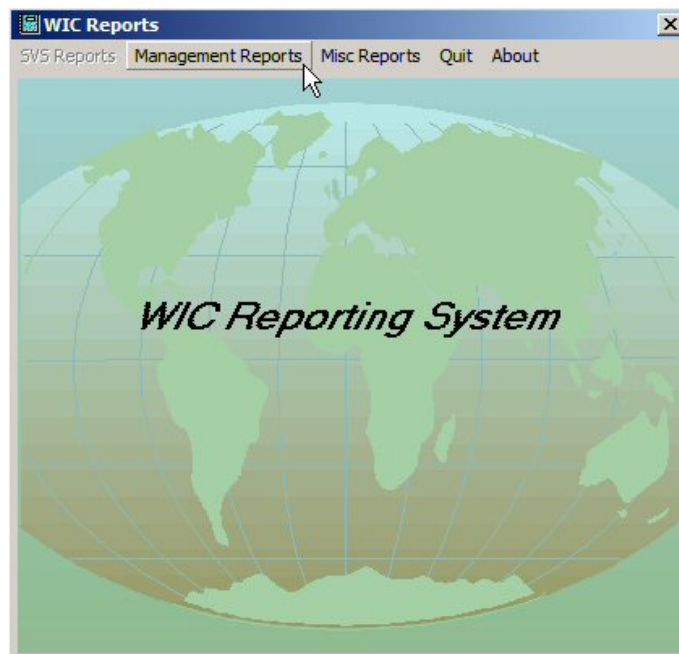
1. Bring WIC ID card (Traiga su ID de WIC)
2. Bring WIC ID card (Traiga su ID de WIC)

C. Accessing the Automated Appointment Reminder Cards:

1. Click on “Reports” from the top menu bar in the WIC Certification System.
2. Click on “Run Additional Reports.”

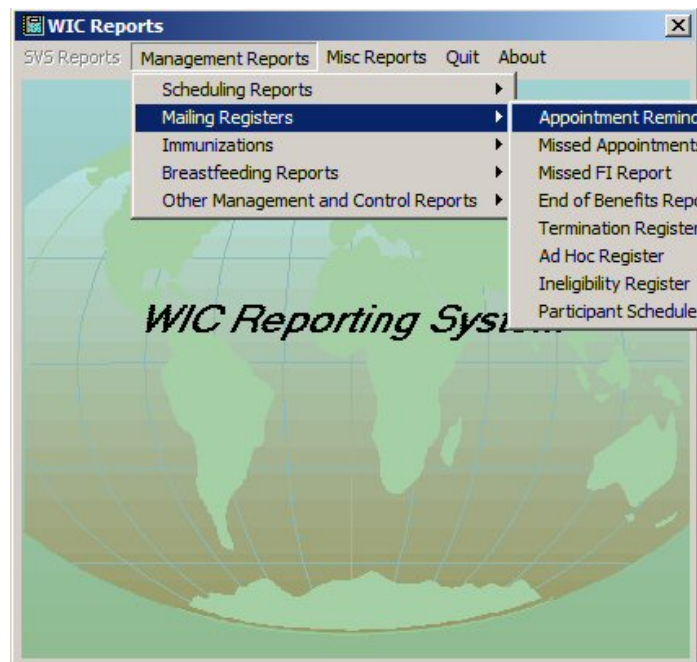
The screenshot shows the 'WIC Main Screen - User STATE logged on'. The 'Reports' menu is open, displaying options: 'FI Sequence Report', 'Participant Master Record', 'Schedule Detail', 'Participant Schedule', 'Schedule Summary', 'Inquire on Schedule Detail', and 'Run Additional Reports'. The 'Run Additional Reports' option is highlighted. The main screen contains various input fields for Group ID, Name (L,F,M), Address, City, OH, Zip, Apt, Loc, and DOB. There are also buttons for 'Find', 'Add Group', 'Add Part', 'Clear Group', 'Issue Food', 'Save Participant', 'Save Group', and 'Exit'. The bottom section includes tabs for 'Demographics', 'Pregnancy Info', 'Visit', 'Risk', 'Obligations', 'Schedule', 'Comments', and 'Immunization'. The 'Demographics' tab is active, showing fields for Guardian Name (L,F,M), Sex, Marital Status, Maiden Name, Ref ID, Household Size, Res Stat, Ethnic Class/Race Codes, Educ (1-30), Prim Lang, Monthly Income, Income Proof, Emp Status, Src Care, Pub Asst, and Ref From.

- The WIC Reporting System screen will display:

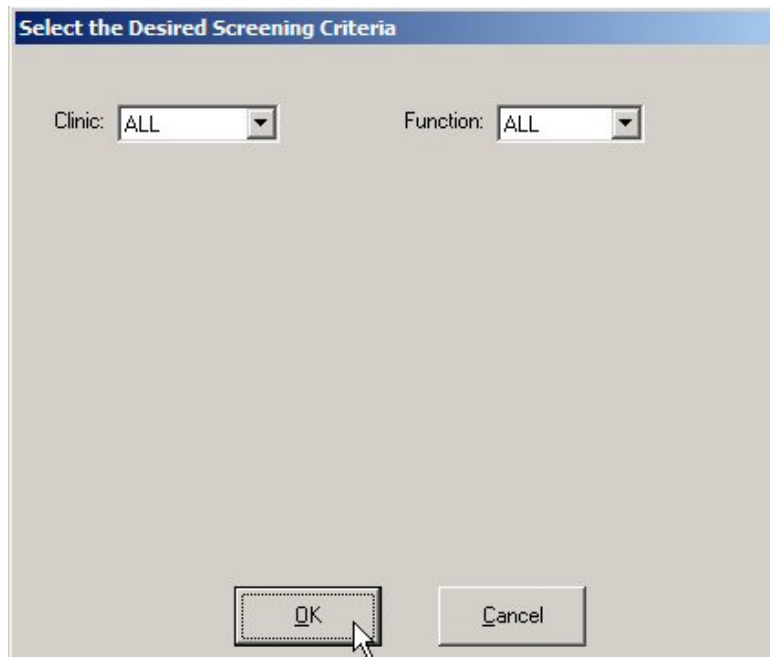


3. Click on “Management Reports” from the top menu bar on the WIC Reporting System screen.

4. Click on “Mailing Registers.”
5. Click on “Appointment Reminder Cards.”

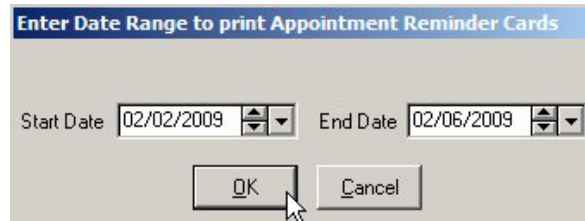


6. A window will appear, titled “Select the Desired Screening Criteria”:

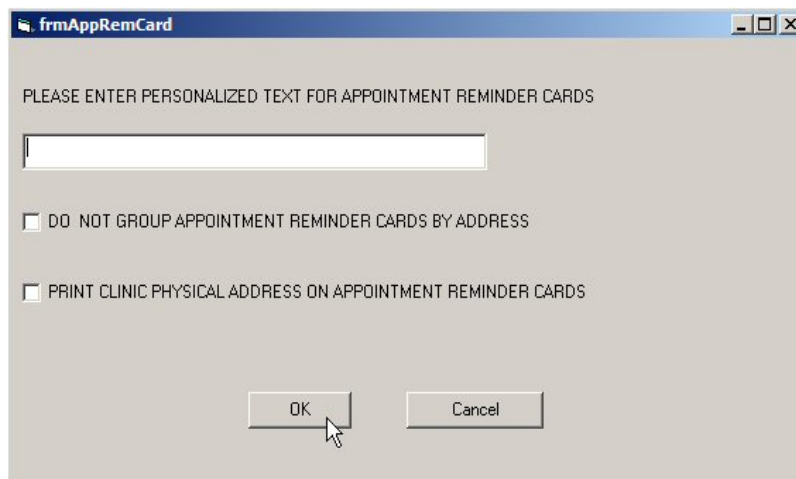


- The Clinic field will default to “ALL,” but you may select a specific clinic by clicking on the drop down box to the right of the Clinic field.

- The Function field will default to “ALL,” but you may select to print for a specific appointment type, e.g., “C” for Certification, by clicking on the drop down box to the right of the Function field.
 - Click the “OK” button at the bottom of the screen once you have entered your selections.
7. A window will appear that will allow you to enter your desired date range. After you have entered the “Start Date” and “End Date,” click the “OK” button at the bottom of the window.

A screenshot of a Windows-style dialog box titled "Enter Date Range to print Appointment Reminder Cards". It features two date pickers: "Start Date" with the value "02/02/2009" and "End Date" with the value "02/06/2009". Below the date pickers are two buttons: "OK" and "Cancel". A mouse cursor is pointing at the "OK" button.

8. A window will appear, titled “frmAppRemCard”:

A screenshot of a Windows-style dialog box titled "frmAppRemCard". It contains a text area with the prompt "PLEASE ENTER PERSONALIZED TEXT FOR APPOINTMENT REMINDER CARDS". Below the text area are two checkboxes: "DO NOT GROUP APPOINTMENT REMINDER CARDS BY ADDRESS" and "PRINT CLINIC PHYSICAL ADDRESS ON APPOINTMENT REMINDER CARDS". At the bottom are "OK" and "Cancel" buttons. A mouse cursor is pointing at the "OK" button.

- Click on the text field to enter a personalized message up to 45 characters in length. This message will print on the top of **every** Appointment Reminder Card for the date range you selected. If you do not wish to print a personalized message, leave the field blank.
- If you wish to print a card for each participant, click and place a checkmark on the box that reads “DO NOT GROUP APPOINTMENT REMINDER CARDS BY ADDRESS.” If you leave this box blank, one card will be printed for all participants with the same address that have an appointment on the same day within the date range that you specified. The appointment date and time that will print on the card will default to the earliest appointment time.

- If you wish to print the clinic’s physical address as the return address on the cards, click to place a checkmark on the box that reads “PRINT CLINIC PHYSICAL ADDRESS ON APPOINTMENT REMINDER CARDS.” If you leave this box blank, the system will print the clinic’s mailing address as the return address on the cards.
 - Click the “OK” button at the bottom of the screen.
9. The Appointment Reminder Cards will automatically preview on the screen. There will be four cards per page. You may wish to preview each page prior to printing to reduce addressing errors.

<p>WIC CLINIC 123 Anywhere Street Anytown, OH 10000</p> <p>You have an appointment for WIC on: (Click once on this box for WIC #):</p> <p>Thursday 1/1/2009 at 9:00AM Please bring all items to WIC: (Preferer bring only the items to be brought)</p> <p>A.B.C. on the back of this card (on all other sides of this card) =====</p> <p>If you do not bring this appointment, your WIC services will stop within 30 days. (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>If you cannot bring your appointment, please call the WIC clinic at: (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>(555)555-5555</p>	<p>WIC CLINIC 123 Anywhere Street Anytown, OH 10000</p> <p>You have an appointment for WIC on: (Click once on this box for WIC #):</p> <p>Thursday 1/1/2009 at 9:00AM Please bring all items to WIC: (Preferer bring only the items to be brought)</p> <p>A.B.C. on the back of this card (on all other sides of this card) =====</p> <p>If you do not bring this appointment, your WIC services will stop within 30 days. (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>If you cannot bring your appointment, please call the WIC clinic at: (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>(555)555-5555</p>	<p>To the parent or guardian of: CUCUMBER MELON, CHOCOLATE CREAM, ORANGE CREAM 45678 ALPHABET ST APT 4B COLUMBUS, OH 43201</p>
<p>WIC CLINIC 123 Anywhere Street Anytown, OH 10000</p> <p>You have an appointment for WIC on: (Click once on this box for WIC #):</p> <p>Thursday 1/1/2009 at 9:00AM Please bring all items to WIC: (Preferer bring only the items to be brought)</p> <p>A.B.C. on the back of this card (on all other sides of this card) =====</p> <p>If you do not bring this appointment, your WIC services will stop within 30 days. (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>If you cannot bring your appointment, please call the WIC clinic at: (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>(555)555-5555</p>	<p>WIC CLINIC 123 Anywhere Street Anytown, OH 10000</p> <p>You have an appointment for WIC on: (Click once on this box for WIC #):</p> <p>Thursday 1/1/2009 at 9:00AM Please bring all items to WIC: (Preferer bring only the items to be brought)</p> <p>A.B.C. on the back of this card (on all other sides of this card) =====</p> <p>If you do not bring this appointment, your WIC services will stop within 30 days. (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>If you cannot bring your appointment, please call the WIC clinic at: (If no appointment is made, the services of WIC will terminate on 30 days)</p> <p>(555)555-5555</p>	<p>To the parent or guardian of: CUCUMBER MELON, CHOCOLATE CREAM, ORANGE CREAM 45678 ALPHABET ST APT 4B COLUMBUS, OH 43201</p>
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10. Print the Appointment Reminder Cards by clicking on the printer icon in the upper left corner of the screen.



Please print only one copy of the cards. **(Reminder: To prevent cardstock waste, be sure that the cardstock is loaded in the printer with the PRE-PRINTED SIDE UP and with the heading “WIC Appointment Notice” aligned on the left side of the printer paper tray. (Please refer to Step B for instructions on how to properly load the paper.)**

11. Click on the “Close” button in the lower right corner of the screen after the cards have printed.



12. A window will appear, asking “Would you like to print the Appointment Record Report?”:



- Click the “Yes” button.
- If you clicked “No” in error, repeat steps 3 through 8 using the exact same date range. Do not reprint the Appointment Reminder Cards; close the Appointment Reminder Card screen and then click on “Yes” in the “Would you like to print the Appointment Record Report?” window.
- The Appointment Record Report will automatically preview on the screen, and will list everyone for whom you just printed Appointment Reminder Cards.

SARITA KIRK 499-000458 DOB: 7/18/1985 App Date: 1/27/2009 Date ARC Printed: 1/27/2009	TELLIE A PISCONE 499-000512 DOB: 1/1/1989 App Date: 1/2/2009 Date ARC Printed: 1/27/2009
NICH ABA 499-000253 DOB: 8/12/2008 App Date: 1/27/2009 Date ARC Printed: 1/27/2009	MISBY A FUZZBALL 499-000499 DOB: 1/1/1989 App Date: 1/2/2009 Date ARC Printed: 1/27/2009
CUCUMBER ANGEL 499-000491 DOB: 9/12/2004 App Date: 1/28/2009 Date ARC Printed: 1/27/2009	INDOR A FUZZBALL 499-000499 DOB: 1/1/1989 App Date: 1/2/2009 Date ARC Printed: 1/27/2009
RASPBERRY GLACE 499-000492 DOB: 7/18/2004 App Date: 1/28/2009 Date ARC Printed: 1/27/2009	MEANCAT A FUZZBALL 499-000500 DOB: 8/1/2007 App Date: 1/2/2009 Date ARC Printed: 1/27/2009
CHOCOLATE CREAM 499-000494 DOB: 8/24/2008 App Date: 1/28/2009 Date ARC Printed: 1/27/2009	CALLIE M KUTYS 499-000423 DOB: 8/1/2008 App Date: 1/2/2009 Date ARC Printed: 1/27/2009
ORANGE CREAM 499-000495 DOB: 8/24/2008 App Date: 1/28/2009 Date ARC Printed: 1/27/2009	SABYTA A BABYCAT 499-000505 DOB: 12/14/2008 App Date: 1/2/2009 Date ARC Printed: 1/27/2009
CAMEL BAK 499-000497 DOB: 10/12/1978 App Date: 1/29/2009 Date ARC Printed: 1/27/2009	NEWPERSON SMITH 499-000518 DOB: 4/12/2003 App Date: 1/1/2009 Date ARC Printed: 1/27/2009
GRAFFIE BAK 499-000497 DOB: 5/24/2002 App Date: 1/29/2009 Date ARC Printed: 1/27/2009	
ZERKA BAK 499-000498 DOB: 1/1/2009 App Date: 1/29/2009 Date ARC Printed: 1/27/2009	
MOLLY NEWPERSON 499-000524 DOB: 1/1/1982 App Date: 1/23/2009 Date ARC Printed: 1/27/2009	

This report is your record of issuing an Appointment Reminder Card to the participant and **serves as documentation for notice of termination**. It is designed to print on Avery 5160 or 5960 labels.

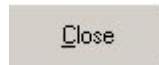
- The label provides the following information:
 - Participant Name
 - Participant ID
 - Date of Birth
 - Appointment Date
 - Date the Appointment Reminder Card was printed

13. Print the Appointment Record Report by clicking on the printer icon in the upper left corner of your screen.



IMPORTANT: REPLACE the cardstock with Avery 5160 or 5960 labels before printing the report.

14. Click on the “Close” button in the lower right corner of the screen after the report has printed.



D. Using the Appointment Record Report

- Staff have two options as to when to affix the labels:
 1. Place all printed labels in every participant chart as soon as the Appointment Record Report is run, **or**
 2. After running the Termination Report, only place labels in the charts of participants who missed their appointments.
- Place the label in a readily accessible area of the participant chart.

Never place labels overtop of each other as this could lead to missing documentation for a terminated participant.

WIC Appointment Notice



- A. Please bring yourself/children listed on the back of this post card.
Por favor traiga a usted/niños enlistados en el otro lado de esta tarjeta.

The reason for the appointment is (La razón para esta cita es):

B. Certification for WIC eligibility. *Certificación para elegibilidad de WIC.*

Bring this appointment notice and (Traiga esta notificación de cita y):

1. Proof of income (Current paystubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid Card),
Prueba de ingresos (Prueba de pago reciente, carta de aprobación de Healthy Start, Ohio Works First, Food Stamps o Tarjeta de Medicaid reciente),
2. Proof of identity for yourself (birth certificate, driver's license, WIC ID, or Medicaid Card),
Su prueba de identidad (certificado de nacimiento, licencia de conducir, identificación de WIC, o Tarjeta de Medicaid),
3. Proof of identity and age for your children (birth certificate, crib card, shot record, WIC ID, or Medicaid Card),
Prueba de identidad y de edad de sus niños (certificado de nacimiento, tarjeta de "crib" (crib card), historial de vacunas, identificación de WIC, o Tarjeta de Medicaid),
4. Proof of residence showing your name and current address (utility or credit bill, or Ohio driver's license),
Prueba de donde reside que tenga su nombre y dirección actual (factura de tarjeta de crédito, electricidad, agua o gas o licencia de conducir),
5. If pregnant, a doctor's statement showing due date,
Si está embarazada, una nota del médico afirmando su fecha de dar parto,
6. Children's shot records. *Historial de inmunización de los niños.*
7. _____

C. Nutrition Education and WIC Food Issuance. *Educación de Nutrición y dado de cupones de WIC.*

1. Bring WIC ID card. *Traiga el ID de WIC.*
2. _____

HEA 4495

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Rev 12/12

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This institution is an equal opportunity provider.

Rev 12/12

Please read instructions carefully. Please type or print clearly with blue or black ink. For further information, you may consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

Por favor lea las instrucciones atentamente. Por favor escriba a máquina o con letra de molde clara con tinta azul o negra. Para más información puede consultar el Sitio web del Secretario de Estado en: www.OhioSecretaryofState.gov o llamar al 1-877-767-6446.

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

NOTICE: This form must be *received or postmarked* by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the *last four digits* of your Social Security number on line 10. If you have neither, please write "None."

Current valid photo identification card, military identification, or current (within one year) utility bill, bank statement, paycheck, government check or government document (except board of elections notifications) showing your name and current address.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

1. Usted es ciudadano de los Estados Unidos.
2. Usted tendrá al menos 18 años de edad el día de las elecciones generales o antes de las mismas.
3. Usted habrá sido un residente de Ohio durante al menos los 30 días previos a las elecciones en las que quiere votar.
4. Usted no está encarcelado (en la cárcel o en prisión) por un delito grave.
5. Usted no ha sido declarado incompetente a fines de votación por un tribunal testamentario.
6. Usted no ha sido privado de sus derechos de forma permanente por violaciones de leyes electorales.

AQUELLAS PERSONAS QUE COMETAN FRAUDE ELECTORAL SERÁN CULPABLES DE UN DELITO DE QUINTO GRADO.

☐ **Updating my name**
Actualizar mi nombre

I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Declaro, so pena de fraude electoral, que soy ciudadano de los Estados Unidos, que habré vivido en este estado durante al menos los 30 días previos a las elecciones siguientes y que tendré al menos 18 años de edad en el momento de las elecciones generales.

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.OhioSecretaryofState.gov or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include a current and valid photo identification, a military identification, or a copy of a current utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot. Voters who do not have any of the above forms of identification, including a Social Security number, will still be able to vote by signing an affirmation swearing to the voter's identity under penalty of election falsification and by casting a provisional ballot. For more information on voter identification requirements, please consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call 1-877-767-6446.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections. For your county board's address please visit www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (767-6446).

CÓMO CONSEGUIR UNA BOLETA O PAPELETA DE VOTO EN AUSENCIA

Usted tiene derecho a votar mediante una boleta o papeleta de voto en ausencia en Ohio sin tener que dar un motivo. Las solicitudes de boletas o papeletas de voto en ausencia se pueden obtener de la junta electoral de su condado o del Secretario de Estado en: www.OhioSecretaryofState.gov o llamando al 1-877-767-6446.

REQUISITOS DE IDENTIFICACIÓN PARA LOS VOTANTES DE OHIO

Los votantes deben traer identificación a las urnas para poder verificar su identidad. La identificación puede incluir una identificación con fotografía válida y actual, una identificación militar o una copia de un recibo o factura actual de servicios básicos, estados de cuentas bancarias, cheque del gobierno u otro documento del gobierno, excepto una notificación de unas elecciones o una notificación de registro de votante enviada por una junta electoral, que muestre el nombre y domicilio actual del votante. Los votantes que no faciliten uno de estos documentos aún podrán votar facilitando los cuatro últimos dígitos del número del Seguro Social del votante y depositando un voto provisional. Los votantes que no tengan ninguna de las formas de identificación indicadas previamente, incluyendo un número del Seguro Social, aún podrán votar firmando una declaración jurada sobre la identidad del votante, so pena de fraude electoral, y depositando un voto. Para obtener más información acerca de los requisitos de identificación de los votantes, por favor consulte el Sitio web del Secretario de Estado en: www.OhioSecretaryofState.gov o llame al 1-877-767-6446.

AQUELLAS PERSONAS QUE COMETAN FRAUDE ELECTORAL SERÁN CULPABLES DE UN DELITO DE QUINTO GRADO.

CDC Table for Calculated Body Mass Index Values for Selected Heights and Weights for Ages 2 to 20 Years

Body Mass Index (BMI) is determined as follows:

English Formula:

$$\text{Weight in pounds} \div \text{Height in inches} \div \text{Height in inches} \times 703 = \text{BMI}$$

Metric Formula:

$$\text{Weight in kilograms} \div \text{Height in meters} \div \text{Height in meters} = \text{BMI}$$

The above BMI formulas have already been calculated and are presented in this table entitled *Calculated Body Mass Index Values for Selected Heights and Weights for Ages 2 to 20 Years*. To use the BMI table, first locate the child's height and weight in the height and weight ranges listed in the upper right corner of each page. The table of contents contains a list of height and weight ranges and may be used to locate the page numbers for specific BMI values. Please note that some height and weight measurements are found on more than one page, so be sure that *both* the height and weight measurements are within the range listed at the top of the page. Weight measurements are listed in increasing sequential order. Once the exact page has been located in the table, the point where height and weight intersect represents the BMI value. This value is then plotted on the BMI-for-age growth chart to determine whether the child is within a normal growth pattern, overweight, at risk of becoming overweight, or underweight.

In the table, English height measurements (inches) are shown in 1/2-inch increments for heights below 48 inches and 1-inch increments for heights between 48 and 78 inches. English weight measurements (pounds) are shown in 1/2-pound increments for weights under 60 pounds, 1-pound increments for weights between 60 and 110 pounds, and 2-pound increments for weights between 112 and 250 pounds. The corresponding metric values in centimeters and kilograms are included next to the English values in the table. Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.

June 2000



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention



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Calculated Body Mass Index

29"–37" and 18 lbs.–26 lbs.

Height Cm In		Weight																	
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																	
		Kg	8.2	8.4	8.6	8.8	9.1	9.3	9.5	9.8	10.0	10.2	10.4	10.7	10.9	11.1	11.3	11.6	11.8
		Lb	18	18.5	19	19.5	20	20.5	21	21.5	22	22.5	23	23.5	24	24.5	25	25.5	26
73.7	29		15.0	15.5	15.9	16.3	16.7	17.1	17.6	18.0	18.4	18.8	19.2	19.6	20.1	20.5	20.9	21.3	21.7
74.9	29.5		14.5	14.9	15.3	15.8	16.2	16.6	17.0	17.4	17.8	18.2	18.6	19.0	19.4	19.8	20.2	20.6	21.0
76.2	30		14.1	14.5	14.8	15.2	15.6	16.0	16.4	16.8	17.2	17.6	18.0	18.4	18.7	19.1	19.5	19.9	20.3
77.5	30.5		13.6	14.0	14.4	14.7	15.1	15.5	15.9	16.2	16.6	17.0	17.4	17.8	18.1	18.5	18.9	19.3	19.7
78.7	31		13.2	13.5	13.9	14.3	14.6	15.0	15.4	15.7	16.1	16.5	16.8	17.2	17.6	17.9	18.3	18.7	19.0
80.0	31.5			13.1	13.5	13.8	14.2	14.5	14.9	15.2	15.6	15.9	16.3	16.7	17.0	17.4	17.7	18.1	18.4
81.3	32				13.0	13.4	13.7	14.1	14.4	14.8	15.1	15.4	15.8	16.1	16.5	16.8	17.2	17.5	17.9
82.6	32.5					13.3	13.6	14.0	14.3	14.6	15.0	15.3	15.6	16.0	16.3	16.6	17.0	17.3	
83.8	33						13.2	13.6	13.9	14.2	14.5	14.8	15.2	15.5	15.8	16.1	16.5	16.8	
85.1	33.5							13.2	13.5	13.8	14.1	14.4	14.7	15.0	15.3	15.7	16.0	16.3	
86.4	34								13.1	13.4	13.7	14.0	14.3	14.6	14.9	15.2	15.5	15.8	
87.6	34.5									13.3	13.6	13.9	14.2	14.5	14.8	15.1	15.4		
88.9	35										13.2	13.5	13.8	14.1	14.3	14.6	14.9		
90.2	35.5											13.1	13.4	13.7	13.9	14.2	14.5		
91.4	36													13.0	13.3	13.6	13.8	14.1	
92.7	36.5																13.2	13.5	13.7
94.0	37																	13.1	13.4

Calculated Body Mass Index

29"–43" and 26.5 lbs.–34.5 lbs.

		Weight																	
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																	
Height		Kg	12.0	12.2	12.5	12.7	12.9	13.2	13.4	13.6	13.8	14.1	14.3	14.5	14.7	15.0	15.2	15.4	15.6
		Lb	26.5	27	27.5	28	28.5	29	29.5	30	30.5	31	31.5	32	32.5	33	33.5	34	34.5
Cm	In																		
73.7	29	22.2	22.6	23.0	23.4	23.8	24.2	24.7	25.1	25.5	25.9	26.3	26.8	27.2	27.6	28.0	28.4	28.8	
74.9	29.5	21.4	21.8	22.2	22.6	23.0	23.4	23.8	24.2	24.6	25.0	25.4	25.9	26.3	26.7	27.1	27.5	27.9	
76.2	30	20.7	21.1	21.5	21.9	22.3	22.7	23.0	23.4	23.8	24.2	24.6	25.0	25.4	25.8	26.2	26.6	27.0	
77.5	30.5	20.0	20.4	20.8	21.2	21.5	21.9	22.3	22.7	23.1	23.4	23.8	24.2	24.6	24.9	25.3	25.7	26.1	
78.7	31	19.4	19.8	20.1	20.5	20.9	21.2	21.6	21.9	22.3	22.7	23.0	23.4	23.8	24.1	24.5	24.9	25.2	
80.0	31.5	18.8	19.1	19.5	19.8	20.2	20.5	20.9	21.3	21.6	22.0	22.3	22.7	23.0	23.4	23.7	24.1	24.4	
81.3	32	18.2	18.5	18.9	19.2	19.6	19.9	20.3	20.6	20.9	21.3	21.6	22.0	22.3	22.7	23.0	23.3	23.7	
82.6	32.5	17.6	18.0	18.3	18.6	19.0	19.3	19.6	20.0	20.3	20.6	21.0	21.3	21.6	22.0	22.3	22.6	23.0	
83.8	33	17.1	17.4	17.8	18.1	18.4	18.7	19.0	19.4	19.7	20.0	20.3	20.7	21.0	21.3	21.6	22.0	22.3	
85.1	33.5	16.6	16.9	17.2	17.5	17.9	18.2	18.5	18.8	19.1	19.4	19.7	20.0	20.4	20.7	21.0	21.3	21.6	
86.4	34	16.1	16.4	16.7	17.0	17.3	17.6	17.9	18.2	18.5	18.9	19.2	19.5	19.8	20.1	20.4	20.7	21.0	
87.6	34.5	15.7	15.9	16.2	16.5	16.8	17.1	17.4	17.7	18.0	18.3	18.6	18.9	19.2	19.5	19.8	20.1	20.4	
88.9	35	15.2	15.5	15.8	16.1	16.4	16.6	16.9	17.2	17.5	17.8	18.1	18.4	18.7	18.9	19.2	19.5	19.8	
90.2	35.5	14.8	15.1	15.3	15.6	15.9	16.2	16.5	16.7	17.0	17.3	17.6	17.9	18.1	18.4	18.7	19.0	19.2	
91.4	36	14.4	14.6	14.9	15.2	15.5	15.7	16.0	16.3	16.5	16.8	17.1	17.4	17.6	17.9	18.2	18.4	18.7	
92.7	36.5	14.0	14.2	14.5	14.8	15.0	15.3	15.6	15.8	16.1	16.4	16.6	16.9	17.2	17.4	17.7	17.9	18.2	
94.0	37	13.6	13.9	14.1	14.4	14.6	14.9	15.2	15.4	15.7	15.9	16.2	16.4	16.7	16.9	17.2	17.5	17.7	
95.3	37.5	13.2	13.5	13.7	14.0	14.2	14.5	14.7	15.0	15.2	15.5	15.7	16.0	16.2	16.5	16.7	17.0	17.2	
96.5	38		13.1	13.4	13.6	13.9	14.1	14.4	14.6	14.9	15.1	15.3	15.6	15.8	16.1	16.3	16.6	16.8	
97.8	38.5			13.0	13.3	13.5	13.8	14.0	14.2	14.5	14.7	14.9	15.2	15.4	15.7	15.9	16.1	16.4	
99.1	39					13.2	13.4	13.6	13.9	14.1	14.3	14.6	14.8	15.0	15.3	15.5	15.7	15.9	
100.3	39.5						13.1	13.3	13.5	13.7	14.0	14.2	14.4	14.6	14.9	15.1	15.3	15.5	
101.6	40								13.2	13.4	13.6	13.8	14.1	14.3	14.5	14.7	14.9	15.2	
102.9	40.5									13.1	13.3	13.5	13.7	13.9	14.1	14.4	14.6	14.8	
104.1	41											13.2	13.4	13.6	13.8	14.0	14.2	14.4	
105.4	41.5												13.1	13.3	13.5	13.7	13.9	14.1	
106.7	42														13.2	13.4	13.6	13.8	
108.0	42.5																13.0	13.2	13.4
109.2	43																		13.1

Calculated Body Mass Index

29"-43" and 35 lbs.-43 lbs.

		Weight																	
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																	
Height		Kg	15.9	16.1	16.3	16.6	16.8	17.0	17.2	17.5	17.7	17.9	18.1	18.4	18.6	18.8	19.1	19.3	19.5
Cm In		Lb	35	35.5	36	36.5	37	37.5	38	38.5	39	39.5	40	40.5	41	41.5	42	42.5	43
73.7	29		29.3	29.7	30.1	30.5	30.9	31.3	31.8	32.2	32.6	33.0	33.4	33.9	34.3	34.7			
74.9	29.5		28.3	28.7	29.1	29.5	29.9	30.3	30.7	31.1	31.5	31.9	32.3	32.7	33.1	33.5	33.9	34.3	34.7
76.2	30		27.3	27.7	28.1	28.5	28.9	29.3	29.7	30.1	30.5	30.9	31.2	31.6	32.0	32.4	32.8	33.2	33.6
77.5	30.5		26.5	26.8	27.2	27.6	28.0	28.3	28.7	29.1	29.5	29.9	30.2	30.6	31.0	31.4	31.7	32.1	32.5
78.7	31		25.6	26.0	26.3	26.7	27.1	27.4	27.8	28.2	28.5	28.9	29.3	29.6	30.0	30.4	30.7	31.1	31.5
80.0	31.5		24.8	25.2	25.5	25.9	26.2	26.6	26.9	27.3	27.6	28.0	28.3	28.7	29.1	29.4	29.8	30.1	30.5
81.3	32		24.0	24.4	24.7	25.1	25.4	25.7	26.1	26.4	26.8	27.1	27.5	27.8	28.2	28.5	28.8	29.2	29.5
82.6	32.5		23.3	23.6	24.0	24.3	24.6	25.0	25.3	25.6	26.0	26.3	26.6	27.0	27.3	27.6	28.0	28.3	28.6
83.8	33		22.6	22.9	23.2	23.6	23.9	24.2	24.5	24.9	25.2	25.5	25.8	26.1	26.5	26.8	27.1	27.4	27.8
85.1	33.5		21.9	22.2	22.6	22.9	23.2	23.5	23.8	24.1	24.4	24.7	25.1	25.4	25.7	26.0	26.3	26.6	26.9
86.4	34		21.3	21.6	21.9	22.2	22.5	22.8	23.1	23.4	23.7	24.0	24.3	24.6	24.9	25.2	25.5	25.8	26.2
87.6	34.5		20.7	21.0	21.3	21.6	21.9	22.2	22.4	22.7	23.0	23.3	23.6	23.9	24.2	24.5	24.8	25.1	25.4
88.9	35		20.1	20.4	20.7	20.9	21.2	21.5	21.8	22.1	22.4	22.7	23.0	23.2	23.5	23.8	24.1	24.4	24.7
90.2	35.5		19.5	19.8	20.1	20.4	20.6	20.9	21.2	21.5	21.8	22.0	22.3	22.6	22.9	23.2	23.4	23.7	24.0
91.4	36		19.0	19.3	19.5	19.8	20.1	20.3	20.6	20.9	21.2	21.4	21.7	22.0	22.2	22.5	22.8	23.1	23.3
92.7	36.5		18.5	18.7	19.0	19.3	19.5	19.8	20.1	20.3	20.6	20.8	21.1	21.4	21.6	21.9	22.2	22.4	22.7
94.0	37		18.0	18.2	18.5	18.7	19.0	19.3	19.5	19.8	20.0	20.3	20.5	20.8	21.1	21.3	21.6	21.8	22.1
95.3	37.5		17.5	17.7	18.0	18.2	18.5	18.7	19.0	19.2	19.5	19.7	20.0	20.2	20.5	20.7	21.0	21.2	21.5
96.5	38		17.0	17.3	17.5	17.8	18.0	18.3	18.5	18.7	19.0	19.2	19.5	19.7	20.0	20.2	20.4	20.7	20.9
97.8	38.5		16.6	16.8	17.1	17.3	17.6	17.8	18.0	18.3	18.5	18.7	19.0	19.2	19.4	19.7	19.9	20.2	20.4
99.1	39		16.2	16.4	16.6	16.9	17.1	17.3	17.6	17.8	18.0	18.3	18.5	18.7	19.0	19.2	19.4	19.6	19.9
100.3	39.5		15.8	16.0	16.2	16.4	16.7	16.9	17.1	17.3	17.6	17.8	18.0	18.2	18.5	18.7	18.9	19.2	19.4
101.6	40		15.4	15.6	15.8	16.0	16.3	16.5	16.7	16.9	17.1	17.4	17.6	17.8	18.0	18.2	18.5	18.7	18.9
102.9	40.5		15.0	15.2	15.4	15.6	15.9	16.1	16.3	16.5	16.7	16.9	17.1	17.4	17.6	17.8	18.0	18.2	18.4
104.1	41		14.6	14.8	15.1	15.3	15.5	15.7	15.9	16.1	16.3	16.5	16.7	16.9	17.1	17.4	17.6	17.8	18.0
105.4	41.5		14.3	14.5	14.7	14.9	15.1	15.3	15.5	15.7	15.9	16.1	16.3	16.5	16.7	16.9	17.1	17.3	17.6
106.7	42		13.9	14.1	14.3	14.5	14.7	14.9	15.1	15.3	15.5	15.7	15.9	16.1	16.3	16.5	16.7	16.9	17.1
108.0	42.5		13.6	13.8	14.0	14.2	14.4	14.6	14.8	15.0	15.2	15.4	15.6	15.8	16.0	16.2	16.3	16.5	16.7
109.2	43		13.3	13.5	13.7	13.9	14.1	14.3	14.4	14.6	14.8	15.0	15.2	15.4	15.6	15.8	16.0	16.2	16.4

Calculated Body Mass Index

43.5"–48" and 35 lbs.–43 lbs.

Height		Weight																	
		Kg	15.9	16.1	16.3	16.6	16.8	17.0	17.2	17.5	17.7	17.9	18.1	18.4	18.6	18.8	19.1	19.3	19.5
		Lb	35	35.5	36	36.5	37	37.5	38	38.5	39	39.5	40	40.5	41	41.5	42	42.5	43
Cm	In																		
110.5	43.5		13.0	13.2	13.4	13.6	13.7	13.9	14.1	14.3	14.5	14.7	14.9	15.0	15.2	15.4	15.6	15.8	16.0
111.8	44				13.1	13.3	13.4	13.6	13.8	14.0	14.2	14.3	14.5	14.7	14.9	15.1	15.3	15.4	15.6
113.0	44.5					13.1	13.3	13.5	13.7	13.8	14.0	14.2	14.4	14.6	14.7	14.9	15.1	15.3	
114.3	45						13.0	13.2	13.4	13.5	13.7	13.9	14.1	14.2	14.4	14.6	14.8	14.9	
115.6	45.5							13.1	13.2	13.4	13.6	13.8	13.9	14.1	14.3	14.4	14.6		
116.8	46									13.1	13.3	13.5	13.6	13.8	14.0	14.1	14.3		
118.1	46.5										13.0	13.2	13.3	13.5	13.7	13.8	14.0		
119.4	47												13.0	13.2	13.4	13.5	13.7		
120.7	47.5															13.1	13.2	13.4	
121.9	48																		13.1

Calculated Body Mass Index

30"–44" and 43.5 lbs.–51.5 lbs.

Height		Weight																	
		Kg	19.7	20.0	20.2	20.4	20.6	20.9	21.1	21.3	21.5	21.8	22.0	22.2	22.5	22.7	22.9	23.1	23.4
Cm In		Lb	43.5	44	44.5	45	45.5	46	46.5	47	47.5	48	48.5	49	49.5	50	50.5	51	51.5
76.2	30		34.0	34.4	34.8														
77.5	30.5		32.9	33.3	33.6	34.0	34.4	34.8											
78.7	31		31.8	32.2	32.6	32.9	33.3	33.7	34.0	34.4	34.8								
80.0	31.5		30.8	31.2	31.5	31.9	32.2	32.6	32.9	33.3	33.7	34.0	34.4	34.7					
81.3	32		29.9	30.2	30.6	30.9	31.2	31.6	31.9	32.3	32.6	33.0	33.3	33.6	34.0	34.3	34.7		
82.6	32.5		29.0	29.3	29.6	30.0	30.3	30.6	31.0	31.3	31.6	32.0	32.3	32.6	32.9	33.3	33.6	33.9	34.3
83.8	33		28.1	28.4	28.7	29.1	29.4	29.7	30.0	30.3	30.7	31.0	31.3	31.6	32.0	32.3	32.6	32.9	33.2
85.1	33.5		27.3	27.6	27.9	28.2	28.5	28.8	29.1	29.4	29.8	30.1	30.4	30.7	31.0	31.3	31.6	32.0	32.3
86.4	34		26.5	26.8	27.1	27.4	27.7	28.0	28.3	28.6	28.9	29.2	29.5	29.8	30.1	30.4	30.7	31.0	31.3
87.6	34.5		25.7	26.0	26.3	26.6	26.9	27.2	27.5	27.8	28.1	28.4	28.6	28.9	29.2	29.5	29.8	30.1	30.4
88.9	35		25.0	25.3	25.5	25.8	26.1	26.4	26.7	27.0	27.3	27.5	27.8	28.1	28.4	28.7	29.0	29.3	29.6
90.2	35.5		24.3	24.5	24.8	25.1	25.4	25.7	25.9	26.2	26.5	26.8	27.1	27.3	27.6	27.9	28.2	28.5	28.7
91.4	36		23.6	23.9	24.1	24.4	24.7	25.0	25.2	25.5	25.8	26.0	26.3	26.6	26.9	27.1	27.4	27.7	27.9
92.7	36.5		23.0	23.2	23.5	23.7	24.0	24.3	24.5	24.8	25.1	25.3	25.6	25.9	26.1	26.4	26.7	26.9	27.2
94.0	37		22.3	22.6	22.9	23.1	23.4	23.6	23.9	24.1	24.4	24.7	24.9	25.2	25.4	25.7	25.9	26.2	26.4
95.3	37.5		21.7	22.0	22.2	22.5	22.7	23.0	23.2	23.5	23.7	24.0	24.2	24.5	24.7	25.0	25.2	25.5	25.7
96.5	38		21.2	21.4	21.7	21.9	22.2	22.4	22.6	22.9	23.1	23.4	23.6	23.9	24.1	24.3	24.6	24.8	25.1
97.8	38.5		20.6	20.9	21.1	21.3	21.6	21.8	22.1	22.3	22.5	22.8	23.0	23.2	23.5	23.7	24.0	24.2	24.4
99.1	39		20.1	20.3	20.6	20.8	21.0	21.3	21.5	21.7	22.0	22.2	22.4	22.6	22.9	23.1	23.3	23.6	23.8
100.3	39.5		19.6	19.8	20.1	20.3	20.5	20.7	21.0	21.2	21.4	21.6	21.9	22.1	22.3	22.5	22.8	23.0	23.2
101.6	40		19.1	19.3	19.6	19.8	20.0	20.2	20.4	20.7	20.9	21.1	21.3	21.5	21.8	22.0	22.2	22.4	22.6
102.9	40.5		18.6	18.9	19.1	19.3	19.5	19.7	19.9	20.1	20.4	20.6	20.8	21.0	21.2	21.4	21.6	21.9	22.1
104.1	41		18.2	18.4	18.6	18.8	19.0	19.2	19.4	19.7	19.9	20.1	20.3	20.5	20.7	20.9	21.1	21.3	21.5
105.4	41.5		17.8	18.0	18.2	18.4	18.6	18.8	19.0	19.2	19.4	19.6	19.8	20.0	20.2	20.4	20.6	20.8	21.0
106.7	42		17.3	17.5	17.7	17.9	18.1	18.3	18.5	18.7	18.9	19.1	19.3	19.5	19.7	19.9	20.1	20.3	20.5
108.0	42.5		16.9	17.1	17.3	17.5	17.7	17.9	18.1	18.3	18.5	18.7	18.9	19.1	19.3	19.5	19.7	19.9	20.0
109.2	43		16.5	16.7	16.9	17.1	17.3	17.5	17.7	17.9	18.1	18.3	18.4	18.6	18.8	19.0	19.2	19.4	19.6
110.5	43.5		16.2	16.3	16.5	16.7	16.9	17.1	17.3	17.5	17.6	17.8	18.0	18.2	18.4	18.6	18.8	18.9	19.1
111.8	44		15.8	16.0	16.2	16.3	16.5	16.7	16.9	17.1	17.2	17.4	17.6	17.8	18.0	18.2	18.3	18.5	18.7

Calculated Body Mass Index

44.5"–51" and 43.5 lbs.–51.5 lbs.

Height		Weight																	
		Kg	19.7	20.0	20.2	20.4	20.6	20.9	21.1	21.3	21.5	21.8	22.0	22.2	22.5	22.7	22.9	23.1	23.4
Cm In		Lb	43.5	44	44.5	45	45.5	46	46.5	47	47.5	48	48.5	49	49.5	50	50.5	51	51.5
113.0	44.5		15.4	15.6	15.8	16.0	16.2	16.3	16.5	16.7	16.9	17.0	17.2	17.4	17.6	17.8	17.9	18.1	18.3
114.3	45		15.1	15.3	15.5	15.6	15.8	16.0	16.1	16.3	16.5	16.7	16.8	17.0	17.2	17.4	17.5	17.7	17.9
115.6	45.5		14.8	14.9	15.1	15.3	15.5	15.6	15.8	16.0	16.1	16.3	16.5	16.6	16.8	17.0	17.2	17.3	17.5
116.8	46		14.5	14.6	14.8	15.0	15.1	15.3	15.5	15.6	15.8	15.9	16.1	16.3	16.4	16.6	16.8	16.9	17.1
118.1	46.5		14.1	14.3	14.5	14.6	14.8	15.0	15.1	15.3	15.4	15.6	15.8	15.9	16.1	16.3	16.4	16.6	16.7
119.4	47		13.8	14.0	14.2	14.3	14.5	14.6	14.8	15.0	15.1	15.3	15.4	15.6	15.8	15.9	16.1	16.2	16.4
120.7	47.5		13.6	13.7	13.9	14.0	14.2	14.3	14.5	14.6	14.8	15.0	15.1	15.3	15.4	15.6	15.7	15.9	16.0
121.9	48		13.3	13.4	13.6	13.7	13.9	14.0	14.2	14.3	14.5	14.6	14.8	15.0	15.1	15.3	15.4	15.6	15.7
124.5	49				13.0	13.2	13.3	13.5	13.6	13.8	13.9	14.1	14.2	14.3	14.5	14.6	14.8	14.9	15.1
127.0	50								13.1	13.2	13.4	13.5	13.6	13.8	13.9	14.1	14.2	14.3	14.5
129.5	51												13.1	13.2	13.4	13.5	13.7	13.8	13.9
132.1	52															13.0	13.1	13.3	13.4

Calculated Body Mass Index

32.5"–46.5" and 52 lbs.–60 lbs.

Height		Weight																	
		Kg	23.6	23.8	24.0	24.3	24.5	24.7	24.9	25.2	25.4	25.6	25.9	26.1	26.3	26.5	26.8	27.0	27.2
		Lb	52	52.5	53	53.5	54	54.5	55	55.5	56	56.5	57	57.5	58	58.5	59	59.5	60
Cm	In																		
82.6	32.5		34.6	34.9															
83.8	33		33.6	33.9	34.2	34.5	34.9												
85.1	33.5		32.6	32.9	33.2	33.5	33.8	34.1	34.5	34.8									
86.4	34		31.6	31.9	32.2	32.5	32.8	33.1	33.5	33.8	34.1	34.4	34.7	35.0					
87.6	34.5		30.7	31.0	31.3	31.6	31.9	32.2	32.5	32.8	33.1	33.4	33.7	34.0	34.3	34.6	34.9		
88.9	35		29.8	30.1	30.4	30.7	31.0	31.3	31.6	31.9	32.1	32.4	32.7	33.0	33.3	33.6	33.9	34.1	34.4
90.2	35.5		29.0	29.3	29.6	29.8	30.1	30.4	30.7	31.0	31.2	31.5	31.8	32.1	32.4	32.6	32.9	33.2	33.5
91.4	36		28.2	28.5	28.8	29.0	29.3	29.6	29.8	30.1	30.4	30.7	30.9	31.2	31.5	31.7	32.0	32.3	32.5
92.7	36.5		27.4	27.7	28.0	28.2	28.5	28.8	29.0	29.3	29.6	29.8	30.1	30.3	30.6	30.9	31.1	31.4	31.7
94.0	37		26.7	27.0	27.2	27.5	27.7	28.0	28.2	28.5	28.8	29.0	29.3	29.5	29.8	30.0	30.3	30.6	30.8
95.3	37.5		26.0	26.2	26.5	26.7	27.0	27.2	27.5	27.7	28.0	28.2	28.5	28.7	29.0	29.2	29.5	29.7	30.0
96.5	38		25.3	25.6	25.8	26.0	26.3	26.5	26.8	27.0	27.3	27.5	27.8	28.0	28.2	28.5	28.7	29.0	29.2
97.8	38.5		24.7	24.9	25.1	25.4	25.6	25.9	26.1	26.3	26.6	26.8	27.0	27.3	27.5	27.7	28.0	28.2	28.5
99.1	39		24.0	24.3	24.5	24.7	25.0	25.2	25.4	25.7	25.9	26.1	26.3	26.6	26.8	27.0	27.3	27.5	27.7
100.3	39.5		23.4	23.7	23.9	24.1	24.3	24.6	24.8	25.0	25.2	25.5	25.7	25.9	26.1	26.4	26.6	26.8	27.0
101.6	40		22.8	23.1	23.3	23.5	23.7	23.9	24.2	24.4	24.6	24.8	25.0	25.3	25.5	25.7	25.9	26.1	26.4
102.9	40.5		22.3	22.5	22.7	22.9	23.1	23.4	23.6	23.8	24.0	24.2	24.4	24.6	24.9	25.1	25.3	25.5	25.7
104.1	41		21.7	22.0	22.2	22.4	22.6	22.8	23.0	23.2	23.4	23.6	23.8	24.0	24.3	24.5	24.7	24.9	25.1
105.4	41.5		21.2	21.4	21.6	21.8	22.0	22.2	22.5	22.7	22.9	23.1	23.3	23.5	23.7	23.9	24.1	24.3	24.5
106.7	42		20.7	20.9	21.1	21.3	21.5	21.7	21.9	22.1	22.3	22.5	22.7	22.9	23.1	23.3	23.5	23.7	23.9
108.0	42.5		20.2	20.4	20.6	20.8	21.0	21.2	21.4	21.6	21.8	22.0	22.2	22.4	22.6	22.8	23.0	23.2	23.4
109.2	43		19.8	20.0	20.2	20.3	20.5	20.7	20.9	21.1	21.3	21.5	21.7	21.9	22.1	22.2	22.4	22.6	22.8
110.5	43.5		19.3	19.5	19.7	19.9	20.1	20.2	20.4	20.6	20.8	21.0	21.2	21.4	21.6	21.7	21.9	22.1	22.3
111.8	44		18.9	19.1	19.2	19.4	19.6	19.8	20.0	20.2	20.3	20.5	20.7	20.9	21.1	21.2	21.4	21.6	21.8
113.0	44.5		18.5	18.6	18.8	19.0	19.2	19.3	19.5	19.7	19.9	20.1	20.2	20.4	20.6	20.8	20.9	21.1	21.3
114.3	45		18.1	18.2	18.4	18.6	18.7	18.9	19.1	19.3	19.4	19.6	19.8	20.0	20.1	20.3	20.5	20.7	20.8
115.6	45.5		17.7	17.8	18.0	18.2	18.3	18.5	18.7	18.8	19.0	19.2	19.4	19.5	19.7	19.9	20.0	20.2	20.4
116.8	46		17.3	17.4	17.6	17.8	17.9	18.1	18.3	18.4	18.6	18.8	18.9	19.1	19.3	19.4	19.6	19.8	19.9
118.1	46.5		16.9	17.1	17.2	17.4	17.6	17.7	17.9	18.0	18.2	18.4	18.5	18.7	18.9	19.0	19.2	19.3	19.5

Calculated Body Mass Index

47"–56" and 52 lbs.–60 lbs.

Height		Weight																	
		Kg	23.6	23.8	24.0	24.3	24.5	24.7	24.9	25.2	25.4	25.6	25.9	26.1	26.3	26.5	26.8	27.0	27.2
		Lb	52	52.5	53	53.5	54	54.5	55	55.5	56	56.5	57	57.5	58	58.5	59	59.5	60
Cm	In																		
119.4	47	16.6	16.7	16.9	17.0	17.2	17.3	17.5	17.7	17.8	18.0	18.1	18.3	18.5	18.6	18.8	18.9	19.1	
120.7	47.5	16.2	16.4	16.5	16.7	16.8	17.0	17.1	17.3	17.5	17.6	17.8	17.9	18.1	18.2	18.4	18.5	18.7	
121.9	48	15.9	16.0	16.2	16.3	16.5	16.6	16.8	16.9	17.1	17.2	17.4	17.5	17.7	17.9	18.0	18.2	18.3	
124.5	49	15.2	15.4	15.5	15.7	15.8	16.0	16.1	16.3	16.4	16.5	16.7	16.8	17.0	17.1	17.3	17.4	17.6	
127.0	50	14.6	14.8	14.9	15.0	15.2	15.3	15.5	15.6	15.7	15.9	16.0	16.2	16.3	16.5	16.6	16.7	16.9	
129.5	51	14.1	14.2	14.3	14.5	14.6	14.7	14.9	15.0	15.1	15.3	15.4	15.5	15.7	15.8	15.9	16.1	16.2	
132.1	52	13.5	13.7	13.8	13.9	14.0	14.2	14.3	14.4	14.6	14.7	14.8	15.0	15.1	15.2	15.3	15.5	15.6	
134.6	53	13.0	13.1	13.3	13.4	13.5	13.6	13.8	13.9	14.0	14.1	14.3	14.4	14.5	14.6	14.8	14.9	15.0	
137.2	54					13.0	13.1	13.3	13.4	13.5	13.6	13.7	13.9	14.0	14.1	14.2	14.3	14.5	
139.7	55									13.0	13.1	13.2	13.4	13.5	13.6	13.7	13.8	13.9	
142.2	56													13.0	13.1	13.2	13.3	13.5	

Calculated Body Mass Index

35.5"–51" and 61 lbs.–77 lbs.

Height		Weight																	
		Kg	27.7	28.1	28.6	29.0	29.5	29.9	30.4	30.8	31.3	31.8	32.2	32.7	33.1	33.6	34.0	34.5	34.9
		Lb	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77
Cm	In																		
90.2	35.5		34.0	34.6															
91.4	36		33.1	33.6	34.2	34.7													
92.7	36.5		32.2	32.7	33.2	33.8	34.3	34.8											
94.0	37		31.3	31.8	32.4	32.9	33.4	33.9	34.4	34.9									
95.3	37.5		30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5	35.0							
96.5	38		29.7	30.2	30.7	31.2	31.6	32.1	32.6	33.1	33.6	34.1	34.6						
97.8	38.5		28.9	29.4	29.9	30.4	30.8	31.3	31.8	32.3	32.7	33.2	33.7	34.2	34.6				
99.1	39		28.2	28.7	29.1	29.6	30.0	30.5	31.0	31.4	31.9	32.4	32.8	33.3	33.7	34.2	34.7		
100.3	39.5		27.5	27.9	28.4	28.8	29.3	29.7	30.2	30.6	31.1	31.5	32.0	32.4	32.9	33.3	33.8	34.2	34.7
101.6	40		26.8	27.2	27.7	28.1	28.6	29.0	29.4	29.9	30.3	30.8	31.2	31.6	32.1	32.5	33.0	33.4	33.8
102.9	40.5		26.1	26.6	27.0	27.4	27.9	28.3	28.7	29.1	29.6	30.0	30.4	30.9	31.3	31.7	32.1	32.6	33.0
104.1	41		25.5	25.9	26.3	26.8	27.2	27.6	28.0	28.4	28.9	29.3	29.7	30.1	30.5	31.0	31.4	31.8	32.2
105.4	41.5		24.9	25.3	25.7	26.1	26.5	26.9	27.4	27.8	28.2	28.6	29.0	29.4	29.8	30.2	30.6	31.0	31.4
106.7	42		24.3	24.7	25.1	25.5	25.9	26.3	26.7	27.1	27.5	27.9	28.3	28.7	29.1	29.5	29.9	30.3	30.7
108.0	42.5		23.7	24.1	24.5	24.9	25.3	25.7	26.1	26.5	26.9	27.2	27.6	28.0	28.4	28.8	29.2	29.6	30.0
109.2	43		23.2	23.6	24.0	24.3	24.7	25.1	25.5	25.9	26.2	26.6	27.0	27.4	27.8	28.1	28.5	28.9	29.3
110.5	43.5		22.7	23.0	23.4	23.8	24.2	24.5	24.9	25.3	25.6	26.0	26.4	26.8	27.1	27.5	27.9	28.2	28.6
111.8	44		22.2	22.5	22.9	23.2	23.6	24.0	24.3	24.7	25.1	25.4	25.8	26.1	26.5	26.9	27.2	27.6	28.0
113.0	44.5		21.7	22.0	22.4	22.7	23.1	23.4	23.8	24.1	24.5	24.9	25.2	25.6	25.9	26.3	26.6	27.0	27.3
114.3	45		21.2	21.5	21.9	22.2	22.6	22.9	23.3	23.6	24.0	24.3	24.7	25.0	25.3	25.7	26.0	26.4	26.7
115.6	45.5		20.7	21.1	21.4	21.7	22.1	22.4	22.8	23.1	23.4	23.8	24.1	24.5	24.8	25.1	25.5	25.8	26.1
116.8	46		20.3	20.6	20.9	21.3	21.6	21.9	22.3	22.6	22.9	23.3	23.6	23.9	24.3	24.6	24.9	25.3	25.6
118.1	46.5		19.8	20.2	20.5	20.8	21.1	21.5	21.8	22.1	22.4	22.8	23.1	23.4	23.7	24.1	24.4	24.7	25.0
119.4	47		19.4	19.7	20.1	20.4	20.7	21.0	21.3	21.6	22.0	22.3	22.6	22.9	23.2	23.6	23.9	24.2	24.5
120.7	47.5		19.0	19.3	19.6	19.9	20.3	20.6	20.9	21.2	21.5	21.8	22.1	22.4	22.7	23.1	23.4	23.7	24.0
121.9	48		18.6	18.9	19.2	19.5	19.8	20.1	20.4	20.8	21.1	21.4	21.7	22.0	22.3	22.6	22.9	23.2	23.5
124.5	49		17.9	18.2	18.4	18.7	19.0	19.3	19.6	19.9	20.2	20.5	20.8	21.1	21.4	21.7	22.0	22.3	22.5
127.0	50		17.2	17.4	17.7	18.0	18.3	18.6	18.8	19.1	19.4	19.7	20.0	20.2	20.5	20.8	21.1	21.4	21.7
129.5	51		16.5	16.8	17.0	17.3	17.6	17.8	18.1	18.4	18.7	18.9	19.2	19.5	19.7	20.0	20.3	20.5	20.8

Calculated Body Mass Index

52"–64" and 61 lbs.–77 lbs.

Height		Weight																	
		Kg	27.7	28.1	28.6	29.0	29.5	29.9	30.4	30.8	31.3	31.8	32.2	32.7	33.1	33.6	34.0	34.5	34.9
		Lb	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77
Cm	In																		
132.1	52		15.9	16.1	16.4	16.6	16.9	17.2	17.4	17.7	17.9	18.2	18.5	18.7	19.0	19.2	19.5	19.8	20.0
134.6	53		15.3	15.5	15.8	16.0	16.3	16.5	16.8	17.0	17.3	17.5	17.8	18.0	18.3	18.5	18.8	19.0	19.3
137.2	54		14.7	14.9	15.2	15.4	15.7	15.9	16.2	16.4	16.6	16.9	17.1	17.4	17.6	17.8	18.1	18.3	18.6
139.7	55		14.2	14.4	14.6	14.9	15.1	15.3	15.6	15.8	16.0	16.3	16.5	16.7	17.0	17.2	17.4	17.7	17.9
142.2	56		13.7	13.9	14.1	14.3	14.6	14.8	15.0	15.2	15.5	15.7	15.9	16.1	16.4	16.6	16.8	17.0	17.3
144.8	57		13.2	13.4	13.6	13.8	14.1	14.3	14.5	14.7	14.9	15.1	15.4	15.6	15.8	16.0	16.2	16.4	16.7
147.3	58				13.2	13.4	13.6	13.8	14.0	14.2	14.4	14.6	14.8	15.0	15.3	15.5	15.7	15.9	16.1
149.9	59						13.1	13.3	13.5	13.7	13.9	14.1	14.3	14.5	14.7	14.9	15.1	15.3	15.6
152.4	60								13.1	13.3	13.5	13.7	13.9	14.1	14.3	14.5	14.6	14.8	15.0
154.9	61										13.0	13.2	13.4	13.6	13.8	14.0	14.2	14.4	14.5
157.5	62												13.2	13.4	13.5	13.7	13.9	14.1	
160.0	63															13.1	13.3	13.5	13.6
162.6	64																	13.0	13.2

Calculated Body Mass Index

40.5"–60" and 78 lbs.–94 lbs.

Height		Weight																	
		Kg	35.4	35.8	36.3	36.7	37.2	37.6	38.1	38.6	39.0	39.5	39.9	40.4	40.8	41.3	41.7	42.2	42.6
		Lb	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94
Cm	In																		
101.6	40		34.3	34.7															
102.9	40.5		33.4	33.9	34.3	34.7													
104.1	41		32.6	33.0	33.5	33.9	34.3	34.7											
105.4	41.5		31.8	32.2	32.7	33.1	33.5	33.9	34.3	34.7									
106.7	42		31.1	31.5	31.9	32.3	32.7	33.1	33.5	33.9	34.3	34.7							
108.0	42.5		30.4	30.8	31.1	31.5	31.9	32.3	32.7	33.1	33.5	33.9	34.3	34.6					
109.2	43		29.7	30.0	30.4	30.8	31.2	31.6	31.9	32.3	32.7	33.1	33.5	33.8	34.2	34.6	35.0		
110.5	43.5		29.0	29.4	29.7	30.1	30.5	30.8	31.2	31.6	32.0	32.3	32.7	33.1	33.4	33.8	34.2	34.6	34.9
111.8	44		28.3	28.7	29.1	29.4	29.8	30.1	30.5	30.9	31.2	31.6	32.0	32.3	32.7	33.0	33.4	33.8	34.1
113.0	44.5		27.7	28.0	28.4	28.8	29.1	29.5	29.8	30.2	30.5	30.9	31.2	31.6	32.0	32.3	32.7	33.0	33.4
114.3	45		27.1	27.4	27.8	28.1	28.5	28.8	29.2	29.5	29.9	30.2	30.6	30.9	31.2	31.6	31.9	32.3	32.6
115.6	45.5		26.5	26.8	27.2	27.5	27.8	28.2	28.5	28.9	29.2	29.5	29.9	30.2	30.6	30.9	31.2	31.6	31.9
116.8	46		25.9	26.2	26.6	26.9	27.2	27.6	27.9	28.2	28.6	28.9	29.2	29.6	29.9	30.2	30.6	30.9	31.2
118.1	46.5		25.4	25.7	26.0	26.3	26.7	27.0	27.3	27.6	28.0	28.3	28.6	28.9	29.3	29.6	29.9	30.2	30.6
119.4	47		24.8	25.1	25.5	25.8	26.1	26.4	26.7	27.1	27.4	27.7	28.0	28.3	28.6	29.0	29.3	29.6	29.9
120.7	47.5		24.3	24.6	24.9	25.2	25.6	25.9	26.2	26.5	26.8	27.1	27.4	27.7	28.0	28.4	28.7	29.0	29.3
121.9	48		23.8	24.1	24.4	24.7	25.0	25.3	25.6	25.9	26.2	26.5	26.9	27.2	27.5	27.8	28.1	28.4	28.7
124.5	49		22.8	23.1	23.4	23.7	24.0	24.3	24.6	24.9	25.2	25.5	25.8	26.1	26.4	26.6	26.9	27.2	27.5
127.0	50		21.9	22.2	22.5	22.8	23.1	23.3	23.6	23.9	24.2	24.5	24.7	25.0	25.3	25.6	25.9	26.2	26.4
129.5	51		21.1	21.4	21.6	21.9	22.2	22.4	22.7	23.0	23.2	23.5	23.8	24.1	24.3	24.6	24.9	25.1	25.4
132.1	52		20.3	20.5	20.8	21.1	21.3	21.6	21.8	22.1	22.4	22.6	22.9	23.1	23.4	23.7	23.9	24.2	24.4
134.6	53		19.5	19.8	20.0	20.3	20.5	20.8	21.0	21.3	21.5	21.8	22.0	22.3	22.5	22.8	23.0	23.3	23.5
137.2	54		18.8	19.0	19.3	19.5	19.8	20.0	20.3	20.5	20.7	21.0	21.2	21.5	21.7	21.9	22.2	22.4	22.7
139.7	55		18.1	18.4	18.6	18.8	19.1	19.3	19.5	19.8	20.0	20.2	20.5	20.7	20.9	21.2	21.4	21.6	21.8
142.2	56		17.5	17.7	17.9	18.2	18.4	18.6	18.8	19.1	19.3	19.5	19.7	20.0	20.2	20.4	20.6	20.8	21.1
144.8	57		16.9	17.1	17.3	17.5	17.7	18.0	18.2	18.4	18.6	18.8	19.0	19.3	19.5	19.7	19.9	20.1	20.3
147.3	58		16.3	16.5	16.7	16.9	17.1	17.3	17.6	17.8	18.0	18.2	18.4	18.6	18.8	19.0	19.2	19.4	19.6
149.9	59		15.8	16.0	16.2	16.4	16.6	16.8	17.0	17.2	17.4	17.6	17.8	18.0	18.2	18.4	18.6	18.8	19.0
152.4	60		15.2	15.4	15.6	15.8	16.0	16.2	16.4	16.6	16.8	17.0	17.2	17.4	17.6	17.8	18.0	18.2	18.4

Calculated Body Mass Index

61"–71" and 78 lbs.–94 lbs.

Height Cm In		Weight																	
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																	
		Kg	35.4	35.8	36.3	36.7	37.2	37.6	38.1	38.6	39.0	39.5	39.9	40.4	40.8	41.3	41.7	42.2	42.6
		Lb	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94
154.9	61		14.7	14.9	15.1	15.3	15.5	15.7	15.9	16.1	16.2	16.4	16.6	16.8	17.0	17.2	17.4	17.6	17.8
157.5	62		14.3	14.4	14.6	14.8	15.0	15.2	15.4	15.5	15.7	15.9	16.1	16.3	16.5	16.6	16.8	17.0	17.2
160.0	63		13.8	14.0	14.2	14.3	14.5	14.7	14.9	15.1	15.2	15.4	15.6	15.8	15.9	16.1	16.3	16.5	16.7
162.6	64		13.4	13.6	13.7	13.9	14.1	14.2	14.4	14.6	14.8	14.9	15.1	15.3	15.4	15.6	15.8	16.0	16.1
165.1	65			13.1	13.3	13.5	13.6	13.8	14.0	14.1	14.3	14.5	14.6	14.8	15.0	15.1	15.3	15.5	15.6
167.6	66				13.1	13.2	13.4	13.6	13.7	13.9	14.0	14.2	14.4	14.5	14.7	14.8	15.0	15.2	
170.2	67							13.2	13.3	13.5	13.6	13.8	13.9	14.1	14.3	14.4	14.6	14.7	
172.7	68									13.1	13.2	13.4	13.5	13.7	13.8	14.0	14.1	14.3	
175.3	69											13.1	13.3	13.4	13.6	13.7	13.9		
177.8	70															13.1	13.2	13.3	13.5
180.3	71																		13.1

Calculated Body Mass Index

44"–68" and 95 lbs.–112 lbs.

Height		Weight																	
		Kg	43.1	43.5	44.0	44.5	44.9	45.4	45.8	46.3	46.7	47.2	47.6	48.1	48.5	49.0	49.4	49.9	50.8
		Lb	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	112
Cm	In																		
111.8	44		34.5	34.9															
113.0	44.5		33.7	34.1	34.4	34.8													
114.3	45		33.0	33.3	33.7	34.0	34.4	34.7											
115.6	45.5		32.3	32.6	32.9	33.3	33.6	34.0	34.3	34.6	35.0								
116.8	46		31.6	31.9	32.2	32.6	32.9	33.2	33.6	33.9	34.2	34.6	34.9						
118.1	46.5		30.9	31.2	31.5	31.9	32.2	32.5	32.8	33.2	33.5	33.8	34.1	34.5	34.8				
119.4	47		30.2	30.6	30.9	31.2	31.5	31.8	32.1	32.5	32.8	33.1	33.4	33.7	34.1	34.4	34.7		
120.7	47.5		29.6	29.9	30.2	30.5	30.8	31.2	31.5	31.8	32.1	32.4	32.7	33.0	33.3	33.7	34.0	34.3	34.9
121.9	48		29.0	29.3	29.6	29.9	30.2	30.5	30.8	31.1	31.4	31.7	32.0	32.3	32.7	33.0	33.3	33.6	34.2
124.5	49		27.8	28.1	28.4	28.7	29.0	29.3	29.6	29.9	30.2	30.5	30.7	31.0	31.3	31.6	31.9	32.2	32.8
127.0	50		26.7	27.0	27.3	27.6	27.8	28.1	28.4	28.7	29.0	29.2	29.5	29.8	30.1	30.4	30.7	30.9	31.5
129.5	51		25.7	25.9	26.2	26.5	26.8	27.0	27.3	27.6	27.8	28.1	28.4	28.7	28.9	29.2	29.5	29.7	30.3
132.1	52		24.7	25.0	25.2	25.5	25.7	26.0	26.3	26.5	26.8	27.0	27.3	27.6	27.8	28.1	28.3	28.6	29.1
134.6	53		23.8	24.0	24.3	24.5	24.8	25.0	25.3	25.5	25.8	26.0	26.3	26.5	26.8	27.0	27.3	27.5	28.0
137.2	54		22.9	23.1	23.4	23.6	23.9	24.1	24.4	24.6	24.8	25.1	25.3	25.6	25.8	26.0	26.3	26.5	27.0
139.7	55		22.1	22.3	22.5	22.8	23.0	23.2	23.5	23.7	23.9	24.2	24.4	24.6	24.9	25.1	25.3	25.6	26.0
142.2	56		21.3	21.5	21.7	22.0	22.2	22.4	22.6	22.9	23.1	23.3	23.5	23.8	24.0	24.2	24.4	24.7	25.1
144.8	57		20.6	20.8	21.0	21.2	21.4	21.6	21.9	22.1	22.3	22.5	22.7	22.9	23.2	23.4	23.6	23.8	24.2
147.3	58		19.9	20.1	20.3	20.5	20.7	20.9	21.1	21.3	21.5	21.7	21.9	22.2	22.4	22.6	22.8	23.0	23.4
149.9	59		19.2	19.4	19.6	19.8	20.0	20.2	20.4	20.6	20.8	21.0	21.2	21.4	21.6	21.8	22.0	22.2	22.6
152.4	60		18.6	18.7	18.9	19.1	19.3	19.5	19.7	19.9	20.1	20.3	20.5	20.7	20.9	21.1	21.3	21.5	21.9
154.9	61		17.9	18.1	18.3	18.5	18.7	18.9	19.1	19.3	19.5	19.7	19.8	20.0	20.2	20.4	20.6	20.8	21.2
157.5	62		17.4	17.6	17.7	17.9	18.1	18.3	18.5	18.7	18.8	19.0	19.2	19.4	19.6	19.8	19.9	20.1	20.5
160.0	63		16.8	17.0	17.2	17.4	17.5	17.7	17.9	18.1	18.2	18.4	18.6	18.8	19.0	19.1	19.3	19.5	19.8
162.6	64		16.3	16.5	16.6	16.8	17.0	17.2	17.3	17.5	17.7	17.9	18.0	18.2	18.4	18.5	18.7	18.9	19.2
165.1	65		15.8	16.0	16.1	16.3	16.5	16.6	16.8	17.0	17.1	17.3	17.5	17.6	17.8	18.0	18.1	18.3	18.6
167.6	66		15.3	15.5	15.7	15.8	16.0	16.1	16.3	16.5	16.6	16.8	16.9	17.1	17.3	17.4	17.6	17.8	18.1
170.2	67		14.9	15.0	15.2	15.3	15.5	15.7	15.8	16.0	16.1	16.3	16.4	16.6	16.8	16.9	17.1	17.2	17.5
172.7	68		14.4	14.6	14.7	14.9	15.1	15.2	15.4	15.5	15.7	15.8	16.0	16.1	16.3	16.4	16.6	16.7	17.0

Calculated Body Mass Index

69"–77" and 95 lbs.–112 lbs.

Height		Weight																	
		Kg	43.1	43.5	44.0	44.5	44.9	45.4	45.8	46.3	46.7	47.2	47.6	48.1	48.5	49.0	49.4	49.9	50.8
		Lb	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	112
Cm	In																		
175.3	69		14.0	14.2	14.3	14.5	14.6	14.8	14.9	15.1	15.2	15.4	15.5	15.7	15.8	15.9	16.1	16.2	16.5
177.8	70		13.6	13.8	13.9	14.1	14.2	14.3	14.5	14.6	14.8	14.9	15.1	15.2	15.4	15.5	15.6	15.8	16.1
180.3	71		13.2	13.4	13.5	13.7	13.8	13.9	14.1	14.2	14.4	14.5	14.6	14.8	14.9	15.1	15.2	15.3	15.6
182.9	72			13.0	13.2	13.3	13.4	13.6	13.7	13.8	14.0	14.1	14.2	14.4	14.5	14.6	14.8	14.9	15.2
185.4	73					13.1	13.2	13.3	13.5	13.6	13.7	13.9	14.0	14.1	14.2	14.4	14.5	14.8	
188.0	74								13.1	13.2	13.4	13.5	13.6	13.7	13.9	14.0	14.1	14.4	
190.5	75											13.1	13.2	13.4	13.5	13.6	13.7	14.0	
193.0	76													13.0	13.1	13.3	13.4	13.6	
195.6	77																	13.0	13.3

Calculated Body Mass Index

48"–76" and 114 lbs.–146 lbs.

Height Cm In		Weight																	
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																	
		Kg	51.7	52.6	53.5	54.4	55.3	56.2	57.2	58.1	59.0	59.9	60.8	61.7	62.6	63.5	64.4	65.3	66.2
		Lb	114	116	118	120	122	124	126	128	130	132	134	136	138	140	142	144	146
121.9	48		34.8																
124.5	49		33.4	34.0	34.6														
127.0	50		32.1	32.6	33.2	33.7	34.3	34.9											
129.5	51		30.8	31.4	31.9	32.4	33.0	33.5	34.1	34.6									
132.1	52		29.6	30.2	30.7	31.2	31.7	32.2	32.8	33.3	33.8	34.3	34.8						
134.6	53		28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5				
137.2	54		27.5	28.0	28.5	28.9	29.4	29.9	30.4	30.9	31.3	31.8	32.3	32.8	33.3	33.8	34.2	34.7	
139.7	55		26.5	27.0	27.4	27.9	28.4	28.8	29.3	29.7	30.2	30.7	31.1	31.6	32.1	32.5	33.0	33.5	33.9
142.2	56		25.6	26.0	26.5	26.9	27.4	27.8	28.2	28.7	29.1	29.6	30.0	30.5	30.9	31.4	31.8	32.3	32.7
144.8	57		24.7	25.1	25.5	26.0	26.4	26.8	27.3	27.7	28.1	28.6	29.0	29.4	29.9	30.3	30.7	31.2	31.6
147.3	58		23.8	24.2	24.7	25.1	25.5	25.9	26.3	26.8	27.2	27.6	28.0	28.4	28.8	29.3	29.7	30.1	30.5
149.9	59		23.0	23.4	23.8	24.2	24.6	25.0	25.4	25.9	26.3	26.7	27.1	27.5	27.9	28.3	28.7	29.1	29.5
152.4	60		22.3	22.7	23.0	23.4	23.8	24.2	24.6	25.0	25.4	25.8	26.2	26.6	27.0	27.3	27.7	28.1	28.5
154.9	61		21.5	21.9	22.3	22.7	23.1	23.4	23.8	24.2	24.6	24.9	25.3	25.7	26.1	26.5	26.8	27.2	27.6
157.5	62		20.9	21.2	21.6	21.9	22.3	22.7	23.0	23.4	23.8	24.1	24.5	24.9	25.2	25.6	26.0	26.3	26.7
160.0	63		20.2	20.5	20.9	21.3	21.6	22.0	22.3	22.7	23.0	23.4	23.7	24.1	24.4	24.8	25.2	25.5	25.9
162.6	64		19.6	19.9	20.3	20.6	20.9	21.3	21.6	22.0	22.3	22.7	23.0	23.3	23.7	24.0	24.4	24.7	25.1
165.1	65		19.0	19.3	19.6	20.0	20.3	20.6	21.0	21.3	21.6	22.0	22.3	22.6	23.0	23.3	23.6	24.0	24.3
167.6	66		18.4	18.7	19.0	19.4	19.7	20.0	20.3	20.7	21.0	21.3	21.6	22.0	22.3	22.6	22.9	23.2	23.6
170.2	67		17.9	18.2	18.5	18.8	19.1	19.4	19.7	20.0	20.4	20.7	21.0	21.3	21.6	21.9	22.2	22.6	22.9
172.7	68		17.3	17.6	17.9	18.2	18.5	18.9	19.2	19.5	19.8	20.1	20.4	20.7	21.0	21.3	21.6	21.9	22.2
175.3	69		16.8	17.1	17.4	17.7	18.0	18.3	18.6	18.9	19.2	19.5	19.8	20.1	20.4	20.7	21.0	21.3	21.6
177.8	70		16.4	16.6	16.9	17.2	17.5	17.8	18.1	18.4	18.7	18.9	19.2	19.5	19.8	20.1	20.4	20.7	20.9
180.3	71		15.9	16.2	16.5	16.7	17.0	17.3	17.6	17.9	18.1	18.4	18.7	19.0	19.2	19.5	19.8	20.1	20.4
182.9	72		15.5	15.7	16.0	16.3	16.5	16.8	17.1	17.4	17.6	17.9	18.2	18.4	18.7	19.0	19.3	19.5	19.8
185.4	73		15.0	15.3	15.6	15.8	16.1	16.4	16.6	16.9	17.2	17.4	17.7	17.9	18.2	18.5	18.7	19.0	19.3
188.0	74		14.6	14.9	15.2	15.4	15.7	15.9	16.2	16.4	16.7	16.9	17.2	17.5	17.7	18.0	18.2	18.5	18.7
190.5	75		14.2	14.5	14.7	15.0	15.2	15.5	15.7	16.0	16.2	16.5	16.7	17.0	17.2	17.5	17.7	18.0	18.2
193.0	76		13.9	14.1	14.4	14.6	14.9	15.1	15.3	15.6	15.8	16.1	16.3	16.6	16.8	17.0	17.3	17.5	17.8

Calculated Body Mass Index

77"–78" and 114 lbs.–146 lbs.

Height		Weight																	
		Kg	51.7	52.6	53.5	54.4	55.3	56.2	57.2	58.1	59.0	59.9	60.8	61.7	62.6	63.5	64.4	65.3	66.2
		Lb	114	116	118	120	122	124	126	128	130	132	134	136	138	140	142	144	146
Cm	In																		
195.6	77		13.5	13.8	14.0	14.2	14.5	14.7	14.9	15.2	15.4	15.7	15.9	16.1	16.4	16.6	16.8	17.1	17.3
198.1	78		13.2	13.4	13.6	13.9	14.1	14.3	14.6	14.8	15.0	15.3	15.5	15.7	15.9	16.2	16.4	16.6	16.9

Calculated Body Mass Index

55"–78" and 148 lbs.–180 lbs.

		Weight																	
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																	
Height	Weight																		
	Kg	Lb	67.1	68.0	68.9	69.9	70.8	71.7	72.6	73.5	74.4	75.3	76.2	77.1	78.0	78.9	79.8	80.7	81.6
Cm	In	Lb	148	150	152	154	156	158	160	162	164	166	168	170	172	174	176	178	180
139.7	55		34.4	34.9															
142.2	56		33.2	33.6	34.1	34.5	35.0												
144.8	57		32.0	32.5	32.9	33.3	33.8	34.2	34.6										
147.3	58		30.9	31.3	31.8	32.2	32.6	33.0	33.4	33.9	34.3	34.7							
149.9	59		29.9	30.3	30.7	31.1	31.5	31.9	32.3	32.7	33.1	33.5	33.9	34.3	34.7				
152.4	60		28.9	29.3	29.7	30.1	30.5	30.9	31.2	31.6	32.0	32.4	32.8	33.2	33.6	34.0	34.4	34.8	
154.9	61		28.0	28.3	28.7	29.1	29.5	29.9	30.2	30.6	31.0	31.4	31.7	32.1	32.5	32.9	33.3	33.6	34.0
157.5	62		27.1	27.4	27.8	28.2	28.5	28.9	29.3	29.6	30.0	30.4	30.7	31.1	31.5	31.8	32.2	32.6	32.9
160.0	63		26.2	26.6	26.9	27.3	27.6	28.0	28.3	28.7	29.1	29.4	29.8	30.1	30.5	30.8	31.2	31.5	31.9
162.6	64		25.4	25.7	26.1	26.4	26.8	27.1	27.5	27.8	28.2	28.5	28.8	29.2	29.5	29.9	30.2	30.6	30.9
165.1	65		24.6	25.0	25.3	25.6	26.0	26.3	26.6	27.0	27.3	27.6	28.0	28.3	28.6	29.0	29.3	29.6	30.0
167.6	66		23.9	24.2	24.5	24.9	25.2	25.5	25.8	26.1	26.5	26.8	27.1	27.4	27.8	28.1	28.4	28.7	29.1
170.2	67		23.2	23.5	23.8	24.1	24.4	24.7	25.1	25.4	25.7	26.0	26.3	26.6	26.9	27.3	27.6	27.9	28.2
172.7	68		22.5	22.8	23.1	23.4	23.7	24.0	24.3	24.6	24.9	25.2	25.5	25.8	26.2	26.5	26.8	27.1	27.4
175.3	69		21.9	22.2	22.4	22.7	23.0	23.3	23.6	23.9	24.2	24.5	24.8	25.1	25.4	25.7	26.0	26.3	26.6
177.8	70		21.2	21.5	21.8	22.1	22.4	22.7	23.0	23.2	23.5	23.8	24.1	24.4	24.7	25.0	25.3	25.5	25.8
180.3	71		20.6	20.9	21.2	21.5	21.8	22.0	22.3	22.6	22.9	23.2	23.4	23.7	24.0	24.3	24.5	24.8	25.1
182.9	72		20.1	20.3	20.6	20.9	21.2	21.4	21.7	22.0	22.2	22.5	22.8	23.1	23.3	23.6	23.9	24.1	24.4
185.4	73		19.5	19.8	20.1	20.3	20.6	20.8	21.1	21.4	21.6	21.9	22.2	22.4	22.7	23.0	23.2	23.5	23.7
188.0	74		19.0	19.3	19.5	19.8	20.0	20.3	20.5	20.8	21.1	21.3	21.6	21.8	22.1	22.3	22.6	22.9	23.1
190.5	75		18.5	18.7	19.0	19.2	19.5	19.7	20.0	20.2	20.5	20.7	21.0	21.2	21.5	21.7	22.0	22.2	22.5
193.0	76		18.0	18.3	18.5	18.7	19.0	19.2	19.5	19.7	20.0	20.2	20.4	20.7	20.9	21.2	21.4	21.7	21.9
195.6	77		17.6	17.8	18.0	18.3	18.5	18.7	19.0	19.2	19.4	19.7	19.9	20.2	20.4	20.6	20.9	21.1	21.3
198.1	78		17.1	17.3	17.6	17.8	18.0	18.3	18.5	18.7	19.0	19.2	19.4	19.6	19.9	20.1	20.3	20.6	20.8

Calculated Body Mass Index

61"-78" and 182 lbs.-214 lbs.

		Weight																														
		Whenever a child's specific height or weight measurement is not listed, round to the closest number in the table.																														
		Kg	82.6	83.5	84.4	85.3	86.2	87.1	88.0	88.9	89.8	90.7	91.6	92.5	93.4	94.3	95.3	96.2	97.1													
		Lb	182	184	186	188	190	192	194	196	198	200	202	204	206	208	210	212	214													
Height																																
Cm	In																															
154.9	61		34.4	34.8																												
157.5	62		33.3	33.7	34.0	34.4	34.8																									
160.0	63		32.2	32.6	32.9	33.3	33.7	34.0	34.4	34.7																						
162.6	64		31.2	31.6	31.9	32.3	32.6	33.0	33.3	33.6	34.0	34.3	34.7																			
165.1	65		30.3	30.6	31.0	31.3	31.6	32.0	32.3	32.6	32.9	33.3	33.6	33.9	34.3	34.6	34.9															
167.6	66		29.4	29.7	30.0	30.3	30.7	31.0	31.3	31.6	32.0	32.3	32.6	32.9	33.2	33.6	33.9	34.2	34.5													
170.2	67		28.5	28.8	29.1	29.4	29.8	30.1	30.4	30.7	31.0	31.3	31.6	32.0	32.3	32.6	32.9	33.2	33.5													
172.7	68		27.7	28.0	28.3	28.6	28.9	29.2	29.5	29.8	30.1	30.4	30.7	31.0	31.3	31.6	31.9	32.2	32.5													
175.3	69		26.9	27.2	27.5	27.8	28.1	28.4	28.6	28.9	29.2	29.5	29.8	30.1	30.4	30.7	31.0	31.3	31.6													
177.8	70		26.1	26.4	26.7	27.0	27.3	27.5	27.8	28.1	28.4	28.7	29.0	29.3	29.6	29.8	30.1	30.4	30.7													
180.3	71		25.4	25.7	25.9	26.2	26.5	26.8	27.1	27.3	27.6	27.9	28.2	28.5	28.7	29.0	29.3	29.6	29.8													
182.9	72		24.7	25.0	25.2	25.5	25.8	26.0	26.3	26.6	26.9	27.1	27.4	27.7	27.9	28.2	28.5	28.8	29.0													
185.4	73		24.0	24.3	24.5	24.8	25.1	25.3	25.6	25.9	26.1	26.4	26.7	26.9	27.2	27.4	27.7	28.0	28.2													
188.0	74		23.4	23.6	23.9	24.1	24.4	24.7	24.9	25.2	25.4	25.7	25.9	26.2	26.4	26.7	27.0	27.2	27.5													
190.5	75		22.7	23.0	23.2	23.5	23.7	24.0	24.2	24.5	24.7	25.0	25.2	25.5	25.7	26.0	26.2	26.5	26.7													
193.0	76		22.2	22.4	22.6	22.9	23.1	23.4	23.6	23.9	24.1	24.3	24.6	24.8	25.1	25.3	25.6	25.8	26.0													
195.6	77		21.6	21.8	22.1	22.3	22.5	22.8	23.0	23.2	23.5	23.7	24.0	24.2	24.4	24.7	24.9	25.1	25.4													
198.1	78		21.0	21.3	21.5	21.7	22.0	22.2	22.4	22.6	22.9	23.1	23.3	23.6	23.8	24.0	24.3	24.5	24.7													

Calculated Body Mass Index

66"-78" and 216 lbs.-250 lbs.

Height		Weight																		
		Kg	98.0	98.9	99.8	100.7	101.6	102.5	103.4	104.3	105.2	106.1	107.0	108.0	108.9	109.8	110.7	111.6	112.5	113.4
		Lb	216	218	220	222	224	226	228	230	232	234	236	238	240	242	244	246	248	250
Cm	In																			
167.6	66	34.9																		
170.2	67	33.8	34.1	34.5	34.8															
172.7	68	32.8	33.1	33.5	33.8	34.1	34.4	34.7	35.0											
175.3	69	31.9	32.2	32.5	32.8	33.1	33.4	33.7	34.0	34.3	34.6	34.9								
177.8	70	31.0	31.3	31.6	31.9	32.1	32.4	32.7	33.0	33.3	33.6	33.9	34.1	34.4	34.7					
180.3	71	30.1	30.4	30.7	31.0	31.2	31.5	31.8	32.1	32.4	32.6	32.9	33.2	33.5	33.8	34.0	34.3	34.6	34.9	
182.9	72	29.3	29.6	29.8	30.1	30.4	30.7	30.9	31.2	31.5	31.7	32.0	32.3	32.5	32.8	33.1	33.4	33.6	33.9	
185.4	73	28.5	28.8	29.0	29.3	29.6	29.8	30.1	30.3	30.6	30.9	31.1	31.4	31.7	31.9	32.2	32.5	32.7	33.0	
188.0	74	27.7	28.0	28.2	28.5	28.8	29.0	29.3	29.5	29.8	30.0	30.3	30.6	30.8	31.1	31.3	31.6	31.8	32.1	
190.5	75	27.0	27.2	27.5	27.7	28.0	28.2	28.5	28.7	29.0	29.2	29.5	29.7	30.0	30.2	30.5	30.7	31.0	31.2	
193.0	76	26.3	26.5	26.8	27.0	27.3	27.5	27.8	28.0	28.2	28.5	28.7	29.0	29.2	29.5	29.7	29.9	30.2	30.4	
195.6	77	25.6	25.9	26.1	26.3	26.6	26.8	27.0	27.3	27.5	27.7	28.0	28.2	28.5	28.7	28.9	29.2	29.4	29.6	
198.1	78	25.0	25.2	25.4	25.7	25.9	26.1	26.3	26.6	26.8	27.0	27.3	27.5	27.7	28.0	28.2	28.4	28.7	28.9	

Ohio WIC Management Evaluation

Checklist for WIC Certification Appointments

Project:

Clinic:

Reviewer:

- The following procedures must occur at all cert/recert appointments; however the order will depend on clinic flow.
- Income verification should always occur before nutrition risk is determined.
- All information on the WTW letter must be completed & explained before the participant/guardian signs the letter, except in the case of an authorized representative.

P N B I C

Greet Participant/Sign-in Sheets:

Participant/Guardian Leaves:

Total Time:

VENA Observation

SS / HP	
	Treats participant with courtesy, respect and a positive attitude (smile/eye contact/welcome)
	Practices active listening techniques and observation skills (nodding/leaning forward/ attentive eyes)
	Uses reflective listening techniques to check for understanding (clarifies/affirms/recaps)
	Projects appropriate nonverbal behaviors and assesses participant nonverbal cues
	Assesses and responds appropriately to participant's needs
	Shows respect for cultural (language/ age/race/etc.) differences
	Uses resources for non-English speaking participants appropriately and proficiently
	Critical Thinking skills are used throughout the appointment
	Evidence of teamwork (communication/ assisting coworkers/etc.)

Explanation of WIC Program - Certification & Recertification Appointments

- These points can be covered by clerk, HP, etc...no certain order as long as all are covered.

	Nutrition Support (education and strategies for a healthy diet/supplemental foods/referrals and BF support)
	Nutrition Assessment (identify nutrition needs/medical conditions/dietary practices/interests/wants /needs)
	WIC Staff and Participant Work in Partnership (open dialogue/two-way communication)
	WIC Food Benefits are Prescribed for the Individual
	Supplemental Program (only provides part of foods for the month)
	Reapplication for Services (placed on program for 6 months, as long as keep appointments)

Application

- If **not** eligible, complete and explain *Notice: The WIC Program Cannot Serve You* letter, and offer consultation with Health Professional.

	Verbally review information provided		Check category
	Check residency/physical presence		Signatures/dates
	Check identity		Update computer screen
	Income calculations/documentation		Use correct form

Other

	Voter Registration <ul style="list-style-type: none"> • Must offer voter registration form & designated voter registration notice of rights (Do <u>not</u> just ask)
	Immunization <ul style="list-style-type: none"> • Screen and refer/Update system as applicable
	Health History Forms <ul style="list-style-type: none"> • Participant completes (unless mailed) - Check that the forms are completed correctly • Note: Some projects do the anthropometric measurements before these forms are completed

Ohio WIC Management Evaluation

Anthropometric Measurements

- Can be completed by any WIC staff, as long as trained appropriately

	Explain what measurements will be taken
	Take appropriate measurements and document on growth chart/prenatal chart
	Make sure scales are zero balanced after pad or paper placement
	Check diapers before measuring weights for infants & toddlers (best practice)
	Use universal precautions doing blood work

HP Review/Assessment

- ***Only** an HP can do these tasks

	Allows participant lead discussions (uses a combination of open and closed questions)
	Reviews completed HHX form with participant/guardian*
	Reviews growth chart/prenatal grid with participant/guardian, as needed *
	Clarify information and determine risk*
	Completes appropriate screens, if computer available
	Explains risk to participant/guardian*
	Provides counseling/education* <ul style="list-style-type: none"> • Expresses to participant/caregiver nutrition/health concerns related to her assessment of participant • Gives participant/guardian the opportunity to identify a goal • Provides appropriate education & counseling based on what the participant/guardian said
	Provides one or two (unless requested) written materials*
	Documents goal and risk on WTW letter*
	Reviews WTW letter: <ul style="list-style-type: none"> • Rights/responsibilities; fair hearing; date for next appointment; information sharing; signatures
	Offers drug/alcohol info (If certification visit – this includes infants)
	Documents assessment & plan on Nutrition Care Plan (NCP) Form/determine if high risk*
	Determines midcertification class offering with participant input <ul style="list-style-type: none"> • Explain NE will be offered at 3 month appointment
	Determines food package* (obtain prescription as needed)
	Refers if needed

Benefit Issuance

	Issue benefits/schedule midcertification appointment
	Explain procedure for picking up next set of benefits
	Participant/guardian accesses the WNC (verifies has received benefits)
	Discuss how to use WNC (cash value and WIC items)
	Give foods list/Quick Response (QR) codes
	Tell the participant/caregiver to call local project if problems with WNC
	Give vendor list
	Tell participant/caregiver to keep WNC & PIN safe, if the WNC is lost/stolen/damaged, call the clinic

Notes:

CODES FOR PUBLIC ASSISTANCE, INCOME PROOF, AND REFERRALS

Public Assistance: Required

CODE	DESCRIPTION	
01	Participation in OWF (Ohio Works First), Medicaid, and Food Assistance	
02	Participation in OWF (Ohio Works First),and Medicaid	
03	Medicaid	
04	Food Assistance	
05	Participation in Medicaid and Food Assistance	
06	Removed – Do not use	
07	Disability Financial Assistance	
08	Head Start	
09	School Breakfast Program	
10	School Lunch Program	
11	TEFAP (Temporary Emergency Food Assistance Program)	
12	Refugee Resettlement Program	
13	None	

Income Proof: Required

CODE	DESCRIPTION	
01	OWF (Ohio Works First)	
02	Medicaid	
03	Food Assistance	
04	Refugee Resettlement Program	
05	Removed – Do not use	
06	Disability Financial Assistance	
07	Check Stubs	
08	Employment Contract	
09	Current Business/Accounting records	
10	W-2 Form	
11	1040 (federal Income Tax Form)	
12	State Income Tax Form	
13	Savings/Checking/CD Account	
14	Written Statement from Agency/Organization	
15	Telephone Confirmation from Agency/Organization	
16	Statement of Income Documented	
17	0 Income Statement Documented	
18	Divorce/Dissolution Decree	
19	Lease/Contract	
20	VOC Transfer	
21	Removed – Do not use	
22	Multiple Documents	
23	Unemployment Compensation	

	Income Proof: Required - Continued	
24	Supplemental Security Income (SSI)	
25	Workers' Compensation	
26	Foster Care Payment	
27	Mineral Rights Payment	
28	Lump Sum Allocation	
29	Social Security	
30	Child Support	

Referral Codes To and From: Required

01	CDJFS (County Dept. of Job & Family Services)	
02	CFHS (Child and Family Health Services)	
03	CMH (Children with Medical Handicaps)	
04	HMG (Help Me Grow)	
05	OWF (Ohio Works First)	
06	Food Assistance	
07	County Public Children Services Agencies	
08	At-Risk Pregnancy Services	
09	Primary Health Care	
10	Healthchek	
11	EFNEP (Expanded Food and Nutrition Education Program)	
12	Child Support Enforcement	
13	Immunizations	
14	Alcohol and Drug Counseling	
15	Grads	
16	Food Bank	
17	Head Start	
18	Social Service Agency	
19	Breastfeeding Support	
20	OIMRI (Ohio Infant Mortality Reduction Initiative)	
21	Weight Management	
22	Word of Mouth	
23	Lead	
24	Car Seat Program	
25	Oral Health	
26	Smoking Cessation	
27	None	

Common Immunization Abbreviations

Impact Vaccine			
Groups	Vaccine Name	Other Abbreviations	Popular brands
DTP	Diphtheria, Tetanus, Pertussis	DTaP	Daptacel, Tripedia
FLU	Influenza	--	FluMist, Fluzone
HAV	Hepatitis A	Hep A	Havrix, Vaqta
HBV	Hepatitis B	Hep B	Engerix B, Recombivax
HPV	Human Papillomavirus	--	Cervarix, Gardasil
HIB	Haemophilus influenzae type b	Hib	ActHIB, Hiberix
MMR	Measles, Mumps, Rubella	MMRV (if it includes varicella)	MMR II, Proquad (MMRV)
Meningococcal	Meningococcal Conjugate	MCV	MCV4, Menactra, Menveo
	Pneumococcal conjugate	PCV	Prenar 13, Pneumovax
	Polio	IPOL (inactivated)	IPOL
Rotavirus	Rotavirus	RV	Rotarix, RotaTeq
VAR	Varicella (Chickenpox)	--	Varivax, Zostavax (for zoster, or shingles)

Popular Combination Vaccines

Pentacel
 Pediarix
 Twinrix
 Comvax
 Kinrix
 ProQuad

Combination Of:

DTP, HIB, Polio
 DTP, HBV, Polio
 HAV, HBV
 HIB, HBV
 DTP, Polio (booster only)
 MMR and VAR (MMRV)

Note: This is only a cheat sheet, not a reference guide!

September, 2012

Session Date:

Participant's Name:

**Department of Defense WIC Overseas Program
Participant Profile Report/Verification of Certification Card (VOC)**

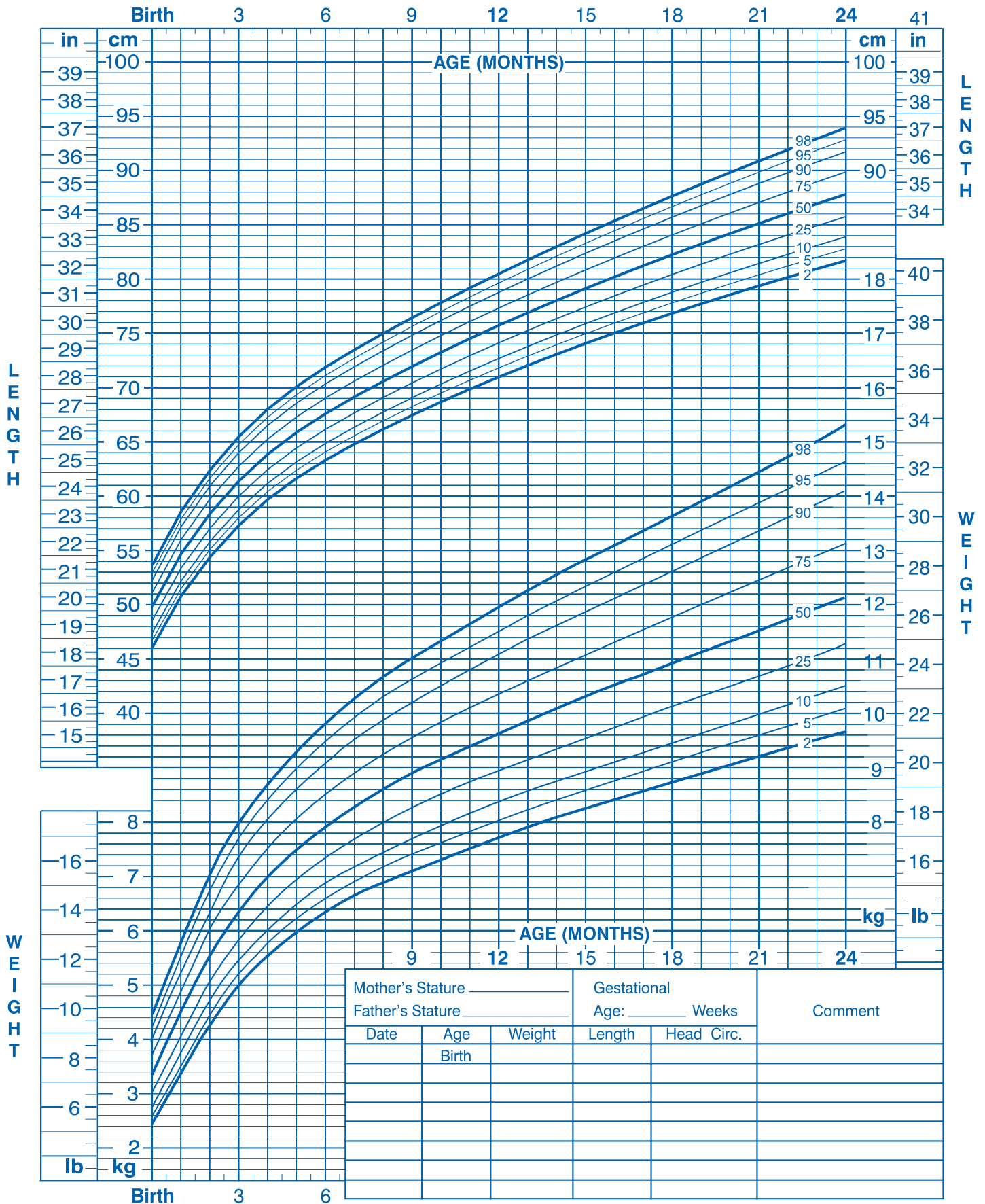
Address 1:		Address 2:		Participant Type:	
Gender: DOB:		Education:		Category:	
Marital:		Unit Phone #:		Home Phone:	
Participant ID:		Language		Race/Ethnic:	
Spouse/Parent/Guardian name:				Home Phone:	
Address1:		Address2:		Unit Phone:	
Annual Income		Primary Source:		Econ. Unit	
Sponsor Name:				Home Phone #:	
Sponsor Address 1:		Sponsor Address 2:		Unit Phone #:	
Relationship		UIC:		DEROS:	
Authorized proxy:					
Encounter Type:		WIC Site ID:		Begin Cert Date: End Cert Date:	
Height: Weight: BMI:		Hematocrit:		Date of Measurement:	
Nutrition Risks:		Priority:		EDD:	
Nutrition Education:		Date Provided:		Health Care Source:	
Food Prescription ID:					
FI One: xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxx		FI Two: xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxx		FI Three: xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxx	
Food Instrument Issued for Dates:					
Participant Rights and Obligations: I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. I understand I have a right to appeal any decision which I am aggrieved. This certification form is being submitted in connection with the receipt of Federal funds. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and federal law. I hereby certify that I am not currently enrolled in any other WICO or WIC Program. I understand that to do so would be deliberate misuse of program benefits and could result in the loss of these benefits.					
Participant or Parent/Guardian Signature:		Date:		Competent Professional Authority:	
Print Name.					

Birth to 24 months: Boys

Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____

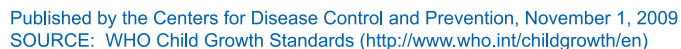


Published by the Centers for Disease Control and Prevention, November 1, 2009
 SOURCE: WHO Child Growth Standards (<http://www.who.int/childgrowth/en>)

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RECORD # _____

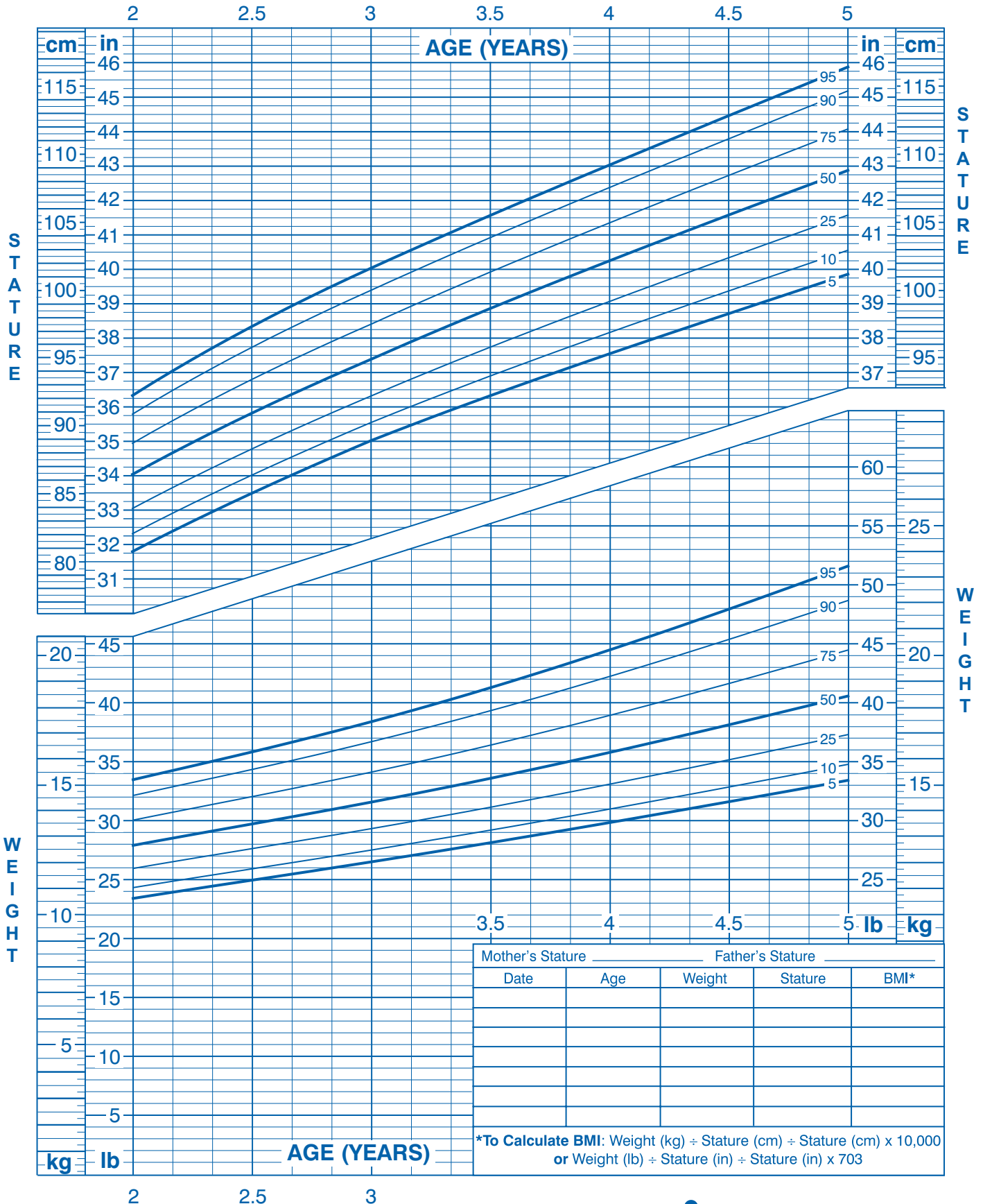


2 to 5 years: Boys

Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Available at <http://www.nal.usda.gov/wicworks>

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2002).
<http://www.cdc.gov/growthcharts>

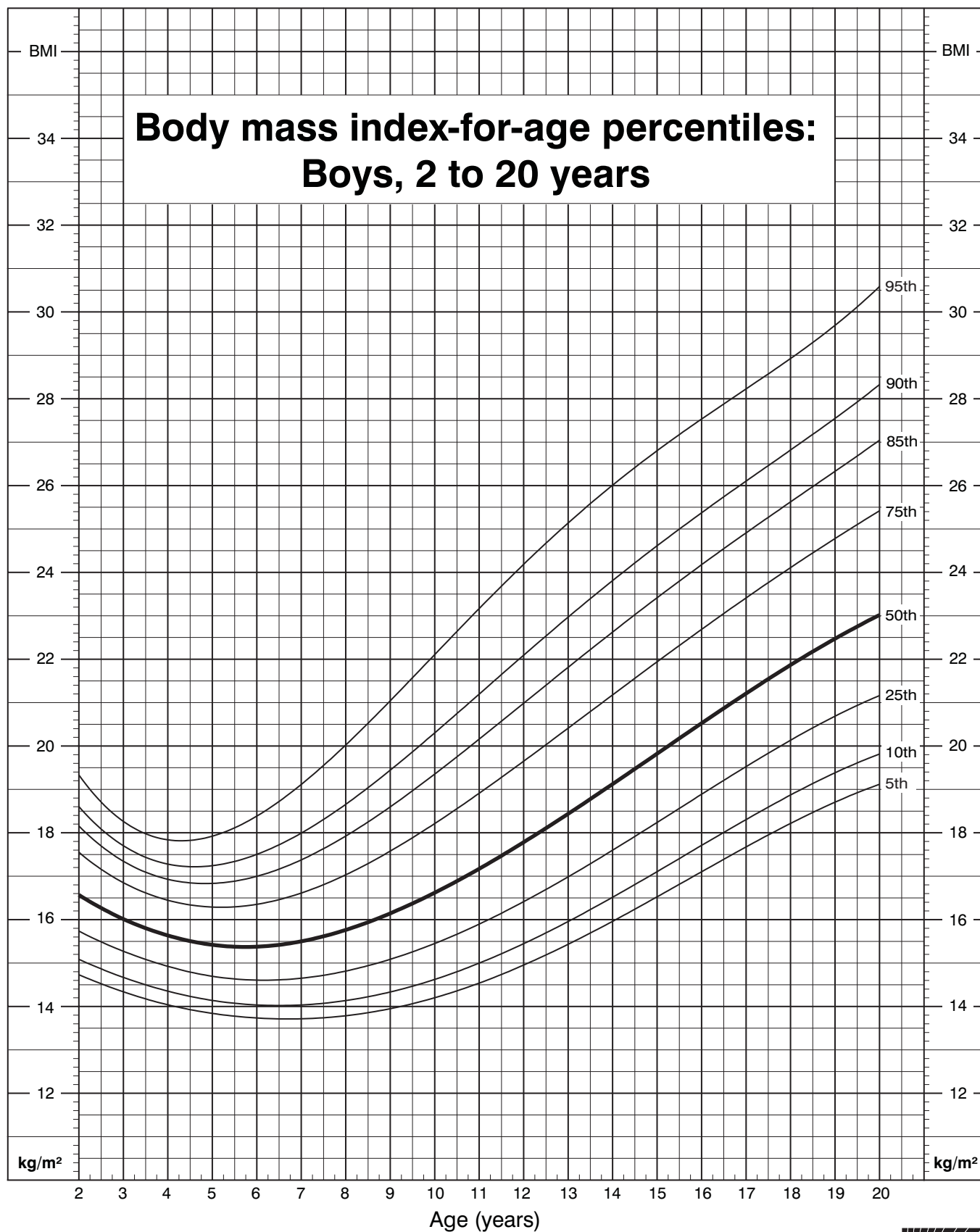


WIC Makes A Difference



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CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



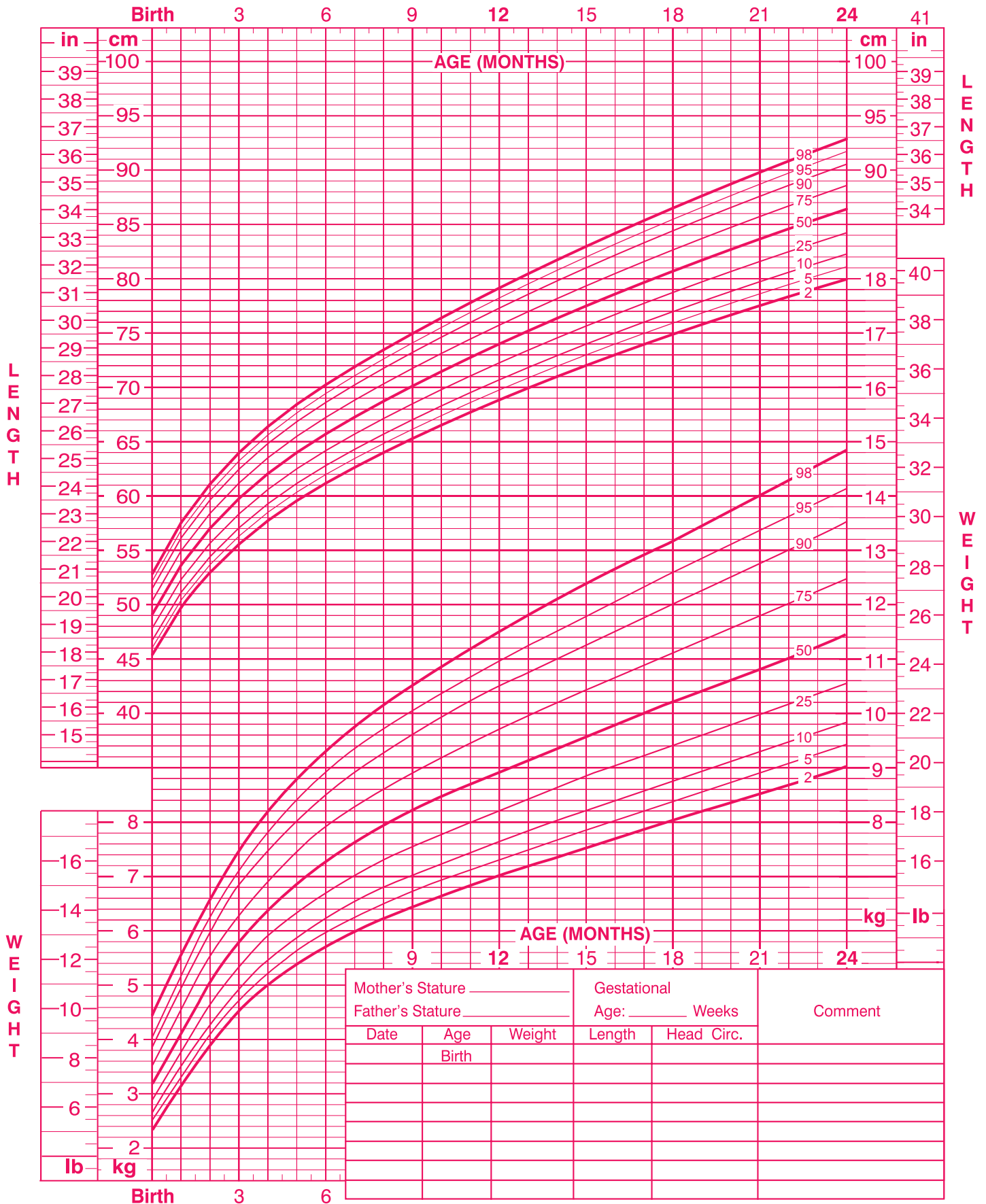
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Birth to 24 months: Girls

Length-for-age and Weight-for-age percentiles

NAME _____

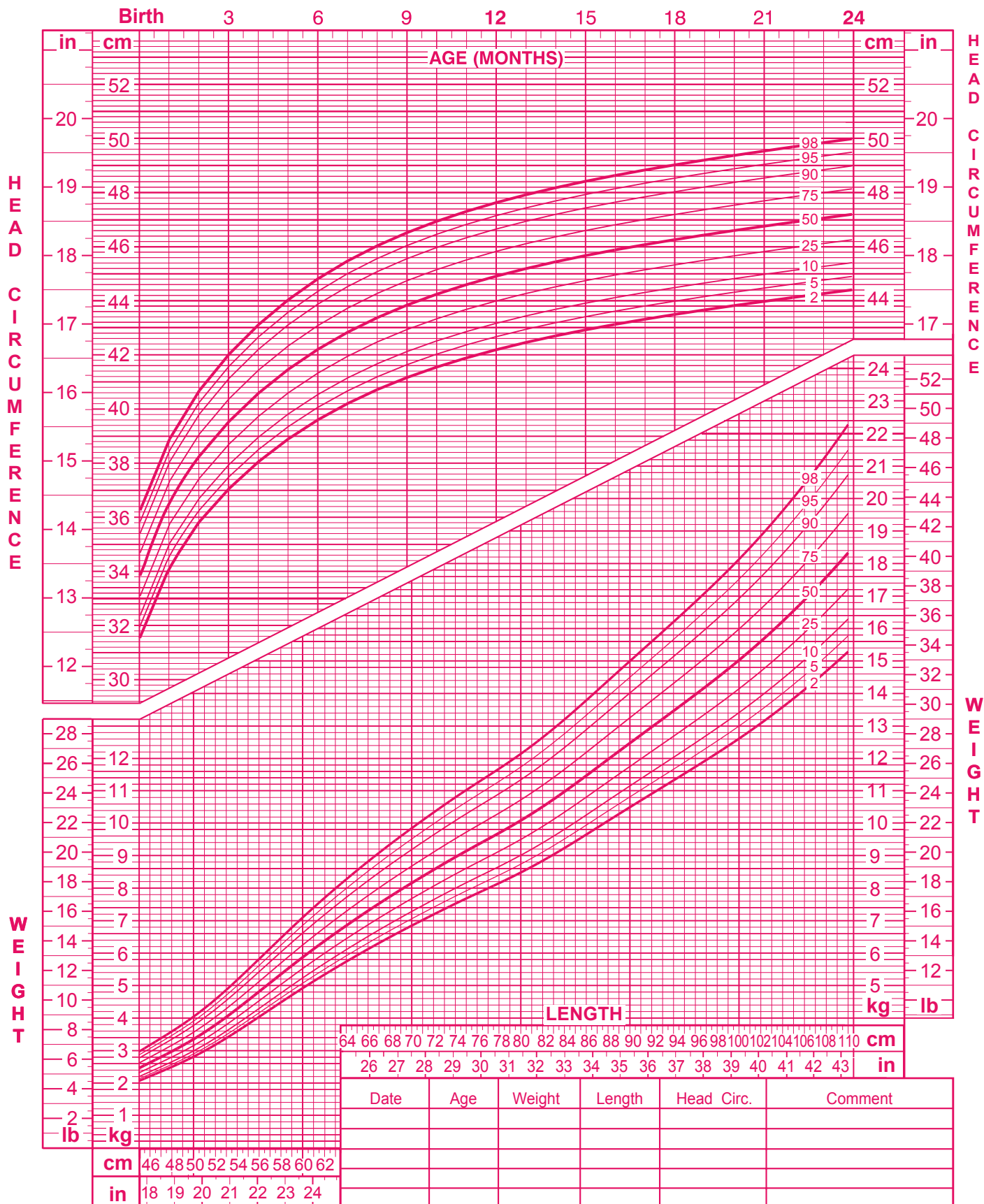
RECORD # _____



Birth to 24 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

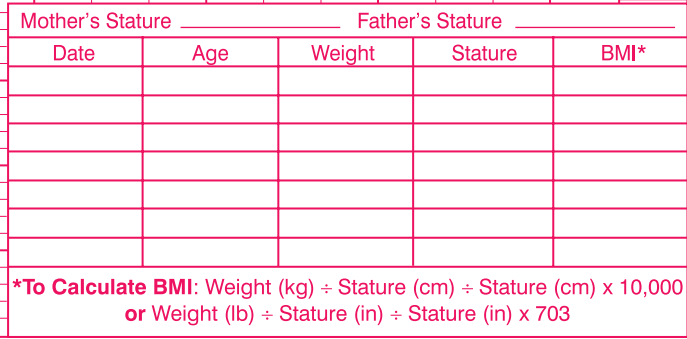
NAME _____

RECORD # _____



Stature-for-age and Weight-for-age percentiles

RECORD # _____



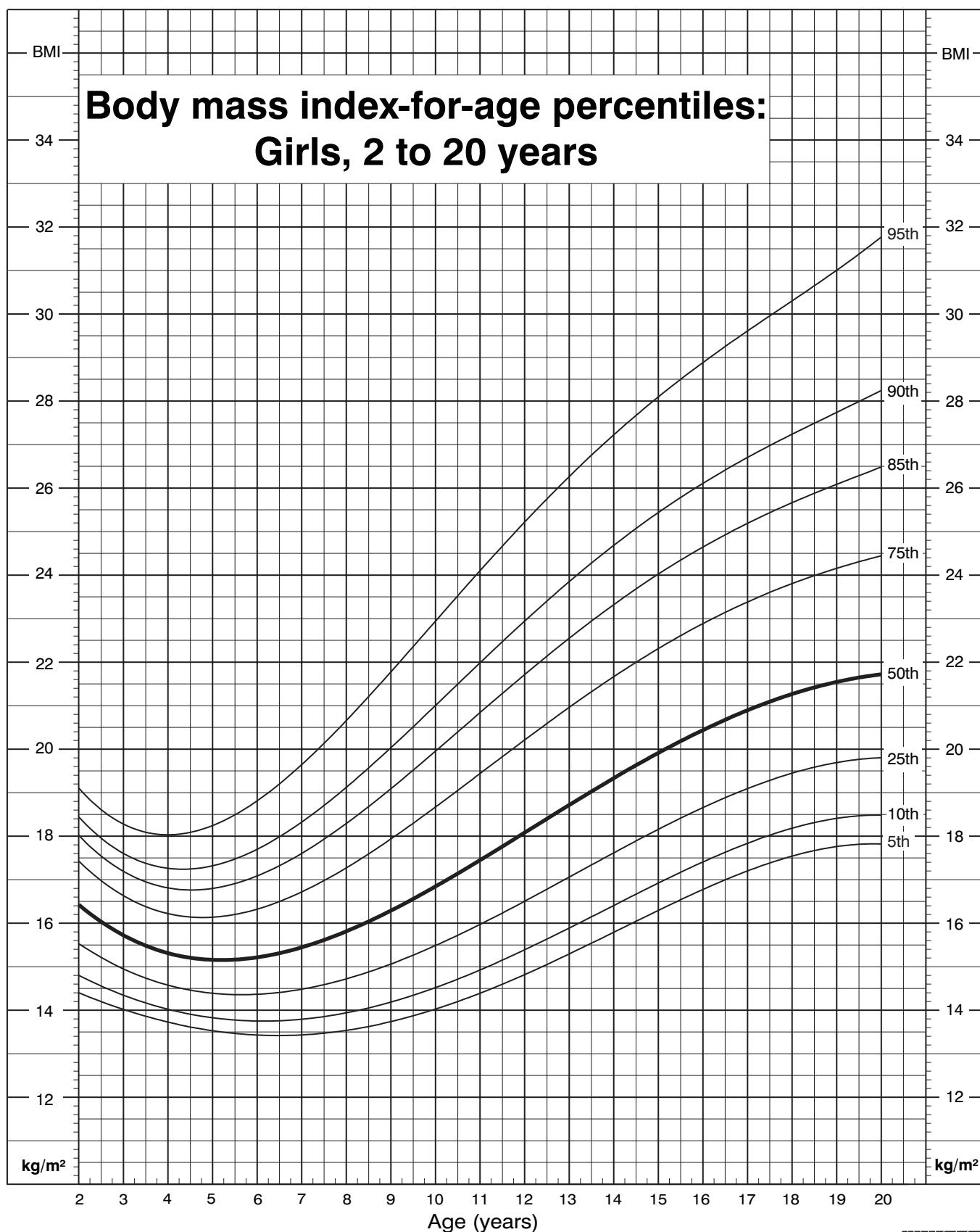
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2002). <http://www.cdc.gov/growthcharts>



SAFER • HEALTHIER • PEOPLE™



CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).



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Your WIC clinic is:

Ohio Department of Health WIC Program ID Card

Please bring this card to each WIC appointment.

Clinic Number	
Group Number	

Name and Identification Number of Participants

Name and Signature of Participant/Parent/Guardian

Print name
Signature

Names and Signatures of Alternate Shoppers

Print name
Signature

Print name
Signature

HEA 4436 Rev. 11/11

*Breastfeed...for healthy babies,
moms, and communities.*

Always bring this ID folder to **all WIC appointments** and to **the store**.

Next WIC appointment:

[illegible]

You must reapply for WIC every 6 months. At other appointments we will provide nutrition information and more coupons. Please call if you need to change an appointment.


[illegible]

Care and use of WIC coupons and WIC ID Card



At the Clinic

Keep all scheduled appointments.
If you miss appointments, you
will not get your WIC coupons.

 Only you or your alternate shopper are allowed to pick up and use the coupons for you or your children. Alternate shoppers must be at least 16 years old.

The persons named on the WIC ID card must show this ID card to pick up coupons at the WIC clinic.

You will be asked to sign coupon stubs to verify receipt of coupons.

Tell the WIC health professional if you are not using all the foods listed on your coupons.

Give the WIC staff any coupons that have expired.

Report lost or stolen coupons to the WIC clinic right away, although they will **not** be replaced.



Before you shop

Do not fold, tear, bend, or write
on your WIC coupons.

Be sure the store where you shop accepts WIC coupons.

Use your WIC coupons between first and last dates to use.

Teach your alternate shopper how to read and use the WIC coupons and the Authorized Foods List. Lend your alternate shopper the WIC ID card and list of authorized vendors to shop at the store for you.

Use one coupon each week to help prevent food spoilage and help the foods last through the month. Take only the coupons you plan to use with you to the store.

Do not use all of the formula coupons at one time. If your baby has problems with the formula, you will need to bring to the clinic the unused coupons to make a change.

Check that you and your alternate shopper have signed the WIC ID card.

Take the WIC ID card to the store.



At the Store

Do not make any changes on the coupons or WIC ID card.

Buy the foods listed on the coupons and be sure to get the full amount. You cannot get change, credit, or rain checks for anything you do not buy.

Compare prices among authorized foods. Take advantage of weekly sales and specials. Use cents off coupons from manufacturers and stores. Use your store's advantage and rewards card. This helps WIC serve more people.



Be sure the foods you choose are listed on the Authorized Foods List. Substitution of an unauthorized food item is not allowed.

At the Cash Register

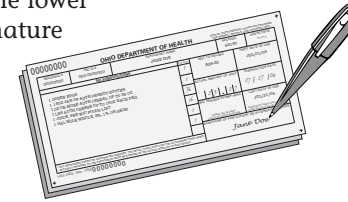
Separate your WIC foods from all other foods. Show the ID card and tell the cashier that you have

WIC coupons.

Group your WIC foods according to how they are listed on each coupon you are spending.

Give the cashier the coupons. The cashier must write in the amount of the WIC foods you bought, the total cost and the date. The cashier will return the coupons to you for you to sign.

Sign the coupons in the lower right corner. Your signature shows that you have received WIC foods equaling the total cost written on the coupons.



Note: The store must charge you the same as they charge other customers. Make sure the total is correct before signing.

Return the signed coupons and ID card to the cashier so he can compare signatures.

Note: The WIC program requires the cashier to see the WIC ID card before accepting the coupons. The signature on the coupons must match the signatures on the ID card or the cashier will refuse the sale.

How to read a WIC coupon

The diagram illustrates the layout of an Ohio Department of Health WIC coupon form, with various fields and sections labeled for identification:

- Top Section:**
 - SEQUENCE #** (00000000): Labeled "The coupon number (also the sequence number)".
 - WIC ID #** (000-0000000): Labeled "Participant's WIC Identification number".
 - PARTICIPANT NAME** (JANE DOE): Labeled "Who it is issued to".
 - PACKAGE** (42187) and **AGENCY/SITE** (****): Labeled "For state use only".
 - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**: Labeled "Date the coupon was used".
- NO SUBSTITUTIONS** Section:
 - Lists food items and quantities: 1 DOZEN EGGS, 1 18OZ JAR OF AUTH PEANUT BUTTER, 1 OZ OR MORE AUTH CEREAL UP TO 36 OZ, 1 LBS AUTH CHEESE UP TO 16OZ EACH PKG, 1 JUICE, SEE WIC FOODS LIST, 1 GAL MILK-WHOLE, 2%, 1%, OR SKIM.
 - # of items** column: 1, 1, 36, 16, 1, 1.
 - NOT TO EXCEED**: *****
 - FIRST DATE OF USE**: JUL/01/04.
 - ACTUAL AMOUNT OF SALE**: 2 | 3 | . | 0 | 7
 - TRANSACTION DATE**: 07 / 07 / 04.
 - WIC VENDOR STAMP HERE**: (Blank)
 - LAST DATE OF USE**: JUL/31/04.
 - SIGNATURE OF PARTICIPANT OR ALTERNATE SHOPPER**: Jane Doe.
- Bottom Section:**
 - NOT NEGOTIABLE EXCEPT BY CONTRACTED VENDORS. THE RETAIL TOTAL COST FOR THE AUTHORIZED FOOD ITEMS ACTUALLY PROVIDED TO THE PARTICIPANT MUST BE ENTERED IN THE ACTUAL AMOUNT OF SALE BLOCK.**
 - HEA 4402 (Rev. 7/04)** and **00000000**: Labeled "How much was spent (cashiers fill in)".
 - Identification of vendor**: (Blank).
 - Participant or alternate shopper signs the coupon here when using the coupon.**: Labeled "It must be signed in front of the cashier".
- Additional Annotations:**
 - A list of the types of foods and the amounts of each food that the coupon can be used for**: Points to the "NO SUBSTITUTIONS" list.
 - When it can be used**: Points to the date fields.

ImpactSIIS: A Quick Guide for WIC Staff

My username: _____

My password: _____

Facility ID: _____

A. Get Started

1. Go online to www.impactsiis.org.
2. Sign on at the top of the Login Page with your username and temporary password provided by your Trainer or Key Master.
3. Create your own password using at least eight characters with one numeral and one special character.
4. Pick your secret question and answer from the dropdown box. This will allow you to reset your password if you forget it.
5. Accept your invitation by entering your Facility ID.
6. If you forget your password, click on Forgot Your Password? in the upper right corner of the Login Page and follow the directions to create a new password.

B. Find a Patient Record

1. After logging in, click on the Patient tab at the top of the page.
2. Click on the Advanced Search link in the bottom right corner of the Patient Search window.
3. Click on the dropdown arrow for the Identification field and select WIC Identifier, enter the participant ID in the box to the right of the Identification field, and click the Search button.

Or

4. Type in the last name, first name and birth date of the patient in the appropriate fields and click the Search button (start with fuzzy search; use exact search if too many results appear).
5. Click on the line of the patient record you wish to see.

C. Print an Immunization Forecast

1. After finding the patient record, click on Immunizations on the left side menu.
2. Click on the Grid view radio button in the middle of the page.
3. At the bottom of the page, click on Print.

D. Key Masters: Grant Access to Additional WIC Staff

1. After logging in, click on the Administration tab at the top right of the page.
2. Click Employees on the left side menu.
3. Click the Add New button in the lower right corner of the page and enter the last name, first name and email address. Do not change the default settings:
 - a. Employee Type: Other
 - b. Work Status: Active
 - c. Security Level: Add/Edit/Delete
4. Click Save Changes. **Note:** As soon as you Save Changes, the new user's username and temporary password will appear. Please be sure to record this information and share with the new user.

E. Other Functions and Information

1. Click on the Help tab in the upper right corner of the Home Page and select the desired topic or search for a topic not listed by entering it in the Search field in the upper right corner of the page.
2. On the Login Page, click on Resources on the left side menu and under Training, select Impact SIIS Virtual Training. You may then select from a list of training videos.

F. Questions? Contact ODH

1. Impact Help Desk (hours M-F 8am – 5 pm)
Ph: 1-866-349-0002 email: impact@odh.ohio.gov
2. Other contact information may be found under Resources on the Login Page, including regional trainer information.

WIC Immunization Key Master Training

Impact

Statewide Immunization Information
System



Topics

- Adding Editing Clinic and Employee information
- Adding a new patient record
- Merging duplicate patient records



Key Masters Have Access to Admin Tab

Statewide Immunization Information System

Welcome Andrew Harris
[Preferences](#) | [My Practice](#) | [Logout](#)

Home Patient Vaccines Reminder Recall Upload Reports **Administration** Help Call Center

Practitioner: ODH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAACR Andrew Harris

News & Information

Welcome to Your IMPACT SIIS
posted by Andrew Harris on 6/13/2011

Properly identified Hepatitis A vaccine lots have been updated from Hep-A Adult to Hep-A Pediatric, keeping the brand name intact. A note indicating this change has been applied to each vaccine in the patient record.

There is a shortage of Kinrix (DTaP-IPV) vaccine, with no pre-filled syringes and no vials for about 10 weeks. Provider orders will be filled with separate DTaP and IPV vaccines.

Please confirm that your practice is displayed in the upper left Practice drop down menu.

Please be advised, Zostavax is now located in the Varicella (VAR) group.

If assistance is required during the transition, please use the resources listed below.

Support:
Call Center: 1-866-349-0002 M-F 8am-5pm
Option 1: Login Support (including password issues)
Option 2: ImpactSIIS User Support

E-mail: impact@odh.ohio.gov

You must have one of the following browsers in order to use this site:

- [Microsoft Internet Explorer \(Version 7.0 and above\)](#)
- [Firefox Version 3 and above](#)
- [Google Chrome](#)

Helpful Links

- [ImpactSIIS Resource Center - Help Videos](#)
- [Frequently Asked Questions](#)
- [Request to be Removed \(Opt Out\) Form](#)

Missing Immunization Appointment(30 days)

There are no children in the last 30 days that have missed appointments.

Appointment Summary

There are no currently scheduled appointments.

Provider Profile Reports

No reports available.

Lots Expiring in 90 Days

No lots will be expiring in the next 90 days.

Report Status (30 days)

There are no reports to give any information on.

Last 5 Uploads

File Name	Status	User
test2.txt	File Rejected	Impact Admin
NotAScript.txt	File Rejected	Impact Admin

This tab is not visible to general ImpactSIIS users.

SIIS
2TT2

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Admin Tab Allows Management of Clinic and Employee Information



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Clinics Page Displays Active Clinic Information

The screenshot shows the ImpactSIIS Statewide Immunization Information System interface. The top navigation bar includes links for Home, Patient, Vaccines, Reminder Recall, Upload, Reports, Administration, Help, and Call Center. The left sidebar shows a tree view with Administration, Clinics, Employees, and VIS. The main content area displays the Clinics page, which includes a table of active clinics and detailed information for the selected clinic, AMCI.

Clinic Administration Table:

Clinic	Phone	Federal Tax #	ODH #	NPI #	Status
AMCI	(703) 848-7320	346402018	31234567890		Active
CCHC-W	(937) 496-7155		31234567890		Active

☐ Display Inactive Clinics.

Practice Information Table:

Practice Name	Practice Type	IRMS #	VFC Status	Tracking Inventory:
ODH TEST SITE (TRAINING)	LHD	22151	Is NOT Eligible	Is NOT Tracked
Agreement Date	Authorized Individual First Name	Authorized Individual Last Name		
Sending Interface Type	Uploading Type Data	Reminder/Recall	R/R Notification By	
Other Software	Migration Data	No reminder/recall	SIIS-Statewide	

Clinic Information Table:

Clinic Name	Clinic Status	Clinic Type
AMCI	Active	
Address 1	Address 2	
1410 SPRING HILL RD	3000034	
Zip Code	City (County)	State
43215	COLUMBUS (FRANKLIN)	OHIO
Phone Number	Fax Number	Website
(703) 848-7320		
Federal Tax Id	ODH #	NPI #
346402018	31234567890	
Contact First Name	Contact Last Name	Contact Email
DARRIN	ROSEBROOK	

Buttons: Edit Clinic, Add New

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Annotations:

- Click this box to see clinics that have been made "no longer clinic" or "inactive" in ImpactSIIS. (Points to the "Display Inactive Clinics" checkbox)
- Click anywhere on line to view read-only clinic information, or click pencil symbol to edit. (Points to the clinic table row)

Immunize. It Matters.

Employee Page Displays Active Employee List

Click this box to see employees that have been made "no longer an employee" or "inactive" in ImpactSIIS.

Click anywhere on line to view read-only employee information, or click pencil symbol to edit.

Last Name	First Name	Access	Status	Category	Give Vacc
Aacr	Aacr	Add/Edit/Delete	Active	Physician	False
Aacr	Test	School Key Master	Active	Billing	False
Augustine	Heidi	Key Master	Active	Nurse	True
Barkha	Makhankar	Add/Edit/Delete	Active	Office Manager	False
Deshmukh	Swarup	Add/Edit/Delete	Active	General Office	False
Doe	John	Key Master	Pending Invite	Nurse Practitioner	True
Doe	Jane	Add/Edit/Delete	Pending Invite	Other	False
Drake	Jerry	Key Master	Active	Physician	True
Fdisable	Fdisable	Key Master	Active	Medical Assistant	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Frenton	Dustin	Key Master	Active	Office Manager	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Harris	Andrew	Key Master	Active	Physician	True
Hartley	Jamie	Key Master	Active	Nurse	True
Keymaster	School	School Key Master	Active	Office Manager	False
Kumar	Niranjan	Key Master	Active	Physician	True
Kumaravadivel	Ramesbabu	Key Master	Active	General Office	False
Lyberg	Carla	Key Master	Active	Nurse	False
Meyer	Lisa	Key Master	Active	General Office	False
Miss	Lucy	Add/Edit/Delete	Active	Other	True
Missy	Chris	Add/Edit/Delete	Active	General Office	True

☐ Display Inactive Employees.

Employee Information

Last Name	First Name	Email Address	Vaccine Giver
AACR	TEST		False
Employee Type	Work Status	Security Level	Login User Name
BILLING	Active	School Key Master	TESTAACR
Federal TaxId	Medicaid #	Provider NPI	Medical/Practitioner #

Edit Employee Add New

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Adding a New Employee

Statewide Immunization Information System

Search Patient...

Practices: ODH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAACR Vaccine Giver: Andrew Harris

Administration

Employees

Last Name	First Name	Access	Status	Category	Give Vacc
Aacr	Aacr	Add/Edit/Delete	Active	Physician	False
Aacr	Test	School Key Master	Active	Billing	False
Augustine	Heidi	Key Master	Active	Nurse	True
Barkha	Makhjankar	Add/Edit/Delete	Active	Office Manager	False
Deshmukh	Swarup	Add/Edit/Delete	Active	General Office	False
Doe	John	Key Master	Pending Invite	Nurse Practitioner	True
Doe	Jane	Add/Edit/Delete	Pending Invite	Other	False
Drake	Jerry	Key Master	Active	Physician	True
Fdisable	Fdisable	Key Master	Active	Medical Assistant	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Frenton	Dustin	Key Master	Active	Office Manager	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Harris	Andrew	Key Master	Active	Physician	True
Hartley	Jamie	Key Master	Active	Nurse	True
Keymaster	School	School Key Master	Active	Office Manager	False
Kumar	Niranjan	Key Master	Active	Physician	True
Kumaravadivel	Ramesbabu	Key Master	Active	General Office	False
Lyberg	Carla	Key Master	Active	Nurse	False
Meyer	Lisa	Key Master	Active	General Office	False
Miss	Lucy	Add/Edit/Delete	Active	Other	True
Missy	Chris	Add/Edit/Delete	Active	General Office	True

☐ Display Inactive Employees.

Add New

If you need to add an employee to your active employee list, click "Add New."

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Adding a New Employee

ImpactSIIS Statewide Immunization Information System

Welcome Moe Szyslak
[Preferences](#) | [My Practice](#) | [Logout](#)

...Search Patient... Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: ODH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAAACR Vaccine Giver: Andrew Harris

> Administration
 > Clinics
 > Employees
 > VIS

Last Name	First Name	Access	Status	Category	Give Vacc
Aaacr	Aaacr	Add/Edit/Delete	Active	Physician	False
Aacr	Test	School Key Master	Active	Billing	False
Augustine	Heidi	Key Master	Active	Nurse	True
Barkha	Makhjankar	Add/Edit/Delete	Active	Office Manager	False
Deshmukh	Swarup	Add/Edit/Delete	Active	General Office	False
Doe	John	Key Master	Pending Invite	Nurse Practitioner	True
Doe	Jane	Add/Edit/Delete	Pending Invite	Other	False
Drake	Jerry	Key Master	Active	Physician	True
Fdisable	Fdisable	Key Master	Active	Medical Assistant	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Frenton	Dustin	Key Master	Active	Office Manager	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Harris	Andrew	Key Master	Active	Physician	True
Hartley	Jamie	Key Master	Active	Nurse	True
Keymaster	School	School Key Master	Active	Office Manager	False
Kumar	Niranjan	Key Master	Active	Physician	True
Kumaravadivel	Ramesbabu	Key Master	Active	General Office	False
Lyberg	Carla	Key Master	Active	Nurse	False
Meyer	Lisa	Key Master	Active	General Office	False
Miss	Lucy	Add/Edit/Delete	Active	Other	True
Missy	Chris	Add/Edit/Delete	Active	General Office	True

☐ Display Inactive Employees.

Employee Information

Last Name *	First Name *	Email Address *	Vaccine Giver
Employee Type	Work Status	Security Level *	
OTHER	Active	Add/Edit/Delete	

NOTE: The following fields have to be completed only for "Physicians/Nurse Practitioner/Physician Assistants" of Record.

Federal TaxId	Medicaid #	Medical/Practitioner's License #	Provider NPI *
---------------	------------	----------------------------------	----------------

* Required Fields

Save Cancel

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Just fill in the required information to add a new employee.

Note that these fields at the bottom are not required.

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Immunize. It Matters.

Adding a New Employee

A popup window will appear giving you the new employee's username and TEMPORARY password—be sure and write the password down before clicking “Okay.”

Note that the employee's status will remain “pending invite” until he/she signs in and completes the Single Sign On (SSO) process.

The screenshot shows the IMPACT Statewide Immunization System interface. A table titled "Employee Administration" lists various employees. A popup window titled "Employee Created!" is displayed, providing the following information:

Employee Created!

The user has been created for Facility Id 603. Please record this information and provide it to the user. Their new username and temporary password are: Homer.Simpson - 52J157UZ

The popup includes an "Okay" button. Below the popup, the "Employee Information" form is visible, showing details for Homer Simpson, including Last Name, First Name, Email Address, and Vaccine Giver.

Last Name	First Name	Access	Status	Category	Give Vacc
Aacr	Aacr	Add/Edit/Delete	Active	Physician	False
Aacr	Tset	School Key Master	Active	Billing	False
Alouattine	Heidi	Key Master	Active	Nurse	True
Barlow	Malchankar	Add/Edit/Delete	Active	Office Manager	False
Dashmukh	Swarup	Add/Edit/Delete	Active	General Office	False
Doe	John	Key Master	Pending Invite	Nurse Practitioner	True
Doe	Jane	Add/Edit/Delete	Pending Invite	Other	False
Drake	Jerry	Key Master	Active	Physician	True
Edisable	Idisable	Key Master	Active	Medical Assistant	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Frenton	Dustin	Key Master	Active	Office Manager	True
Frenton	Dustin	Add/Edit/Delete	Active	Other	False
Harris	Andrew			Physician	True
Hartley	Jamie			Nurse	True
Keymaster	School			Office Manager	False
Kumar	Niranga			Physician	True
Kumaravadevel	Ramesh			General Office	False
Lyberg	Carla			Nurse	False
Meyer	Lisa			General Office	False
Risk	Lisa			Other	True
Missy				General Office	True

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Single Sign On

All new users must complete the SSO process of

- 1) entering their temporary password,
- 2) creating their own permanent one,
- 3) choosing a secret question and
- 4) entering the Facility ID.

Firefox | IMPACTSIS RECRUITMENT & TRAINING... | IMPACT Statewide Immunization Sys... | User Detail

ohio.gov | https://odhgateway.odh.ohio.gov/Impact/Login/ChangePassword.aspx?Message=Your Password has expired and must be changed. | moe's tavern

Statewide Immunization Information System

Change Password

Your Password has expired and must be changed.

New Password:

Confirm Password:

[Save](#)

Password Format Requirements

Keeping your password private is the best way to guard against someone accessing IMPACT SIS while pretending to be you. Password theft is the most utilized means of gaining unlawful access to secure applications.

It is also important not to use a password that can be easily guessed. For example, using your name, your pet's name, or a family member's name is not recommended.

In order to comply with HIPAA standards the following password rules apply:

- 1) Must be a minimum length of eight(8) characters.
- 2) Must include at least one numeric character.
Example: 1 2 3 4 5 6 7 8 9 0
- 3) Must include at least one "special" character.
Example: ! # \$ % & * _ - + = () ^ @ ~ ? < > | \ /

Set Secret Question and Answer

Secret Question:

Secret Answer:

[Save](#)

Practice Invites

You have been invited to join 'ODH TEST SITE (TRAINING)'.

Please Enter the Practice ID for this Practice to confirm the invitation:

[Accept Invite](#) [Decline Invite](#)

Adding a New Patient

If you do not find the patient record you're looking for after using fuzzy search, click "create new patient" to add the client to ImpactSIIS.

Patient Search

Search Criteria

Last Name: test First Name: a Birth Date:

Search Method: ☐ Exact ☒ Fuzzy

Search Reset Advanced Search

Select a patient record to open the patient dashboard.

Score	Last	First	Middle	Birth Date	Mom Maiden	Phone Number	City	County	Address
84	test	al	f	01/01/70			Wright Patterson	MONTGOMERY	123 First Street, Wright Patterson 45431
84	TEST	A NEWBORN	A	05/01/07					
84	TEST	A NEWBORN	A	10/10/05			Burton	GEAUGA	, Burton 44021
84	TEST	A NEWBORN	A	01/10/95			Burton	GEAUGA	, Burton 44021
84	TEST	ADOPTMOM		01/30/89	ADOPT	(123) 456-7890	Alpha	IRON	455 West 5th, Alpha 49902
84	TEST	AIMEE		12/01/76		(513) 521-8177	Cincinnati	HAMILTON	6535 Daly Rd, Cincinnati 45224
84	TEST	ALDEN	R.	05/12/97		(330) 303-0558	Negley	COLUMBIANA	47919 Tomahawk Dr., Negley 44441
84	TEST	AMANDA	R	02/11/86			Xenia	GREENE	1902 Gayhart Dr, Xenia 45385
84	TEST	ANGELINE		08/31/20					
84	TEST	ANITA		04/01/11		(614) 234-8999			
84	TEST	ANITA				(614) 234-9201			
84	TEST	ANITA				(614) 555-5555	Columbus	FRANKLIN	5965 East Broad Street, Columbus 43219
84	TEST	ANNIE	Q	03/25/06		(614) 355-2186	Grove City	FRANKLIN	5500 Spring Hill Rd, Grove City 43123
84	TEST	ANNIE		02/06/08		(614) 645-9999			
84	TEST	APRIL	MCHA	06/04/95		(937) 555-5555	Columbus	FRANKLIN	1234 Test Street, Columbus 43215
84	TEST	ATLANTA		10/10/85		(216) 884-1111	Parma	CUYAHOGA	4816 Yorkshire Road, Parma 44134
84	TEST	ATLANTA		10/10/99		(440) 123-1234	Parma	CUYAHOGA	6681 Ridge Road, Parma 44134
84	TEST	AVA THOMAS		12/01/10		(440) 111-1111	Parma	CUYAHOGA	6681 Ridge Rd 205, Parma 44129
71	TEST FOR SCM	ADULT	B	05/03/00			Columbus	FRANKLIN	Unknown, Columbus 43205
71	TEST P	ALLI		06/11/07			Columbus	FRANKLIN	1111 Summit St, Columbus 43202
71	TESTA	AARON	M.	11/24/82		(330) 722-8068	Medina	MEDINA	210 Montview Drive, Medina 44256
71	TESTA	AARON		03/27/98		(216) 221-2255	Lakewood	CUYAHOGA	2057 Arthur, Lakewood 44107
71	TESTA	AARON-MICHAEL	XAVIER	03/27/98	BELZ				
71	TESTA	ADAM	J.	05/31/85		(330) 722-8068	Medina	MEDINA	210 Montview Drive, Medina 44256
71	TESTA	ALBERT		03/13/41		(440) 543-9476	Riverside	MONTGOMERY	9454 Stafford Rd, Riverside 45431

Viewing 1 - 25 of 152 records.

Previous 1234567 Next

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Adding a New Patient

Fill in required demographic information (denoted by red asterisk).

The screenshot shows the ImpactSIIS Statewide Immunization Information System interface. The browser window has tabs for 'IMPACTSIS RECRUITMENT & TRAINING...', 'IMPACT Statewide Immunization Sys...', and 'User Detail'. The address bar shows 'https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Demographic/Demographic.aspx?action=add'. The user is logged in as 'Moe Szyslak'.

The interface includes a navigation bar with links: Home, Patient, Vaccines, Reminder Recall, Upload, Reports, Administration, Help, and Call Center. Below this is a search bar and a dropdown menu for 'Practices' (currently set to 'ODH TEST SITE (TRAINING)').

The main form is titled 'Demographics' and contains several fields, some marked with a red asterisk (*) indicating they are required:

- Last Name * (testpatient)
- First Name * (Guinevere)
- Middle Name (Renee)
- Suffix
- Mothers Maiden Name (Simpson)
- Birth Date * (04/01/2010)
- Gender * (Female)
- Deceased / Date
- VFC Status * (Not Eligible - N)
- Reminder/Recall (None)
- Refusal / Date
- MOGE / Date
- Nationality (None)
- Race (American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino)
- Ethnicity (None)
- Language (None)

Below the demographics section are three sub-sections:

- Identification Types:** A table with columns 'Identification Type' and 'Number'. It contains one entry: 'Birth Registry Number'. There is an 'Add New Identifier' button.
- Insurance Information:** A table with columns 'Active', 'Provider', and 'Number'. It contains one entry: 'ADMIRAL LIFE IC OF AMERICA'. There is an 'Add New Insurance' button.
- Aliases:** A table with columns 'First Name', 'Middle Name', and 'Last Name'. There is an 'Add New Alias' button.

At the bottom of the form, there is a 'Notes' section with a 'Note' field and an 'Add New Note' button. A red asterisk (*) indicates required fields. At the bottom right, there are 'Continue' and 'Cancel' buttons. The footer shows '© Copyright Ohio Department of Health | Version: 2.5.29285.0'.

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Search for Existing Contact

You must search for the contact (e.g., mother) in the database just like a patient search. If the contact is not in ImpactSIIS you can create a new contact.

ImpactSIIS Statewide Immunization Information System

Welcome Andrew Harris
[Preferences](#) | [My Practice](#) | [Logout](#)

Search Patient... Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: ODH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAAACR Vaccine Giver: Andrew Harris

Contact List

Search for an Existing Contact

Last Name	First Name	Phone Number	Birth Date
Simpson	Marge	() - -	

Last Name	First Name	Address	County	Phone Number	Birth Date
SIMPSON	MARGERET	200A Sandusky Rd , South Point 45680	Lawrence		
SIMPSON	MARGERET	1306 East 349 Street P. O. Box , Eastlake 44095	Lake	(440) 602-9490	05/10/44
SIMPSON	MARGET	200A Sandusky , South Point 45680	Lawrence		
SIMPSON	Mark	19909 Fairway Ave , Cleveland 44137	Cuyahoga	(216) 475-2080	07/12/89
SIMPSON	MARC	100 Oak St , Mount Vernon 43050	Knox		10/11/85
SIMPSON	MARCIA	1733 Queensbridge Dr , Columbus 43235	Franklin	(773) 350-1111	02/07/69
SIMPSON	MARGIE	15802 Biltmore Ave , Cleveland 44128	Cuyahoga		11/17/44
SIMPSON	MARGO	986 Gertrude Ave , Logan 43138	Hocking	(740) 385-7708	08/22/36
SIMPSON	MARISSA	P.O. Box 274 , Westfield Center 44251	Medina	(330) 887-5561	10/30/90
SIMPSON	MARISSA	1004 Essex Drive , Lima 45804	Allen	(419) 223-0111	
SIMPSON	MARISSA	3053 Robin Drive , Ravenna 44266	Portage	(330) 296-4077	12/06/92
SIMPSON	MARISSA	730 Washinton St , Monroe 48161	Monroe		06/15/84
SIMPSON	MARISSA	666 Plainfield Rd , Akron 44312	Summit		10/16/08
SIMPSON	MARK	5871 Garnier Ave , Westerville 43081	Franklin	(614) 933-0343	05/19/68
SIMPSON	MARK	3390 E State St , Barb 44203	Summit	(330) 753-4000	12/21/56

Viewing 1 - 15 of 51 records.
[Previous](#) [1](#) [2](#) [3](#) [4](#) [Next](#)

[Create New Contact](#) [Search](#) [Add Self Contact](#)

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Adding a New Contact

Fill in required contact information. Note that contacts can have multiple phone numbers, emails, and street addresses.

The screenshot shows the ImpactSIIS Statewide Immunization Information System interface. The browser tabs include Firefox, IMPACTSIS RECRUITMENT & TRAINING, IMPACT Statewide Immunization Sys..., ODH Application Gateway, and Yahoo! Mail. The URL is https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Contact/Contact.aspx?v=NewPatient. The page header shows 'Welcome Andrew Harris' and navigation links for Preferences, My Practice, and Logout. The main navigation bar includes Home, Patient, Vaccines, Reminder Recall, Upload, Reports, Administration, Help, and Call Center. The 'Contact List' section is active, displaying a form for adding a new patient contact. The form includes fields for Primary, Relationship, Last Name, First Name, Middle Name, Birthdate, Phone Numbers, Email Addresses, and Addresses. The 'Primary' checkbox is checked, and the 'Relationship' is set to 'Foster Mother'. The 'Last Name' is 'Simpson' and the 'First Name' is 'Marge'. The 'Phone Numbers' section shows a 'MOBILE' number '(937)-111-1111'. The 'Email Addresses' section is empty. The 'Addresses' section shows a 'HOME' address '215 East Avenue' with 'Zip' '45501' and 'City (County)' 'SPRINGFIELD (CLARK)' and 'State' 'OHIO'. The form has 'Save' and 'Cancel' buttons at the bottom right. A footer note states '© Copyright Ohio Department of Health | Version: 2.5.29285.0'.

ImpactSIIS Statewide Immunization Information System

Welcome Andrew Harris

Preferences | My Practice | Logout

Search Patient...

Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: ODH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAACR Vaccine Giver: Andrew Harris

Contact List

Contact Information

Primary	Relationship	Last Name *	First Name *	Middle Name	Birthdate
<input checked="" type="checkbox"/>	Foster Mother	Simpson	Marge		

Phone Numbers

Type	Phone Number *
MOBILE	(937)-111-1111

Add New Number

Email Addresses

Email Address

Add New Email

Addresses

Type	Address 1 *	Address 2	Zip	City (County)	State
HOME	215 East Avenue		45501	SPRINGFIELD (CLARK)	OHIO

Add New Address

* Required Fields
** Either phone number or address are required

Save Cancel

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javascript:__doPostBack('ct00\$phMainContent\$ucSimplePatientSearch\$lnkCreateNewContact','')

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Adding a New Contact



TESTPATIENT, GUINEVERE RENEE (DOB:4/1/2010)

Primary Contact:
SIMPSON, MARGE (Foster Mother)
(937) 111-1111
215 East Avenue
Springfield Ohio 45501

Lead Test Result: **None**
Lead Test Date: **None**

VFC Eligibility: **Is Not Eligible**
Next Appt: **4/1/2010 7:00 AM**
Immunization Status: **Past Due**

Contact List

	Relationship	Name	Address	Phone	Email	
➔	Foster Mother	Simpson, Marge	215 East Avenue Springfield, Ohio 45501	(937) 111-1111		 

Add Contact

This contact defaults to primary contact for the new patient (denoted by the blue arrow symbol). Note that the primary contact's address is listed on the patient record.

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Merging Duplicate Records

If you find duplicate records in the patient search, as Key Master you have the ability to merge duplicates into a single record.

IMPACT - Patient Search

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Search.aspx

Practice: OOH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAACR Vaccine Giver: Andrew Harris

Patient Search

Search Criteria

Last Name: test First Name: a Birth Date: Search Method: ☐ Exact ☒ Fuzzy Search Search Reset Advanced Search

Select a patient record to open the patient dashboard.

Score	Last	First	Middle	Birth Date	Mom Maiden	Phone Number	City	County	Address
71	TEST-MILLER	ANNA		01/01/11		(614) 722-6200	Columbus	FRANKLIN	555 S 18Th St , Columbus 43205
71	testp	alvin		03/03/10	Bashforth	(419) 555-5555	Upper Sandusky	WYANDOT	123456 Test Road , Upper Sandusky 43351
71	testp	amya		06/10/04		(614) 614-6141	Chillicothe	ROSS	123 Nolk Rd , Chillicothe 45601
71	testp	amyo		04/01/09		(614) 555-5555			
71	testp	amyq		03/01/09		(614) 999-9999			
71	testp	amyr		03/15/09		(614) 999-9999			
71	testp	amys		03/16/09		(614) 999-9999			
71	Testp	amyd		07/20/06		(614) 999-9999			
71	Testp	Amye		06/28/04		(614) 999-9999			
71	Testp	amyf		08/08/07		(614) 999-9999			
71	Testp	amyg		01/01/03		(614) 999-9999			
71	Testp	amyi		02/02/04		(614) 999-9999			
71	Testp	Amyj		07/07/95		(614) 999-9999			
71	Testp	Amyk		08/08/96		(614) 999-9999			
71	Testp	Amyl		09/09/97		(614) 999-9999			
71	Testp	Amym		01/05/03		(614) 999-9999			
71	Testp	Amyn		02/03/10		(614) 999-9999			
71	Testp	Amyt		04/05/11		(614) 444-4444			
71	TestP	Alex A		07/18/02		(614) 333-1233			
71	TestP	Alex B		06/03/08			La Rue	MARION	1234 Main St. , La Rue 43332
71	TESTP	AANN		03/05/09			Columbus	FRANKLIN	1 Test , Columbus 43212
71	TESTP	ADAM		05/16/05		(937) 555-5555	Sylvania Township	LUCAS	1601 Lexington Dr , Sylvania Township 43623
71	TESTP	ADAM		01/01/06		(937) 555-5555	Sylvania Township	LUCAS	1601 Lexington Dr , Sylvania Township 43623
71	TESTP	ADAM		06/02/05		(937) 555-5555	Sylvania Township	LUCAS	1601 Lexington Dr , Sylvania Township 43623

[Add to Queue](#)
[Add to Merge/Link List](#)
[Delete Patient](#)

Adds the patient into a pending list of other patients that are awaiting to be merged or linked.

[Create New Patient](#)

Viewing 101 - 125 of 153 records.
[Previous](#) [1234567](#) [Next](#)

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https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Search.aspx#

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Merging Duplicate Records

Clicking “add to merge/link/delete list puts that patient record in the queue. You must then click “back to search” to go back and get the other duplicate record, and put it in the queue as well. Note this queue is accessible from the menu on the home tab.

The screenshot shows the ImpactSIIS Statewide Immunization Information System interface. The top navigation bar includes links for Home, Patient, Vaccines, Reminder Recall, Upload, Reports, Administration, Help, and Call Center. The main content area is titled "Patient Merge/Delete/Link" and features a "WARNING!" box with a yellow triangle icon. Below the warning, there is a search section with fields for Status (All), From Date Added (7/5/2011), and To Date Added (7/5/2011). A "Back to Search" button is highlighted with a red arrow pointing to it from the text box on the left. The "Patients Awaiting Record Changes" section displays a table with columns: Select, Patient#, Name, DOB, SSN, Date Added, and Remove. The table contains one row with Patient# 10871305, Name amyp testp, DOB 4/1/2009, and Date Added 7/5/2011. Below the table are buttons for "Back to Search", "Compare To...", and "Cancel". The "Record Change Requests" section at the bottom states: "There are currently no Merge, Delete, or Link requests matching the specified search criteria."

Select	Patient#	Name	DOB	SSN	Date Added	Remove
<input type="checkbox"/>	10871305	amyp testp	4/1/2009		7/5/2011	Remove

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Merging Duplicate Records

When you have both records in the merge queue, select one and click “compare to...”

The screenshot shows the ImpactSIIS Statewide Immunization Information System interface. The top navigation bar includes links for Home, Patient, Vaccines, Reminder Recall, Upload, Reports, Administration, Help, and Call Center. The main content area is titled "Patient Merge/Delete/Link" and features a warning message: "Merge/Delete/Link should be used with EXTREME CAUTION. There are some important considerations and consequences you need to consider each time you Merge/Delete/Link patient records." Below the warning is a search section with fields for Status (All), From Date Added (7/5/2011), and To Date Added (7/5/2011). A table titled "Patients Awaiting Record Changes" lists two patients: 10871306 (amyp testp) and 10871305 (amyp testp). The table has columns for Patient#, Name, DOB, SSN, Date Added, and Remove. The "Remove" column contains links to "Remove" for each patient. Below the table are buttons for "Back to Search", "Compare To...", and "Cancel". At the bottom, a section titled "Record Change Requests" states: "There are currently no Merge, Delete, or Link requests matching the specified search criteria."

Select	Patient#	Name	DOB	SSN	Date Added	Remove
<input type="radio"/>	10871306	amyp testp	3/1/2009		7/5/2011	Remove
<input type="radio"/>	10871305	amyp testp	4/1/2009		7/5/2011	Remove

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Merging Duplicate Records

Then select the other record you wish to compare and click “compare records.”

IMPACT Statewide Immunization System

ohio.gov https://odhgateway.odh.ohio.gov/Impact/PatientMergeDeleteLink/CompareList.aspx?rcpid=12fae9a0-af42-4b83-9411-75e882ede854

ODH TEST SITE (TRAINING) AMCI AAACR AAACR Andrew Harris

> Home
> Queue
> Merge/Delete/Link
> Appointments
> Daily View
> Weekly View

Patient Merge/Link Process

Compare This Record

Patient #	Name	Birth Date	SSN	Requested Date
10871306	amyg testp	3/1/2009		7/5/2011

With

#	Select	Patient #	Name	DOB	SSN	Requested Date
1	<input type="radio"/>	7275400	JASEAN LEE TERRY	5/27/2007	281132320	9/7/2010
2	<input type="radio"/>	5827389	LAONIE MAURICE LAMPKIN	1/26/2004		9/7/2010
3	<input type="radio"/>	9341906	QUALANNO STOVALL	9/4/1998	269040999	9/7/2010
4	<input type="radio"/>	9181875	LILLIAN RUTH HUFFMAN	8/20/2009		10/21/2010
5	<input type="radio"/>	3656833	ROBERT TAYLOR dont use this one	4/9/1994		4/22/2011
6	<input type="radio"/>	1726358	ROBERT TAYLOR	4/9/1994		4/22/2011
7	<input type="radio"/>	1910354	KAREN N WIECHERS			2/19/2009
8	<input type="radio"/>	4334237	ROBIN JOHNSON dont use this one	3/6/1997		5/10/2011
9	<input type="radio"/>	1908507	KAREN WIECHERS			2/19/2009
10	<input type="radio"/>	3558924	ROBERT TAYLOR dont use this one	4/9/1994		4/22/2011
11	<input type="radio"/>	3075117	ROBERT TAYLOR dont use this one	4/9/1994		4/22/2011
12	<input type="radio"/>	1905807	KAREN WIECHERS			2/19/2009
13	<input type="radio"/>	2963723	ROBERT TAYLOR dont use this one	4/9/1994	276909196	4/22/2011
14	<input type="radio"/>	8079320	WALTER I BLAKE	5/14/2007		12/19/2008
15	<input type="radio"/>	3545332	ISHA PATIL	7/8/2004	291044160	11/13/2009
16	<input type="radio"/>	6800363	SON77 M PUMA	1/1/2006		10/4/2009
17	<input type="radio"/>	8499634	KAREN WIECHERS			2/19/2009
18	<input type="radio"/>	1326768	JADEN M TURNER	10/19/2001	289060647	3/31/2008
19	<input type="radio"/>	2267256	PAMELA PFLUM			4/13/2009
20	<input type="radio"/>	3861098	LATHAN R CHAPMAN	10/19/2004		11/29/2005
21	<input type="radio"/>	5839481	JOHN D ANGELO BUSTOS	1/14/2005		1/31/2007
22	<input type="radio"/>	500581	ALEX MICHAEL JACOBS	1/6/1999		3/8/2006
23	<input type="radio"/>	5582810	DE MARKUS L JACKSON	3/31/2000		12/2/2009
24	<input type="radio"/>	6735638	KAREN WIECHERS			2/19/2009
25	<input type="radio"/>	2266272	KAREN WIECHERS			2/19/2009
26	<input type="radio"/>	4333867	ROBIN JOHNSON dont use this one	3/6/1997		5/10/2011
27	<input type="radio"/>	6440600	KAREN WIECHERS			2/19/2009
28	<input type="radio"/>	1906546	KAREN WIECHERS		999999999	2/19/2009
29	<input type="radio"/>	1905216	PAMELA PFLUM			4/13/2009
30	<input type="radio"/>	4334239	ROBIN JOHNSON dont use this one	3/6/1997		5/10/2011
31	<input checked="" type="radio"/>	10871305	amyg testp	4/1/2009		7/5/2011
32	<input type="radio"/>	1293637	HAILI JO BAKER	8/30/2001	286110513	10/25/2010
33	<input type="radio"/>	1951265	KENT M TESTD	1/2/2002		7/20/2006
34	<input type="radio"/>	723463	JAQUON T THOMPkins	6/29/2000		9/21/2006
35	<input type="radio"/>	3951920	ARTURO R TORRES-SANTIAGO	3/20/2001		4/1/2008
36	<input type="radio"/>	4634521	JOHN BUSTOS	1/14/2005		1/31/2007
37	<input type="radio"/>	4283884	KI'SEAN TYRIE EDMONDSON	6/8/2005		9/24/2007
38	<input type="radio"/>	5840994	KI SEAN EDMONDSON	6/8/2005		9/24/2007

Compare Records Cancel

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Merging Duplicate Records

IF the two appear to be records for the same person, continue by clicking "mark as to be merged."

Firefox | IMPACT Statewide Immunization System... | Ohio.gov | https://odhgateway.odh.ohio.gov/Impact/PatientMergeDeleteLink/Compare.aspx?ind=53d619ca-9fcd-48b0-adc1-ff6902562df8&relind=1

> Merge/Delete/Link
> Appointments
> Daily View
> Weekly View

Patient Record 1					Patient Record 2				
Last Name:	testp				Last Name:	testp			
First Name:	amyq				First Name:	amyp			
Middle Name:					Middle Name:				
Birth Date:	3/1/2009				Birth Date:	4/1/2009			
SSN:					SSN:				
Gender:	Male				Gender:	Female			
Deceased:	No				Deceased:	No			
Mom's Maiden Name:					Mom's Maiden Name:				
Nationality:					Nationality:				
Race:					Race:				
Language:					Language:				
VFC:	VFC eligible - Medicaid/Medicaid Managed Care				VFC:	VFC eligible - Medicaid/Medicaid Managed Care			
Medicaid #:					Medicaid #:				
Address:					Address:				
Address2:					Address2:				
Zip:					Zip:				
City:					City:				
County:					County:				
State:					State:				
Phone Number:	(614) 999-9999				Phone Number:	(614) 999-9999			
Email Address:					Email Address:				

Immunizations					Immunizations				
For Record 1					For Record 2				
#	Vaccine Group	Vaccine Name	Vaccine Date	Lot #	#	Vaccine Group	Vaccine Name	Vaccine Date	Lot #
1	DTP	DTP-UNK	6/26/2009		1	HBV	HBV-UNK	4/1/2009	
2	HBV	HBV-UNK	6/26/2009		2	DTP	DTP-UNK	6/2/2009	
3	HIB	Hib-UNK	6/26/2009		3	HBV	HBV-UNK	6/2/2009	
4	POL	POLIO-UNK	6/26/2009		4	HIB	Hib-UNK	6/2/2009	
5	PNE	Pneumococcal ps-UNK	6/26/2009		5	POL	POLIO-UNK	6/2/2009	
					6	PNE	PREVNAR-7	6/2/2009	amy876
					7	Rotavirus	ROTA-UNK	6/2/2009	
					8	DTP	DTP-UNK	8/15/2009	
					9	HIB	Hib-UNK	8/15/2009	
					10	POL	POLIO-UNK	8/15/2009	
					11	PNE	PREVNAR-7	8/15/2009	amy876
					12	Rotavirus	ROTA-UNK	8/15/2009	
					13	DTP	DTP-UNK	10/14/2009	
					14	HIB	Hib-UNK	10/14/2009	
					15	POL	POLIO-UNK	10/14/2009	
					16	PNE	PREVNAR-7	10/14/2009	amy876
					17	FLU	FLU-UNK	10/14/2009	
					18	HIB	Hib-UNK	4/30/2010	
					19	MMR	MMR-UNK	4/30/2010	
					20	VAR	VAR-UNK	4/30/2010	
					21	PNE	PREVNAR-7	4/30/2010	amy876
					22	HAV	HAV-UNK	4/30/2010	
					23	FLU	FLU-UNK	4/30/2010	
					24	DTP	Infanrix	6/30/2010	bash951
					25	HBV	Engerix-B Ped (PFS)	6/30/2010	abc1234
					26	PNE	Prevna-13	6/30/2010	abash7894

Mark as To Be Merged Mark as To Be Linked Cancel

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Immunize. It Matters.

Merging Duplicate Records

IMPACT Statewide Immunization System

Statewide Immunization Information System

Welcome Moe Szyslak
[Preferences](#) | [My Practice](#) | [Logout](#)

...Search Patient...

Practices: ODH TEST SITE (TRAINING) Clinic: AMCI Provider: AAACR AAACR Vaccine Giver: Andrew Harris

> **Home**
> Queue
> **Merge/Delete/Link**
> Appointments
> Daily View
> Weekly View

Patient Merge/Delete/Link

WARNING! Merge/Delete/Link should be used with **EXTREME CAUTION**. There are some important considerations and consequences you need to consider each time you Merge/Delete/Link patient records.

Search

Status: (All)
From Date Added: 7/5/2011 To Date Added: 7/5/2011
[Modify Search](#) [Reset](#)

Patients Awaiting Record Changes
There are currently no Patients matching the specified search criteria.
[Back to Search](#) [Compare To...](#) [Cancel](#)

Record Change Requests

Patient#	Name	DOB	SSN	Date Added	Date Processed	Status	Request Type	Remove	Process
10871306	amya testp	3/1/2009		7/5/2011		Submitted	Merge	Remove	Merge Records
10871305	amyp testp	4/1/2009							

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The records are now marked in the queue as waiting to be merged. To complete the process, click "merge records."

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Merging Duplicate Records

On this page, you can select the most accurate information *from either record*, making the end result the most complete patient record possible.

IMPACT Statewide Immunization System

https://odhgateway.odh.ohio.gov/Impact/PatientMergeDeleteLink/Merge.aspx?rcid=680c2ba6-7e58-4790-a4b3-f91db9d61392

Switch Records

☐ Check All Patient Record 1

☒ Last Name: testp
☒ First Name: amyq
☒ Middle Name:
☒ Birth Date: 3/1/2009
☒ SSN:
☒ Gender: Male
☒ Deceased:
☒ Mom's Maiden Name:
☒ Nationality: (None selected)
☒ Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African-American
☐ Hispanic or Latino
☐ More than one Race Reported
☒ Language: American Sign Language
☒ Ethnicity: (None)
☒ VFC: Medicaid - Y

☐ Check All Patient Record 2

☐ Last Name: testp
☐ First Name: amyp
☐ Middle Name:
☐ Birth Date: 4/1/2009
☐ SSN:
☐ Gender: Female
☐ Deceased:
☐ Mom's Maiden Name:
☐ Nationality: (None selected)
☐ Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African-American
☐ Hispanic or Latino
☐ More than one Race Reported
☐ Language: American Sign Language
☐ Ethnicity: (None)
☐ VFC: Medicaid - Y

Merge Contact Record(s)

For Record 1					For Record 2				
	Name	Address	Phone/Email	Relationship		Name	Address	Phone/Email	Relationship
<input checked="" type="checkbox"/>	Mama Mia Testp	, ()	(614) 999-9999 No email address given.	Mother	<input checked="" type="checkbox"/>	Mama Mia Testp	, ()	(614) 999-9999 No email address given.	Foster Mother

Merge Immunization Record(s)

For Record 1					For Record 2						
	#	Vaccine Group	Vaccine Name	Vaccine Date	Lot#		#	Vaccine Group	Vaccine Name	Vaccine Date	Lot#
<input checked="" type="checkbox"/>	1	DTP	DTP-UNK	6/26/2009		<input checked="" type="checkbox"/>	1	HBV	HBV-UNK	4/1/2009	
<input checked="" type="checkbox"/>	2	HBV	HBV-UNK	6/26/2009		<input checked="" type="checkbox"/>	2	DTP	DTP-UNK	6/2/2009	
<input checked="" type="checkbox"/>	3	HIB	Hib-UNK	6/26/2009		<input checked="" type="checkbox"/>	3	HBV	HBV-UNK	6/2/2009	
<input checked="" type="checkbox"/>	4	POL	POLIO-UNK	6/26/2009		<input checked="" type="checkbox"/>	4	HIB	Hib-UNK	6/2/2009	
<input checked="" type="checkbox"/>	5	PNE	Pneumococcal ps-UNK	6/26/2009		<input checked="" type="checkbox"/>	5	POL	POLIO-UNK	6/2/2009	
						<input checked="" type="checkbox"/>	6	PNE	PREVNAR-7	6/2/2009	amy876
						<input checked="" type="checkbox"/>	7	Rotavirus	ROTA-UNK	6/2/2009	
						<input checked="" type="checkbox"/>	8	DTP	DTP-UNK	8/15/2009	
						<input checked="" type="checkbox"/>	9	HIB	Hib-UNK	8/15/2009	
						<input checked="" type="checkbox"/>	10	POL	POLIO-UNK	8/15/2009	
						<input checked="" type="checkbox"/>	11	PNE	PREVNAR-7	8/15/2009	amy876
						<input checked="" type="checkbox"/>	12	Rotavirus	ROTA-UNK	8/15/2009	
						<input checked="" type="checkbox"/>	13	DTP	DTP-UNK	10/14/2009	
						<input checked="" type="checkbox"/>	14	HIB	Hib-UNK	10/14/2009	
						<input checked="" type="checkbox"/>	15	POL	POLIO-UNK	10/14/2009	
						<input checked="" type="checkbox"/>	16	PNE	PREVNAR-7	10/14/2009	amy876
						<input checked="" type="checkbox"/>	17	FLU	FLU-UNK	10/14/2009	
						<input checked="" type="checkbox"/>	18	HIB	Hib-UNK	4/30/2010	
						<input checked="" type="checkbox"/>	19	MMR	MMR-UNK	4/30/2010	
						<input checked="" type="checkbox"/>	20	VAR	VAR-UNK	4/30/2010	
						<input checked="" type="checkbox"/>	21	PNE	PREVNAR-7	4/30/2010	amy876

The computer defaults to keep everything from the record on the left, along with all contact and immunization information. If you want information from the record on the right, simply checkmark it.

Immunize. It Matters.

Merging Duplicate Records

When you are finished, click “merge” at the bottom of the screen and you will be prompted to say you are sure you want to merge. The merge will then be complete.

<input checked="" type="checkbox"/>	26 PNE	(PFS) Prevnar-13	6/30/20
-------------------------------------	--------	---------------------	---------

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WIC Immunization User Training

Impact

Statewide Immunization Information
System



Topics

- Patient Look-up
- Adding Historical Shots to Immunization Record
- Adding/Editing Contact Information



WIC IMPACT SIIS Training

Click here to contact Impact SIIS staff for assistance.

Enter log-in information here

Statewide Immunization Information System

Ohio **ImpactSIIS**

Immunize. It Matters.

Ohio Department of Health

User Name: Password: [Forgot your Password?](#) [Registration Information](#)

WARNING - The information contained in this system is protected by the Privacy Act (5 USC 552(3)4). Unauthorized access, use or tampering with this computer system and its data will subject violators to criminal, civil, and/or administrative action. When you log in you are agreeing to the conditions contained in the user [Security Agreement](#).

Welcome to ImpactSIIS

Managed by the Ohio Department of Health, ImpactSIIS serves as an interactive system for administering, delivering and tracking vaccinations for the people of Ohio. It was developed to achieve complete and timely immunization for all people, but especially for the age group most at risk- birth through two years of age.

As a central processing point of data and management, ImpactSIIS provides an accurate, efficient way to ensure that children and Ohioans of all ages receive the right vaccinations at the right times without unnecessary repetition.

It is our goal to provide accurate, up-to-date information on immunization and vaccination so that health care providers, parents, schools and other stakeholders can achieve the highest levels of coordination and knowledge for a healthier, safer Ohio.

How Do I...

- [How do I register for Impact?](#)
- [How do I use Impact?](#)

Current News in Immunization

- [FDA approves the first vaccine to prevent meningococcal disease in infants and toddlers](#)
- [Late Doses of HPV Vaccine May Still Be Effective](#)

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Internet | Protected Mode: Off | 100%

SIIS

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Home Tab

Verify that your WIC clinic is displayed here. Choose correct clinic from dropdown if necessary.

IMPACT Statewide Immunization System: Home - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/Home/Default.aspx

IMPACT Statewide Immunization System

Welcome Andrew Harris
Preferences | My Practice | Logout

Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practice: GOOD SAMARITAN FAMILY PRACTICE CEN
Clinic: GOOD SAMARITAN FAMILY PRACTICE CEN
Provider: ANNE PROULX
Vaccine Giver: JANE CLIFTON

Search Patient...

Home
> Queue
> Merge/Delete/Link
> Appointments
> Daily View
> Weekly View

News & Information

Welcome to Your IMPACT SIIS
posted by Andrew Harris on 5/10/2011

There is a shortage of Kinrix (DTaP-IPV) vaccine, with no pre-filled syringes and no vials for about 10 weeks. Provider orders will be filled with separate DTaP and IPV vaccines.

Please confirm that your practice is displayed in the upper left Practice drop down menu.

Please be advised, Zostavax is now located in the Varicella (VAR) group.

If assistance is required during the transition, please use the resources listed below.

Support:
Call Center: 1-866-349-0002 M-F 8am-5pm
Option 1: Login Support (including password issues)
Option 2: ImpactSIIS User Support

E-mail: impact@odh.ohio.gov

You must have one of the following browsers in order to use this site:

- Microsoft Internet Explorer (Version 7.0 and above)
- Firefox Version 3 and above
- Google Chrome

Helpful Links

- ImpactSIIS Resource Center - Help Videos
- Frequently Asked Questions
- Request to be removed (Opt Out) Form

Missing Immunization Appointment(30 days)

Patients Name	Days Late
CARSON LEE SIBLEY	8
JADEN THOMAS COLSTON	4

Appointment Summary

There are no currently scheduled appointments.

Provider Profile Reports

No reports available.

Lots Expiring in 90 Days

Group	Name	Lot	Manufacturer	Expires	Source
FLU	Fluzone 0.25	U3581BA	PMC	6/3/2011	Public
FLU	Fluzone 0.25	U3645DA	PMC	6/3/2011	Public
FLU	Fluzone 0.25	UT3576DA	PMC	6/3/2011	Public
FLU	Fluzone 0.25	UT3581AA	PMC	6/3/2011	Public
FLU	Fluzone 0.25	UT3643AA	PMC	6/3/2011	Public
FLU	Fluzone 0.25	UT3667BA	PMC	6/3/2011	Public
FLU	Fluzone 0.5	U3739AA	PMC	6/3/2011	Public
FLU	Fluzone 0.5	U3787AA	PMC	6/3/2011	Public
FLU	Fluzone 0.5	UH180AA	PMC	6/3/2011	Public
FLU	Fluzone 0.5	UH180AB	PMC	6/3/2011	Public
FLU	Fluzone 0.5	UH224AC	PMC	6/3/2011	Public
Meningococcal	Menactra	U3434AA	PMC	8/3/2011	Public

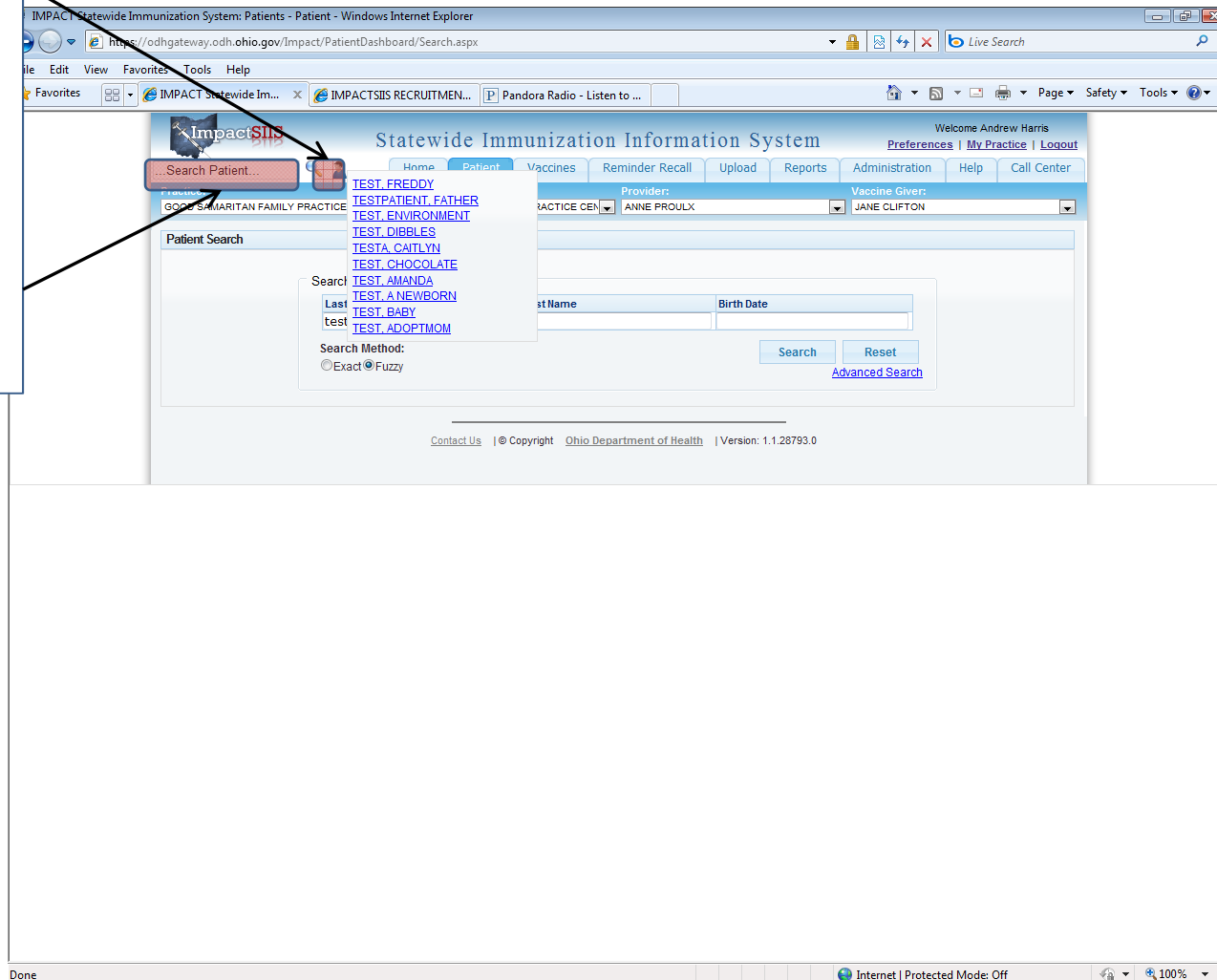
Helpdesk info also found here.

SIIS

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Patient Tab

These patient search features are always available no matter what page you are on.



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Immunize. It Matters.

Patient Tab

Note that fuzzy search option is chosen. That is why the search produced many results with just "test, a" in search parameters.

IMPACT - Patient Search - Windows Internet Explorer

https://odhgateway1st.odh.ohio.gov/Impact/PatientDashboard/Search.aspx

File Edit View Favorites Tools Help

IMPACT - Patient Search IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

Welcome Impact Admin
Preferences | My Practice | Logout

...Search Patient... Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practice: ODH IMMUNIZATION PROGRAM Clinic: ODH IMMUNIZATION PROGRAM Provider: Frenon Dustin Vaccine Giver: Cheryl Paneligan

Patient Search

Search Criteria

Last Name First Name Birth Date

test a

Search Method: ☒ Fuzzy ☐ Exact ☐ Advanced Search

Search Reset

Select a patient record to open the patient dashboard.

Score	Last	First	Middle	Birth Date	Mom Maiden	Phone Number	City	County	Address
84	test	al	f	01/01/70			Wright Patterson	MONTGOMERY	123 First Street Montgomery 45431
84	TEST	A NEWBORN	A	10/10/05			Burton	GEAUGA	Geauga 44021
84	TEST	A NEWBORN	A	05/01/07					
84	TEST	A NEWBORN	A	01/10/95			Burton	GEAUGA	Geauga 44021
84	TEST	ADOPTMOM		01/30/89	ADOPT	(123) 456-7890	Alpha	IRON	455 West 5th Iron 49902
84	TEST	AIMEE		12/01/76		(513) 521-8177	Cincinnati	HAMILTON	6535 Daly Rd Hamilton 45224
84	TEST	ALDEN	R.	05/12/97		(330) 303-0558	Negley	COLUMBIANA	47919 Tomahawk Dr. Columbiana 44441
84	TEST	AMANDA	R.	02/11/86			Xenia	GREENE	1902 Gayhart Dr Greene 45385
84	TEST	ANGELINE		08/31/20					
84	TEST	ANITA				(614) 555-5555	Columbus	FRANKLIN	5965 East Broad Street Franklin 43219
84	TEST	ANITA				(614) 234-9201			
84	TEST	ANITA		04/01/11		(614) 234-8999			
84	TEST	ANNIE		02/06/08		(614) 645-9999			
84	TEST	ANNIE	Q	03/25/06		(614) 355-2186	Grove City	FRANKLIN	5500 Spring Hill Rd Franklin 43123
84	TEST	APRIL	MCHA	06/04/95		(419) 636-0000	Bryan	WILLIAMS	433 W High Street Williams 43506
84	TEST	ATLANTA		10/10/99		(440) 123-1234	Parma	CUYAHOGA	6681 Ridge Road Cuyahoga 44134
84	TEST	ATLANTA		10/10/85		(216) 884-1111	Parma	CUYAHOGA	4816 Yorkshire Road Cuyahoga 44134
84	TEST	AVA THOMAS		08/17/09		(440) 111-1111	Parma	CUYAHOGA	6681 Ridge Rd 205 Cuyahoga 44129
71	TEST FOR SCM	ADULT	B	05/03/00			Columbus	FRANKLIN	Unknown Franklin 43205
71	TEST P	ALLI		06/11/07			Columbus	FRANKLIN	1111 Summit St Franklin 43202
71	TESTA	AARON	M.	11/24/82		(330) 722-8068	Medina	MEDINA	210 Montview Drive Medina 44256
71	TESTA	AARON		03/27/98		(216) 221-2255	Lakewood	CUYAHOGA	2057 Arthur Cuyahoga 44107
71	TESTA	AARON-MICHAEL	XAVIER	03/27/98	BELZ				
71	TESTA	ADAM	J.	05/31/85		(330) 722-8068	Medina	MEDINA	210 Montview Drive Medina 44256

Done

Internet | Protected Mode: Off

100%

SIIS
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Patient Dashboard

Use the left-hand menu bar or click these buttons to open up the Demographic, Contact, or Immunization sections of the patient record.

IMPACT Statewide Immunization System: Patients - Windows Internet Explorer

https://odhgatewaytst.odh.ohio.gov/Impact/PatientDashboard/Default.aspx

File Edit View Favorites Tools Help

IMPACT Statewide Im... IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

IMPACTSIS Statewide Immunization Information System

Welcome Impact Admin Preferences My Practice Logout

Search Patient...

Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: ODH IMMUNIZATION PROGRAM Clinics: ODH IMMUNIZATION PROGRAM Provider: Frenton Dustin Vaccine Given: Cheryl Panagari

> Patients
> Demographics
> Contacts
> Immunizations
> Add Current
> Add Historical
> Add Immunity
> Add Refusal
> Add Appointment
> Contraindications
> Lead Test Results
> School Information

TEST, A NEWBORN A (DOB:10/10/2005)

Primary Contact: TEST, A NEWBORN (Self) Lead Test Result: None VFC Eligibility: Is Eligible
Lead Test Date: None Next Appt: 4/10/2006 Immunization Status: Past Due
Burton Ohio 44021

Demographic Summary

Name: TEST, A NEWBORN A
Birth Date: 10/10/2005
Gender: Female
Primary Contact: TEST, A NEWBORN
Relationship: Self

Contact Summary

Full Name	Relation	Imm. Status
TEST, A NEWBORN	Self	Past Due

Associated Individuals ?

Full Name	Imm. Status
-----------	-------------

Immunization Summary

Immunizations on File: 9 Last Evaluation Date: 5/11/2011

Group	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7
DTP	12/16/2005	2/16/2006	3/16/2006	DUE NOW			
FLU	4/21/2011	DUE NOW					
HAV	10/10/2006	11/1/2007					
HBV	12/16/2005	2/16/2006	3/16/2006	11/1/2007			
HIB	12/16/2005	2/16/2006					
MMR	10/10/2006	DUE NOW					
POL	12/16/2005	2/16/2006	3/16/2006	DUE NOW			
VAR	Chicken Pox or Varicella						

Due Now Refusal Given Too Early Do Not Count Incorrect Spacing Given Late Immunity

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Add Historical

Enter up to five different shot dates at a time (here three different dates are entered).

Notice that all of the shots the patient received on each day are check-marked.

IMPACT Statewide Immunization System: Immunizations - Add Historical - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Immunization/Immunization.aspx?action=addHistorical

File Edit View Favorites Tools Help

IMPACT Statewide Im... IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

GOOD SAMARITAN FAMILY PRACTICE CEN... GOOD SAMARITAN FAMILY PRACTICE CEN... ANNE PROULX JANE CLIFTON

TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact: TEST, APRIL (Self)
(419) 636-0000
433 W High Street
Bryan Ohio 43506

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Not Eligible
Next Appt: 6/4/1995
Immunization Status: Past Due

Immunizations

Group	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7
DTP	DUE NOW						
FLU	DUE NOW						
HAV	DUE NOW						
HBV	DUE NOW						
HPV	DUE NOW						
Meningococcal	DUE NOW						
MMR	DUE NOW						
POL	DUE NOW						
VAR	DUE NOW						

Hospital HBV
Date Given: 6/4/1995 HBV: ☒ HBIG: ☐

1st Visit Date 8/10/1995		2nd Visit Date 10/10/1995		3rd Visit Date 12/10/1995		4th Visit Date 5/10/2011		5th Visit Date 5/11/2011	
DTP	<input checked="" type="checkbox"/>	DTP	<input checked="" type="checkbox"/>	DTP	<input checked="" type="checkbox"/>	DTP	<input type="checkbox"/>	DTP	<input type="checkbox"/>
HBV	<input checked="" type="checkbox"/>	HBV	<input checked="" type="checkbox"/>	HBV	<input type="checkbox"/>	HBV	<input type="checkbox"/>	HBV	<input type="checkbox"/>
HIB	<input checked="" type="checkbox"/>	HIB	<input checked="" type="checkbox"/>	HIB	<input checked="" type="checkbox"/>	HIB	<input type="checkbox"/>	HIB	<input type="checkbox"/>
MMR	<input type="checkbox"/>	MMR	<input type="checkbox"/>	MMR	<input type="checkbox"/>	MMR	<input type="checkbox"/>	MMR	<input type="checkbox"/>
POL	<input checked="" type="checkbox"/>	POL	<input checked="" type="checkbox"/>	POL	<input type="checkbox"/>	POL	<input type="checkbox"/>	POL	<input type="checkbox"/>
VAR	<input type="checkbox"/>	VAR	<input type="checkbox"/>	VAR	<input type="checkbox"/>	VAR	<input type="checkbox"/>	VAR	<input type="checkbox"/>
PNE	<input checked="" type="checkbox"/>	PNE	<input checked="" type="checkbox"/>	PNE	<input checked="" type="checkbox"/>	PNE	<input type="checkbox"/>	PNE	<input type="checkbox"/>
Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>
Other2	<input type="checkbox"/>	Other2	<input type="checkbox"/>	Other2	<input type="checkbox"/>	Other2	<input type="checkbox"/>	Other2	<input type="checkbox"/>
Other3	<input type="checkbox"/>	Other3	<input type="checkbox"/>	Other3	<input type="checkbox"/>	Other3	<input type="checkbox"/>	Other3	<input type="checkbox"/>
Rotavirus	<input checked="" type="checkbox"/>	Rotavirus	<input checked="" type="checkbox"/>	Rotavirus	<input checked="" type="checkbox"/>	Rotavirus	<input type="checkbox"/>	Rotavirus	<input type="checkbox"/>
HAV	<input type="checkbox"/>	HAV	<input type="checkbox"/>	HAV	<input type="checkbox"/>	HAV	<input type="checkbox"/>	HAV	<input type="checkbox"/>
Meningococcal	<input type="checkbox"/>	Meningococcal	<input type="checkbox"/>	Meningococcal	<input type="checkbox"/>	Meningococcal	<input type="checkbox"/>	Meningococcal	<input type="checkbox"/>
FLU	<input type="checkbox"/>	FLU	<input type="checkbox"/>	FLU	<input type="checkbox"/>	FLU	<input type="checkbox"/>	FLU	<input type="checkbox"/>
HPV	<input type="checkbox"/>	HPV	<input type="checkbox"/>	HPV	<input type="checkbox"/>	HPV	<input type="checkbox"/>	HPV	<input type="checkbox"/>
H1N1	<input type="checkbox"/>	H1N1	<input type="checkbox"/>	H1N1	<input type="checkbox"/>	H1N1	<input type="checkbox"/>	H1N1	<input type="checkbox"/>

* Required Fields

Save Changes Cancel

Immunization.aspx?action=addHistorical

Immunize. It Matters.

Shots Added to Record

IMPACT Statewide Immunization System: Patients - Immunizations - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Immunization/Immunization.aspx

File Edit View Favorites Tools Help

IMPACT Statewide Im... IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

Page Safety Tools

Welcome Andrew Harris
Preferences My Practice Logout

Search Patient... Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: GOOD SAMARITAN FAMILY PRACTICE CEN... Clinics: GOOD SAMARITAN FAMILY PRACTICE CEN... Providers: ANNE PROULX Vaccine Givers: JANE CLIFTON

> Patients
> Demographics
> Contacts
> Immunizations
> Add Current
> Add Historical
> Add Immunity
> Add Refusal
> Add Appointment
> Contraindications
> Lead Test Results
> School Information

TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact: TEST, APRIL (Self)
(419) 636-0000
433 W High Street
Bryan Ohio 43506

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Immunizations

Detail: Short: Grid: Schedule:

Group	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7
DTP	08/10/95	10/10/95	12/10/95	DUE NOW			
FLU	DUE NOW						
HAV	DUE NOW						
HBV	06/04/95	08/10/95	12/10/95				
HIB	08/10/95	10/10/95	12/10/95				
HPV	DUE NOW						
Meningococcal	DUE NOW						
MMR	DUE NOW						
PNE	08/10/95	10/10/95	12/10/95				
POL	08/10/95	10/10/95	DUE NOW				
Rotavirus	08/10/95	10/10/95	12/10/95				
VAR	DUE NOW						

Add Historical Add Current Add Appointment Add Immunity Lead Results Add Refusal

Day/Camp Form Show Trace Print

Due Now Refusal On File Given Too Early Do Not Count Incorrect Spacing Given Late Immunity

* The Immunization Status is evaluated based on the Consensus recommendations of the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and Immunization Practices Advisory Committee (ACIP).

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Example of Algorithm at Work

IMPACT Statewide Immunization System: Patients - Immunizations - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Immunization/Immunization.aspx

File Edit View Favorites Tools Help

IMPACT Statewide Im... IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

IMPACTSIS Statewide Immunization Information System

Welcome Andrew Harris Preferences My Practice Logout

Search Patient... Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: GOOD SAMARITAN FAMILY PRACTICE CEN... Clinics: GOOD SAMARITAN FAMILY PRACTICE CEN... Providers: ANNE PROULX Vaccine Givers: JANE CLIFTON

> Patients
> Demographics
> Contacts
> Immunizations
> Add Current
> Add Historical
> Add Immunity
> Add Refusal
> Add Appointment
> Contraindications
> Lead Test Results
> School Information

TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact: TEST, APRIL (Self)
(419) 636-0000
433 W High Street
Bryan Ohio 43506

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Immunizations

Detail: Short: Grid: Schedule:

Group	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7
DTP	08/10/95	10/10/95	12/10/95				
FLU	DUE NOW			DUE NOW			
HAV	08/10/95	DUE NOW					
HBV	06/04/95	08/10/95	12/10/95				
HIB	08/10/95	10/10/95	12/10/95				
HPV	DUE NOW						
Meningococcal	DUE NOW						
MMR	DUE NOW						
PNE	08/10/95	10/10/95	12/10/95				
POL	08/10/95	10/10/95	DUE NOW				
Rotavirus	08/10/95	10/10/95	12/10/95				
VAR	DUE NOW						

Add Historical Add Current Add Appointment Add Immunity Lead Results Add Refusal

Day/Camp Form Show Trace Print

Due Now Refusal On File Given Too Early Do Not Count Incorrect Spacing Given Late Immunity

* The Immunization Status is evaluated based on the Consensus recommendations of the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and Immunization Practices Advisory Committee (ACIP).

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Notice the Hep A vaccine is shown in deep blue as given too early (first dose should be given at 12 mo).

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Detailed View of Shot Record

Notice that there are four different views available for shot records; just click the buttons to change the views.

Wide Immunization System: Patients - Immunizations - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Immunization/Immunization.aspx

IMPACT Statewide Im... IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact: TEST, APRIL (Self) (419) 636-0000
Lead Test Result: None
Lead Test Date: None
VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Immunizations

Detail Short Grid Schedule

Dose	Vaccine Name	Given	Status	Body Site	Lot Number	Gave Vaccine	Provider	VIS Date
DTP Recommended								
1	DTP-UNK	08/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
2	DTP-UNK	10/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
3	DTP-UNK	12/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
4			DUE NOW					
FLU Recommended								
1			DUE NOW					
HAV Recommended								
1	HAV-UNK	08/10/95	Bad Age			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
2			DUE NOW					
HBV Not Recommended								
1	HBV-UNK	06/04/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
2	HBV-UNK	08/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
3	HBV-UNK	12/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
HIB Complete								
1	Hib-UNK	08/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
2	Hib-UNK	10/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
3	Hib-UNK	12/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕
HPV Recommended								
1			DUE NOW					
Meningococcal Recommended								
1			DUE NOW					
MMR Recommended								
1			DUE NOW					
PNE Complete								
1	PNUcn-UNK	08/10/95	Good			HISTORICAL (UNKNOWN)	HISTORICAL (UNKNOWN)	✂ ✕

Press to Delete this Dose Record. Only the Provider of Record for a dose may delete it.

Done

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Contact Screen

The Contact screen is for updating patient contact info, including address, phone number, email, etc. This info is tied to contacts (e.g. mom or dad), NOT patients.

Statewide Immunization System: Patients - Contacts - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Contact/Contact.aspx

View Favorites Tools Help

IMPACT Statewide Im... IMPACTSIIS RECRUITMEN... Pandora Radio - Listen to ...

Page Safety Tools

Welcome Andrew Harris
Preferences My Practice Logout

Search Patient...

Practices: GOOD SAMARITAN FAMILY PRACTICE CEN Clinic: GOOD SAMARITAN FAMILY PRACTICE CEN Provider: ANNE PROULX Vaccine Giver: JANE CLIFTON

> Patients
> Demographics
> Contacts
> Immunization
> Add Current
> Add Historical
> Add Immunity
> Add Refusal
> Add Appointment
> Contraindications
> Lead Test Results
> School Information

TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact: TEST, APRIL (Self)
(419) 636-0000
433 W High Street
Bryan Ohio 43506

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Contact List

	Relationship	Name	Address	Phone	Email	
+	Self	TEST, APRIL	433 W High Street Bryan, Ohio 43506	(419) 636-0000		✎ ✕

Add Contact

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Internet | Protected Mode: Off | 100%

Patients can have more than one contact, including self, but ONLY ONE primary contact.

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Searching for Contact

When adding a new contact for a patient, you must first search to see if the contact is already in ImpactSIIS, similar to looking up patients in ImpactSIIS.

Statewide Immunization System: Patients - Contacts - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Contact/Contact.aspx

View Favorites Tools Help

IMPACT Statewide Im... IMPACTSIIS RECRUITMEN... Pandora Radio - Listen to ...

Page Safety Tools ? >>

ImpactSIIS Statewide Immunization Information System

Welcome Andrew Harris Preferences My Practice Logout

Search Patient... Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Practices: GOOD SAMARITAN FAMILY PRACTICE CEN... Clinics: GOOD SAMARITAN FAMILY PRACTICE CEN... Providers: ANNE PROULX Vaccine Givers: JANE CLIFTON

> Patients
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> School Information

TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact:
TEST, APRIL (Self)
(419) 636-0000
433 W High Street
Bryan Ohio 43506

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Contact List

Search for an Existing Contact

Last Name	First Name	Phone Number	Birth Date
Test	Mom	() - - - -	12/1/1970

Your search has not returned any results.
If you are confident that the contact does not exist in our system then add a new contact.

[Create New Contact](#)

Search Go Back

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Adding New Primary Contact

You can have more than one phone, email, and address for each contact.

IMPACT Statewide Immunization System: Patients - Contacts - Windows Internet Explorer

https://odhgateway.odh.ohio.gov/Impact/PatientDashboard/Contact/Contact.aspx

IMPACT Statewide Im... IMPACTSIS RECRUITMEN... Pandora Radio - Listen to ...

IMPACTSIS Statewide Immunization Information System

Welcome Andrew Harris
Preferences | My Practice | Logout

Search Patient...

Practices: GOOD SAMARITAN FAMILY PRACTICE CEN... Clinics: GOOD SAMARITAN FAMILY PRACTICE CEN... Providers: ANNE PROULX Vaccine Givers: JANE CLIFTON

> Patients
> Demographics
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TEST, APRIL MCHA (DOB:6/4/1995)

Primary Contact: TEST, APRIL (Self)
(419) 636-0000
433 W High Street
Bryan Ohio 43506

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Contact List

	Relationship	Name	Address	Phone	Email
+	Self	TEST, APRIL	433 W High Street Bryan, Ohio 43506	(419) 636-0000	

Contact Information

Primary	Relationship	Last Name *	First Name *	Middle Name	Birthdate
<input checked="" type="checkbox"/>	Mother	Test	Mom	R	12/10/1970

Phone Numbers

Type	Phone Number *
HOME	(614)-222-2222

[Add New Number](#)

Email Addresses

Email Address
momtest@yahoo.com

[Add New Email](#)

Addresses

Type	Address 1 *	Address 2	Zip	City (County)	State
HOME	1234 Test Street		43215	COLUMBUS (FRANKLIN)	OHIO

[Add New Address](#)

* Required Fields
** Either phone number or address are required

Save Cancel

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Don't Change—Add New

Radio buttons designate primary phone, email, and address for EACH contact.

The screenshot displays the ImpactSIIS Statewide Immunization Information System interface. The patient profile for TEST, APRIL MCHA (DOB: 6/4/1995) is shown. The interface includes a navigation menu on the left with options like Patients, Demographics, and Contacts. The main content area shows contact details, including a contact list, contact information, phone numbers, email addresses, and addresses. Radio buttons are used to designate the primary contact for each field.

Primary Contact: TEST, MOM (Mother)
(614) 222-2222
1234 Test Street
Columbus Ohio 43215
momtest@yahoo.com

Lead Test Result: None
Lead Test Date: None
VFC Eligibility: Is Not Eligible
Next Appt: 12/4/1995
Immunization Status: Past Due

Contact List

Relationship	Name	Address	Phone	Email	
<input checked="" type="radio"/> Mother	Test, Mom	1234 Test Street Columbus, Ohio 43215	(614) 222-2222	momtest@yahoo.com	✓✗
<input type="radio"/> Self	TEST, APRIL	433 W High Street Bryan, Ohio 43506	(419) 636-0000		✓✗

Contact Information

Primary	Relationship	Last Name *	First Name *	Middle Name	Birthdate
<input checked="" type="checkbox"/>	Mother	Test	Mom	R	12/10/1970

Phone Numbers

Type	Phone Number *
<input type="radio"/> HOME	(614)-222-2222
<input checked="" type="radio"/> MOBILE	(614)-333-3333

Email Addresses

Email Address
momtest@yahoo.com
mom.works@us.gov

Addresses

Type	Address 1 *	Address 2	Zip	City (County)	State
<input checked="" type="radio"/> HOME	1234 Test Street		43215	COLUMBUS (FRANKLIN)	OHIO
<input type="radio"/> WORK	555 Washington Way		11111	TESTCITY (ADAMS)	OHIO

* Required Fields
** Either phone number or address are required

Save Cancel

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Patient Address Updated to Primary Contact

Patient takes on primary contact's MAIN address (as designated by radio button)

munization System: Patients - Contacts - Windows Internet Explorer

odhgateway.odh.ohio.gov/Impact/PatientDashboard/Contact/Contact.aspx

Search Patient...

Practices: GOOD SAMARITAN FAMILY PRACTICE CEN... Clinic: GOOD SAMARITAN FAMILY PRACTICE CEN... Provider: ANNE PROULX Vaccine Giver: JANE CLIFTON

Statewide Immunization Information System

Welcome Andrew Harris Preferences My Practice Logout

Home Patient Vaccines Reminder Recall Upload Reports Administration Help Call Center

Primary Contact: TEST, MOM (Mother) (614) 222-2222 1234 Test Street Columbus Ohio 43215 momtest@yahoo.com

TEST, APRIL MCHA (DOB:6/4/1995)

Lead Test Result: None VFC Eligibility: Is Not Eligible
Lead Test Date: None Next Appt: 12/4/1995
Immunization Status: Past Due

Contact List

Relationship	Name	Address	Phone	Email	
Mother	Test, Mom	1234 Test Street Columbus, Ohio 43215	(614) 222-2222	momtest@yahoo.com	✓✗
Self	TEST, APRIL	433 W High Street Bryan, Ohio 43506	(419) 636-0000		✓✗

Add Contact

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SIIS
2TT2

Immunize. It Matters.

Notice: The WIC Program Cannot Serve You

Dear _____,

The WIC program cannot serve you as of _____ because you do not meet the rules checked below:

☐ You did not provide information that is needed to determine your eligibility as follows:

☐ Your household income is more than the maximum allowed.

☐ Your six month postpartum period has ended and you are not breastfeeding.

☐ Your breastfed infant is one year old on _____.

☐ You will turn five years old on _____.

☐ You moved out of our WIC service area.

☐ You missed a recertification appointment.

☐ You did not pick up food benefits for two months.

☐ Other: _____

☐ Your name is being placed on a waiting list because service slots are full at this time.

If you think we are wrong in not giving WIC services, you have the right to ask for a fair hearing. You must ask our staff for the hearing within 60 days from the date of this letter.

Signature of Parent, Guardian, or Representative	Date	Signature of WIC Staff
--	------	------------------------

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If you wish to file a Civil Rights program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), 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).

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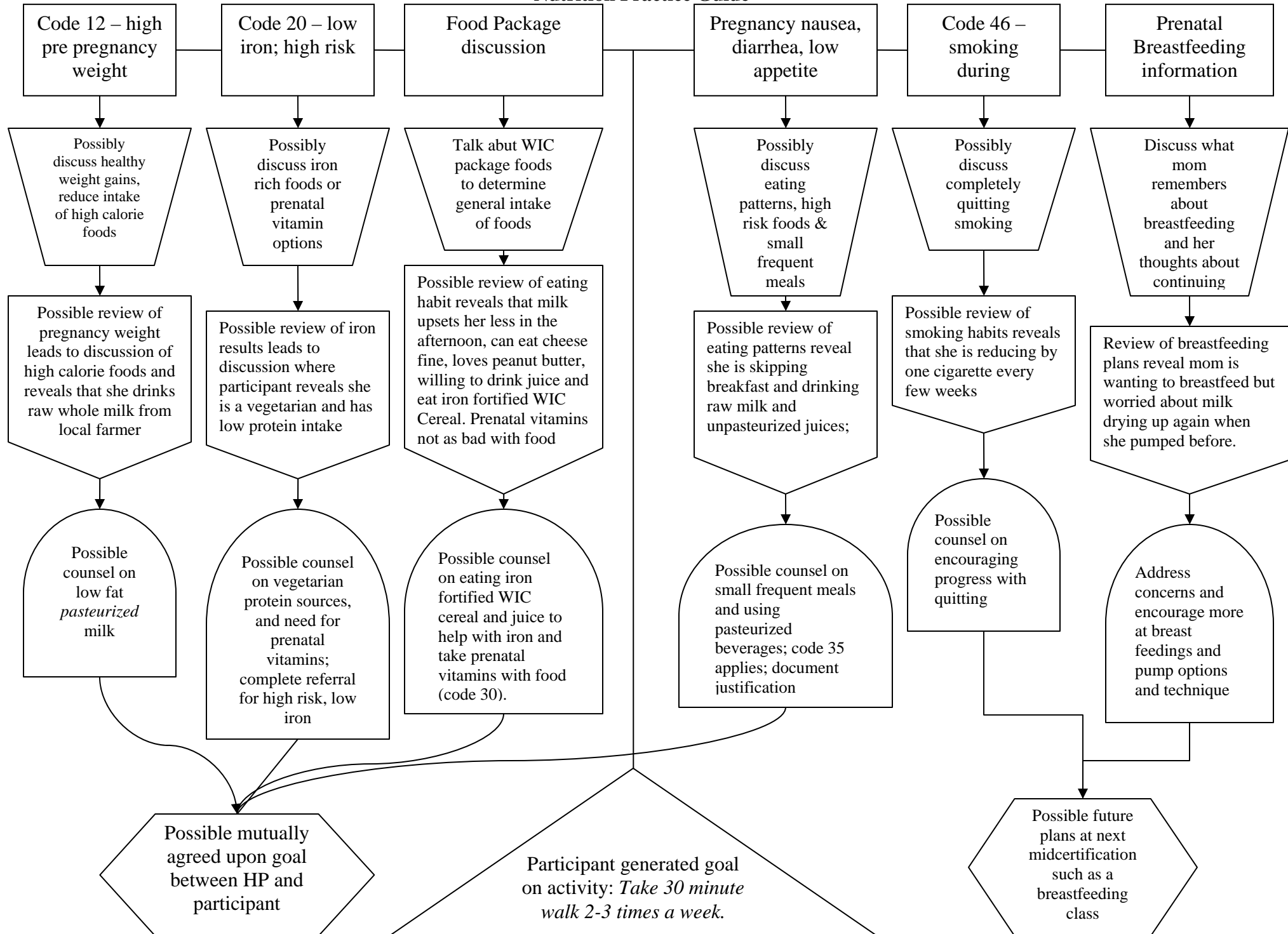
Ohio Department of Health

Nutrition Care Plan

Name		ID# (optional)	
S/O (optional)			
A			
Previous goal met? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
HR	Referral	Mom risk (61, 71)	BF Infant risk (70)
P			
Package	Signature		Date

Notes

Nutrition Practice Guide



Ohio Department of Health
Immunization Record Card – Parent's Copy

Child's name	Birthdate
--------------	-----------

Vaccine	Dose	Type of vaccine	Date given (mo/day/yr)	Provider	Date next dose due
Diphtheria, Tetanus, Pertussis (DTaP, DT, Tdap, Td) Tdap/Td booster every 10 years	1				
	2				
	3				
	4				
	5				
Hepatitis B	HBIG administered at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Date given / /				
	1				
	2				
	3				
Hib (Haemophilus influenzae type b)	1				
	2				
	3				
	4				
Polio (IPV/OPV)	1				
	2				
	3				
	4				
Pneumococcal PCV, PPSV	1				
	2				
	3				
	4				
Rotavirus	1				
	2				
	3				
Hepatitis A	1				
	2				
Measles, Mumps, Rubella (MMR)	1				
	2				
Varicella (chickenpox)	1				
	2				
	If had disease, give date / /				
Influenza					
Human Papillomavirus (HPV)	1				
	2				
	3				
Meningococcal (conjugate MCV4, polysaccharide MPSV4)	1				

Vaccine	Dose	Type of vaccine	Date given (mo/day/yr)	Provider	Date next dose due
Other (travel, IG)					

Lead Poisoning Screening		Sample draw date		*Type	Result	Sample draw date		*Type	Result		
*Specimen Type: V=venous C=capillary		/ /		V	C	µg/dL	/ /		V	C	µg/dL
Recommended childhood schedule= Total of two lead screenings: 12 mo and 24 mo; 2nd blood test ≥ 12 mo after the 1st blood test.											

Child's address
Child's state
Child's ZIP
Child's county
Child's sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Child's SSN
Child's insurance number

Physician name
Physician address
Physician phone ()

Parent/Guardian name
Parent/Guardian address
Parent/Guardian SSN
Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian
Parent/Guardian phone ()

Parent/Guardian name
Parent/Guardian address
Parent/Guardian SSN
Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian
Parent/Guardian phone ()

Ohio Department of Health
Immunization Program

An equal opportunity employer/provider

HEA 3309 8/10

3816.11



Immunization Record

for

Child's name

Take this card each time
your child visits
the doctor or nurse.

You will need this record card for:

- WIC Visits
- Head Start
- Child Care
- School
- College
- Lead Poisoning Screening

Keep this card in a safe place.

Never lose your child's immunization record.
Ask your healthcare providers if they participate
in www.impactsis.org, Ohio's Immunization Registry.
All participating Ohio healthcare providers can obtain
your record through this free confidential service.

ODH-WIC Program

Update Participant Immunization Data

Participant ID: _____ Date: _____

Name: _____

Immunization History:

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7
DTP							
FLU							
HAV							
HBV							
HIB							
HPV							
MNG-CCL							
MMR							
PNE							
POL							
VAR							
Other							

Key: **DTP**- diphtheria, tetanus, pertussis; **FLU**- Influenza; **HAV**- Hepatitis A; **HBV**- Hepatitis B; **HIB**- haemophilus b
HPV- human papilloma virus; **MNG-CCL**- meningococcal; **MMR**- measles, mumps, rubella; **PNE**- pneumococcal
POL- polio; **VAR**- varicella

Obtaining Blood Samples

- 1) **Puncture the finger** - All clinics must use a sterile, disposable finger-stick device with a retractable blade. Refer to the following general procedure:
 - a. Uncap a sterile, disposable finger-stick device.
 - b. **Firmly** grasp the individual's middle finger holding the finger below the level of the heart.
 - c. Pick up the sterile, disposable finger-stick device with your other hand.
 - d. Hold the finger-stick device slightly to the side of the ball of the finger. (Not only is blood flow at its best at this point, it also is less painful.)
 - e. Prick the finger. (See Figure 1.)
 - f. Refer to the manufacturer's directions for the proper use of specific finger-stick devices.

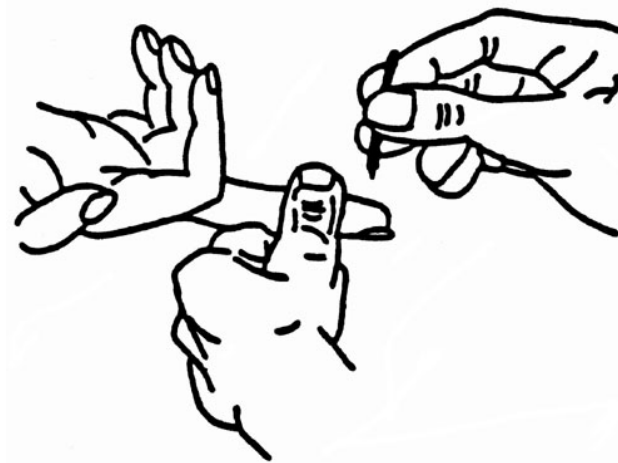


Figure 1 Puncture the Finger

- 2) **Eliminate the first two or three blood drops with dry sterile gauze** - The first two or three drops of blood may contain tissue juices and be contaminated with extraneous materials which have been clinging to the surface of the skin. (See Figure 2.)

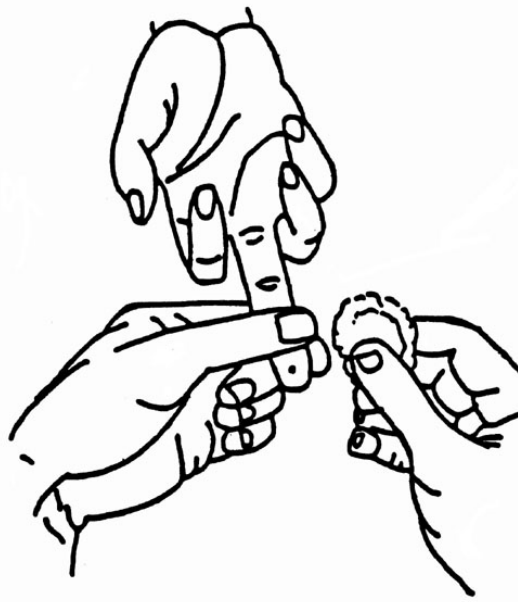


Figure 2 Eliminate the first two or three blood drops

- a. Wipe the two or three blood drops away with dry sterile gauze. This will enable the ensuing blood to form a rounded drop and not dribble over the side of the finger. The staff person must work rapidly once the puncture is made because the blood will clot in a matter of minutes.
 - b. If the blood does not flow freely, massage the finger toward the puncture to induce bleeding, keeping the finger below the level of the individual's heart. Remove the first two or three drops of blood as instructed above.
- 4) **Produce a large, rounded blood drop** - A large, rounded blood drop is needed for the HemoCue 201+ analyzer. Complete the following procedure:
- a. Hold the sides of the individual's middle finger as illustrated in Figure 3.
 - b. With your thumb and index finger, grasp the individual's finger about 3 inches above the puncture.
 - c. Using your thumb and index finger, massage the fleshy portion of the individual's finger. Repeat this massaging process several times.
 - d. The last time you massage the finger, clamp down **hard** at the line in the first joint of the individual's finger.
 - e. Gently squeeze the sides of the individual's finger (Figure 3).

A large rounded drop of blood should form at the site of the puncture.

- a. Do not squeeze too hard with your hand. Too much squeezing will cause the flow of tissue juices and make the blood clot.

- b. When squeezing with your hand, always make sure that the blood is dammed off by firm pressure. If the blood is not dammed off, it will simply flow back toward the heart and not come out of the puncture.

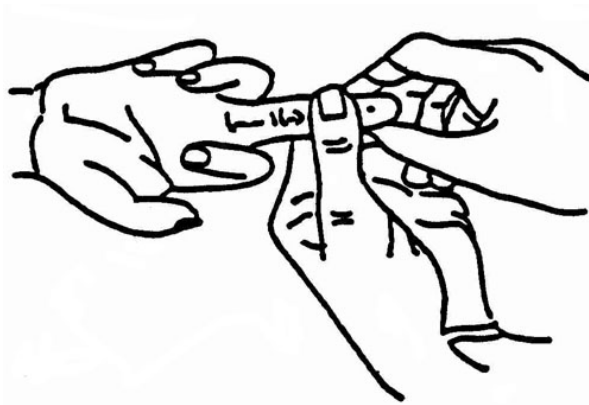


Figure 3 Produce a rounded drop of blood

- 5) **Withdraw the blood** – Use the microcuvette as explained in Section 267.2.
- 6) **Prevent further bleeding** - After the blood has been withdrawn the following procedure should be followed:
 - a. Ask the participant to hold gauze/cotton on the puncture for 30 seconds.
 - b. Cover the puncture with a band aid.
 - c. Staff are not permitted to remove gloves until **all** materials utilized are disposed of properly.

Ohio WIC Program No Proof Form

The Ohio WIC program requires each applicant to show proof of identity, residence, and income to determine eligibility. You stated that you do not have some or all of the proofs. Please complete the following information for determining eligibility without required proofs.

1. I do not have the required proof of the following check-marked items:

___Identity ___Address ___Income

2. I do not have the required proof because:

___fire

___migrant farm worker

___flood (or other natural disaster)

___evacuee due to disaster

___victim of theft

___refugee

___loss in recent move

___unemployed

___homeless

___pending unemployment benefits

___pending Ohio Works First benefits

___other reason (please list)_____

3. I last received income on (date) _____, from (state: employer or other source) _____, in the amount of \$_____ per ___week, ___every two weeks ___ twice per month ___ monthly.

4. I expect to have income on (date)_____, from (state: employer or other source)_____, in the amount of \$_____ per ___week, ___every two weeks ___ twice per month ___ monthly.

5. I am meeting housing and food needs by_____

I certify that the information I provided is correct to the best of my knowledge. I understand making a false or misleading statement, or misrepresenting, concealing or withholding facts may result in my paying back the cost of food issued to me and may result in prosecution under state and federal law.

Applicant Signature: _____ Date:_____

Staff Signature: _____ Date: _____

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Ohio WIC Program No Proof Form Instructions

Purpose of Form:

This form is for the applicant to confirm in writing and provide the reason why proof of identification, address, or income cannot be provided. This form is **only** to be used for the exceptions where proof may not be available due to the applicant being a victim of theft; loss in recent move; fire, flood, or other natural disaster; a homeless individual; a migrant farm worker; a refugee; or an evacuee due to disaster. This form is not to be used on a routine basis for applicants that forget to bring in documentation.

Questions and Responses:

If the applicant is unable to write responses to the questions on the form, then project staff must write the applicant's responses.

1. The applicant indicates which proofs cannot be provided; any one or all can be checked.
2. The applicant checks reason or states reason for proofs not being available.
3. When income proof is checked, the applicant provides information on last income received.
4. When income proof is checked, the applicant provides information on next time income is expected.
5. The applicant indicates how housing and food needs are being met.

Questions 2, 3 and 4 may help project staff with determining need for referral for unemployment compensation, public assistance, or other income assistance programs.

Question 5 may help project staff with determining need for referral for housing and other food program assistance.

Certification Statement:

The applicant must read the "I certify...statement." If the applicant cannot read, project staff reads the statement for the applicant.

Applicant Signature:

The applicant signs and dates the form upon completion.

Staff Signature:

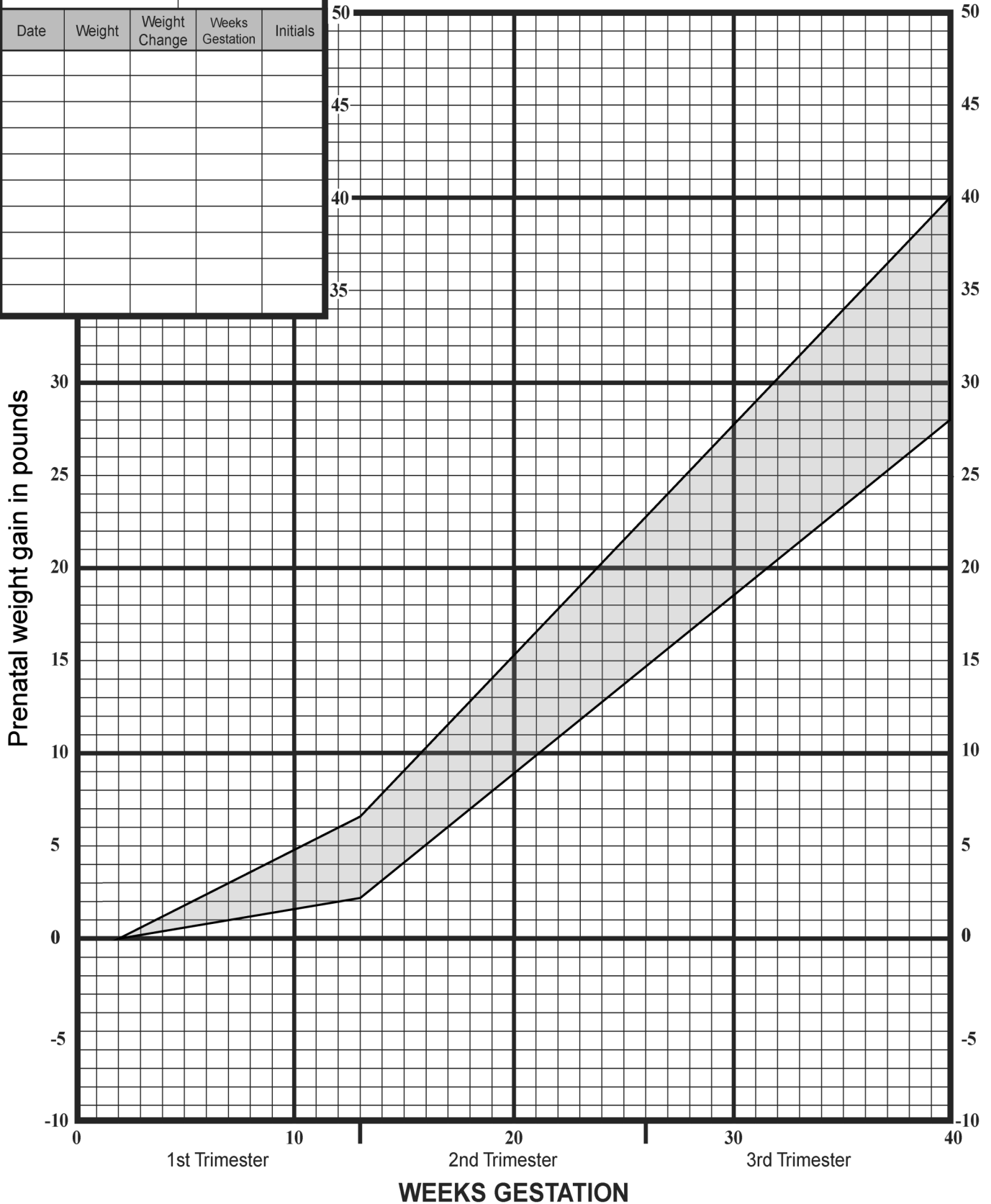
Interviewing project staff signs and dates the form upon completion.

REMINDER: Print and file in WIC chart.

PRENATAL WEIGHT GAIN CHART

Pre-Pregnancy Underweight
28-40 lbs BMI < 18.5

NAME				
HEIGHT (WITHOUT SHOES)			PREGRAVID BMI	
PREGRAVID WEIGHT			EDC	
Date	Weight	Weight Change	Weeks Gestation	Initials

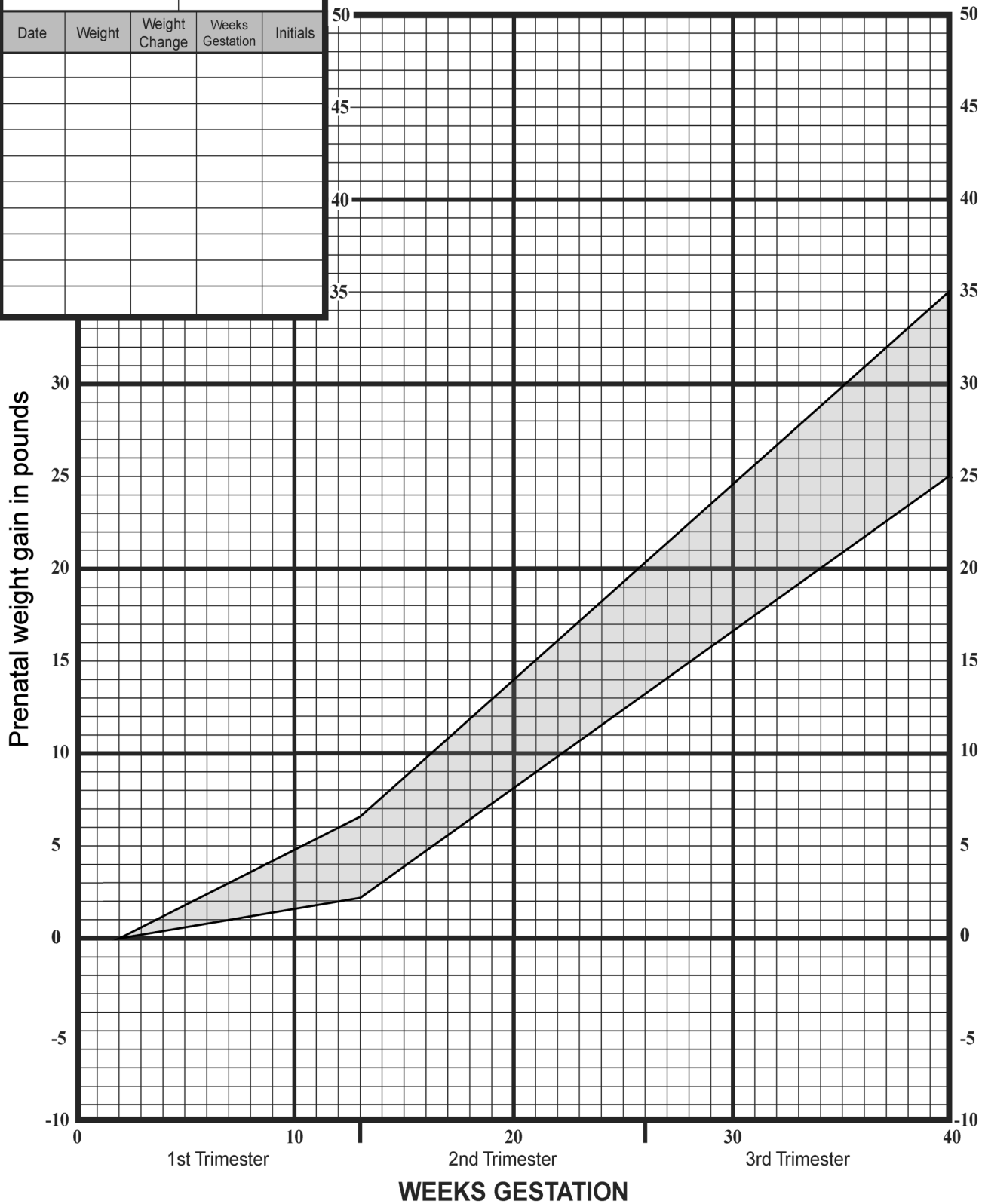


REMINDER: Print and file in WIC chart.

[illegible]

PRENATAL WEIGHT GAIN CHART

Pre-Pregnancy Normal Weight
25-35 lbs BMI 18.5-24.9

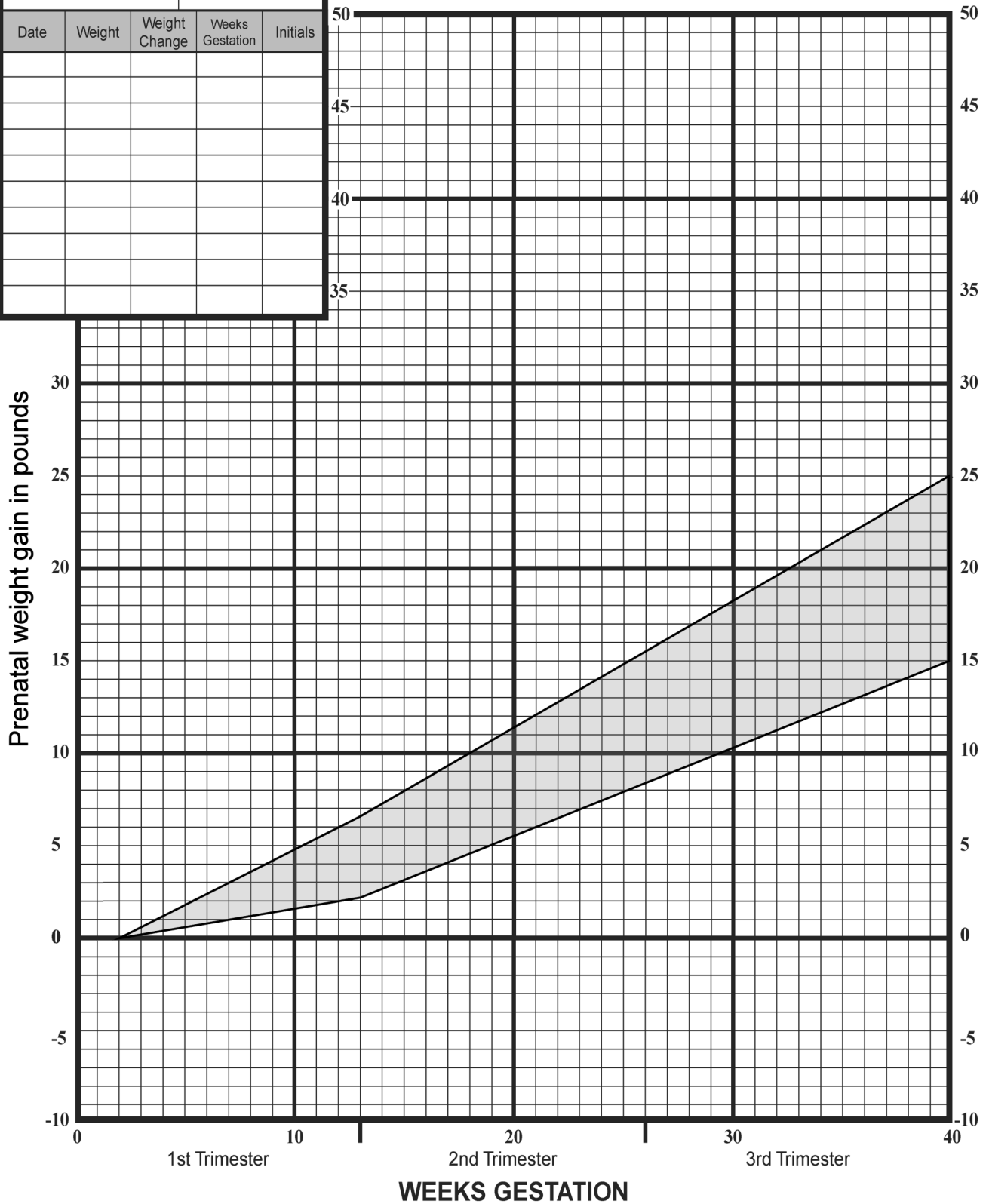


REMINDER: Print and file in WIC chart.

PRENATAL WEIGHT GAIN CHART

Pre-Pregnancy Overweight
15-25 lbs BMI 25.0-29.9

NAME				
HEIGHT (WITHOUT SHOES)			PREGRAVID BMI	
PREGRAVID WEIGHT			EDC	
Date	Weight	Weight Change	Weeks Gestation	Initials

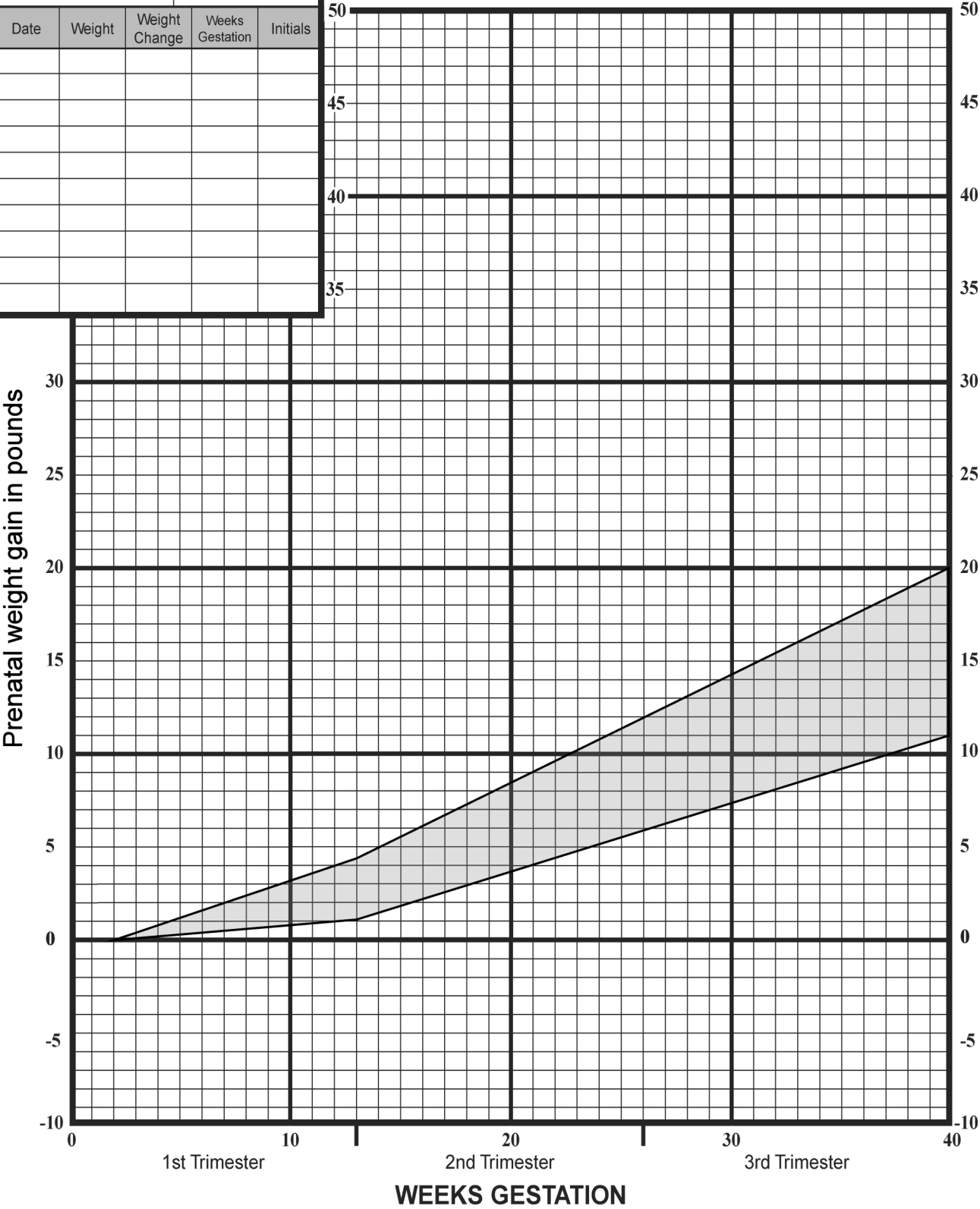


REMINDER: Print and file in WIC chart.

NAME				
HEIGHT (WITHOUT SHOES)			PREGRAVID BMI	
PREGRAVID WEIGHT			EDC	
Date	Weight	Weight Change	Weeks Gestation	Initials

PRENATAL WEIGHT GAIN CHART

Pre-Pregnancy Obese
11-20 lbs BMI ≥ 30



PRIVATE PHYSICIAN/HOSPITAL/CLINIC MEDICAL SERVICES
MEMORANDUM OF AGREEMENT
FY_____

_____**WIC PROGRAM**_____
(Project Name) (Project Number)

Physician's Name:_____

Specialty:_____

Office Address:_____

Office Telephone Number:_____

Office Hours:_____

Please circle the categories of people you provide health services to:

Pregnant Women Breastfeeding Women Postpartum Women

Infants 0 -1 Children 1-5

Do you accept Medicaid payment? Yes No

If Yes, what is your provider
number?_____

Do you accept reduced fees for services? Yes No

List hospital
affiliations_____ (optional)

MEMORANDUM OF AGREEMENT

By and between the _____ and
Name of Local Agency

_____.
Name of Physician

WHEREAS, the _____, as a designated Local
Name of Local Agency

Agency for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program), wishes to provide WIC Program services to eligible women, (pregnant, postpartum, and breastfeeding), infants, and children, but does not provide the health services which the WIC Program requires; and

WHEREAS, _____, is a physician licensed by
Name of Physician

the State Medical Board of Ohio, pursuant to Chapter 4731 of the Ohio Revised Code or the State Medical Board of _____ to practice medicine or surgery or osteopathic medicine and surgery;

NOW THEREFORE, it is mutually agreed by and between the _____
Name of Local Agency
(Hereinafter referred to as the "Local Agency") and _____
Name of Physician

(hereinafter referred to as the "Physician") that the covenants enumerated in this agreement will be kept and performed.

1. The Physician shall provide such pediatric, obstetrical, lactation, and other services as the Physician deems appropriate in the exercise of his or her professional medical judgment to persons who seek such services upon referral from the Local Agency.
2. With the written consent of the patient, the Physician shall provide the Local Agency with such information pertaining to the patient as the Local Agency may require in order to determine the patient's eligibility for participation in the WIC Program.
3. The Physician understands that the Local Agency shall not reimburse the Physician for providing health services to patients who the Local Agency refers to the Physician.
4. The Physician or clinic shall, in providing its services and in its terms and conditions of employment, comply with all requirements under federal and state law pertaining to nondiscrimination and equal employment opportunity, including Title VI of the 1964 Civil Rights Act and pertinent federal regulations.
5. This agreement shall take effect on October 1, ____ and shall remain in effect through September 30, ____ unless terminated by either party upon written notice of termination being served by the party terminating on the other party. A 30 day notification of termination by the terminating party is required.

BY:

Signature of the WIC Program Director Date

Signature of Physician or Clinic Administrator Date

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹		HepB	HepB			HepB							
Rotavirus ²				RV	RV	RV ²							
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	see footnote ³	DTaP				DTaP	
<i>Haemophilus influenzae</i> type b ⁴				Hib	Hib	Hib ⁴		Hib					
Pneumococcal ⁵				PCV	PCV	PCV		PCV				PPSV	
Inactivated Poliovirus ⁶				IPV	IPV			IPV				IPV	
Influenza ⁷													
Measles, Mumps, Rubella ⁸								MMR		see footnote ⁸		MMR	
Varicella ⁹								Varicella		see footnote ⁹		Varicella	
Hepatitis A ¹⁰												HepA Series	
Meningococcal ¹¹												MCV4	

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
- The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hibrix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.

- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See *MMWR* 2010;59(No. RR-11).

- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Department of Health and Human Services • Centers for Disease Control and Prevention

RISK CODE JUSTIFICATIONS

Chapter 200

Justification Risk Code 10

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. 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.

The 2009 Institute of Medicine (IOM) report: *Weight Gain During Pregnancy: Reexamining the Guidelines* 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. 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.

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 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 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 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds. 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 pounds 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. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy. For WIC eligibility

determinations, multi-fetal pregnancies are considered a nutrition risk in and of themselves (Risk #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.

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.

Justification Risk Code 11

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.

Childhood obesity is one of the most important long-term health 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.

The 2009 Institute of Medicine (IOM) report: *Weight Gain During Pregnancy: Reexamining the Guidelines* 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. 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.

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 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 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.

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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. 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.

Justification Risk Codes 13 and 14

Underweight women who become pregnant are at a higher risk for delivery of low birth weight (LBW) infants, retarded fetal growth, and perinatal mortality. Prepregnancy underweight is also associated with a higher incidence of various pregnancy complications, such as antepartum hemorrhage, premature rupture of membranes, anemia, endometritis, 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* 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. The reexamination of the guidelines consisted of a review of the determinants of a wide range of short-and longterm 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.

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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. Prepregnancy 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 prepregnancy weight. In most cases therefore, prepregnancy 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 or all of which need to be addressed.

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) infant(s), 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.

Justification Risk Codes 12 and 15

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. 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 .

One goal of prenatal nutritional counseling is to achieve recommended weight gain during pregnancy. 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* 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. 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.

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The percentage of adolescents who are overweight has increased rapidly and more than 60% of adults in the US 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.

Justification Risk Code 16

Women who do not receive early and adequate prenatal care are more likely to deliver premature, growth retarded, or low birth weight infants. 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. Several studies have reported significant health and nutrition benefits for pregnant women enrolled in the WIC program.

Justification Risk Code 17

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, 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.

Justification Risk Code 20

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 Hb nor Hct tests 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.

Justification Risk Code 21

Venous blood measurement lead levels at or above the level identified in CDC published guidelines are associated with harmful effects on health, nutritional status, learning or behavior for everyone. Because published guidelines are currently available only for children, similar thresholds should be used for other participant categories until category-specific guidelines are available from CDC.

Lead poisoning is a persistent, but entirely preventable public health problem in the United States. It is most common in children, but can occur in other groups as well. Blood lead levels have been declining in the U.S. population as a whole in recent years, but children remain at risk. Children absorb more lead more readily than adults and children's developing nervous systems are particularly vulnerable to lead's effects.

In pregnant women lead crosses the placenta and can have a detrimental impact on a developing fetus. Adequate intake of calories, calcium, magnesium, iron, zinc, and various vitamins (e.g. thiamin, ascorbic acid, and vitamin E) decreases the absorption of lead in adults and the susceptibility of children to the toxic effects of lead.

Individuals exposed to lead who participate in WIC may benefit from referrals to lead treatment programs, guidance on how to reduce exposure to lead, supplemental food, and the importance of diet in minimizing absorption.

Measurement of blood lead levels replaces the Erythrocyte Protoporphyrin (EP) test as the recommended screening tool because EP is not sensitive enough at blood lead levels below 25ug/dl. Venous blood samples are preferable, but capillary samples

may be more feasible at some sites. Elevated blood lead levels obtained using capillary samples should be confirmed using venous blood. If EP is used, elevated results should be followed by a blood test using a venous blood sample. Iron deficiency can also cause elevated EP concentrations. Iron deficiency and lead poisoning often coexist.

Justification Risk Code 22

Women with a previous delivery of an infant weighing >9 lbs. (4000 grams) 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 grams). Risks for the infant include dystoxia, meconium aspiration, clavicular fracture, brachia plexus injury, and asphyxia.

Justification Risk Code 23

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 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.

Justification Risk Code 30

Compulsively ingesting non-food items (pica)/routine ingestion by child of nonfood items

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. 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 and a smaller head circumference in the infant. 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.

Infants are not identified to be at risk for pica because developmentally, infants indiscriminately put numerous items hand-to-mouth.

WIC nutrition education and food can benefit the client by modifying the behavior.

For children

Pica is the compulsive eating of nonnutritive substances and can have serious medical implications. Pica is observed most commonly in areas of low socioeconomic status and is more common in women (especially pregnant women) and in children. Pica has also been seen in children with obsessive-compulsive disorders, mental retardation, sickle cell disease. Complications of this disorder include: iron-deficiency anemia, lead poisoning, intestinal obstruction, acute toxicity from soil contaminants, and helminthic infestations.

Consuming dietary supplements with potentially harmful consequences

Participants 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. Pregnant and lactating women are at higher risk secondary to the potential transference of harmful substances to their infant.

For women

Most nutrient toxicities occur through excessive supplementation of particular nutrients, such as, vitamins A, B-6 and niacin, iron and selenium. Large doses of vitamin A may be teratogenic. Because of this risk, the Institute of Medicine recommends avoiding preformed vitamin A supplementation during the first trimester of pregnancy. Besides nutrient toxicities, nutrient-nutrient and drug-nutrient interactions may adversely affect health.

For infants and children

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 7-55 % with echinacea and ginger being the most common. Some botanical (including herbal) teas may be safe; however, others have undesirable effects during pregnancy and breastfeeding. Herbal supplements such as, blue cohosh and pennyroyal stimulate uterine contractions, which may increase the risk of miscarriage or premature labor. 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.

While some herbal teas may be safe, some have undesirable effects, particularly on infants and young children who are fed herbal teas or who receive breast milk from

mothers who have ingested herbal teas. Examples of teas with potentially harmful effects to children include: licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, pokeroor or pokeweed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Maté, kola nut or gotu cola, and chamomile. 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. 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.

Inadequate vitamin/mineral supplementation recognized as essential by national public health policy

For women

The Recommended Dietary Allowance (RDA) for pregnant women is 27mg of iron per day. The Centers for Disease Control and Prevention recommends iron supplementation for all pregnant women to prevent iron deficiency; however, pregnant women should seek guidance from a qualified health care provider before taking dietary supplements.

During pregnancy and lactation the iodine requirement is sharply elevated. The RDA for iodine during pregnancy is 220 μg and 290 μg during lactation. Severe iodine deficiency during pregnancy can cause cretinism and adversely affect cognitive development in children. Even mild iodine deficiency may have adverse affects on the cognitive function of children. 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 μg per liter. The American Thyroid Association recommends that women receive prenatal vitamins containing 150 μg of iodine daily during pregnancy and lactation. The iodine content of prenatal vitamins in the United States is not mandated, thus not all prenatal vitamins contain iodine. 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.

Folic acid consumed from fortified foods and/or a vitamin supplement in addition to folate found naturally in food reduces this risk. 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. Folate occurs naturally and is found in foods, such as dark green leafy vegetables, strawberries, and orange juice.

Studies show that consuming 400 mcg of folic acid daily interconceptionally can prevent 50 percent of neural tube defects. 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. 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. 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.

For infants

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. Further, to prevent rickets and vitamin D deficiency in healthy infants and children, the AAP recommends a supplement of 400 IU per day for the following:

1. All breastfed and partially breastfed infants unless they are weaned to at least 1 liter per day of vitamin D-fortified formula.
2. All nonbreastfed infants who are ingesting less than 1 liter per day of vitamin D-fortified formula.

For children

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. 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. Since 1 quart of milk is in excess of the recommended 2 cups of milk per day for pre-school children, most children will require a vitamin D supplement.

Ingesting foods that could be contaminated with pathogenic microorganisms

Food-borne illness is a serious public health problem. 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*).

For women

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. 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.

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.

For infants and children

According to the AAP, to prevent food-borne illness, the foods listed below should not be fed to young children or infants. 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. Pasteurized fruit juices are free of microorganisms. Unpasteurized juice may contain pathogens, such as *Escherichia coli*, *Salmonella*, and *Cryptosporidium* organisms. These organisms can cause serious disease, such as hemolytic-uremic syndrome, and should never be fed to infants and children. Unpasteurized juice must contain a warning on the label that the product may contain harmful bacteria.
- 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—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).
- Raw or undercooked meat, fish, poultry, or eggs--Young children or infants should not eat raw or undercooked meat or poultry, raw fish or shellfish , including oysters, clams, mussels, and scallops—these foods may contain harmful bacteria or parasites that could cause children to contract a dangerous food borne 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.

- 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.

Justification Risk Code 31

The 1996 Institute of Medicine (IOM) report, *WIC Nutrition Risk Criteria: A Scientific Assessment*, raised questions on the quality of traditional dietary assessment methods (e.g., 24-hour recall and food frequency questionnaires) and recommended further research on the development and validation of diet assessment methodologies. 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* (see Clarification).

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.

IOM Committee Findings Related to Dietary Risk (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 (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 (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 (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 risks. 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*.

Justification Risk Code 35

For women

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.
- Low maternal vitamin D status and depressed infant vitamin D status.
- Low folic acid and NTD.

Low calorie intake during pregnancy may lead to inadequate prenatal weight gain, which is associated with infant intrauterine growth restriction (IUGR) and birth defects. 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.

Strict vegan diets may be highly restrictive and result in nutrient deficiencies. Nutrients of potential concern that may require supplementation are:

- Riboflavin
- Iron
- Zinc
- Vitamin B12
- Vitamin D
- Calcium
- Selenium

The pregnant adolescent who consumes a vegan diet is at even greater risk due to her higher nutritional needs. The breastfeeding woman who chooses a vegan or macrobiotic diet increases her risk and her baby's risk for vitamin B12 deficiency. Severe vitamin B12 deficiency resulting in neurological damage has been reported in infants of vegetarian mothers.

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. 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.

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. A breastfeeding woman who has had gastric bypass surgery is at risk of vitamin B12 deficiency for herself and her infant.

For infants

Highly restrictive diets prevent adequate intake of nutrients, interfere with growth and development, and may lead to other adverse physiological effects. Infants older than 6 months are potentially at the greatest risk of overt deficiency states related to inappropriate restrictions of the diet, although deficiencies of vitamin B12 and essential fatty acids may appear earlier. Infants are particularly vulnerable during the

weaning period if fed a macrobiotic diet and may experience psychomotor delay in some instances. 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. 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.

For children

Highly restrictive diets prevent adequate intake of nutrients, interfere with growth and development, and may lead to other adverse physiological effects. 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. 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.

Justification Risk Code 36

For infants

Dental caries is a major health problem in U.S. preschool children, especially in low-income populations. 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. The AAP and the American Academy of Pedodontics recommend 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 mouth. 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. 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.

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. 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. The sugars in the liquid pool around the infant's teeth and gums feed the bacteria there and decay is the result. 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. The damage begins as white lesions and progresses to brown or black discoloration typical of caries. When early childhood caries is severe, the decayed crowns may break off and the permanent teeth developing below may be damaged. Undiagnosed dental caries and other oral pain may contribute to feeding problems and failure to thrive in young children.

Unrestricted use of a bottle, containing fermentable carbohydrates, is a risk because the more times a child consumes solid or liquid food, the higher the caries risk. 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). 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.

For children

Dental caries is a major health problem in U.S. preschool children, especially in low-income populations. 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. Solid foods such as cereal should not be put into a bottle for feeding; this is a form of forcefeeding 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. 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. 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.
- 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.
- 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. Allowing toddlers to use a bottle or cup containing fermentable carbohydrates unsupervised during waking hours provides an almost constant supply of carbohydrates and sugars. 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. The sugars in the liquid pool around the child's teeth and gums feed the bacteria there and decay is the result. 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. The damage begins as white lesions and progresses to brown or black discoloration typical of caries. When early childhood caries are severe, the decayed crowns may break off and the permanent teeth developing below may be damaged. Undiagnosed dental caries and other oral pain may contribute to feeding problems and failure to thrive in young children. 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. 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). 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.

For infants and children

Propping the bottle deprives infants of vital human contact and nurturing which makes them feel secure. It 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.

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.

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". 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. Parents who consistently attempt to control their children's food intake may give children few opportunities to learn to control their own food intake. 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. 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. 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 has 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. Forcing a child to clean his or her plate may lead to overeating or development of an aversion to certain foods. The toddler and preschooler are striving to be independent. Self-feeding is important even though physically they may not be able to handle feeding utensils or have good eye-hand coordination. Children should be able to manage the feeding process independently and with dispatch, without either unnecessary dawdling or hurried eating. Self-feeding milestones include: During infancy, older infants progress from semisolid foods to thicker and lumpier foods to soft pieces to finger-feeding table food. 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 food 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. However, the foods offered should be modified so that the child can chew and swallow the food without difficulty.

Justification Risk Code 37

Routinely feeding inappropriate beverages as the primary milk source.

Goat's milk, sheep's milk, imitation and substitute milks (that are unfortified or inadequately fortified) do not contain nutrients in amounts appropriate as a primary milk source for children. 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. 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 skinfold thickness, lose energy reserves, and are at risk of inadequate intake of essential fatty acids.

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. Consumption of foods and beverages high in fermentable carbohydrates, such as sucrose, increases the risk of early childhood caries and tooth decay.

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". 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. Parents who consistently attempt to control their children's food intake may give children few opportunities to learn to control their own food intake. 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. 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. 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 has 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. Forcing a child to clean his or her plate may lead to overeating or development of an aversion to certain foods. The toddler and preschooler are striving to be independent. Self-feeding is important even though physically they may not be able to handle feeding utensils or have good eye-hand coordination. Children should be able to manage the feeding process independently and with dispatch, without either unnecessary dawdling or hurried eating. Self-feeding milestones include: During infancy, older infants progress from semisolid foods to thicker and lumpier foods to soft pieces to finger-feeding table food. 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. However, the foods offered should be modified so that the child can chew and swallow the food without difficulty.

Routine consumption of 12 or more ounces of fruit juice per day by young children may displace other more nutritious foods. Excessive juice intake has been linked with failure to thrive and gastrointestinal disturbances. In addition, some young children who consume excessive amounts of sorbitol-containing fruit juices (e.g. prune, pear, sweet cherry, and apple juice) can develop chronic nonspecific diarrhea.

Justification Risk Code 38

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. For infants fed infant formula, iron-fortified formula is generally recommended as a substitute for breastfeeding. Rapid growth and increased physical activity significantly increase the need for iron and utilizes iron stores. 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. 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. 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. Sweetened condensed milk has an abundance of sugar that displaces other nutrients or causes over consumption of calories. Homemade formulas prepared with canned evaporated milk do not contain optimal kinds and amounts of nutrients infants need. Goat's milk, sheep's milk, imitation milks, and substitute milks do not contain nutrients in amounts appropriate for infants.

Routinely offering complementary foods or other substances that are inappropriate in type or timing.

Infants, especially those living in poverty, are at high risk for developing early childhood caries. 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.

Feeding solid foods too early (i.e., before 4-6 months of age) by, for example, adding diluted cereal or other solid foods to bottles deprives infants of the opportunity to learn to feed themselves. The major objection to the introduction of beikost 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. Before 4 months of age, the infant possesses an extrusion reflex that enables him/her to swallow only liquid foods. The extrusion reflex is toned down at four months. 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. 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. If solid foods are introduced before the infant is developmentally ready, breastmilk or iron-fortified formula necessary for optimum growth is displaced. 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.

Offering juice before solid foods are introduced into the diet could risk having juice replace breastmilk or infant formula in the diet. This can result in reduced intake of protein, fat, vitamins, and minerals such as iron, calcium, and zinc. It is prudent to give juice only to infants who can drink from a cup.

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.

Routinely feeding inappropriately diluted formula.

Over-dilution can result in water intoxication resulting in hyponatremia; irritability; coma; inadequate nutrient intake; failure to thrive; poor growth. Underdilution of formula increases calories, protein, and solutes presented to the kidney for excretion, and can result in hypernatremia, tetany, and obesity. Dehydration and metabolic acidosis can occur with under-dilution of formula. Powdered formulas vary in density so manufacturer's 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.

Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breastmilk or formula.

Infant formula must be properly prepared in a sanitary manner in order to be safe for consumption. Further, prepared infant formula and expressed breastmilk are perishable foods, which must be handled and stored properly in order to be safe for consumption.

Published guidelines on the handling and storage of infant formula indicate that it is unsafe to feed an infant prepared formula which, for example:

- 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 48 hours for concentrated or ready-to-feed formula, or 24 hours for powdered formula;
- remains in a bottle one hour after the start of feeding; and/or
- remains in a bottle from an earlier feeding.

Lack of sanitation may cause gastrointestinal infection. 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. Manufacturers' instructions vary in the length of time it is considered to be safe to hold prepared infant formula without refrigeration before bacterial growth accelerates to an extent that the infant is placed at risk . Published guidelines on the handling and storage of breastmilk may differ among pediatric nutrition authorities. However, the following breastmilk feeding, handling, and storage practices, for example, are considered inappropriate and unsafe:

- feeding fresh breastmilk held in the refrigerator for more than 48 hours; or held in the freezer for greater than 6 months.
- thawing frozen breastmilk in the microwave oven;
- refreezing breastmilk;
- adding freshly expressed unrefrigerated breastmilk to already frozen breastmilk in a storage container**;
- feeding previously frozen breastmilk thawed in the refrigerator that has been refrigerated for more than 24 hours, and/or
- saving breastmilk from a used bottle for another use at another feeding.

** The appropriate and safe practice is to add chilled freshly expressed breastmilk, in an amount that is smaller than the milk that has been frozen for no longer than 24 hours.

Although there are variations in the recommended lengths for breastmilk to be held at room temperature or stored in the refrigerator or freezer, safety is more likely to be assured by using the more conservative guidelines.

The water used to prepare concentrated or powdered infant formula and prepare bottles and nipples must be safe for consumption. Water used for formula preparation which is contaminated with toxic substances (such as nitrate at a concentration above 10 milligrams per liter, lead, or pesticides) poses a hazard to an infant's health and should NOT be used.

General Justification Statements

From 4-12 months of age, the transition should take place whereby nutrient and caloric intake from a liquid diet of breastmilk or infant formula is gradually replaced with solid foods. There is a critical or sensitive period of development in relation to eating, when a specific stimulus, solid food, must be introduced for the infant to learn the action of accepting and eating table food, which is more difficult to masticate. If solid foods are withheld until a later age, the infant will have considerably more difficulty accepting them.

Between 24 and 28 weeks of age, chewing movements (up-and-down movement of the jaws) occurs. This, combined with the ability to grasp, the hand-to-mouth route of grasped objects, and sitting posture, indicates a readiness of the infant to finger feed. Thus, the shape of the food presented for the child to finger feed is important. Melba toast, crackers, and teething biscuits are frequently introduced at this time.

This type of feeding 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.

Cases of choking and aspiration have occurred when feeding infants foods of inappropriate size, shape, and consistency. In particular, hard, round, smooth, slick, sticky pieces or pieces that do not break apart easily that can block breathing should be avoided (such as carrots, grapes, hot dogs, nuts, seeds, hard round candies, popcorn, raw vegetables, tough meat and others.) The texture of solid foods fed to infants should be decided based on age and developmental readiness. Early solids should have a smooth texture which can gradually be thickened to a firmer texture over time. Table foods should be tender and cut in pieces that can be easily chewed and swallowed.

Honey has been implicated as the primary food source of *Clostridium botulinum* during infancy. These spores are extremely resistant to heat 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.

Excessive intake of nutrient-poor and high-calorie foods and beverages can increase the risk of iron-deficiency anemia and poor growth by displacing nutrients from breastmilk or iron-fortified formula and other more appropriate foods in the infant's diet.

Caffeine is a cerebral, respiratory, cardiac, and central nervous system stimulant. It also acts as a diuretic, is a smooth muscle relaxant, and increases plasma glucose, free fatty acids and gastric secretions. Due to these effects on the body, caffeine is an inappropriate and potentially harmful substance to feed infants.

If infants increase their calorie consumption via high-calorie, low-nutrient beverages and foods, the risk of obesity increases.

Water intoxication can occur if infants are fed excessive amounts of water. Symptoms of the condition include respiratory failure, seizures, and convulsions. A total of 4-8 ounces per day of plain water is appropriate for infants when solid foods are started or in hot weather for formula fed or partially breastfed babies.

Justification Risk Code 39

The IOM Report (p.204) states, "empirical evidence on the interactions of high parity with both age and short interpregnancy interval does suggest significant (nutritional) risks associated with high parity at young ages and high parity with short interpregnancy intervals."

Since factors such as adolescent pregnancy (<18 years of age) and short interpregnancy interval are used independently as risk criteria, women with such risks would be eligible for participation in WIC. Studies by Kramer (1987) and MacLeod & Kiely (1988) (pg.202) show that "multiparity has little effect for women age 20-34 years and decreases for women over age 35." These studies demonstrate the risk of delivering LBW babies for women under the age of 20 years. Thus, low birth weight increases the likelihood of physical and mental developmental deficiencies among surviving infants, and even a higher incidence of death.

Justification Risk Code 40

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 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 from the nutritional stresses of the past pregnancy, and in turn have an impact on nutrition related risks in subsequent pregnancies.

Justification Risk Code 42

Multi-fetal 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 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds. 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 pounds 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. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy. 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.

Justification Risk Code 43

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, 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 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 cofounders. 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.

Justification Risk Code 44

Hyperemesis

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 for weight loss, dehydration, and metabolic imbalances. Nutrition risk is based on chronic conditions, not single episodes.

Gestational Diabetes Mellitus

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. 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. The criteria for the diagnosis of GDM are shown in Table 1 (see Clarification).

Pregnancy is an insulin-resistant and diabetogenic state. Deterioration of glucose tolerance occurs normally during pregnancy, particularly in the 3rd trimester. Untreated or poorly treated GDM results in a higher risk of morbidity and mortality for both the mother and the fetus.

Established risk factors for GDM are advanced maternal age, obesity, and family history of diabetes. 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. 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.

Infants of women with GDM are at an increased risk of developing obesity, impaired glucose tolerance or diabetes as children or young adults. GDM is associated with a

higher incidence of maternal and fetal complications. Maternal complications include polycythemia, respiratory distress syndrome, and increased rate of stillbirth. 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.

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. 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. 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. Breastfeeding should be strongly encouraged as it is associated with maternal weight loss and reduced insulin resistance for both mother and offspring. WIC nutrition services can reinforce and support the medical and diet therapies (such as MNT) that participants with GDM receive from 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 licensed 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.
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. 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.

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).

History of Gestational Diabetes Mellitus

Women who have had a pregnancy complicated by GDM are 40-60% more likely to develop diabetes within 15-20 years, usually type 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. In addition, if a woman's lipid levels are elevated, a history of GDM is also a risk factor for cardiovascular disorders.

There is evidence to suggest that some women with a history of GDM show relative beta-cell dysfunction during and after pregnancy. 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.

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. Exercise also has a beneficial effect on insulin action by enhancing peripheral tissue glucose uptake. 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. The National Diabetes Education Program (NDEP) is currently promoting a GDM Diabetes Prevention Initiative, targeting both providers and women with a history of GDM. 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.

* Diet Composition

Carbohydrate is the main nutrient that affects postprandial glucose elevations. 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.

Because there is wide inter-individual variability in the glycemic index each women 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 habitus, weight gain and physical activity; and should be modified as needed throughout pregnancy to achieve treatment goals.

Clarification

Self-reporting of “History of...” conditions should be treated in the same manner as self-reporting of current conditions requiring a physician’s diagnosis, i.e., the applicant may report to the CPA that s/he 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.

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 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.

History of Preeclampsia

Preeclampsia is defined as pregnancy-induced hypertension (>140 mm Hg systolic or 90mm Hg diastolic) with proteinuria developing usually after the twentieth week of gestation. Clinical symptoms of preeclampsia may include: edema, renal failure, and the HELLP (Hemolysis, Elevated Liver enzymes and Low Platelets) syndrome.

Preeclampsia is a leading cause of maternal death and a major contributor to maternal and perinatal morbidity. Women who have had preeclampsia in a prior pregnancy have an increased risk of recurrence (about 20% overall). 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.

Risk factors for preeclampsia include:

- 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. Also, calcium may prevent preeclampsia among women with very low baseline calcium intake.

There is no treatment for preeclampsia. The condition resolves itself only when the pregnancy terminates or a placenta is delivered. 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 inter-conceptual 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. These include:

- Gaining recommended weight based on pre-pregnancy BMI, in order to help return to a healthy post partum 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

Post-Partum 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. 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. 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. WIC can also discourage smoking and alcohol consumption and counsel pregnant women to gain recommended weight based on pre-pregnancy BMI and to return to pre-pregnancy weight or a healthy BMI of <25 for the benefit of future pregnancies.

Clarification

Self-reporting of “History of...” conditions should be treated in the same manner as self-reporting of current conditions requiring a physician’s diagnosis, i.e., the applicant may report to the CPA that s/he 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.

Justification Risk Code 45

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 SGA outcomes increased two-fold if a woman had two or more spontaneous abortions (SAB). Adverse outcomes related to history of SAB include recurrent SAB, LBW (including preterm and SGA infants), premature rupture of membranes, neural tube defects and major congenital malformations. Nutrients implicated include energy, protein, folate, zinc, and vitamin A.

Postpartum: A SAB has been implicated as an indicator of possible neural tube defect in a subsequent pregnancy. Women who have had an 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.

Justification Risk Code 46

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). 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.

Maternal smoking exposes the infant to nicotine and other compounds, including cyanide and carbon monoxide, in utero and via breastmilk. In utero exposure to maternal smoking is associated with reduced lung function among infants. In addition, maternal smoking exposes infants and children to environmental tobacco smoke (ETS). (See below.)

Because smoking increases oxidative stress and metabolic turnover of vitamin C, the requirement for this vitamin is higher for women who smoke. 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.

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 made up of over 4,000 chemicals, including Polycyclic Aromatic Hydrocarbons (PAHs) and carbon monoxide. Sidestream smoke has a different chemical make-up than mainstream smoke. Sidestream smoke contains higher levels of virtually all carcinogens, compared to mainstream smoke. 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. 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.

ETS is a known human carcinogen. Women who are exposed to ETS are at risk for lung cancer and cardiovascular diseases. Prenatal or postnatal ETS exposure is related to numerous adverse health outcomes among infants and children, including sudden infant death syndrome (SIDS), upper respiratory infections, periodontal disease, increased severity of asthma/wheezing, metabolic syndrome, decreased cognitive function, lower birth weight and smaller head circumference. 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.

Studies suggest that the health effects of ETS exposure at a young age could last into adulthood. These include cancer, specifically lung cancer, and cardiovascular diseases. There is strong evidence that ETS exposure to the fetus and/or infant results in permanent lung damage.

ETS exposure increases inflammation and oxidative stress. Inflammation is associated with asthma, cardiovascular diseases, cancer, chronic obstructive pulmonary disease, and metabolic syndrome. 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.

Antioxidants may modulate oxidative stress-induced lung damage among both smokers and non-smokers. Fruits and vegetables are the major food sources of antioxidants that may protect the lung from oxidative stress. Research indicates that consuming fruits and vegetables is more beneficial than taking antioxidant supplements. 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.

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. 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.

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.

Clarification

In a comprehensive scientific report, the Surgeon General concluded that there is no risk-free level of exposure to secondhand smoke. 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)

Because the definition used by other Federal agencies for ETS exposure is specific to “inside the home” and has been validated, 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.

Justification Risk Code 47-48

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, nor is 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 to women is to not 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 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.

Justification Risk Code 49

Preterm birth causes at least 75% of neonatal deaths not due to congenital malformations. 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 weight as risk factors. A history of one previous preterm birth is associated with a recurrent risk of 17-37%; the risk increases with the number of prior preterm births and decreases with the number of term deliveries.

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. 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. 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.

Justification Risk Code 50

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.

Justification Risk Code 51

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/VLBW, 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.

Justification Risk Code 52

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 a lack of total dietary energy and to 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).

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.

Justification Risk Code 53

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).

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.

Justification Risk Code 54

For infants and children 1-2 years old:

In 2006, WHO released international growth standards for infants and children aged 0-59 months, 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. For persons 2-20 years, the 2000 CDC growth charts will continue to be used.

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.

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.

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 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.

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.

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. 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). (See Clarification for information about standard deviations and the cut-off used to determine high weight-for-length.)

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.

For children 2-5 years old

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.

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.

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*. 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. Although an imperfect tool, elevated BMI among children most often indicates increased risk for future adverse health outcomes and/or development of diseases. BMI should serve as the initial screen and as the starting point for classification of health risks.

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 (≥ 95 th percentile) undergo a medical assessment and careful evaluation to identify any underlying health risks or secondary complications. 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.

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.

Justification Risk Code 55

The rise in the prevalence of overweight and 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 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.

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. 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*. 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. Although an imperfect tool, elevated BMI among children most often indicates increased risk for future adverse health outcomes and/or development of diseases. BMI should serve as the initial screen and as the starting point for classification of health risks.

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. The presence of parental obesity should lead to greater efforts by nutrition services staff to assist families in establishing or improving healthy behaviors.

Justification Risk Code 56

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.

Justification Risk Code 57

Impairment of fetal growth can have adverse effects on the nutrition and health of children during infancy and childhood, including higher mortality and morbidity, slower physical growth, and possibly slower mental development. Infants who are small for gestational age (SGA) are also more likely to have congenital abnormalities. Severely growth-retarded infants are at markedly increased risk for fetal and neonatal death, hypoglycemia, hypocalcemia, polycythemia, and neurocognitive complications of pre- and intrapartum hypoxia. Over the long term, growth-retarded infants may have permanent mild deficits in growth and neurocognitive development.

WIC Staff should routinely complete anthropometric assessments and follow-up (to include coordination with and referral to, other health care providers and services) for infants/children with a diagnosis/history of SGA who have not yet demonstrated normal growth patterns.

Justification Risk Code 58

The American Academy of Pediatrics recommends that all children have a head-circumference measurement at each well-child visit until 2 years of age (3). It is recommended that the measurements be plotted on gender specific growth charts to identify children with a head size or growth pattern that warrants further evaluation (3). Low head circumference (LHC) is associated with pre-term birth and very low birth weight (VLBW) as well as a variety of genetic, nutrition, and health factors (4). Head size is also related to socioeconomic status and the relationship is mediated in part by nutrition factors (4). LHC is indicative of future nutrition and health risk, particularly poor neurocognitive abilities (4). LHC among VLBW children is associated with lower IQ and poorer academic achievement (5). Some studies suggest that interventions to improve antenatal and postnatal head circumference growth may contribute to better scholastic outcomes (5).

Clarification

The cut-off for LHC 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.

Justification Risk Code 59

Infant mortality rates are higher among full-term infants who weigh >4000g (9lbs) than for infants weighing between 3,000 and 4,000g (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. When large for gestational age occurs with pre-term birth, the mortality risk is higher than when either condition exists alone. 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.

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.

Justification Risk Code 63

On occasion, a participant's nutritional status may be improved, to the point that she/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 she/he then re-enters the Program at equal or greater nutritional 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 preventative 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 into 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.

Justification Risk Code 65

Cognitive limitation in a parent or primary caretaker has been recognized as a risk factor for failure to thrive (FTT) as well as abuse and neglect. The retarded 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 also represent social risk factors for FTT. Chemical dependency is also strongly associated with abuse and neglect. In 22 States, 90% of caretakers reported for child abuse are active substance abusers. All of these maternal conditions may contribute to a lack of synchrony between the infant and mother during feeding and therefore interfere with the infant's growth process. Nutrient intake depends on the synchronization of maternal and infant behaviors involved in feeding interactions.

Justification Risk Code 66

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.

Justification Risk Code 67

Battering during pregnancy is associated with increased risks of low birth weight, pre-term delivery, and chorioamnionitis, as well as poor nutrition and health behaviors. Battered women are more likely to have a low maternal weight gain, be anemic, consume an unhealthy diet, and abuse drugs, alcohol, and cigarettes.

Serious neglect and physical, emotional, or sexual abuse have short- and long- term physical, emotional, and functional consequences for children. Nutritional neglect is the most common cause of poor growth in infancy and may account for as much as half of all cases of non-organic failure to thrive.

Justification Risk Code 68

Fetal Alcohol Syndrome (FAS) is a combination of permanent, irreversible birth defects attributable solely to alcoholic consumption by the mother during pregnancy. There is no 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 physiology manifestations. FAE and ARBD are generally less severe than FAS and their effects are widely variable. Therefore, 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.

Justification Risk Code 69

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 predominately 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 pregnancy, she needs breastfeeding counseling.

Justification Risk Code 70

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. Lactation requires an additional 500 Kcal per day (approximately) as well as increased protein, calcium, and other vitamins and minerals. Inadequate maternal nutrition may result in decreased nutrient content of the milk. Special attention should therefore be given to the health and nutritional status of breastfed infants whose mothers are at nutritional risk.

Justification Risk Code 71

- a. 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.
- b. 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.
- c. Mastitis is a breast infection that causes 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.
 - d. 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.
 - e. 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 milk 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 women's health care provider are indicated.
 - f. 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 30's, older mothers may have fewer functioning milk glands resulting in greater difficulty producing an abundant milk supply.
 - g. 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.
 - h. 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.

Justification Risk Code 74

- a. 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 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/dl, 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 general 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.
- b. 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.
 - c. Difficulty latching onto 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 consultant should be made.
 - d. These are all 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 of inadequate weight gain 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. Performing an infant test weighing procedure (weighing the clothed infant before and after breastfeeding) can help confirm suspicions about inadequate milk consumption during breastfeeding and determine whether the "slow gaining" infant is obtaining sufficient milk.

- The maximum acceptable weight loss after birth in breastfed infants is 10%, but few babies lose this much weight unless a breastfeeding problem is present. When a baby loses $>8\%$ from birth weight, breastfeeding should be evaluated and appropriate interventions suggested to improve milk intake. Continued weight loss after the mother's milk comes in suggests a problem with milk transfer from breast to baby. By 4 to 5 days of age, breastfed babies should start to gain about an ounce each day, or 5 to 7 ounces each week. Most will surpass their birth weight by 10 to 14 days.
- The literature regarding inadequate stooling varies widely in terms of quantification; this condition is best diagnosed by the pediatrician or other health care practitioner.

Justification Risk Code 75

Exclusive breastfeeding provides ideal nutrition to an infant and is sufficient to support optimal growth and development in the first 6 months of life. Frequent breastfeeding is critical to the establishment and maintenance of an adequate milk supply for the infant. 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. Exclusive breastfeeding protects infants from early exposure to contaminated foods and liquids. In addition, infants, who receive breastmilk more than infant formulas, have a lower risk of being overweight in childhood and adolescence.

Justification Risk Code 80-81

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 the commitment.

Justification Risk Code 91

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. The below embedded links provide the most up-to-date information about the disease state as well as treatment.

Amino Acid Metabolism Disorders (3)

- Phenylketonuria (includes 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 I
- Glycogen storage disease type II (See also Pompe disease)
- Glycogen storage disease type III
- Glycogen storage disease type IV (Andersen 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-hydroxyacyl-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 acidemia) (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).

Lysosomal 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 I 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.

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.

Justification Risk Code 93

Cancer

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.

Celiac Disease

CD affects approximately 1% of the U.S. population. 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. 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.

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.

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. 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.

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.

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-ssets/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. (See nutrition risk criterion #93, *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.

Central Nervous System Disorders

Epileptics are at nutrition risk due to alterations in nutritional status from prolonged anti-convulsion therapy, inadequate growth, and physical injuries from seizures. The ketogenic diet has been used for the treatment of refractory epilepsy in children. However, children on a ketogenic diet for six months or more have been observed to have slower gain in weight and height. Growth monitoring and nutrition counseling to increase energy and protein intakes while maintaining the ketogenic status are recommended. 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.

Oral motor dysfunction is associated with infants and children with cerebral palsy. 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. 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. 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. Participants treated with levodopa-carbidopa may also need to increase the intake of B vitamins. 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, 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. 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 B₁₂ and a diet low in animal fat have been suggested to have beneficial effects in relapsing-remitting MS. 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. 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.

Depression

Appetite changes are a distinguishing feature of depression. Severe depression is often associated with anorexia, bulimia, and weight loss. Maternal depressive symptoms are associated with pre-term birth among low-income urban African-American women. Depressed pregnant women are more likely to smoke during pregnancy, attend prenatal care less frequently, have a higher incidence of low birth weight infants, and experience higher perinatal mortality rates. WIC can provide much needed nutrition education and counseling that encourages clinically depressed women to continue healthy eating habits as well as referrals to other health care and social service programs that may be of more direct assistance to the clinically depressed WIC participant.

Developmental Delays, Sensory or Motor Delays Interfering with the Ability to Eat

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 have: 1) 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) to use enteral feedings to supply complete nutritional needs which may potentially increase the risk for specific nutrient deficiencies. 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 an adequate diet.

- 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 2 ½ 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.

Diabetes Mellitus and Pre-Diabetes

-Diabetes Mellitus

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.

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 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. 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.

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 a predominantly insulin secretory defect with insulin resistance). The Expert Committee on Diagnosis and Classification of Diabetes Mellitus, working under the sponsorship of the American Diabetes Association, has identified the criteria for the diagnosis of diabetes mellitus (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.

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.

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.

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.

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 > 200 mg/dL (11.1 mmol/L) during a 75-g oral glucose tolerance test (OGTT).

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.

-Pre-Diabetes

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 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. Often times, individuals with IGT manifest hyperglycemia only when challenged with the oral glucose load used in standardized oral glucose tolerance test.

The prevalence of IFG and IGT increases greatly between the ages of 20-49 years. In people who are >45 years of age and overweight (BMI >25), the prevalence of IFG is 9.3%, and for IGT, it is 12.8%.

Screening for pre-diabetes is critically important in the prevention of type 2 diabetes. The American Diabetes Association recommends 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 syndrome, which includes 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 at 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.

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.

The WIC food package provides high fiber, low fat foods emphasizing consumption of whole grains, fruits, vegetables and dairy products. This will further assist WIC families in reducing their risk for diabetes.

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.

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.

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 or IGT and a normal FPG, and highest (38-65%) in those with combined IFG and IGT.

Recommendations for testing for pre-diabetes and diabetes in asymptomatic, undiagnosed adults are listed 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 lb or were diagnosed with gestational diabetes mellitus
 - hypertension (blood pressure >140/90 mmHg or on therapy for hypertension)

- HDL cholesterol level <35 mg/dl and/or a triglyceride level >250 mg/dl
 - 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 and 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 oral 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.

Drug Nutrient Interaction

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.

Eating Disorders

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.

Food Allergies

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. 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%. Further research has found that food allergy affects more children than recently reported with the prevalence estimated to be 8 %. 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. 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.

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 or 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.

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. 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. The most common food intolerance is lactose intolerance (see nutrition risk criterion #93, *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. 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.

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. 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.

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. 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.

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. Examples of non-IgE-mediated reactions to specific foods include celiac disease (see nutrition risk criterion #93, *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).

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.

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. 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.

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. 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. 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.

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.

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.

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 can be re-challenged at 9-12 months of age. The re-challenging of foods should be done with HCP oversight.

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.
- Provide hypoallergenic formula for participants with appropriate medical documentation, as needed.
- Tailor food packages to substitute or remove offending foods.
- Educate participants on maintaining adequate nutritional intake while avoiding offending foods.
- Monitor weight status and growth patterns of participants.
- Educate participants about reading food labels and identifying offending foods and ingredients. See resources below:

<http://www.fda.gov/downloads/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.

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.

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.

Gastro-Intestinal Disorders

Gastrointestinal disorders increase nutritional risk in a number of ways, including restricted 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 disease resistance. Nutrition management plays a prominent role in the treatment of gastrointestinal disorders.

-Gastroesophageal Reflux Disease (GERD)

GERD is irritation and inflammation of the esophagus due to reflux of gastric acid into the esophagus. 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. 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. 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.

-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 B12 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.

-Short Bowel Syndrome (SBS)

SBS is the result of extensive small bowel resection. 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. The loss of a large segment of the small bowel causes malabsorption syndrome. Total parenteral 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 B12 may be needed. The pediatric client's nutritional status must be assessed and growth closely monitored.

-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.

-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

malabsorption 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 (0.74g/kg).

-Pancreatic Disease

In chronic pancreatitis, there is a 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.

-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 severe fasting may increase risk for these disorders. Since lipids stimulate gallbladder contractions, 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.

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.

Genetic and Congenital Disorders

For women, infants, and children with these disorders, special attention to nutrition may be required to achieve adequate growth and/or to maintain health.

Severe cleft lip and palate anomalies commonly cause difficulty with chewing, sucking and swallowing, even after extensive repair efforts. 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 manifestation 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 adaption by the residual intestine begins and may last as long as 12-18 months. Even after oral feedings are stabilized, close follow-up and frequent assessment of the nutritional status of infants with repaired congenital gastrointestinal anomalies is recommended.

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 bladder, 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.

Nonbilious projectile vomiting characteristically begins at two to three weeks of age and progresses to almost complete gastric outlet obstruction. Pyloric stenosis is associated with constipation, weight loss, dehydration and electrolyte imbalance. Most commonly it requires surgical correction within the first month of life. However, surgical repair is frequently unavailable, delayed, or not completely effective leaving residual nutrition and potential growth problems. The infant remains at risk until full recovery from surgery and gastrointestinal function returns to normal.

Hypertension and Prehypertension

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. People with high blood pressure can be asymptomatic for years. 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. People with prehypertension are twice as likely to develop hypertension.

There is no cure for hypertension; however lifestyle modifications can prevent high blood pressure and are critical in the management of hypertension and prehypertension.

Risk factors for hypertension include:

- Age (increases with age)
- Race/ethnicity (occurs more often and earlier in African Americans)
- Overweight or 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. In hypertensive individuals, dietary intervention is not only effective in reducing blood pressure but also in delaying drug treatment.

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 and 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. Hypertensive disorders of pregnancy are categorized as:

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 risk 44, History of Preeclampsia.

The following conditions are associated with an increased incidence of pregnancy-induced hypertension:

- Inadequate diet
- Nutritional deficiencies, including low protein, essential fatty acid, or magnesium intake
- Inadequate calcium intake in early pregnancy
- 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.

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. Children with high blood pressure are more likely to become hypertensive adults. Therefore, they should have their blood pressure checked regularly beginning at the age of three.

Epidemiologic data suggests an association between childhood obesity and high

blood pressure. 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.

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 conducive 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.

Hypoglycemia

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.

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.

WIC can provide nutrition management that concentrates on frequent feedings to support adequate growth for infants and children. WIC can also provide nutrition education to help manage hypoglycemia in women that includes consuming a balanced diet, low carbohydrate snacks and exercise.

Infectious Diseases

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 (AIDS) results. 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.

Lactose Intolerance

Lactose intolerance occurs because of a deficiency in the levels of the lactase enzyme. 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.

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.

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.

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.

Developmental lactase deficiency is the relative lactase deficiency observed among pre-term infants of less than 34 weeks gestation. One study in preterm infants reported benefit from the use of lactase-supplemented feedings or lactose-reduced formulas. The use of lactose-containing formulas and human milk does not seem to have any short- or long-term deleterious effects in preterm infants.

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.

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. Inadequate dairy intake increases the risk of metabolic syndrome, hypertension, preeclampsia, obesity and certain forms of cancer, especially colon cancer.

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.
- 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, 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. 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. The demonstration of lactose malabsorption does not necessarily indicate that an individual will be symptomatic.

Nutrient Deficiency Diseases

The presence of macro- and micronutrient 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.

Recent Major Surgery, Trauma, Burns

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.

Renal Disease

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.

Thyroid Disorders

The thyroid gland manufactures three thyroid hormones: thyroxine (T4), triiodothyronine (T3), and calcitonin. The thyroid hormones regulate how the body gets energy from food (metabolism). Iodine is an essential component of the T4 and T3 hormones 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. 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 an 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. 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 T4 must increase by at least 50% during pregnancy. 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 (T4 and T3). An excessive consumption of iodine ($> 1000 \mu\text{g/d}$) may cause fetal and maternal hyperthyroidism. In other circumstances, the thyroid might develop nodules which secrete excessive amounts of thyroid hormone regardless of iodine status. 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. 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. Postpartum maternal hyperthyroidism is likely in women with prenatal hyperthyroidism.

The primary medical therapy for hyperthyroidism is radioactive iodine therapy which is contraindicated during pregnancy and lactation. 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.

Mothers with iodine deficiency during the first half of pregnancy may produce offspring with severe, irreversible brain damage. 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.

When iodine nutrition status is adequate, autoimmune thyroid disease (AITD) – also called Hashimoto's thyroiditis - is the most common type of hypothyroidism during pregnancy. 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.

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.

Congenital hypothyroidism due to maternal iodine deficiency is a leading cause of preventable mental retardation. 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. The condition is exacerbated by coexisting selenium and vitamin A deficiencies or iron deficiency. 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.

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. Smoking is a significant precipitating factor in the onset of postpartum thyroiditis. Women with a past history of postpartum thyroiditis have a risk of long-term permanent hypothyroidism and recurrence of postpartum thyroiditis in subsequent pregnancies. Tests for this condition consist of radioactive products necessitating a temporary cessation of breastfeeding (usually up to 3 days).

Other Medical Conditions

- 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 Infectious Diseases.

Justification Risk Code 94

Early childhood caries results from inappropriate feeding practices. Nutrition counseling can prevent primary tooth loss, damage to the permanent teeth and potential speech problems.

Missing more than 7 teeth in adults seriously affects chewing ability. This leads to eating only certain foods which in turn affects nutritional intake.

Periodontal disease is a significant risk factor for pre-term low birth weight resulting from pre-term labor or premature rupture of the membranes. There is evidence that gingivitis of pregnancy results from "end tissue deficiency" of folic acid and will respond to folic acid supplementation as well as plaque removal.

Justification Risk Code 95

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 forty-three percent 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, and recently entered into the ranks of the homeless and consider their condition to be temporary.

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.

Justification Risk Code 96

"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.

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Sample Discussion Starters Using the WIC Food Package for All Categories

Milk

- “WIC provides milk as a benefit, how’s Johnny doing with drinking his milk?”
- “Now that Mary is almost one year old she will be getting milk in her food package. Have you thought about introducing milk in a cup?”
- “Does your WIC food package provide enough milk or do you ever have to buy extra milk at the store? Oh, so you get milk from your local farmer; do you know if it’s pasteurized?”

Cheese

- “Do you not like milk, do you eat any cheese? Cheese is high in calcium which you need to build bones, what other foods do you eat that are high in calcium? What other kinds of cheese do you eat?”

Peanut Butter

- “WIC provides peanut butter which is a good source of iron and protein, how often does Andy eat peanut butter? What other protein foods does he like to eat such as lunch meat, hot dogs or chicken? How do you prepare them?”
- “While WIC provides peanut butter and it is a healthy food you still want to watch the portion size because it is high in fat. What other foods do you eat that might also be high in fat?”

Eggs

- “Right now you are getting two dozen eggs in your WIC food package which is a good source of protein. What other good protein sources do you eat?”

Juice

- “Your WIC food package provides juice, how often does Cindy drink juice? How much does she drink at a time, can you show me? Do you ever buy juice from a farmer’s market?”

Cereal

- “How often does Eric eat WIC cereal? Oh, so he gets it as snacks? Tell me about those, how often does he have a snack? What kinds of things do you give him as snacks besides cereal?”

Infant Cereal

- “Your baby will be able to get infant cereal next month, when do you think you’d like to start solid foods? What have you heard about starting solids?”

Breastfeeding/Formula

- “How is your baby doing with feedings? Can you tell me more about how much he is taking at each feeding and how often? Tell me about how you prepare your bottles for Nathan?”

Other Tips

- Have older children use food models to show you what foods they like on their plate
 - “Oh I see you really like spaghetti? What other foods do you eat with spaghetti?”

Location of CPA	HT	WT	BMI	HGB
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Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Breastfeeding Women and Postpartum Women

Name		Today's date		Age (39, 40)
Date this pregnancy ended	What was your due date? (49)	Your weight at delivery	Your weight before pregnancy (11)	
Check one <input type="checkbox"/> live birth _____pounds _____ounces <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion <input type="checkbox"/> infant death (22, 45, 49)				
Number of past pregnancies (39)	How many ended in live birth? (42)	Date previous pregnancy ended (43)		
Prenatal doctor or clinic		Date of last doctor visit		

If you are currently breastfeeding, fill out **Sections 1 and 2**. If you are **not** currently breastfeeding fill out **Section 2**.

Section 1

My baby breastfeeds every _____ hours or _____ times a day and _____ times a night	How long on each side? _____ (70)
If your baby gets bottles What is in the bottle? _____	How often? _____
Do you have problems with <input type="checkbox"/> Let down <input type="checkbox"/> Hot, hard breasts <input type="checkbox"/> Latch <input type="checkbox"/> Pain in your breasts <input type="checkbox"/> Sore nipples <input type="checkbox"/> Other _____	<input type="checkbox"/> No problems (74)
How long do you want to breastfeed your baby?	
Are you going back to work or school? <input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No	
What kind of support for breastfeeding do you have at home?	
Would you like more breastfeeding help? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2

Did you ever breastfeed your baby? <input type="checkbox"/> Still breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Why did you stop? _____	How old was your baby when you stopped? _____
Did you have a C-section? <input type="checkbox"/> Yes <input type="checkbox"/> No (93)		
List any problems you have had. With this pregnancy _____ With past pregnancies _____ <input type="checkbox"/> None (44)		
Check any health problems you currently have. <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Dental <input type="checkbox"/> High blood pressure <input type="checkbox"/> Lactose intolerance <input type="checkbox"/> Other _____ <input type="checkbox"/> None (91, 93, 94)		
List any medicines you take. (93)		

Sample WIC Health History for Fetal/Infant Loss

Has the doctor tested your blood for lead?		(21)
<input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Have you ever had a baby with a birth weight of nine pounds or more?		(22, 49)
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was your baby born three or more weeks early?		(49)
<input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No		
Was your baby born with any health problems?		(23)
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, explain _____		
Check all supplements you take.		
<input type="checkbox"/> Prenatal vitamins/vitamins <input type="checkbox"/> Iron <input type="checkbox"/> Herbs <input type="checkbox"/> Calcium		
<input type="checkbox"/> Other _____ <input type="checkbox"/> None		
(30)		
Are you on a special diet?		
<input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No		
(30, 35, 91, 93)		
List your food allergies		
<input type="checkbox"/> None		
(93)		
Check any of these non-food items that you eat or crave .		
<input type="checkbox"/> Paint chips <input type="checkbox"/> Ice <input type="checkbox"/> Printed paper <input type="checkbox"/> Dirt/clay <input type="checkbox"/> Starch <input type="checkbox"/> Coffee grounds		
<input type="checkbox"/> Other _____ <input type="checkbox"/> None		
(30)		
Check all that apply.		
<input type="checkbox"/> Someone else shops for food. <input type="checkbox"/> I usually shop for food. <input type="checkbox"/> I usually do not eat at home.		
<input type="checkbox"/> Someone else does the cooking. <input type="checkbox"/> I usually cook. <input type="checkbox"/> I live in a shelter, motel, or temporary place.		
<input type="checkbox"/> I have a working stove or microwave and refrigerator in my home.		
<input type="checkbox"/> I run out of money or food stamps to buy food.		
(66, 95)		
What do you think about your eating habits?		
Name one or two things you do for physical activity or exercise.		
How many cigarettes, pipes, cigars do/did you smoke?		
Now _____ a day _____ a week <input type="checkbox"/> None		
Last three months of this pregnancy _____ a day _____ a week <input type="checkbox"/> None		
Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None		
(46)		
If anyone living in your home smokes, where do they smoke?		
<input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes		
(46)		
Check all alcoholic beverages you drink.		
<input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Coolers <input type="checkbox"/> Liquor		
Now _____ a day _____ a week <input type="checkbox"/> None		
Last three months of this pregnancy _____ a day _____ a week <input type="checkbox"/> None		
Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None		
(47, 66)		
Check all drugs you currently use.		
<input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroin		
<input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalants <input type="checkbox"/> Prescription drugs (misuse)		
<input type="checkbox"/> Other _____ <input type="checkbox"/> None		
(48, 66, 93)		
During the last six months, have you been physically, sexually or verbally abused?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
(67)		
Do you have any questions or concerns?		

THE WIC PROGRAM CAN NOW SERVE YOU

Dear _____:

Your name can now be taken off the WIC waiting list. You must return to the clinic below on _____ for information on receiving your WIC food.
Your child need not accompany you.

Clinic Name _____

Address _____

Phone _____

If your income has changed you must bring proof of income.

If you cannot make your appointment, call the clinic before the date listed above.

If you do not call or visit the clinic your name will be removed from waiting list and you will not receive your WIC food.

You have a right to ask for a fair hearing if this agency denies you participation in the WIC program. You must ask for a hearing within 60 days from the date of notification of suspension. At the time of the fair hearing you may be represented and/ or accompanied by a relative, friend, legal counsel, or other spokesperson.

Date

Signature of WIC personnel

Standards for eligibility and participation in WIC are the same for everyone regardless of race, color, national origin, age, handicap and sex.

Ohio Department of Health
Div. of WIC
0571.13 – Revised 7-86

File Copy

Voter Registration Form

Please read instructions carefully. Please type or print clearly with blue or black ink.

For further information, you may consult the Secretary of State's Web site at: www.sos.state.oh.us or call 1-877-767-6446.

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of the election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be *received or postmarked* by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice prior to Election Day, please contact your county board of elections.

Lines 1 and 2 below are required by law. You *must* answer **both** of the questions for your registration to be processed.

Registering in Person

If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the *last four digits* of your Social Security number on line 10. If you have neither, please write "None."

Registering by Mail

If you register by mail and do **not** provide either a current Ohio driver's license number or the last four digits of your Social Security number, please enclose with your application **a copy** of one of the following forms of identification that shows your name and current address:

Current valid photo identification card, military identification, current (within one year) utility bill, bank statement, paycheck, government check or government document (except board of elections notifications) showing your name and current address.

Your Signature

Your signature is required for your registration to be processed. In the box next to the arrow by line 14, please affix your signature or mark, taking care that it does not touch surrounding lines or type so it can be effectively used to identify you. If your signature is a mark, include the name and address of the person who witnessed the mark beneath the signature line. If by reason of disability you are unable to physically sign, you may follow specific procedures found in Ohio law (R.C. 3501.382) to appoint an attorney-in-fact who may sign this form on your behalf at your direction and in your presence.

Please see information on back of this form to learn how to obtain an absentee ballot.

FOLD HERE

1. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Will you be at least 18 years of age on or before the next general election? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you answered NO to either of the questions, do not complete this form.			
3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.
4. House Number and Street (Enter new address if changed)		Apt. or Lot #	5. City or Post Office
6. ZIP Code		7. Additional Rural or Mailing Address (if necessary)	
8. County where you live		FOR BOARD USE ONLY SEC4010 (Rev. 02/08)	
9. Birthdate (MO-DAY-YR) (required)	10. Ohio driver's license No. OR last 4 digits of Social Security No. (one form of ID required to be listed or provided)	11. Phone No. (voluntary)	City, Village, Twp.
12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street			Ward
Previous City or Post Office	County	State	Precinct
13. CHANGE OF NAME ONLY Former Legal Name		Former Signature	School Dist.
I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.			Cong. Dist.
14. Your Signature →			Senate Dist.
Date <u> </u> / <u> </u> / <u> </u> MO DAY YR			House Dist.



Postage
Required
Post Office will
not deliver
without proper
postage.

**SECRETARY OF STATE
PO BOX 2828
COLUMBUS OH 43216-2828**



HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.sos.state.oh.us or by calling 1-877-767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

R.C. 3503.19

Voters must bring identification to the polls in order to verify identity. Identification may include a current and valid photo identification, a military identification that shows the voter's name and current address, or a copy of a current utility bill, bank statement, government check, paycheck, or other government document, other than a notice of an election or a voter registration notification sent by a board of elections, that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot. Voters who do not have any of the above forms of identification, including a Social Security number, will still be able to vote by signing an affirmation swearing to the voter's identity under penalty of election falsification and by casting a provisional ballot. For more information on voter identification requirements, please consult the Secretary of State's Web site at: www.sos.state.oh.us or call 1-877-767-6446.

**WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY
OF A FELONY OF THE FIFTH DEGREE.**

Ohio Department of Health Welcome to WIC Letter

Dear _____,

The Women, Infants, and Children Program (WIC) is a health program funded by the United States Department of Agriculture. WIC provides nutrition education, breastfeeding support, nutritious foods, and referrals to other health and human service agencies. The purpose of the program is to help improve diet during critical times of growth and development. The foods provided by the program are supplemental and are not intended to provide all of your daily food requirements. WIC foods are only for the participant.

The health professional will assess your health and diet information and discuss nutritional risk factors that could affect your health and growth. **Your nutrition risk today is:**

--

WIC health professionals partner with you to develop nutrition goals to support a healthy pregnancy, breastfeeding and postpartum experience, and growth for infants and children.

I have discussed my nutrition goal with the WIC health professional. I agree to try:

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Date	Height	Length	Weight	Blood iron (Hemoglobin)
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Benefits are for a specific period of time, usually 6 months, called a certification period. An appointment will be made for you to pick up your benefits and for your next certification appointment. These appointments are made before your certification period runs out so that your benefits are not delayed.

Your next WIC clinic visit is scheduled for:

Nutrition Education and Benefit Pickup Date	Next Certification Visit Date
---	-------------------------------

Keep all WIC appointments or your benefits may end.

Your foods will end on _____ because ☐ child turns age 5,
☐ 6 month postpartum period has ended, or
☐ breastfeeding eligibility for WIC has ended.

Information Sharing in the WIC Program

WIC works with many programs to meet your service needs. The *Information Sharing in the WIC Program* pamphlet explains programs that may receive your information for outreach; eligibility; and improving health, education, and well-being for your family.

Sharing information with programs or medical providers not listed in the *Information Sharing in the WIC Program* pamphlet needs your consent. You are not required, but may check or add programs or medical providers below for sharing your information.

☐ Head Start/Early Head Start ☐ Medicaid provider for breast pump _____

☐ Other _____

I have been advised of my rights and responsibilities stated on the back of this letter. I received an *Information Sharing in the WIC Program* pamphlet. I certify that the information I provided is correct to the best of my knowledge. My WIC program application information may be verified. I understand making a false or misleading statement, or misrepresenting, concealing or withholding facts may result in my paying back the cost of benefits issued to me and may result in prosecution under state and federal law.

Signature of Participant or Guardian	Signature of WIC Personnel	WIC Effective Date
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Participant Rights and Responsibilities

Participant Rights

1. You have the right to ask for a fair hearing if you are disqualified from the WIC program. You must ask for a fair hearing within 60 days from the date you are notified of disqualification. At the time of the fair hearing, you may be represented and accompanied by a relative, friend, legal counsel or other spokesperson.
2. You may appeal any decision made by the local agency regarding your eligibility for the program.
3. The local agency will make breastfeeding and nutrition education services available to you or your parent or guardian.

Participant Responsibilities

I understand that failure to abide by my responsibilities may result in disqualification. I and my alternates must:

1. not sell, trade, or give away WIC foods or formula, coupons, breast pumps or electronic benefits transfer (EBT) cards. This includes using online outlets such as Craigslist or Ebay to illegally sell or trade WIC benefits;
2. not accept from the vendor debit, cash, credit, unauthorized foods, or other items of value for WIC coupons or EBT cards;
3. not physically abuse, threaten physical abuse, or verbally abuse anyone at the WIC clinic or store staff;
4. notify the clinic if I have difficulty buying WIC foods at the store or if I am treated unfairly by store staff;
5. not make false or misleading statements or misrepresent, hide or withhold facts to obtain benefits;
6. not receive WIC benefits from more than one WIC program at a time;
7. use WIC foods for participants only. Send coupons, EBT card, or foods benefits with participants if they leave the household;
8. keep WIC appointments and pick up benefits at assigned times and on a regular basis to avoid termination. WIC benefits stop when benefits are not picked up;
9. notify the clinic of a change in income, address, telephone number, family size and pregnancy due date;
10. use coupons during the valid dates;
11. keep coupons or EBT card in a safe place. Lost and stolen coupons cannot be replaced;
12. return loaned breast pumps when asked; and
13. bring back excess, unopened formula and baby foods to the WIC clinic.

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](http://www.ascr.usda.gov/complaint_filing_cust.html), 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.

Ohio Department of Health WIC Application Addendum

By signing this WIC application, I agree to give proof of eligibility for information entered on this form and any other information asked to meet program rules.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided to me under the Medicaid, WIC, and other medical assistance programs.

I also authorize the Ohio Department of Health, the Ohio Department

of Medicaid, and the Ohio Department of Job and Family Services to exchange any information I have provided on this form to enable the departments to determine my eligibility.

I understand that this application is considered without regard to race, color, national origin, sex, age, or disability.

By my signature below, I affirm under penalty of perjury that to the best of my knowledge and belief all the answers on this application are true and complete. I understand that the law provides penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive.

I am requesting that my WIC services be continued.

I have reviewed and updated information since my last application.

☐ Yes ☐ No

Signature of applicant who completed this form	Date of signature
Signature of person who helped complete this form	Date of signature

AGENCY USE ONLY

Pregnancy Verification

☐ Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephoned (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Medical chart location (office name)		

Income Verification

☐ Verification attached (county department of job and family services, employer, other agencies)

Check those that apply		Economic unit size	
<input type="checkbox"/> OWF <input type="checkbox"/> Disability Financial Assistance <input type="checkbox"/> Food Assistance <input type="checkbox"/> Medicaid <input type="checkbox"/> Refugee			
Card number		<input type="checkbox"/> Benefits Notice/Printout <input type="checkbox"/> Provider Information Line <input type="checkbox"/> MITS or EBT Portal	Effective date
Verification statement used (document/check stub/letter) <input type="checkbox"/> Yes <input type="checkbox"/> No	Statement date	Income amount \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly
Telephoned (name)	Agency/Business	Call date	
Confirmed or other information			
<hr/> <hr/>			
Proof of Residence			
<input type="checkbox"/> Ohio License/ID <input type="checkbox"/> Utility/credit bill <input type="checkbox"/> WIC Reminder Card <input type="checkbox"/> Medical card/JFS document <input type="checkbox"/> Other _____			
WIC personnel signature			Date

WIC Authorized Representative Letter

If you are not able to be present at the WIC eligibility appointment, you may have an authorized representative act on your behalf by completing the following letter.

(Date)

Dear WIC Project Staff,

I give permission for _____ to bring my children to the WIC clinic.
(Name of Authorized Representative)

This permission is for: ____ Today's WIC appointment only, or
____ Any WIC appointments during the next six months.

My children's full names are: _____

I understand that my children will have measurements such as height and weight taken and may have a finger stick to check blood iron level.

I have provided my authorized representative with the required forms, checked below, signed as needed, and told my representative what to expect at a WIC appointment. If you have any questions, please call me at this telephone number: _____.

Required Forms

- ____ one of the Ohio WIC Application forms (completed and signed)
- ____ Health History form (completed)
- ____ Immunization records
- ____ Welcome to WIC Letter (signed)
- ____ Proof of:
 - ____ Identity (some examples: driver's license, crib card, birth certificate, shot record Medicaid card, Ohio ID)
 - ____ Residence (some examples: utility or other bill, WIC Appointment reminder, driver's license)
 - ____ Income (some examples: three pay stubs; proof of receiving public assistance, such as Ohio Works First, Medicaid, or Food Stamps; retirement benefits; tax forms)
- ____ Voter Registration Form (signed)
- ____ WIC Nutrition Card/PIN number (the caregiver may elect not to share the PIN number)

Sincerely,

Parent or Guardian Signature

This institution is an equal opportunity provider and employer.

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
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Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Children 1–5 Years

Child's name		Today's date
Your name		Your relationship to child (96)
Child's birth date	Birth weight (51, 59)	Birth length
Child's doctor or clinic		Date of last doctor or clinic visit

Please answer the questions below.

Did your child ever breastfeed? <input type="checkbox"/> Still breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Why did you stop? _____ How old was your child when you stopped? _____	
Was your child born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (50)	
Please check all the health problems your child has. <input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Teeth/gums <input type="checkbox"/> Birth defects <input type="checkbox"/> Lactose intolerant <input type="checkbox"/> Other _____ <input type="checkbox"/> None (68, 91, 93, 94)	
List your child's medicines. <div style="text-align: right;"><input type="checkbox"/> None (93)</div>	
Is your child up to date on shots? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Has the doctor tested your child's blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know (21)	
Has your child seen a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No Do your child's teeth get brushed? <input type="checkbox"/> Yes <input type="checkbox"/> No Where do you get your water? <input type="checkbox"/> Well <input type="checkbox"/> City <input type="checkbox"/> Store bought <input type="checkbox"/> Other _____	
Check all that your child takes. <input type="checkbox"/> Vitamins <input type="checkbox"/> Herbs <input type="checkbox"/> Iron <input type="checkbox"/> Fluoride <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)	
List your child's food allergies. <div style="text-align: right;"><input type="checkbox"/> None (93)</div>	
Is your child on a special diet? <input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No (30, 35, 91, 93)	
Is your child using formula? <input type="checkbox"/> Yes Which formula? _____ <input type="checkbox"/> No (91, 93)	

<p>Check all that apply to your child.</p> <div> <input type="checkbox"/> Drinks from a cup <input type="checkbox"/> Drinks from a bottle <input type="checkbox"/> Goes to bed with a bottle or sippy cup </div> <div> <input type="checkbox"/> Walks around with a bottle or sippy cup <input type="checkbox"/> Is fed through a feeding tube </div>		(36, 94)
<p>What foods does your child refuse to eat?</p>		<input type="checkbox"/> None (35)
<p>Please check all the non-food items your child eats.</p> <div> <input type="checkbox"/> Printed paper <input type="checkbox"/> Paint chips <input type="checkbox"/> Dirt <input type="checkbox"/> Clay <input type="checkbox"/> Ice </div> <div> <input type="checkbox"/> Other _____ <input type="checkbox"/> None </div>		(30)
<p>Check all that apply.</p> <div> <input type="checkbox"/> Child feeds self <input type="checkbox"/> I run out of money or food stamps to buy food </div> <div> <input type="checkbox"/> Child has eating/chewing/swallowing problems <input type="checkbox"/> I have a working stove or microwave and refrigerator in my home. </div> <div> <input type="checkbox"/> Child usually does not eat at home </div> <div> <input type="checkbox"/> Child lives in a shelter, hotel or temporary place. </div>		(37, 66, 93, 95)
<p>What do you think about your child's eating habits?</p>		
<p>How many hours per day is your child physically active?</p> <div> <input type="checkbox"/> Less than one hour <input type="checkbox"/> One–two hours <input type="checkbox"/> Three or more hours </div>		
<p>If anyone in your home smokes, where do they smoke?</p> <div> <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes </div>		
<p>During the last six months, has your child been physically, verbally or sexually abused or neglected?</p> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>		
<p>Do you have any questions or concerns?</p> 		

Location of CPA	HT	WT	BMI	HGB	Mom's BMI	Dad's BMI
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Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Infants

Baby's name			Today's date	
Your name			Your relationship to baby (96)	
Birthdate	Date baby was due (50)	Birth weight (51, 59)	Birth length (52)	
Baby's doctor or clinic		Date of last doctor or clinic visit	Were you on WIC during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No (61)	

Please answer the questions below

My baby breastfeeds	
Every _____ hours or _____ times a day and _____ times a night	<input type="checkbox"/> Not breastfed (71, 75)
Check all that apply to your breastfed baby.	
<input type="checkbox"/> Weak suck <input type="checkbox"/> Slow weight gain <input type="checkbox"/> Problems latching on <input type="checkbox"/> My baby has no problems breastfeeding <input type="checkbox"/> Not breastfeeding <input type="checkbox"/> Other _____ (56, 74)	
Did you ever breastfeed your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Still breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Why did you stop? _____ How old was your baby when you stopped? _____	
Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No (50)	
Check any health problems your baby has.	
<input type="checkbox"/> Colic <input type="checkbox"/> Reflux <input type="checkbox"/> Teeth/gums <input type="checkbox"/> Birth defects <input type="checkbox"/> Slow weight gain <input type="checkbox"/> Jaundice (yellow color) <input type="checkbox"/> Other _____ <input type="checkbox"/> None (56, 68, 91, 93, 94)	
List your baby's medicines. <div style="text-align: right;"><input type="checkbox"/> None</div> (93)	
Is your baby up to date on shots? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Has the doctor tested your baby's blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know (21)	
Do you clean your baby's gums or teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Check all that your baby takes.	
<input type="checkbox"/> Vitamins (vitamin D) <input type="checkbox"/> Iron drops <input type="checkbox"/> Fluoride drops <input type="checkbox"/> Herbs <input type="checkbox"/> Other _____ <input type="checkbox"/> None (30)	
List your baby's food allergies. <div style="text-align: right;"><input type="checkbox"/> None</div> (93)	
How many times a day is your baby's diaper wet or dirty? <div style="text-align: right;">(74)</div>	

If you give your baby bottles, what is in the bottles? <input type="checkbox"/> Breastmilk <input type="checkbox"/> Formula Which formula? _____ <input type="checkbox"/> No bottles used How many ounces a feeding? _____ How often are the feedings? _____ (38)	
If you mix formula, what kind of water do you use? <input type="checkbox"/> Well <input type="checkbox"/> City <input type="checkbox"/> Distilled <input type="checkbox"/> Spring <input type="checkbox"/> Nursery <input type="checkbox"/> I don't mix formula <input type="checkbox"/> Other _____ (38)	
Do you have special instructions for mixing your baby's formula from your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No (38)	
Do you have any questions about mixing your baby's formula? <input type="checkbox"/> Yes <input type="checkbox"/> No (38)	
If you use bottles for your baby, check all that apply. <input type="checkbox"/> I wash my hands before fixing the bottle. <input type="checkbox"/> I reuse leftover bottles of formula. <input type="checkbox"/> I sterilize the bottles and nipples. <input type="checkbox"/> I wash the bottles with hot, soapy water. <input type="checkbox"/> I use the microwave to warm bottles. <input type="checkbox"/> I do not give bottles. (38)	
Other than breastmilk or formula, what else do you put into the bottle? <input type="checkbox"/> Karo® syrup <input type="checkbox"/> Juice <input type="checkbox"/> Punch <input type="checkbox"/> Cow's milk <input type="checkbox"/> Jell-O® water <input type="checkbox"/> Sugar <input type="checkbox"/> Pop <input type="checkbox"/> Sheep/goat's milk <input type="checkbox"/> Tea/coffee <input type="checkbox"/> Cereal <input type="checkbox"/> Honey <input type="checkbox"/> Water <input type="checkbox"/> Gatorade® <input type="checkbox"/> Kool Aid® <input type="checkbox"/> Baby foods <input type="checkbox"/> Other _____ <input type="checkbox"/> Nothing (36, 38)	
Check all that apply. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Baby is fed with a spoon <input type="checkbox"/> Baby drinks from a cup <input type="checkbox"/> Baby feeds self <input type="checkbox"/> Baby's bottle is propped when feeding </div> <div> <input type="checkbox"/> Baby uses an infant feeder <input type="checkbox"/> Baby's pacifier is dipped in _____ <input type="checkbox"/> Baby goes to bed with a bottle <input type="checkbox"/> Baby is usually fed away from home </div> </div> (36, 38)	
If your baby has started the following foods, at what age did you start Cereal _____ Vegetables _____ Fruit _____ Juice _____ Meat _____ Dinners _____ Desserts _____ Cow's milk _____ (36, 38)	
Is there a working stove or microwave and refrigerator in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No (38)	
If anyone living in your home smokes, where do they smoke? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes (46)	
During the last six months, has your baby been physically, sexually or verbally abused or neglected? <input type="checkbox"/> Yes <input type="checkbox"/> No (67)	
Do you have any questions or concerns? _____ _____ _____	

Location of CPA	HT	WT	BMI	HGB
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Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Breastfeeding Women and Postpartum Women

Name		Today's date		Age (39, 40)
Date this pregnancy ended	What was your due date? (49)	Your weight at delivery	Your weight before pregnancy (11)	
Check one <input type="checkbox"/> live birth _____pounds _____ounces <input type="checkbox"/> stillbirth <input type="checkbox"/> miscarriage <input type="checkbox"/> abortion <input type="checkbox"/> infant death (22, 45, 49)				
Number of past pregnancies (39)	How many ended in live birth? (42)	Date previous pregnancy ended (43)		
Prenatal doctor or clinic		Date of last doctor visit		

If you are currently breastfeeding, fill out **Sections 1 and 2**. If you are **not** currently breastfeeding fill out **Section 2**.

Section 1

My baby breastfeeds every _____hours or _____times a day and _____times a night How long on each side? _____ (70)	
If your baby gets bottles What is in the bottle? _____ How often? _____	
Do you have problems with <input type="checkbox"/> Let down <input type="checkbox"/> Hot, hard breasts <input type="checkbox"/> Latch <input type="checkbox"/> Pain in your breasts <input type="checkbox"/> Sore nipples <input type="checkbox"/> Other _____ <input type="checkbox"/> No problems (74)	
How long do you want to breastfeed your baby?	
Are you going back to work or school? <input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No	
What kind of support for breastfeeding do you have at home?	
Would you like more breastfeeding help? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2

Did you ever breastfeed your baby? <input type="checkbox"/> Still breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No Why did you stop? _____ How old was your baby when you stopped? _____	
Did you have a C-section? <input type="checkbox"/> Yes <input type="checkbox"/> No (93)	
List any problems you have had. With this pregnancy _____ With past pregnancies _____ <input type="checkbox"/> None (44)	
Check any health problems you currently have. <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Dental <input type="checkbox"/> High blood pressure <input type="checkbox"/> Lactose intolerance <input type="checkbox"/> Other _____ <input type="checkbox"/> None (91, 93, 94)	
List any medicines you take. (93)	

Has the doctor tested your blood for lead? <input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know	(21)
Have you ever had a baby with a birth weight of nine pounds or more? <input type="checkbox"/> Yes <input type="checkbox"/> No	(22, 49)
Was your baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No	(49)
Was your baby born with any health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____	(23)
Check all supplements you take. <input type="checkbox"/> Prenatal vitamins/vitamins <input type="checkbox"/> Iron <input type="checkbox"/> Herbs <input type="checkbox"/> Calcium <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(30)
Are you on a special diet? <input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No	(30, 35, 91, 93)
List your food allergies _____	<input type="checkbox"/> None (93)
Check any of these non-food items that you eat or crave . <input type="checkbox"/> Paint chips <input type="checkbox"/> Ice <input type="checkbox"/> Printed paper <input type="checkbox"/> Dirt/clay <input type="checkbox"/> Starch <input type="checkbox"/> Coffee grounds <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(30)
Check all that apply. <input type="checkbox"/> Someone else shops for food. <input type="checkbox"/> I usually shop for food. <input type="checkbox"/> I usually do not eat at home. <input type="checkbox"/> Someone else does the cooking. <input type="checkbox"/> I usually cook. <input type="checkbox"/> I live in a shelter, motel, or temporary place. <input type="checkbox"/> I have a working stove or microwave and refrigerator in my home. <input type="checkbox"/> I run out of money or food stamps to buy food.	(66, 95)
What do you think about your eating habits?	
Name one or two things you do for physical activity or exercise.	
How many cigarettes, pipes, cigars do/did you smoke? Now _____ a day _____ a week <input type="checkbox"/> None Last three months of this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None	(46)
If anyone living in your home smokes, where do they smoke? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes	(46)
Check all alcoholic beverages you drink. <input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Coolers <input type="checkbox"/> Liquor Now _____ a day _____ a week <input type="checkbox"/> None Last three months of this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None	(47, 66)
Check all drugs you currently use. <input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroin <input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalants <input type="checkbox"/> Prescription drugs (misuse) <input type="checkbox"/> Other _____ <input type="checkbox"/> None	(48, 66, 93)
During the last six months, have you been physically, sexually or verbally abused? <input type="checkbox"/> Yes <input type="checkbox"/> No	(67)
Do you have any questions or concerns? _____	

Location of CPA	HT	WT	BMI	HGB
-----------------	----	----	-----	-----

Ohio Department of Health • Bureau of Nutrition Services

WIC Health History for Pregnant Women

Name			Today's date		Age (39,40)
Your due date is	Weight before pregnancy (12,13)	Number of past pregnancies (39)	Number of live births (45)	Date last pregnancy ended (43)	
Prenatal doctor or clinic			How far along were you at your first doctor visit for this pregnancy? (16)		

If this is not your first pregnancy, fill out **Sections 1 and 2**. Fill out **Section 2** if this is your first pregnancy.

Section 1

Are you breastfeeding now? <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="text-align: right;">(69)</div>
Have you ever breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why did you stop? _____ How old was your baby when you stopped? _____
Have you had any problems with past pregnancies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list _____ <div style="text-align: right;">(44,45)</div>
Check if you ever had a baby with one of these birth weights. <input type="checkbox"/> 5 pounds and 8 ounces or less <input type="checkbox"/> 9 pounds or more <input type="checkbox"/> Neither <div style="text-align: right;">(22, 49)</div>
Have you ever had a baby born three or more weeks early? <input type="checkbox"/> Yes How many weeks? _____ <input type="checkbox"/> No <div style="text-align: right;">(49)</div>
Have you ever had a baby born with any health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____ <div style="text-align: right;">(23)</div>

Section 2

Check any problems you are having with this pregnancy. <input type="checkbox"/> Heartburn <input type="checkbox"/> Poor appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Other _____ <input type="checkbox"/> None <div style="text-align: right;">(44)</div>
Check any of your health problems. <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Dental <input type="checkbox"/> High blood pressure <input type="checkbox"/> Lactose Intolerance <input type="checkbox"/> Other _____ <input type="checkbox"/> None <div style="text-align: right;">(44, 91, 93, 94)</div>
Have you lost weight during this pregnancy? <input type="checkbox"/> Yes How much? _____ <input type="checkbox"/> No <div style="text-align: right;">(10)</div>
List any medicines you take. <div style="text-align: right;"><input type="checkbox"/> None</div> <div style="text-align: right;">(93)</div>
Check all supplements you take. <input type="checkbox"/> Prenatal vitamins <input type="checkbox"/> Vitamins <input type="checkbox"/> Iron <input type="checkbox"/> Herbs <input type="checkbox"/> Calcium <input type="checkbox"/> Folic acid <input type="checkbox"/> Other _____ <input type="checkbox"/> None <div style="text-align: right;">(30)</div>

Has the doctor tested your blood for lead?		(21)
<input type="checkbox"/> Yes Results _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Are you on a special diet?		(30, 35, 91, 93)
<input type="checkbox"/> Yes, your choice <input type="checkbox"/> Yes, from your doctor <input type="checkbox"/> No		
List your food allergies		(93)
<div style="text-align: right;"><input type="checkbox"/> None</div>		
Check any of these non-food items that you eat or crave .		(30)
<input type="checkbox"/> Paint chips <input type="checkbox"/> Ice <input type="checkbox"/> Printed paper <input type="checkbox"/> Dirt/clay <input type="checkbox"/> Starch <input type="checkbox"/> Coffee grounds <input type="checkbox"/> Other _____ <input type="checkbox"/> None		
Check all that apply.		(66, 95)
<input type="checkbox"/> Someone else shops for food. <input type="checkbox"/> I usually shop for food. <input type="checkbox"/> I usually do not eat at home. <input type="checkbox"/> Someone else does the cooking. <input type="checkbox"/> I usually cook. <input type="checkbox"/> I live in a shelter, motel, or temporary place. <input type="checkbox"/> I have a working stove or microwave and refrigerator in my home. <input type="checkbox"/> I run out of money or food stamps to buy food.		
What do you think about your eating habits?		
Name one or two things you do for physical activity or exercise.		
How many cigarettes, pipes, cigars do/did you smoke?		
Now _____ a day _____ a week <input type="checkbox"/> None Anytime during this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None		
If anyone living in your home smokes, where do they smoke? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car <input type="checkbox"/> No one smokes		
Check all alcoholic beverages you drink. <input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Coolers <input type="checkbox"/> Liquor Now _____ a day _____ a week <input type="checkbox"/> None Anytime during this pregnancy _____ a day _____ a week <input type="checkbox"/> None Three months before this pregnancy _____ a day _____ a week <input type="checkbox"/> None		
Check all drugs you used at any time during this pregnancy. <input type="checkbox"/> Marijuana <input type="checkbox"/> Crack <input type="checkbox"/> Speed <input type="checkbox"/> LSD <input type="checkbox"/> Heroin <input type="checkbox"/> Crystal meth <input type="checkbox"/> Inhalants <input type="checkbox"/> Prescription drugs (misuse) <input type="checkbox"/> Other _____ <input type="checkbox"/> None		
During the last six months, have you been physically, sexually or verbally abused? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have any questions or concerns? _____		

WIC Information on Transferring Groups and Participants Using the Statewide Search



Rules for the Statewide Search

1. The Statewide Search is the most up-to-date information available to determine if a participant is on WIC and from what county the participant has been receiving WIC services.
2. The transfer process time frame is two business days from when the transfer was requested.

Note: *This is assuming that you have internet availability and the clinic is running their data file transfer daily for two consecutive days.*

Example

Day Transfer is Requested

Monday
Tuesday
Wednesday
Thursday
Friday

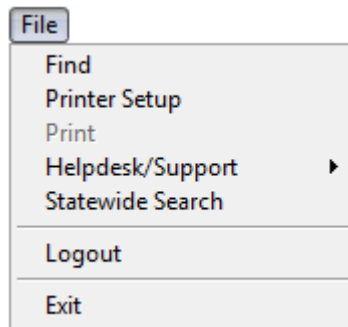
Day You Can Serve Them in WIC

Wednesday
Thursday
Friday
Monday
Tuesday

3. Walk-in clinics requesting transfers: The walk-in clinic concept is wonderful for accommodating new participants to WIC and servicing existing WIC participants. However, if a participant walks in and you believe they are already on WIC somewhere else in the State, the Statewide Search must be used to confirm that. Request the transfer and either schedule a follow up appointment or ask them to return after two business days.
4. Asking the WIC Helpdesk for assistance: The criteria for calling the WIC Helpdesk for assistance with a transfer is “when you have previously requested the transfer and it did not download to your system.” At that point, they can assist in determining the transfer problem that caused the participant to not download. If you did not request the transfer, the WIC Helpdesk will direct you to request the transfer via the Statewide Search. WIC Helpdesk only uses the “fast transfer” to fix issues when users are unable to resolve a transfer problem on their own after it was requested in the system.
5. Cognos should **not** be used to look up transfer information. Cognos is the warehouse for all historical data, so there may be times that Cognos shows a record that is not in the Statewide Search. Remember the Statewide Search is the correct data to use. Only use Cognos to print Master Records for participants.
6. You don’t need to print a master record for everyone transferring within the State of Ohio since everyone has access to the Statewide Search and can look up participants when they call the new clinic to transfer.
7. Once you have requested the transfer through the Statewide Search, you can schedule an appointment using the Schedule tab in the WIC certification system.

How to Use the Statewide Search

1. In the WIC Certification system, move your mouse to the **File Menu** and click. The following drop down menu will appear:



2. Move the mouse to the **Statewide Search** option and click. Go to Step #4.

OR

1. Move your mouse to the **Find Box** on the WIC Main Screen:

WIC Main Screen - User FIXIT logged on

File Edit Issue Show All Participants Schedule Admin Growth Charts Reports Help

Group ID - Name (L,F,M) DOB

Address Apt Phone () - Loc

City OH Zip - PAN

Unused Unused Unused Unused

Part ID - Name (L,F,M) DOB

Category

Address Apt Phone () -

City OH Zip - Loc

Status Farmers' Market Orig Cert Date Base Date

Cert Date Term Date

Demographics Pregnancy Info Visit Risk Obligations Schedule Comments

Guardian Name (L,F,M)

Sex Marital Status Maiden Name Ref ID

Household Size 0 Res Stat

Income \$0 Weekly Multiple

Income Proof

Pub Asst

Ethnic Class/Race Codes

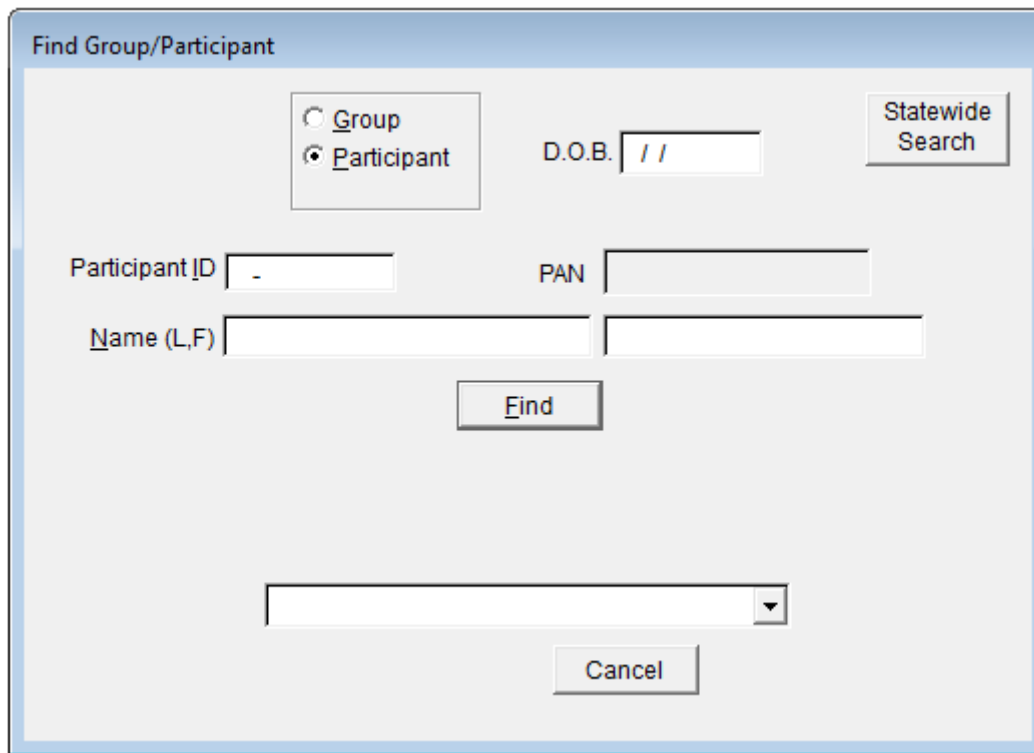
☐ Asian ☐ White ☐ American Indian Or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pac. Islander

Educ (1-30) 0 Prim Lang

Emp Status Src Care

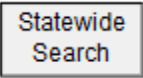
Ref From

The following **Find Participant** screen will appear:

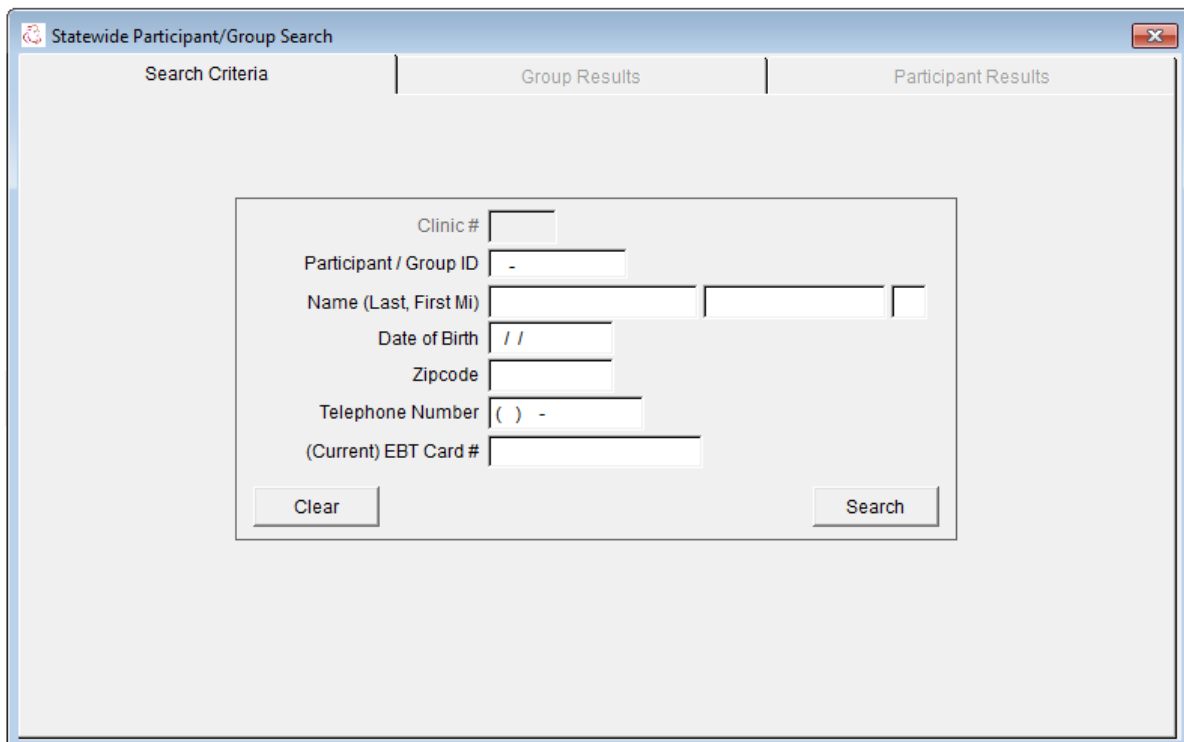


The 'Find Group/Participant' dialog box contains the following elements:

- Radio buttons for 'Group' and 'Participant' (selected).
- A 'D.O.B.' field with a dropdown menu showing ' / /'.
- A 'Statewide Search' button in the top right corner.
- A 'Participant ID' field with a dropdown menu showing '-'.
- A 'PAN' field with a dropdown menu.
- A 'Name (L,F)' field with two text input boxes.
- A 'Find' button.
- A dropdown menu at the bottom.
- A 'Cancel' button.

2. Click on the **Statewide Search** box  and continue with the next Step.

3. Below is the **Statewide Search** screen:



The 'Statewide Participant/Group Search' window features a tabbed interface with three tabs: 'Search Criteria', 'Group Results', and 'Participant Results'. The 'Search Criteria' tab is active and contains a search form with the following fields:

- Clinic # (dropdown menu)
- Participant / Group ID (dropdown menu showing '-')
- Name (Last, First Mi) (text input box)
- Date of Birth (dropdown menu showing ' / /')
- Zipcode (text input box)
- Telephone Number (dropdown menu showing ' () -')
- (Current) EBT Card # (text input box)

At the bottom of the search form are two buttons: 'Clear' and 'Search'.

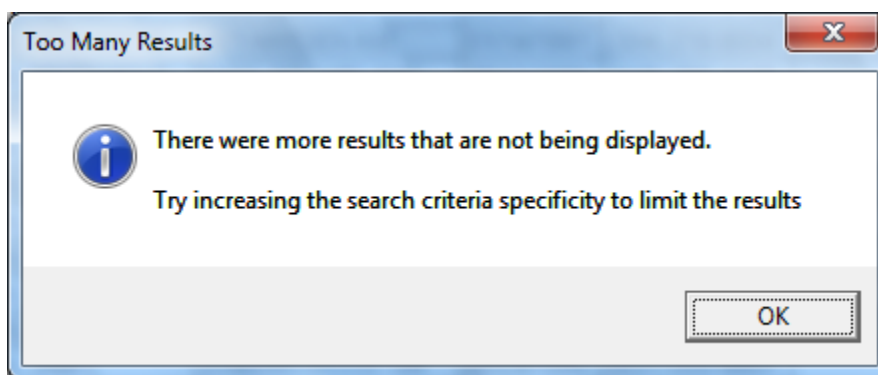
Enter your Search Criteria using any of the following fields:

Criteria	Description
Clinic #	You will see this greyed out (it is only available to the WIC Helpdesk).
Participant / Group ID	Enter the exact Participant or Group ID (you cannot enter a partial number).
Name (Last, First MI)	Enter characters in the last name, first name or middle initial field or some characters in all fields. Keep in mind that this will find all participants that have these characters in the any portion of the name fields. Example: Bar will find Bar, Barron, Sanzibar, Colbarton, etc.
Date of Birth	Enter the exact date of birth using (MM/DD/YYYY) format.
Zip code	Enter a partial zip code or an exact zip code, just remember you are seeing both groups and participants..
Telephone Number	Enter an exact telephone number
(Current) EBT Card #	Enter the exact EBT card number (if you enter the last digits of the card the system will auto complete the first number of the card).

Note: *The Statewide Search allows you to enter partial data. However, the less data you enter, the more results you will retrieve. Entering as much data as you have available will help retrieve fewer results, which are easier to read and sort through.*

The system does not just reference Participant information but shows both Groups and Participants that match your criteria.

If you get the following screen, the system is telling you the criteria are too generic. Try re-entering more specific information:



- [illegible]

When everyone is converted, majority of the transfers will be groups because the food is on one card. The exception will be foster children and shared-custody children.

Group Column Layout

Clinic	-	Displays the clinic the group is currently in
Group ID	-	Displays the current group number assigned to this group
Name	-	Displays the last name, first name of the group head
Address	-	Displays the last known address for the group
DoB	-	Displays the date of birth of the group head
Phone	-	Displays the last known phone number for the group
PAN	-	Displays the EBT card number for the group (if coupons were issued it will remain blank)
S	-	Displays the current status of the group (since status is not attached to groups the group screen will leave this blank)
XFER	-	Once this is clicked, the entire group is immediately in the process of transferring to your clinic... <i>Note: This cannot be cancelled or stopped and the WIC Helpdesk cannot stop the process. If you did this by accident, you will need to call the original clinic the following day and have them request the group transfer back into their clinic.</i>

- Participant Results (2)

Participant Column Layout

Statewide Search Instructions v 1.0, January 2015

Page 6

Transferring A Group

You should transfer a group when **all** participants are transferring into your clinic and remaining in the custody of the Group Head.

Foster Children

1. Children, who are siblings and will not be separated, are to be placed in the same group with the youngest child as the group head. All children will be on the same WNC.
2. When a child is placed individually, that child will be the group head and have his own WNC.
3. If there is more than one foster child assigned to a foster home, each child will be his own group with his own WNC.
4. The foster parent or legal guardian's name must be listed in the "guardian name" area on the demographic tab.

When child and WNC are moved to another foster home, the new foster parent will come to the clinic with the proof of custody and complete an application. Update the "guardian name" on the demographic tab and reset the PIN for the WNC.

If the WNC does not come with the child, request a group transfer. When transfer complete, lock the old card as "failed to function." After six day wait period, issue a new card.

If child is in a new foster home, the WNC does not come with the child, and the child remains in the same clinic, lock the card as "failed to function." After six day wait period, issue a new card.

If the foster child was **not** in a separate group and listed as the group head:

1. Create a new group for that foster child and request the participant transfer into the new group.
2. Transfer the participant into the new group with the new foster child as the **group head**.

Do not transfer the group if there are other children in the group that are remaining with the original foster parent.

Note: *Since EBT will be rolling out in the next six months, we need everyone to follow the same rules. Benefits are affected when your clinic transfers participants since food is issued to the group.*

If a foster child moves from one foster parent to another and the original foster parent has other children in the group, the original foster parent's card will lock and they will not be able to purchase foods. They will need to come into the clinic after six days to have the card unlocked.

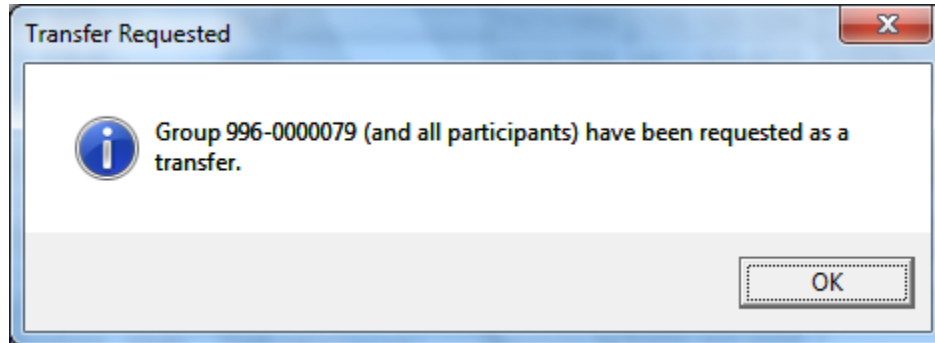
The new foster parent will not be able to access current month foods but will be able to get future month foods.

Best Solution for Foster Children

Make sure each foster child is in a separate group listed as the group head, unless they are siblings that will not be separated, and make sure that the foster parents know that if a child/children goes to another foster home or back to the custodial family that the card/coupons must go with them. There can be multiple groups in the system with the same group head so it will not cause any duals (duals are only created when participant information is identical).

Transferring a Group

When you transfer a group you will see the following screen:



At this point you can go into each participant screen and set up an appointment (after two business days).

Transferring a Participant

When you transfer a participant you will see the following screen:



Enter either an existing group number that is in your system or click on New Group and the system will create a new group ID for this participant.

Q & As Pertaining to Statewide Transfer

Question 1

A participant applies for WIC and is assigned a group/participant ID in the WIC System but does not show up for the appointment. The participant then goes to another clinic (either in the same county or another county). Do I need to request the transfer?

Answer 1

Yes, otherwise it will present as a dual which will require clinic time to resolve. In addition, the Statewide Search will start to show multiple records for the same participant and the potential for transferring the wrong record becomes high. EBT is very dependent on having a unique group record.

Question 2

In the old system I used to reactivate a participant who termed and purged out of my system and now I don't see that as an option. How do I reactivate a purged participant?

Answer 2

The new Statewide Search utilizes the word "transfer" to mean transfer the data from the State System to a clinic system. Whether you're transferring from clinic to clinic or requesting the data about a participant that has purged from your system, the Statewide Search "Transfer" now does both of these functions.

Question 3

I have a walk-in clinic and want to serve all participants when they come in the clinic that day. How can I accomplish this for transfers and reactivation participants?

Answer 3

In both of these situations, data needs to be transferred from the state system to the clinic system to maintain data integrity and will take 2 days. Refer to the schedule on page 1 of the "WIC Information on Transferring Groups and Participants Using the Statewide Search."

The idea of the walk-in clinic is to reduce the number of people that need to be scheduled and immediately provide WIC services to existing and new participants.. A participant that has made appointments at other WIC clinics or did not return to the clinic within 6 months of terming out of the system is not considered a new participant and you must request the transfer through the Statewide Search.

To encourage these participants to return to the clinic, you can hand them all of the paperwork that needs to be completed and you could schedule a time for them to return or just let them know to come back in 2 days. Emphasize that their visit time will be significantly reduced by completing the paperwork before the appointment.

Note: When you transfer a pending or active participant, the schedule screen is activated so that you can schedule a follow-up visit. However, we discovered that if the participant is termed out the schedule screen is not activated. The intent was for anyone to be able to be scheduled upon requesting the transfer, so this will be corrected as soon as possible and you will be notified when the update goes out.

WIC/Impact Report Instructions

May 2012

Screen Patients:

- After logging in, click on the Patient tab and search for a patient. To make matters simpler, try fuzzy searching (e.g. last initial, first initial, birthdate).

The screenshot displays the ImpactSIIS Statewide Immunization Information System interface. At the top, the user is logged in as Andrew Harris, with links for Preferences, My Practice, and Logout. The main navigation bar includes tabs for Home, Patient, Vaccines, Reminder Recall, Upload, Reports, Administration, Help, and Call Center. The Patient tab is selected.

Below the navigation bar, there are dropdown menus for Practice (ODH WIC PROGRAM), Clinic (ODH WIC PROGRAM), Provider (Andrew Harris), and Vaccine Giver (Andrew Harris). The Patient Search section contains a search criteria form with fields for Last Name (t), First Name (a), and Birth Date (1/1/1999). The Search Method is set to Fuzzy. There are Search and Reset buttons, and a link to Advanced Search.

Below the search form, a message states: "Select a patient record to open the patient dashboard." A table of search results is displayed with columns: Score, Last, First, Middle, Birth Date, Mom Maiden, Phone Number, City, County, and Address. The table shows 5 records, all with a score of 81.

Score	Last	First	Middle	Birth Date	Mom Maiden	Phone Number	City	County	Address
81	TELERICO	ANTHONY	M	01/01/99					
81	TESTDIETSCH	ALEX		01/01/99		(614) 457-7127	Columbus	FRANKLIN	2539 TROTTERSLANE DRIVE , COLUMBUS, 43235
81	testp	alexandra		01/01/99		(419) 999-9999	Columbus	FRANKLIN	213 High St , COLUMBUS, 43202
81	TESTPAT	ALBERT		01/01/99		(419) 555-5555	Napoleon	HENRY	566 FUN DR , NAPOLEON, 43545
81	TRANMELL	ANGELIQUE		01/01/99			Middletown	BUTLER	1210 PINE , MIDDLETOWN, 45044

Below the table, there is a link to Create New Patient. The page indicates "Viewing 1 - 5 of 5 records." with Previous, 1, and Next navigation links. The footer contains copyright information for the Ohio Department of Health and the version number 2.5.31582.0.

- Once you select a patient and pull up the patient's screen (as in Figure to the right), the patient is considered to have been "screened," and will appear on the screening report. If you create a new patient, as soon as you enter immunization dates, the patient is "screened" and will appear on the screening report.

Statewide Immunization Information System

Welcome Andrew Harris

[Preferences](#) | [My Practice](#) | [Logout](#)

[Home](#)
[Patient](#)
[Vaccines](#)
[Reminder Recall](#)
[Upload](#)
[Reports](#)
[Administration](#)
[Help](#)
[Call Center](#)

Practice:

Clinic:

Provider:

Vaccine Given:

> Patients

- > Demographics
- > Contacts
- > Immunizations
 - > Add Current
 - > Add Historical
 - > Add Immunity
 - > Add Refusal
- > Add Appointment
- > Contraindications
- > Lead Test Results
- > School Information
- > Vision Screenings
- > Hearing Screenings
- > BMI Measurements
- > Tuberculosis
- > Encounters
- > Account
 - > Add New Payment
 - > Patient Payments

TESTP, ALEXANDRA (DOB:1/1/1999)

Primary Contact:
TESTP, MOM (Mother)
(419) 999-9999
213 High St
Columbus Ohio 43202

Lead Test Result: None
Lead Test Date: None

VFC Eligibility: Is Eligible
Next Appt: 10/1/2012 8:00 AM
Immunization Status: Up to Date

Demographic Summary

- Name: testp, alexandra
- Birth Date: 1/1/1999
- Gender: Female
- Primary Contact: TESTP, MOM
- Relationship: Mother

Contact Summary

Full Name	Relation	Imm. Status
testp, alexandra	Self	Up to Date
testpatient, daddy	Father	Unknown
TESTP, MOM	Mother	Unknown

Associated Individuals ?

Full Name	Imm. Status
angiebaby testp	Past Due
andybaby testp	Due
alvin testp	Past Due
andrew testpatient	Past Due
ANDROTTI TESTP	Past Due

Immunization Summary

Immunizations on file: 36
Last Evaluation Date: 5/17/2012

Group	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7	Dose 8	Dose 9
DTP	3/1/1999	5/1/1999	7/1/1999	2/1/2010	3/1/2004	7/1/2009	10/18/2011	4/28/2012	
FLU	10/1/2008	2/8/2012	Refused						
HAV	2/1/2000	3/1/2004	10/21/2011						
HBV	1/1/1999	3/1/1999	7/1/1999						
HIB	3/1/1999	5/1/1999	7/1/1999	2/1/2010					
HPV	10/5/2011	1/24/2012							
Meningococcal	10/7/2006								
MMR	2/1/2000	3/1/2004							
PNE	3/1/1999	5/1/1999	7/1/1999	2/1/2010					
POL	3/1/1999	5/1/1999	7/1/1999	3/1/2014					
Rotavirus	3/1/1999	5/1/1999	7/1/1999						
VAR	Chicken Pox or Varicella								

Due Now

Given Too Early

Incorrect Spacing

Given Late

Immunity

Refusal

Do Not Count

Note: Vaccine forecasting and evaluation is a tool to use for your benefit. It is not meant to replace onsite evaluation from the provider.

[Add Referral to Immunization Provider](#)

Due Now
Refusal

Given Too Early
Do Not Count

Incorrect Spacing

Given Late

Immunity

Note: Vaccine forecasting and evaluation is a tool to use for your benefit. It is not meant to replace onsite evaluation from the provider.

Add Referral to Immunization Provider

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Adds a Referral to Immunization Provider

Record Patient Referral:

- Click on the “Add Referral to Immunization Provider” button at the bottom of the patient’s screen. You will be able to add a note regarding the referral, if you choose. Once you click the “Save” button, the patient will appear on the referral report.

Add Referral to Immunization Provider

Referral Information

Referral Date	Notes
5/17/2012	Referred to LHD--AFH

Cancel Save

ImpactSIIS Statewide Immunization Information System

Welcome Andrew Harris [Preferences](#) | [My Practice](#) | [Logout](#)

...Search Patient... [Home](#) [Patient](#) [Vaccines](#) [Reminder Recall](#) [Upload](#) **Reports** [Administration](#) [Help](#) [Call Center](#)

Practice: ODH WIC PROGRAM Clinic: ODH WIC PROGRAM Provider: Andrew Harris Vaccine Giver: Andrew Harris

View WIC Reports:

- Click on the Reports tab at the top of the screen. At the bottom of the Reports page is a section titled “WIC Reports,” with the following reports listed underneath:
 - WIC Screenings - Detail Report
 - WIC Screenings - Summary Report
 - WIC Referrals - Detail Report
 - WIC Referrals - Summary Report
- To view a report, click on its title.
- The Detail reports, which default to “All” but allow you to specify a practice, provide patient names. The Summary reports provide totals.

ImpactSIIS Statewide Immunization Information System

Welcome Andrew Harris [Preferences](#) | [My Practice](#) | [Logout](#)

...Search Patient... [Home](#) [Patient](#) [Vaccines](#) [Reminder Recall](#) [Upload](#) **Reports** [Administration](#) [Help](#) [Call Center](#)

Practice: ODH WIC PROGRAM Clinic: ODH WIC PROGRAM Provider: Andrew Harris Vaccine Giver: Andrew Harris

> **Reports**
 > Report Status
 > Saved Queries

Available Reports

- > Immunization Activity Assessment
 - > [CoCASA-Comprehensive Clinic Assessment Software Application](#)
 - > [Vaccines Administered](#)
 - > [Patients Behind On Immunizations](#)
 - > [Patients Needing Premar-13](#)
 - > [Invalid Immunizations](#)
- > Vaccine Management
 - > [Lot Log](#)
 - > [Vaccines for Children \(VFC\) Provider Profile](#)
- > Patient Appointments
 - > [Patient Appointments Report](#)
- > Create Your Own Custom Report
 - > [Ad-Hoc Query Builder \(Background Report\)](#)
- > ODH Reports
 - > [Background Report Log](#)
 - > [Hospital HBV Report](#)
 - > [HBV Report](#)
 - > [Reminder / Recall Report Log](#)
 - > [Reminder / Recall Summary](#)
 - > [Reminder Report](#)
 - > [Recall Report](#)
 - > [Login Information](#)
 - > [Patient Merge/Delete Requests](#)
 - > [Uploaded File Status](#)
 - > [Billable Vaccines Report](#)
- > **WIC Reports**
 - > [WIC Screenings - Detail Report](#)
 - > [WIC Screenings - Summary Report](#)
 - > [WIC Referrals - Detail Report](#)
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Your Saved Queries

WIC Screening Detail Report

Practice: ODH WIC PROGRAM

Screening Date From: 05/16/2012 To: 5/17/2012

View Report

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- To specify the date range for the report, click in the date fields and select your dates from the calendar.
- ***Please note, if you want to capture patients that were screened and/or referred on the same date that you are running the report, please extend your "to" date to the following day (i.e., if you're running the report on 5/17/12 and want to capture all patients screened and/or referred on 5/17/12, the date range for your report needs to be from 5/16/12 to 5/18/12).**
- When you have specified the practice and screening date parameters, click "View Report."

1 of 1 100%

Select a format Export

WIC Screenings - Detail Report Date: 05-17-2012

Last Name	First Name	Birth Date	WIC ID	Practice	Screened By	Screening Date
testp	alexandra	01/01/1999		ODH WIC PROGRAM	Andrew Harris	05/17/2012
testp	alexandra	01/01/1999		ODH WIC PROGRAM	Andrew Harris	05/17/2012
Testpatient	Another	09/22/1979		ODH WIC PROGRAM	Impact Admin	05/16/2012
Testpatient	Another	09/22/1979		ODH WIC PROGRAM	Impact Admin	05/16/2012

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- To print the report, select your format, click on "Export," and then click on the printer icon. (The "Export" function allows you to export the report into a PDF or Excel document.)

Other Reports—WIC Screening Summary, WIC Referrals Detail, WIC Referrals Summary

WIC Screening Summary Report

Screening Date From: 05/16/2012 To: 05/18/2012

Cancel View Report

1 of 2 100% Select a format Export

WIC Screenings - Summary Report Date: 05-17-2012

Practice	Number of Screenings
ODH WIC PROGRAM	4
test practice for glick	1
WIC-00400-ASHTABULA	4
WIC-00900-BUTLER	1
WIC-00921-BUTLER	15
WIC-01200-CLARK	37
WIC-01500-COLUMBIANA	12
WIC-01600-COSHOCTON	1
WIC-01801-CUYAHOGA	29
WIC-01803-CUYAHOGA	4
WIC-01805-CUYAHOGA	13
WIC-01810-CUYAHOGA	61
WIC-01822-CUYAHOGA	7
WIC-01823-CUYAHOGA	5

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- Note that any clinic can view the summary reports, which show the numbers for all WIC clinics.

WIC Referral Detail Report

Practice:

Referral Date From: To:

1 of 1 100% Select a format Export

WIC Referrals - Detail Report Date: 05-17-2012

Last Name	First Name	Birth Date	WIC ID	Practice	Referral Created By	Referral Date
Testpatient	Another	09/22/1979		ODH WIC PROGRAM	Impact Admin	05/16/2012
testp	alexandra	01/01/1999		ODH WIC PROGRAM	Andrew Harris	05/17/2012

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- Note that the referral notes are not displayed in the report, as notes are not saved anywhere on the website. However, notes are saved in the database.

WIC Referral Summary Report

Referral Date From: 05/17/2012 To: 05/18/2012

Cancel View Report

1 of 1 100% Select a format Export

WIC Referrals - Summary Report Date: 05-17-2012

Practice	Number of Referrals
ODH WIC PROGRAM	1
test practice for glick	1

Page 1 of 1

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- Like the Screening Summary report, this report will display number of referrals for all WIC clinics that referred within the date parameters.

Ohio Department of Health
WIC Interagency Referral and Follow-Up Form

Date	Referred to	FAX
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Referring Agency Information

Name		Clinic
Agency		Phone
Address		FAX
City	State	ZIP

Participant Information

Participant name		Birthdate
Parent/Guardian		EDC date
Address		Phone
City	State	ZIP
Email address		

Hgb*	Hct*	Reason for referral and other pertinent medical information
Height*	Weight*	
BMI		

*Indicate date taken if different than the above date.

Consent for Sharing Information

You are not required to consent to sharing any of the above information, but may wish to for the well being of yourself or children. If you decide not to consent, your refusal will not in any way affect the services you receive from WIC. Any information that is shared will be kept confidential.

A signature below indicates you ***give permission*** to share the information included on this form with the “referred to” agency listed above.

Participant, parent, or guardian signature
--

Response from Physician, Health Clinic or Human Services Agency

Please complete, send one copy to the referring agency address, and retain one copy for your files.

Action taken

Signed	Date
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USDA is an equal opportunity provider and employer.

WIC Medical/Nutritional Risk Codes

Revised 10/01/12 PPL 180

An * indicates that you will have to consult your WIC PPM for condition required on WTW

High Risk = { }

Pregnant

Priority I

- 10 slow weight gain {+13}
- 11 high weight gain
- 12 high weight before pregnancy (≥ 25 BMI)
- 13 low weight before pregnancy (< 18.5 BMI) {+10/+46}
- 16 lack of proper prenatal care
- 17 slow fetal growth
- 20 low iron ($< 33/11$, $< 32/10.5$, $< 33/11$) { $\leq 30/10$ }
- 21 high blood lead (≥ 10)
- 22 had a large baby ($\geq 9\#$)
- 23 nutritional birth defect
- 39 many pregnancies before age 20 ($\times 3 \geq 20$ wks < 20 at conception)
- 40 pregnant at a young age (conc. ≤ 17) { ≤ 15 }

- 42 having more than one baby
- 43 close pregnancies (conc. ≤ 16 m/pp)
- 44 condition caused by pregnancy HG, {GD}, HxGD, HxPC, PIH
- 45 past fetal loss (Hx ≥ 2 SABs or Hx fetal death)
- 46 smoking (any daily)/secondhand smoke {+13}
- 47 alcohol use (any) {3ozHL, 6MD, 3 Brs, 3-4ozWn}
- 48 {drug use}
- 49 past early or small baby (≤ 37 wks/5#8oz)
- 69 breastfeeding while pregnant
- 80 transfer
- 91 {inborn errors of metabolism*}

93 {conditions that affect nutrition status*}

94 dental problems

Priority IV

- 30 unhealthy diets (vit/min/herb/germs, pica)
- 31 needs diet guidance
- 35 limited diet (vegan/highly restrictive)
- 66 at risk for poor diet (ltd ability re feeding decisions)
- 67 needs WIC services
- 95 homeless or migrant
- 96 foster care (entered or changed within 6 months)

Breastfeeding

Priority I

- 11 high weight gain (> 40 , > 35 , > 25 , > 20)
- 14 low weight < 18.5 {+46}
- 15 High weight (> 25 BMI)
- 20 low iron (< 15 yr: $< 36/11.8$, ≥ 15 yr. $< 36/12$) { $\leq 33/11$ }
- 21 High blood lead (≥ 10)
- 22 Had a large baby ($\geq 9\#$, any history)
- 23 nutritional birth defect (most recent preg. {MRP})
- 39 many pregnancies before age 20 ($\times 3 \geq 20$ wks)
- 40 pregnant at a young age (conc. ≤ 17) { ≤ 15 }
- 42 having more than one baby
- 43 close pregnancies (conc. ≤ 16 m/pp)

- 44 conditions caused by pregnancy (HxGD & Hx PC)
- 45 past fetal loss (MRP SAB ≥ 20 wks/death 0-28D)
- 46 smoking (any daily)/secondhand smoke {+14}
- 47 alcohol use ($> 2/d$, $5 \times 1/30d$, $5 \times 5/30d$) {3ozHL, 6MD, 3 Brs, 3-4ozWn}
- 48 {drug use (current)}
- 49 past early or small baby (MRP ≤ 37 wks/5#8oz)
- 74 {breastfeeding issues}
- 80 transfer
- 91 {inborn errors of metabolism*}
- 93 {conditions that affect nutrition status*}
- 94 dental problems

Priority IV

- 30 unhealthy diet habits (vit/min/herb/germs, pica)
- 31 needs diet guidance
- 35 limited diet (vegan/highly restrictive)
- 63 prevention
- 66 at risk for poor diet (ltd ability re feeding decisions)
- 67 needs WIC services
- 70 breastfeeding a WIC baby (doc. baby's code)
- 95 homeless or migrant
- 96 foster care (entered or changed within 6 months)

Postpartum

Priority III

20 low iron(<15yr:<36/11.8, ≥15yr:<36/12) {≤**33/11**}

21 high blood lead (≥10)

80 transfer

91 {inborn errors of metabolism*}

93 {conditions that affect nutrition status*}

94 dental problems

Priority VI

11 high weight gain

(>40,>35,>25,>20)

14 low weight (<18.5BMI)

15 high weight (≥25 BMI)

22 had a large baby (≥9#, any history)

23 nutritional birth defect

30 unhealthy diet habits (vit/min/herb/germs, pica)

31 needs diet guidance

35 limited diet (vegan/highly restrictive)

39 many pregnancies before age 20 (x3≥20wks)

40 pregnant at a young age (conc.≤17) {≤**15**}

42 having more than one baby

43 close pregnancies (conc.<16m/pp)

44 condition caused by pregnancy (HxGD/Hx PC)

45 past fetal loss (MRP SAB≥20wks/death 0-28d)

46 smoking (any daily)/secondhand smoke

47 alcohol use (>2/d,5x1/30d,5x5/30d) {**3ozHL, 6MD, 3 Brs, 3-4ozWn**}

48 drug use (current)

49 past early or small baby (MRP≤37wks/5#8oz)

63 prevention

66 at risk for poor diet (ltd ability re feeding decisions)

67 needs WIC services

95 homeless or migrant

96 foster care (entered or changed within 6 months)

Infants

Priority I

20 low iron(<33/11){≤**30/10**}

21 high blood lead (≥10)

46 secondhand smoke

50 born early(≤37 wks){+**51**}

51 low birth weight (≤5#8oz) {+**50**}

52 short for age (≤2%lg/age)

53 underweight (≤2%wt/lg)

54 high wt/lg (≥98%)

55 at risk for growth problems

56 {slow growth}

57 small at birth dx. by MD

58 small head size (≤2%)

59 large at birth (≥9# or ≥90%wt/g.age at birth)

65 at risk for poor growth

68 fetal alcohol syndrome

74 {breastfeeding issues}

80 transfer

81 infant transfer (eligible for 1 yr)

91 {inborn errors of metabolism*}

93 {conditions that affect nutrition status*}

94 dental problems

Priority II

61 baby born to WIC eligible mom (<6mos old)

Priority IV

30 unhealthy diet habits

(vits/min/herb/germs)

31 needs diet guidance

35 limited diet (vegan/highly restrictive)

36 improper bottle or cup use (list specific improper usage)*

38 improper infant feeding (list specific improper practice)*

63 prevention

66 at risk for poor diet (ltd ability re feeding decisions)

67 needs WIC services

71 breastfed by a WIC mom (doc. mom's code)

75 needs breastfed more often (<2m<8/d; ≥2m<6/d)

95 homeless or migrant

96 foster care (entered or changed within 6 months)

Children

Priority III

20 low iron (12m-<2yr:<33/11, 2-5yr:<33/11.1){≤**30/10**}

21 high blood lead (≥10)

46 secondhand smoke

50 born early(≤37 wks) *children less than 24 mo

51 low birth weight (≤5#8oz)

*children less than 24 mo

52 short for age

(≤2% LG/age 1-2 yrs; ≤5% HT/age 2-5 yrs)

53 underweight

(≤2% wt/length 1-2 yrs; ≤5%BMI 2-5 yrs)

54 {high wt/ht (≥98% 1-2 yrs; ≥95% 2-5 yrs)}

55 at risk for growth problems

56 {slow growth}

57 small at birth dx. by MD (< 2yrs)

68 fetal alcohol syndrome

80 transfer

91 {inborn errors of metabolism*}

93 {conditions that affect nutrition status*}

94 dental problems

Priority V

30 unhealthy diet habits (vits/min/herb/germs)

31 needs diet guidance

35 limited diet (vegan/highly restrictive)

36 improper bottle or cup use (list specific practice)*

37 inappropriate feeding practices (list specific practice)*

63 prevention

66 at risk for poor diet (ltd ability re feeding decisions)

67 needs WIC services

95 homeless or migrant

96 foster care (entered or changed within 6 months)

Ohio Department of Health WIC Program Application

Please answer all questions on this page.

A. Parent, guardian or applicant's name		Telephone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Leave message		
Street address	City	State	ZIP	County
Mailing address (if not the same as street address)	City	State	ZIP	

B. In the section below please list everyone who is living in your home, including yourself.

1. Full name—first, middle, last		Relationship to you SELF	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /	
2. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /	
3. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /	
4. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /	
5. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /	
6. Full name—first, middle, last		Relationship to you	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth / /
Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American	If pregnant: number of unborn babies	Due date / /	
C. If anyone in your home is pregnant, is she under a doctor's care? If yes, what is the doctor's name? <input type="checkbox"/> Yes <input type="checkbox"/> No				
D. Has anyone in your home had a pregnancy that ended within the last six months? If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No				
E. Is anyone in your home breastfeeding a baby less than 12 months old? If so, who? <input type="checkbox"/> Yes <input type="checkbox"/> No				

F. Please check Yes or No if anyone in your home is receiving any of the following:

Ohio Works First Cash <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?	Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?	Food Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who?
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For each person in your home who has any income such as wages, self-employment, unemployment, SSI, Social Security, VA pension, workers compensation, alimony, child support, lump-sum payments, please complete the lines below.

Name	Name of income source	Gross amount	How often received
		\$	
		\$	
		\$	

By signing this WIC application, I agree to give proof of eligibility for information entered on this form and any other information asked to meet program rules.

I authorize any person who furnishes me with health care or medical supplies to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided to me under the Medicaid, WIC, and other medical assistance programs.

I also authorize the Ohio Department of Health, the Ohio Department

of Medicaid, and the Ohio Department of Job and Family Services to exchange any information I have provided on this form to enable the departments to determine my eligibility.

I understand that this application is considered without regard to race, color, national origin, sex, age, or disability.

By my signature below, I affirm under penalty of perjury that to the best of my knowledge and belief all the answers on this application are true and complete. I understand that the law provides penalty of fine or imprisonment (or both) for anyone convicted of accepting assistance he or she is not eligible to receive.

Signature of applicant who completed this form	Date of signature
Signature of person who helped complete this form	Date of signature

AGENCY USE ONLY

Pregnancy Verification

☐ Medical statement attached

Medical chart location (office name)	Patient name and number	
Telephoned (name)	Agency/Business	Call date
Verification statement		

Identification Verification

Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Name (Circle one— I C P N B)	<input type="checkbox"/> Present <input type="checkbox"/> Exempt	Document type or number
Medical chart location (office name)		

Income Verification

☐ Verification attached (county department of job and family services, employer, other agencies)

Check those that apply <input type="checkbox"/> OWF <input type="checkbox"/> Disability Financial Assistance <input type="checkbox"/> Food Assistance <input type="checkbox"/> Medicaid <input type="checkbox"/> Refugee		Economic unit size
Card number <input type="checkbox"/> Benefits Notice/Printout <input type="checkbox"/> Provider Information Line <input type="checkbox"/> MITS or EBT Portal		Effective date
Verification statement used (document/check stub/letter) <input type="checkbox"/> Yes <input type="checkbox"/> No	Statement date	Income amount \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly
Telephoned (name)	Agency/Business	Call date
Confirmed or other information 		
Proof of Residence <input type="checkbox"/> Ohio License/ID <input type="checkbox"/> Utility/credit bill <input type="checkbox"/> WIC Reminder Card <input type="checkbox"/> Medical card/JFS document <input type="checkbox"/> Other _____		
WIC personnel signature		Date