Ohio WIC Policy and Procedure Manual

July 2015

OHIO DEPARTMENT OF HEALTH
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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 301Authorized 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 for1-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 331Instructions 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

CHAPTER 100

100. Introduction to Chapter 100 – Administrative Requirements

In order to effectively administer a WIC grant, knowledge of general management procedures, State directives, and financial responsibilities are needed to target staffing and clinic resources toward the optimal service of WIC participants. WIC services must be provided within the specific context of the community served, and WIC projects must demonstrate an ongoing mechanism of communication and coordination with local healthcare entities and participants.

This chapter provides policies and procedures necessary for administration of a local WIC project and grant. The policies and procedures presented in this chapter must be used by local WIC projects to successfully obtain, manage, monitor, and sustain a WIC grant. Title 7 of the Code of Federal Regulations Parts 246.1-9, 246.14-17, 246.19-20, and 246.24-28 serve as the regulatory basis for the information in this chapter. In addition, Food and Nutrition Service (FNS) Instruction Letters and WIC Policy Memorandums and the Ohio Department of Health Grants Administrative Policies and Procedure (OGAPP) Manual were used in the development of this chapter.

The general organization of the Administrative Requirements chapter is as follows:

- Sections 101 through 102 describe the purpose and goals, organizational structure, and policy and procedure directives of the Ohio WIC program.

- Sections 103 through 105 are reserved for policies for the application and selection of local WIC projects (subgrantee agencies). Included in this area will be the process for ODH grant application and approval and the selection criteria utilized by the State WIC agency. Policies governing the use of subcontracting agencies will be included. too.

- Sections 106 through 107 describe policies and procedures for the financial management of a local WIC project. Description of the ODH Grants Services Unit (GSU) budgets, expenditure reporting, inventory procedures, contractual information, allowable costs, program income, calculation of cost per participant, computer equipment repair or replacement, conference or continuing education requests are listed.

- Sections 108 through 109 provide policies for reporting requirements, record retention, and correspondence with the State agency. Section 110 is reserved.

- Sections 111 through 114 describe policies for civil rights requirements, clinic sites, staff recruitment, job responsibilities, and required staff training.

- Sections 115 through 116 describe policies for State agency monitoring of local projects through the Management Evaluation process.

- Section 117 provides policies and guidelines for caseload management, Sections 118-119 are reserved, and Section 120 provides guidance for outreach and use of social media, use of the WIC Advisory Council, and community referral activity. Section 121 is reserved.

- Sections 122 through 124 list policies regarding confidentiality of participant information, requests for fair hearings, and abuse of program rules by participants.

- Sections 125 through 127 are reserved to include policies for WIC system care, local projects awards, and ordering State produced materials.

- Section 128 describes the disaster plan.

101. State WIC Organization, Functions and Responsibilities

The Bureau of Health Services (BHS) State WIC office is responsible for providing regulation and oversight governing the use of WIC funds for serving an assigned caseload of WIC participants in the state of Ohio. The State office performs this function through use of policy and procedure manuals, monitoring visits, state trainings and meetings, coordination with state-level maternal and child care entities, ongoing technical assistance, and a centralized office staff.

101.1 WIC Mission and Goal

The WIC program serves income eligible pregnant, breastfeeding, and postpartum women, infants, and children up to age five who are at risk due to inadequate nutrition, health care, or both. The goal of ODH in releasing funds for the WIC program is to protect and improve the health status and prevent health problems and promote good health within this population. This is accomplished through provision of a health and diet screening; individual and group nutrition education sessions; breastfeeding education and support; referral to prenatal and pediatric health care and other maternal and child health and human services programs; and provision of supplemental, highly nutritious foods.

101.2 State WIC Table of Organization

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is 100 percent federally funded in the state of Ohio through the United States Department of Agriculture, Food and Nutrition Service, Special Nutrition Programs Division. The BHS State WIC office resides in the Office of Health Improvement and Wellness within the Ohio Department of Health (ODH). Located in Appendix 100 are the Tables of Organization for the Ohio Department of Health, Office of Health Improvement and Wellness, and BHS WIC program.

The line of authority can be traced from the Director of Health to the Chief of the Office of Health Improvement and Wellness to the Chief of BHS. Within the BHS WIC program, authority is split among the Executive Office, Program Integrity, Program Development/Data Operations, Vendor Management, Nutrition and Administrative Services, and Program Analysis Units.

1. **BHS Chief**
   The BHS Chief manages and directs the State WIC office and serves as the liaison to the USDA Midwest Regional Office, National WIC Association (NWA), and other interstate WIC agencies, and as liaison to ODH and other intrastate agencies as assigned.

2. **Executive Office**
   The BHS Chief and Executive Office staff perform duties that include coordination and development of statewide policies and procedures; completion of the annual State WIC Plan of Operations and materials to obtain the State WIC grant; management and monitoring the USDA WIC grant to Ohio; State office staff training; compilation of weekly, monthly, and ad hoc federal and state reports; preparation and coordination of all program media, legislative, and public relations activities; administration of the Farmers' Market Nutrition Program (FMNP) grant; and bureau representation on inter- and intra- departmental committees and meetings.

   This office is a clearinghouse for incoming and outgoing correspondence, and acts as a liaison with various governmental, business, and nonprofit organizations including USDA, the United State Department of Health and Human Services, National WIC Association, Children's Defense Fund, the Ohio Senate and House of Representatives and the United States Congress and Senate through the ODH Office of Government Affairs, infant formula companies, retail and WNC vendors, etc.

   The Executive Office is responsible for ensuring that decisions are made for the overall good of the program and take into account the needs and interests of program participants as well as the local WIC projects which serve them. Decisions on issues which have or may have far-reaching effects or consequences throughout ODH and/or the state are channeled by the BHS Chief to the chief of the Office of Health and Wellness Services and ultimately the ODH director for consideration and final approval.

3. Program Integrity Unit

The Program Integrity Unit is responsible for integrity initiatives related to participants and vendors, and the overall planning, implementation, and operation of the statewide Ohio Farmers' Market Nutrition Program (FMNP).

The Program Integrity Unit performs the following duties: coordination of retail vendor compliance activities including compliance buys, inventory audits, coordination with law enforcement entities, and the resulting sanctions and administrative reviews; coordination of participant compliance including monitoring of social media websites and participant claims resulting from fraudulent program activities.

4. Nutrition and Administrative Services (NAS) Unit

The Nutrition and Administrative Services Unit performs the following duties: developing, implementing, and interpreting statewide policies and procedures; reviewing local projects' grant requests; evaluating local projects; monitoring data as related to local project functions; providing technical assistance and training to local WIC staff; coordinating biannual directors meetings for state and local WIC staff; administering breastfeeding peer helper and pump programs; and developing nutrition and breastfeeding education materials. A consultant is assigned from the NAS unit as a direct contact to each local WIC project to answer questions, provide technical assistance, monitor local functions, and evaluate progress.

5. Program Development/Data Operations Unit

The Program Development Unit performs the following duties: providing a variety of technical assistance (e.g., set up kiosks and WIC systems) and training to local WIC staff (e.g., certification system and support staff); preparing outreach plans and materials; writing and implementing statewide policies and procedures concerning system and outreach; developing and coordinating the Authorized Foods List; coordinating the literacy initiative and translating printed materials.

Data Operations includes the Help Desk staff. Help Desk staff answers all system-related questions from the local projects. The following duties are also performed by this section: serves as the data resource section; researches and determines technological upgrades to system operations; resolves problems regarding daily operating system activities; serves as data steward,

and prepares and verifies all data requests; and is the liaison to the ODH Bureau of Information Technology and contractual system partners.

6. Vendor Management Unit

The Vendor Management Unit is responsible for planning, developing, and implementing policy and procedure for food benefits redemption, vendor payments, and vendor monitoring components of the WIC program.

The Vendor Management Unit performs the following duties: conducts vendor training; mediates and resolves vendor problems/contract disputes; prepares vendor contracts; conducts compliance and fraud investigations; and reviews, implements, and interprets vendor rules. A vendor specialist is assigned from this unit to each local WIC project to answer questions, provide technical assistance, and monitor local functions as related to vendor activities. A vendor specialist is also assigned to answer questions and resolve problems for each vendor.

7. Program Analysis Unit

The Program Analysis Unit oversees the analysis and preparation of potentially eligible figures, caseload distribution, grant allocation and expenditures, project participant activities (cost per participant, staffing, etc.), and food obligation projections; analyzes cost impact of alterations/additions to WIC food packages; and prepares infant formula, infant cereal, and infant foods rebate bids and bills monthly for rebate payments.

102. State Directives

The State WIC office provides direction to local WIC projects through several documents to communicate policies, procedures, guidelines, rules and information. It is the local project director's responsibility to orient all staff members to the WIC Policy and Procedure Manual, System and Cognos User Manuals, and Retail Vendor Manual as appropriate. WIC directors must also inform all staff members, as appropriate, of the contents of All Projects Letters, Policy and Procedure Letters, and other communications as well as to implement any actions required.

102.1 Policy and Procedure Manual and Policy and Procedure Letters

The WIC Policy and Procedure Manual (PPM) is the primary program operating tool used by the local WIC project to direct, supervise, and review WIC service delivery. The PPM is issued on a compact disk and must be loaded into the WIC System in each project by the local director.

The Policy and Procedure Letter (PPL), the first item on every PPM disk, provides a summary of all changes being made, or an introduction to the new material being released. State WIC updates the electronic PPM as needed by providing an electronic PPL contained in a new, fully updated PPM disk. A copy of the current disk and each obsolete disk must be filed and kept for audit purposes at the local director's office.

102.2 ODH Grants Administration Policy and Procedure (OGAPP) Manual and Updates

The OGAPP Manual is the primary operating tool for financial management of grants awarded by the Ohio Department of Health. The manual contains the policies, procedures, rules, and regulations for the preparation of all subrecipient applications. Periodic updates are announced on the Grants Management Information System (GMIS) Bulletin Board. The manual is available on the ODH web-site at:

http//www.odh.ohio.gov/about/grants/grants.aspx

Click on OGAPP Manual V100-2

102.3 Certification System and Cognos User Procedure Manuals

The Certification System User Procedure Manual contains the procedures for operating the WIC computer system. The WIC Certification System User Procedure Manual is the primary operating tool for the local WIC project to authorize WIC participants' eligibility on the WIC system and provide benefits. Each WIC clinic has access to a Certification System User Procedure Manual under the help tab in the certification system.

The Cognos User Manual contains procedures for accessing data and reports from all Ohio WIC clinics. Directors are encouraged to use this tool to access individual clinic and project data and compare to others across the state. The Cognos User Manual is found on the clinic L drive.

102.4 Retail Vendor Manual

The Retail Vendor Manual contains the information and procedures needed by contracted WIC vendors to participate in the WIC program. The manual includes how to process a WIC transaction, how to obtain payment, and where to receive the Authorized Foods Lists and other materials. The manual is provided to contracted vendors during local vendor training and assists WIC project directors in answering questions. The Retail Vendor Manual appears in Appendix 300.

102.5 All Projects Letters

All Projects Letters (APLs) are a means by which the State WIC office informs local projects of important information relating to a variety of topics including report deadlines, caseload management, nutrition updates, and funding information. Information contained in these letters may contain draft or pilot project policy pending USDA and ODH approval.

APLs are sent via electronic mail (email). Directors must set up an electronic folder each year on the Administrative computer's hard drive entitled "APLS YEAR." For FY15, the folder would read "APLS 2015." As APLs are received, they are saved to this folder

as named; for example, “001 Electronic All Projects Letters.” Note that a three-digit number is assigned to each letter after the fiscal year to maintain the files in numerical sequence. Electronic APLs are sent biweekly, usually on Mondays. When a holiday falls on the Monday, APLs will be sent on the following Tuesday. Following the end of a fiscal year, a compact disk containing the APLs for the previous fiscal year will be given to each WIC director. After receiving the APL compact disk, local directors can delete the previous APL file from the hard drive of their Administrative computer. A back up plan for staff to access APLs must exist in case of director's absence.

Some physical mailings continue. Items that cannot be emailed will be noted in the text of the APL and placed in regular mail on the same day the emails are sent.

102.6 Routine Vendor Letters

Routine Vendor Letters are a means by which the State WIC office communicates important information to vendors. These letters include: Notice of Contracting in Vendor Regions; Notice of Vendor Training Dates and Locations; and program changes such as authorized foods and electronic benefits transfer. These letters are copied to local project directors and are included with APL distribution.

102.7 State Interprogram Agreements

The State WIC office may enter into written agreements with other programs and organizations for the purposes of coordination of services, outreach and referral, establishing program eligibility, verification of outcome of referral, and joint collaboration on health and nutrition goals. Examples of other programs include Medicaid, Children with Medical Handicaps, Child and Family Health Services, and Immunizations. When State interprogram agreements are entered into or updated, they will be shared with local WIC projects through All Projects Letters and will appear in the Ohio WIC State Plan of Operations.

102.8 Local WIC Project Calendar

The State WIC office issues an annual Local WIC Project Calendar. The calendar consists of a summary of activities by month including meetings, due dates for reporting, scheduled training dates, and State WIC holidays. The calendar provides the quarterly reporting due dates as specified in the WIC grant application.

Not all local projects participate in all items listed, such as the Nutrition and Breastfeeding Advisory Committee (NBAC); these activities are included in the calendar to keep all local WIC projects informed. Project directors should be aware of these dates and plan workflow accordingly.

103 Reserved

106. Grants Administration Fiscal Requirements

This section provides information for meeting ODH grants administration fiscal requirements in conjunction with WIC program financial requirements.

106.7 WIC Equipment Inventory Requirement

A full inventory of all equipment purchased in whole or in part with any WIC funds must be maintained continuously, and, during each, even fiscal year it must be submitted with the fourth Quarterly Activity Report (QAR). Equipment purchased with ODH grant funds must be tagged as property of WIC or ODH for inventory control. The tags must match the inventory report. Such equipment may be required to be returned to ODH at the end of the grant program period.

Complete the biennial inventory using the electronic *Equipment Management System* spreadsheet and Instructions in Appendix 100. The form must be submitted electronically via the Grants Management Information System (GMIS).

107. Additional WIC Operational Requirements

WIC subrecipient agencies must comply with certain operational requirements in addition to the requirements detailed in the Ohio Department of Health Grants Administration Policy and Procedure Manual (OGAPP) and the Subrecipient and Subcontracting Memorandums of Agreement.

107.1-107.7 RESERVED

107.8 Equipment Purchases and Repairs

To purchase equipment, defined by the OGAPP Manual as an item costing $1000.00 or more per unit, the local WIC project must have a line item in the Equipment section of an approved budget and prior written approval from the State WIC office. To obtain State WIC approval, the local project submits a completed *WIC Equipment Request/Repair Approval Form* to the Nutrition and Administrative Services (NAS) Unit. This form is found in the Chapter 100 Appendix.

To complete the *WIC Equipment Request/Repair Approval Form,* the project enters information regarding the agency's purchasing policy and/or three price quotations for the applicable equipment. The project must provide written justification for the purchase. Additional justification is required if the project does not intend to accept the lowest price. Subcontracting projects complete the Form and send it to the subrecipient project for an approval signature. Only the subrecipient project may send approved requests to the State WIC office NAS Unit.

Communications systems, such as telephone answering machines, answering services, voice mail, fax, paging systems and WATS lines, also require a line item in an approved budget and prior written approval by State WIC. The local project obtains three price quotations and submits a completed *WIC Equipment Request/Repair Approval Form*.

Equipment repairs require a line item in the Other Direct Costs section of an approved budget, and costs in excess of $1000.00 require prior written approval from State WIC using a completed *WIC Equipment Request/Repair Approval Form.* Maintenance costs for WIC equipment are also allowable when included in an approved budget; costs in excess of $1000.00 require written approval from State WIC using the completed

WIC Equipment Request/Repair Approval Form. All repairs to non-WIC owned and shared equipment require a line item in an approved budget and prior written approval from State WIC using the completed *WIC Equipment Request/Repair Approval Form*.

All computer-related software and equipment, regardless of cost, require a line item in an approved budget and prior written approval from State WIC before purchasing using the completed *WIC Equipment Request/Repair Approval Form*. All system-related equipment malfunctions must be reported to the WIC Helpline, which will determine details of how the repair is to be made. Local WIC projects should routinely include funds for repair/maintenance of system equipment in the WIC budget.

108. Administrative Reporting Requirements

The following subsections provide a list of administrative reports that are required to be completed by local WIC projects. Some reports must be submitted to the State WIC office in addition to being kept on file at the local project.

108.1 WIC Time Study

Each local project employee paid with any WIC funds, including contract, split-funded, and part-time personnel, is required to complete a time study annually. The purpose of the time study is to document employee time in the categories of nutrition education, clinic services, breastfeeding, breastfeeding peer helper, and administration. The time study results assist local project directors in determining staffing needs for the next fiscal year and ensure compliance with federal requirements for adequate expenditure of funds in the categories of nutrition education and breastfeeding. Copies of the WIC Time Study or Monthly Time and Activity Report and WIC Time Study Flow Sheets or an approved substitution form must be kept on file in the local project for each person included on the WIC budget. The results of the time study must be reflected in the budget for the fiscal year following time study reporting.

If there are days during time study reporting when activities are performed that are out of the ordinary or the day is not a typical work day, then this must be noted in the comments area of the WIC Time Study or Monthly Time and Activity Report. If using an approved locally developed form, make a note on the form. For example, if a clerk is on vacation during the time study period and a health professional spends more time than usual in clinic services, record this in the comments section. The director’s use only box must be completed if the director needs to change the NCBA breakdown. Include a justification for the change.

If a position is created or changed, the WIC Director should contact the Nutrition and Administrative Services (NAS) Consultant. A new time study may need to be completed for the new position or the current time study may need to be adjusted. When vacant positions are filled, new employees should not complete a time study until they have been in the position for at least six months. The time study that was completed by the former employee in that position may be used until the next time study period. The NCBA breakdown on the time study should always match the NCBA breakdown on the budget.

The WIC Time Study Flow Sheet and the WIC Time Study or Monthly Time and Activity Report, along with accompanying directions, are located in the Appendix to Chapter 100. A list of the WIC Budget Categories and associated activities is also located in the Appendix.

There are three ways to comply with the requirement to complete the WIC time study.

1. Staff who works exclusively in WIC must complete an annual WIC time study.

    - Employees must document WIC hours worked for two consecutive weeks during the months of January or February.

    - Select two weeks which are typical work weeks when no sick, vacation, personal, or other leave is planned. If the project director knows that there are not two consecutive weeks during January or February that are typical, the project may request prior approval from the State WIC office to conduct the time study at another time.

    - Record time spent on activities during the day on the WIC Time Study Flow Sheet and write in the accurate time spent in each of the categories – nutrition education, clinic services, breastfeeding, breastfeeding peer helper, and administration. For example, each time an activity begins, the activity is recorded along with the time it begins. When the activity ends, the time is again recorded.

    - Employees that receive paid time for breaks must include the break time as part of the previous or next activity performed before or after the paid break time. If an employee takes less than four hours off during the time study, this time may be recorded as administration time. When more than four hours of time is taken as leave, the time must be made up at the end of the consecutive two weeks by recording the appropriate amount of time missed during the time study.

2. Temporary employees, split funded staff, or staff who work on an as needed basis must complete the WIC Monthly Time and Activity Report each month. The exception with split-funded staff is that those who have clearly defined, 100% WIC time on specific days of the week and clearly defined non-WIC time on specific days may complete a two week time study.

    - Record time spent daily in each category on the WIC Time Study or Monthly Time and Activity Report.

- Tally the information on this sheet monthly and capture the employee's and the supervisor's signatures. The Monthly Time and Activity Report must have at least six months of recorded activities in order to average out the number of hours normally worked in a one week time period.

3. Local projects may request prior approval from the State WIC office to use forms other than the WIC Time Study Flow Sheet and the WIC Time Study or Monthly Time and Activity Report. The WIC Director must keep the approval letter from State WIC on file for all evaluations and audits. If local forms are approved for use, they must document employee time and activities in the categories of nutrition education, clinic services, breastfeeding, and administration.

Breastfeeding Peer Helper Program Time Studies

The breastfeeding peer helper program must document time spent in direct supervision of peers and the peers must document their time providing breastfeeding peer services. Based upon the time study definitions, it is possible for a peer helper's daily time study to reflect peer helper breastfeeding (PHB) time and administration time. Since a peer's salary is paid with only peer helper breastfeeding funds, it is necessary for directors to adjust the time study breakdown. If a peer's time study has time other than peer helper breastfeeding listed, the director must use the "For Director's use only" section and document all of the peer's time in "PHB hours" and complete the justification. While peer time is documented separately from breastfeeding hours on the Time and Activity Report, this time must be included as total breastfeeding time when budgeting for the WIC grant (NCBA).

108.2 WIC Quarterly Activity Report

All projects must complete the WIC Quarterly Activity Report (eQAR Required Forms file) and submit it to State WIC via the Grants Management Information System (GMIS) by the 15th of the month following the end of the quarter. Projects must continue to verify submission on GMIS. The eQAR Required Forms file includes the WIC Quarterly Activity Report and the Quarterly Breast Pump Report (titled Ohio WIC Program State Supplied Pump and Kit Issuance), found in Appendix 100 as well as the Quarterly Breastfeeding Peer Helper Activity Report, found in Appendix 400.

The Quarterly Activity Report includes data from the local project on food issuance and breastfeeding rates. It also includes information on follow-up contacts for breastfeeding support, nutrition education plan progress and any other information which the local project would like to share with State WIC.

The Quarterly Breast Pump Report (titled Ohio WIC Program State Supplied Pump and Kit Issuance) is a part of the WIC Quarterly Activity Report. This form is used to provide State WIC with an accounting of all breast pumps and kits issued by the local project. The Sample Breast Pump Worksheet is an optional form and can be used as a log to assist in the completion of the Ohio WIC Program State Supplied Pump and Kit Issuance form. The Sample Breast Pump Worksheet is not a required form and is not to be submitted as part of the eQAR. It can be used as a log to assist in the completion of the Ohio WIC Program State Supplied Pump and Kit Issuance form and can be revised to suit local project needs for pump data collection.

The Quarterly Breastfeeding Peer Helper Activity Report is part of the WIC Quarterly Activity Report required forms. This form is used to provide State WIC with information regarding peer activities such as contact with women participants, hospital or home visits, and referrals made.

The projects are also provided with an optional electronic file (eQAR Optional Forms file) which is to be submitted to State WIC as necessary. This file includes the Certifying Health Professional/Breastfeeding Coordinator Resume, Breastfeeding Peer Helper Resume, and the Sample Breast Pump Worksheet. All of these forms can be found in Appendix 100.

The following instructions must be used to complete and submit the Quarterly Activity Report.

A. <u>Instructions for Use of eQAR Files</u>

1. Open the file that you would like to work on (either eQAR Required Forms or eQAR Optional Forms).

2. Save the file with the blank forms onto your hard drive ("Save As" to C drive).

3. Fill out your project's data on the blank form and then complete a "Save As" function and name the file by identifying the fiscal year, quarter and project (for example, FY12 First Quarter QAR Adams Brown). Save this file on your hard drive also.

~~4.~~ Attach the completed form to the comments section under program reports in GMIS.

When completing the Quarterly Activity Report, please refer to the eQAR Instructions found in Appendix 100.

The file "eQAR Required Forms" needs to be submitted and verified in GMIS.

The file "eQAR Optional Forms" should be completed only as needed. The Certifying Health Professional/Breastfeeding Coordinator Resume and Breastfeeding Peer Helper Resume need to be submitted only if you have information to report. To submit the eQAR Optional Form, save the file to your hard drive as the blank form. Use that copy to fill out only the forms you need to submit and remove the unwanted forms. Then submit as an attachment in GMIS.

B. Instructions for Submitting the eQAR in GMIS

1. Log on to the ODH Application Gateway (https://odhgateway.odh.ohio.gov)
2. Select GMIS.
3. Click the "select" button beside the applicable program for the current grant year.
4. Click "Continue on to Worklist."
5. Click on the "Project" tab.
6. Select "Program Report" from the drop down list.
7. Select "Comment" next to the applicable reporting period
8. Select "New."
9. Enter in the fiscal year, quarter, project, and report title/supporting document name.
10. Click "Browse" and select the QAR to be attached.
11. Click "Upload."
12. Click "Save."

Only one attachment can be uploaded per comment. To attach additional reports or supporting documentation, repeat steps 7 through 12 for each additional document.

C . Verifying eQAR Program Report Submission in GMIS

1. Log on to the ODH Application Gateway (https://odhgateway.odh.ohio.gov)
2. Select GMIS.
3. Select applicable program title from the list.
4. Click the "Select" button beside the applicable program for the current grant year.
5. Click "Continue on to Worklist."
6. Click on "Reports" tab.
7. Select "Program Report" from the drop down list.
8. Click "Check Box" next to appropriate reporting period.
9. Click the "Approve/Submit" button.
10. Log off the GMIS system.

109. Record Retention Requirements

Local projects must maintain WIC records so that auditors, state and federal evaluators, and participants can have access to them when necessary. The records and documents listed below must be retained for the specified time period following the end of the fiscal year in which the item pertains, unless otherwise noted.

If any litigation, claim, negotiation, audit, or other action involving WIC records or documents has begun before the end of the retention period, the records must be kept until all issues are resolved or until the end of the retention period, whichever is later. The record retention policies must be followed whether an agency is currently a WIC subgrantee or subcontracting agency, or if the agency is no longer a WIC subgrantee or subcontracting agency.

109.1 General Administration Records

1. The following records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains:

    - Grant applications and conditions
    - Advisory committee files (minutes and membership)
    - Staff meeting minutes
    - State/federal correspondence (All Projects Letters, Policy and Procedure Letters, etc.)
    - Program Activity Reports
    - Show Rate and Instruction Worksheet or other NAS approved show rate documentation.
    - Subpoenas and search warrants
    - Written job orientation plans for new health professionals
    - VENA Training and Observation Summary form

2. The following records must be maintained for one year from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains:

    - Current outreach files (copies of letters mailed to physicians, churches, day care centers; copies of locally developed fliers, posters, Tell A Friend cards, placemats; approval letters of locally developed materials; photographs or other examples of documentation of outreach activities; etc.)
    - Documentation of calibration of hematological equipment
    - The most recent obsolete Policy and Procedure disk.

109.2 Financial Records

The following records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains:

- Quarterly Expenditure Reports
- Final Expense Reports
- Approved Project Budgets, Project Budget Revisions, and all supporting documentation (canceled checks, contract copies, insurance policies, receipts, purchase orders, equipment/inventory lists, Equipment and Nutrition Education Request forms, etc.)
- General Ledgers
- Time and Activity Reports (Time Studies)
- Certificates of Attendance/time cards
- Travel vouchers
- System Inventory

It is not necessary to keep equipment/property records, including inventory lists, for more than three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains.

109.3 WIC System Records

1. The following records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains:

    - Automated Response System (ARS) Report when used as the **only** proof of an appointment reminder

2. The following computer report must be maintained for one year:

    - Participation by Priority and Category Report

3. These reports need to be maintained for nine months from the original date of issuance. The nine month time frame from the original date of issuance ensures adequate time for the three months of food instruments issued on any given day to be reconciled and become part of payment files.

    - Food Instrument Stubs

    All food instrument stubs must be maintained for nine months. This includes signed food instrument stubs, voided food instrument stubs, and mailed food instrument stubs. Staff must mark mailed food instrument stubs “mailed,” and

initial and date the mailed food instrument stubs.

4. All other computer generated reports, particularly those reports used as an internal reporting system, may be kept on an as-needed basis. Following is a list of some of these documents.

   - Termination Report
   - Purge Report
   - Participants Currently Certified Without Current Food Benefits
   - Ineligible Report
   - Wait List Report
   - Immunization Reports
   - Racial/Ethnic Report
   - Automated Response System (ARS) Report when not the only proof of an appointment reminder
   - Mailing Registers
   - Redemption Cost Report

109.4 Vendor Records

The following records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains:

- Vendor complaints
- Participant complaints
- Vendor Site Visit Checklist
- Vendor error letters
- Training Sign Out Sheets
- Letters to vendors giving notice of training date
- List of all contracted vendors (provided by State WIC office)

109.5 Participant Records

1. The entire contents of initially ineligible, terminated, and wait listed participant records must be kept for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains.

2. The Ohio Department of Medicaid (ODM 07216) *Application for Health Coverage & Help Paying Costs* form received as a referral and the applicants decline WIC services or cannot be contacted, must be kept for one year from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains.

109.6 Waiting Lists

All Waiting List information must be kept for a period of three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains.

109.7 Fair Hearing Files

The full contents of the Fair Hearing files must be kept for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains. Refer to the section for Fair Hearings for complete information. Fair Hearing files are not filed with participant records.

109.8 Nutrition Education Reports/Evaluations

1. The following records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains:

   - Group Nutrition Education Attendance records
   - High-Risk Plan

2. The following records must be maintained for one year from the date of the Submission of the Final Expense Report for the fiscal year to which the item pertains:

   - Lesson plans including any authorization of non-WIC midcertification nutrition education forms and the current Master Nutrition Education Schedule, which reflects the future three scheduled months of nutrition education classes
   - Nutrition Education Materials file (current materials and evaluation checklists and non-English nutrition education materials)
   - Central Log for returned or donated formula
   - *Ohio WIC Program State Supplied Pump and Kit Issuance Only*
   - *Ohio WIC Loaned/Single-user Electric Breast Pump Survey*

109.9 Record Retention Examples

The following examples may be helpful in determining the length of time records must be kept.

- A participant is terminated in July 2004. Participant records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains. The file must be retained until November 15, 2007 (Final Expense Report submitted = November 15, 2004 + three years = November 15, 2007).

- A centrifuge, worn out beyond repair, is discarded on November 22, 2003. Financial records must be maintained for three years from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains. Records of the purchase and the inventory list must be kept until November 2007 (Final Expense Report submitted = November 15, 2004 + 3 years = November 15, 2007)

- A Purge Report is dated July 2004. The local project director determines the retention time period.

- A Central Log for returned or donated formula with the last date of issuing formula as January 26, 2004. Central logs must be maintained for one year from the date of the submission of the Final Expense Report for the fiscal year to which the item pertains. The log must be maintained until November 15, 2005 (Final Expense Report submitted = November 15, 2004 + 1 year = November 15, 2005).

- An individual participant survey dated May 2004. Individual participant surveys must be maintained for one calendar year. The survey must be retained until May 2005 (one calendar year).

109.10 WIC Record Retention and County Retention Requirements

Section 149.38 of the Ohio Revised Code requires that counties have records review and retention committees and also has the reference to review by the Ohio Historical Society. The Historical Society's review is dependent on whether the record is deemed to be a public or private document. In the case of a WIC participant record, Section 246.26 (d) provides the rule by which a participant's record is considered a private record. This is the section on "Confidentiality" in the WIC program. Therefore, a WIC participant record is a private record and is not subject to review by the Historical Society.

The section of the Ohio Revised Code noted above provides the authority for the committee to establish record retention schedules in its respective jurisdiction. All records, both public and private, are subject to these schedules. It is possible that a committee may establish a longer retention period than is required in WIC. The grantee agency should consult with its legal counsel or the County Records Committee to become familiar with the record retention schedule in the community. The grantee may also wish to make the committee aware of the WIC record retention requirements; due to storage cost considerations, etc., the committee may not want to have a local rule which requires that WIC records be kept longer than they have to be kept.

110. Reserved

111. Civil Rights

The U.S. Department of Agriculture prohibits discrimination in all of its programs, and, specifically, in the WIC program and its respective activities on the basis of race, color, national origin, sex, age, or disability. A public notification system is required to inform applicants, participants, and potentially eligible persons of program availability, program rights and responsibilities, nondiscrimination policy, and filing of complaint procedures. The following subsections provide guidance to ensure nondiscrimination and equal access in the Ohio WIC program with specific references to *Civil Rights Compliance and Enforcement - Nutrition Programs and Activities FNS Instruction 113-1,* which is provided in Appendix 100.

111.1 Nondiscrimination Statements

All information materials, sources, and web sites used by State WIC, local projects, or other subcontractors to inform the public about the WIC program must contain a nondiscrimination statement. The required English statement is:

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

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

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

USDA is an equal opportunity provider and employer.

The required Spanish statement is:

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 (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.

When the material is too small to permit the full statement to be included, the material must, at a minimum, include the statement in print size no smaller than the text.

English: **USDA is an equal opportunity provider and employer.**

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

A nondiscrimination statement is not required to be imprinted on items such as cups, buttons, magnets, and pens that identify the WIC program when the size or configuration make it impractical. In addition, recognizing that radio and television public service announcements are generally short in duration, the nondiscrimination statement does not have to be read in its entirety. Rather, a statement such as "WIC is an equal opportunity provider" is sufficient.

Nutrition education and breastfeeding promotion and support materials that strictly provide a nutrition message with no mention of WIC are not required to contain the nondiscrimination statement.

111.2 "And Justice for All" Poster

The nondiscrimination statement must also be prominently displayed in every WIC clinic through the posting of USDA's "And Justice for All" poster. These posters are provided by the State WIC office when updated and issued by USDA.

111.3 Limited English Proficiency

"Reasonable" efforts must be taken to provide access and service to Limited English Proficiency (LEP) applicants and participants. Among the "reasonableness" factors to consider are: (1) the number of LEP persons eligible to be served or encountered; (2) the frequency LEP persons contact the program; (3) the nature and importance of the program, activity, or service provided; and (4) the resources available to the project versus costs. Materials have been developed and issued in Spanish (see Appendices of the PPM) and telephone translation services are available daily.

111.4 Equal Opportunity for Religious Organizations

USDA encourages the participation of faith and community based organizations on an equal footing with other kinds of local cooperating organizations and avoids barriers that would make participation difficult. Religious organizations that participate in USDA programs retain their independence to carry out their mission, provided that direct USDA funds do not support any inherently religious activities such as worship.

111.5 Assurances

Ohio's annual State Plan of Operations and federal financial application is accompanied by required written assurances that the WIC program will operate in

compliance with all nondiscrimination laws, regulations, instructions, policies, and guidelines. Similar assurance statements appear in the retail vendor contract and the local project and ODH request for proposals.

111.6 Civil Rights Training

Each WIC staff person must receive annual civil rights training with topics that include: collection and use of data, public notification, complaint procedures, compliance review, noncompliance and conflict resolution, reasonable accommodation for disabilities and LEP, and customer service. Records of the training must be maintained either by a training sign-in sheet or meeting minutes, must identify the staff trained, and must be kept according to section 109.1, *General Administration Records*. A *Civil Rights Compliance Training* program on compact disk has been provided for meeting this requirement. In addition, the *Customer Service Standards* section 120.4 is a helpful resource and reference.

111.7 Collecting and Using Data

The WIC Certification system provides for collecting and maintaining required racial and ethnic data. These data help determine how effectively the program reaches potential eligible persons and participants, identify where outreach is needed, assist in selection of locations for compliance reviews, and completing reports.

Self-identification by the participant at the time of certification is the preferred method of obtaining data. Participants must be asked to self-identify their racial and ethnic categories, but only after it has been explained and they understand that the collection has no effect on the determination of their eligibility to participate in the WIC program.

When the participant does not provide racial and ethnic information, the staff must obtain the information through visual observation and record it as observed. Selection of one race is acceptable when local agency staff performs visual identification.

Two ethnic categories are established and one must be selected:

- Not Hispanic or Latino
- Hispanic or Latino – applies to a participant of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Five racial categories are established and one or more may be selected:

- Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- American Indian or Alaskan Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

- Black or African American - A person having origins in any of the black racial groups of Africa.

- Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

111.8 Compliance Reviews

Required civil rights compliance reviews are conducted as part of the biennial local management evaluation. Local review criteria are provided in the WIC Onsite Review Guide in Appendix 100.

111.9 Noncompliance Resolution

A finding of noncompliance may be the result of a routine management evaluation, a special review, or an investigation in which a civil rights requirement, as provided by law, regulation, policy, instruction, or guideline, is not being met. Once noncompliance is determined, written notice and corrective action must be provided immediately to obtain voluntary compliance.

If corrective action is not made within 60 days of notice, the USDA regional office must be notified with specific documentation. If voluntary compliance cannot be obtained with USDA regional office help, then various levels of reporting to the USDA Office of Civil Rights with opportunities to resolve the problem must be taken.

The detailed steps Ohio WIC follows are outlined in FNS Instruction 113-1 pages 26-29 in Appendix 100.

111.10 Complaint Procedures

All complaints alleging discrimination on the basis of race, color, national origin, age, sex, or disability, either written or verbal, must be filed with USDA and processed within specific time frames in FNS Instruction 113-1 pages 29-36. The USDA Civil Rights office determines whether or not complaints will be reviewed and the manner of review.

Right to File: Any person or representative has the right to file a complaint within 180 days of the alleged action. The complainant and the entity that the complaint is filed against are encouraged to resolve the issue at the lowest possible level and as quickly as possible.

Complaints can be verbal or in writing; verbal complaints must be written by the person receiving the complaint. Ohio WIC uses the Sample Complaint form in FNS Instruction 113-1 Appendix E for complaints that are made directly at the local or State level.

Ohio WIC follows the **Guidelines for Processing Civil Rights Complaints i**n FNS Instruction 113-1 pages 30-32 and the **Procedures for Processing and Resolving Complaints of Discrimination** in pages 32-36, including time frames, referral, investigation, and resolution.

112 Clinic Sites

WIC clinic sites are places where individuals apply for and receive services. Clinics should be accessible, cheerful, clean, family-oriented, private, and conducive to learning. The *Clinic Self-Assessment Activity* form in Appendix 100 can be used to evaluate suitability.

A. Types of Clinics

- Permanent clinics are usually operated full-time, and have staff who report routinely.
- Satellite clinics are usually not operated full-time, and have staff who report only one or a few days per month.

B. Characteristics

Many factors influence the number and location of clinics which include, but are not limited to:

1. total amount and layout of space (how many participants can reasonably be served in the space/clinic flow)
2. population density (WIC-eligible population in the area)
3. accessibility (public transportation and handicap accessibility)
4. cost of space (rent, utilities, and other related costs)
    - Donated space must always be sought prior to securing space with associated costs. Rent/space allocation will not be approved for space donated to the local agency.
    - Initial approval of rent/space allocation cost does not constitute automatic renewal of contracts or agreements and approved costs are not transferable from the original site to a new or relocated site.
    - Directors must check GAPP and WIC RFP for any other applicable fiscal regulations that may affect a clinic change (i.e., fees for early termination of utility contract are not reimbursable, etc.)
5. colocation (with health and social services)
6. computer and kiosk needs (cabling requirement, number of ports, internet access, space)

7. available routine health care or service referral for all categories of WIC participants

8. safe environment for participants, staff, and property

C. Clinic Change Process

State approval is required prior to opening, moving or closing a WIC clinic. Without prior State approval, costs associated with the clinic change may be disallowed. Unless there are extenuating circumstances, the WIC director must complete and submit to the NAS consultant the *Request to Open/Move/Close a Clinic* form, found in Appendix 100, at least thirty days prior to the change.

1. Instructions to complete the *Request to Open/Move/Close a Clinic* form:
   - Call your NAS consultant for an electronic copy of the *Request to Open/Move/Close a Clinic* form. Only the electronic form is used.
   - Enter the county and clinic name.
   - Complete all sections of the form. (If any information is not available, state this.)
   - Email the completed form and any necessary attachments to the NAS Consultant.

2. State Approval:
   The return of the *Request to Open/Move/Close a Clinic* form with completed check marks serves as State WIC approval, partial approval or disapproval of the request.

113. Staff Recruitment, Job Responsibilities and Development Standards

WIC subgrantee agencies must comply with certain staffing requirements as outlined in the Request for Proposal (RFP). There are certain conditions that dictate project recruitment practices and staffing standards. Health professional recruitment must be for registered dietitians (RD, LD) licensed to practice in Ohio. All job applicants including WIC directors must be informed that they will be expected to be part of the WIC breastfeeding support team and will be expected to promote breastfeeding appropriate to their role. Language used when interviewing must convey that breastfeeding is the normal way to feed a human infant, and that the same approach will be expected of the new employee in their discussions with WIC participants. WIC directors are encouraged to recruit staff who reflects the diversity of their participants.

- Preference should be given to the best-qualified applicant who also has skills related to breastfeeding promotion and support.
- If an applicant with related training or experience cannot be found, the person hiring new WIC staff must communicate that training will be required for the development of skills related to breastfeeding education and support.

Sections 113.1 through 113.7 provide job-specific duties, trainings and meeting requirements. Section 113.8 provides direction for staff development.

113.1 WIC Director

The subgrantee must designate a WIC program director who has the authority to carry out and monitor the terms of the request for proposal.

1. Minimum Qualifications
   - Demonstrated management experience
   - 2 year degree
   - Ability to budget funds
   - Ability to forecast needs

2. Job Responsibilities
   - Administer the WIC program in the following areas:
     fiscal management, WIC Certification System, participant certification, nutrition and breastfeeding education and support, food issuance, caseload management and outreach activities, clinic and staff scheduling

- Coordinate health services and form partnerships within the community
- Conduct staff training on civil rights and confidentiality and other state-mandated topics
- Record trainings and assure minimum hours are met by dietetic technicians, four year nutrition graduates, breastfeeding coordinators, and peer helpers. May designate other personnel to perform this responsibility.
- Complete mandatory state reports in a timely manner
- Act as liaison to State WIC agency on behalf of the subgrantee
- Manage subcontractors as appropriate

3. Trainings and Meetings
   - Required: New Directors Training, biannual WIC Directors meeting, Regional Directors meetings, Conflict of Interest, Civil Rights, VENA training, WIC System Security training
   - Optional: New Health Professional Training (NHPT), Support Staff (SS) Training, Grow and Glow, Annual Hematological Competency Training, National WIC Association (NWA), Ohio Lactation Consultant Association (OLCA), Nutrition and Breastfeeding Advisory Committee (NBAC) member, regional representative and other committee memberships

4. Hiring Considerations
   - Professional background requirements:
     a) If caseload is less than 2000, the WIC director must be a health professional.

     b) If caseload is between 2001-10,000, consult with the project's Nutrition and Administrative Services (NAS) Consultant before hiring a non-health professional.

     c) If caseload is greater than 10,000, the director need not be a health professional.

   - Smaller projects may not need a full time director unless the director is also a health professional. It is strongly recommended that larger projects have a full time director. Discuss specific needs with your NAS consultant.

- Those applying for WIC director positions must be evaluated for breastfeeding knowledge and skills. Questions such as *"What is your educational background related to breastfeeding?"* or *"What is your experience helping a mother breastfeed?"* should be asked during the interview in order to gain insight into the applicant's knowledge and beliefs.

113.2 Certifying Health Professional

The subgrantee must provide services of a health professional. Dietitians, nurses and four year nutrition/dietetic graduates who completed an internship are required to have current Ohio licenses to practice.

The local agency is responsible for verifying that the credentials of staff that perform WIC certifications meet the requirements of the State WIC office and Ohio law (Dietitian and Nurse Licensure). See WIC Health Professional Hiring Guidelines in Appendix 100 for qualifications, state approval requirements, supervisory responsibilities and other relevant information.

1. Minimum Qualifications
   - It is imperative that every effort be made to recruit an Ohio Licensed Dietitian (LD) as the certifying health professional. See hiring considerations below.
   - Registered Dietitian (RD), Licensed Dietitian (LD), Registered Nurse (RN), Dietetic Technician Registered (DTR), Dietetic Technician (DT), or four year nutrition/dietetics graduate
   - Experience in maternal and child nutrition including breastfeeding education
   - Literacy and language skills appropriate to address the needs of diverse participants

2. Job Responsibilities
   - Assesses and documents a participant's nutrition risk
   - Provide nutrition and breastfeeding counseling and education that is responsive to the identified needs/interests of each participant
   - Prescribe food packages
   - Function as part of the WIC breastfeeding support team

- Teach hand expression and use of breast pumps
- Run data reports
- Optional responsibilities: function as nutrition supervisor, complete heights, weights and laboratory work, serve as breastfeeding coordinator (BFC) or peer helper coordinator, develop the skills necessary to function as support staff

3. Trainings and Meetings

   Required: Competency Based Training/Training Guidelines for WIC Health Professionals, NHPT, WIC University (WIC U), Grow and Glow, Conflict of Interest, Civil Rights, VENA training, WIC System Security training

   (DTs and four year nutrition dietetics graduates are required to complete six hours of continuing education annually.)

   Optional: Breastfeeding and nutrition clinical skills development workshops, Annual Hematological Competency Training, NWA, OLCA, NBAC member and other committee memberships

4. Hiring Considerations

   - Professional background requirements: It is preferred to have an RD, LD who is also a Certified Lactation Consultant (CLC) or has other certified breastfeeding training. Contact your State WIC office NAS Consultant before initiating the hiring process. Projects without a supervising LD on staff must obtain prior written permission to hire any health professional who is not an LD. Recruitment Resources are available in Appendix 100.

   - Those applying for WIC health professional positions must also be evaluated for breastfeeding knowledge and skills. Questions such as *"What is your experience helping a mother breastfeed?"* should be asked during the interview in order to gain insight into the applicant's knowledge and beliefs. If an applicant with related training or experience cannot be found, the person hiring new WIC staff must communicate that training will be required for the development of skills related to breastfeeding education and support. Every effort must be given to select staff who will successfully promote breastfeeding among Ohio's mother-infant dyads.

- Resume requirements: Project directors must submit to their NAS consultant a completed Certifying Health Professional Resume for each health professional working in their program. This is usually accomplished with the grant application; however, if health professional vacancies are filled during the fiscal year, a resume must be sent at the time of hire. When a Certifying Health Professional/Breastfeeding Coordinator Resume is submitted by a limited permit dietitian, the WIC director must report on the Quarterly Activity Report the date in which the individual becomes licensed.

- Exceptions to Filling a Health Professional Vacancy
  All exceptions **must** be discussed with the NAS consultant **prior** to offering a health professional position to an applicant.

  a) Local WIC projects with a supervising LD may recruit a person with a limited permit, a DT, DTR or a Bachelor of Science (BS) degree.

  b) Section 4759-5-04 of the Ohio Administrative Code allows for the employment of a person who is not a health professional of any kind to perform nutritional activities for the WIC program on a temporary basis, upon approval by the State WIC office, until an Ohio LD can be recruited. Local projects must obtain from the State WIC office written approval for filling the health professional vacancy with a person who is not a health professional.

5. Continuing Education
   - RD, LD, RN and DTRs are expected to meet the requirements for continuing education to maintain registration and licensure by their respective credentialing programs and State licensing agencies.
   - DT and four year nutrition/dietetic graduates are required by State WIC to complete six hours of continuing education annually. Documentation of annual hours must be maintained by the project director or designee.

113.3 Support Staff

Support staff is employed to assist in clinic operations and help applicants and participants through eligibility and coupon use processes.

1. Minimum Qualifications
   - High school diploma or General Educational Development (GED) diploma

2. Job Responsibilities
   - Screens participant applications for income, residency, category, physical presence and identity
   - Issues benefits
   - Functions as a part of the breastfeeding (BF) support team
   - Runs data reports
   - Optional responsibilities: may obtain heights, weights, laboratory work, make referrals to community services

3. Trainings and Meetings
   - Required: Conflict of Interest, Civil Rights, VENA training, WIC System Security training
   - Strongly encouraged: Support Staff Training and WIC U
   - Optional: Grow and Glow, Annual Hematological Competency Training, committee memberships

4. Hiring Considerations
   - Applicants must be screened to assess their attitudes toward breastfeeding. Questions such as, *"What are your feelings about supporting breastfeeding?"* or "*How would you feel if a mom breastfed in the WIC waiting room?"* might help identify the most breastfeeding supportive candidate. Preference should be given to the best qualified applicant who shows the most positive attitude toward breastfeeding promotion and support.
   - A former or current WIC participant should be considered.

113.4 Breastfeeding Coordinator

The subgrantee must designate a WIC Breastfeeding Coordinator.

1. Minimum Qualifications
   The breastfeeding coordinator must be a licensed dietitian (LD), registered nurse (RN), or a person working under the supervision of an LD or RN who

has fulfilled one of the criteria listed below:

a) International Board Certified Lactation Consultant (IBCLC);
b) Currently eligible to sit for the International Board of Lactation Consultant Examiners (IBCLE) exam;
c) Completed Certified Lactation Counselor (CLC), Certified Lactation Specialist (CLS), or other WIC approved training of at least 30 course hours.

2. Job Responsibilities

- Coordinate breastfeeding promotion and support services within the WIC project and local community.
- Assist WIC participants in establishing and meeting their breastfeeding goals.
- Provide staff with information to ensure that they meet breastfeeding counseling requirements.
- Refer to 404.3 for Staffing Requirements and Responsibilities, and Appendix 100 for Sample Local WIC Breastfeeding Coordinator Job Description.
- Optional: peer helper supervisor

3. Trainings and Meetings

- Required: Grow and Glow, Breastfeeding Coordinator Meetings as available, Conflict of Interest, Civil Rights, VENA training, WIC System and Security Training
- Optional: Breastfeeding Clinical Skills Workshops, local breastfeeding coalitions are strongly encouraged

4. Hiring Considerations

- Prefer personal breastfeeding experience and previous work with low income, diverse populations. If applicants lack the minimum qualifications, then the candidate's qualifications must be discussed with your NAS consultant or the State WIC Breastfeeding Coordinator.
- Projects may require more full time equivalents (FTEs) of breastfeeding coordinator time but may not require less:

  Caseload ≤ 599 = .15 - .25 FTE
  Caseload 600-1000 = .25 - .5 FTE
  Caseload 1001-2000 = .5 - .75 FTE
  Caseload 2001-10,000 = .75-1.0 FTE
  Caseload > 10,000 = 1.0 FTE

113.5 Breastfeeding Peer Helper

Breastfeeding peer helpers are employed to provide experienced breastfeeding support and guidance one-on-one to WIC breastfeeding mothers.

1. Minimum Qualifications
   - Has breastfed an infant exclusively or substantially for at least six months.
   - Has been a former or current WIC participant or eligible for WIC services.
   - Refer to section 406.2: Guidelines for Hiring a Breastfeeding Peer Helper.

2. Job Responsibilities
   - Provides pregnant and postpartum WIC participants with breastfeeding support.
   - Provides appropriate breastfeeding referrals beyond their scope of practice.
   - Optional: assists with staff training, participant classes, community outreach and bulletin boards

3. Training and Meetings
   - Required: Loving Support Peer Counselor Training, Grow and Glow, Conflict of Interest, Civil Rights, VENA training, WIC System and Security Training
   - Optional: Certified Lactation Counselor/Certified Lactation Specialist Training (CLC/CLS) after one year of employment, annual peer meetings as available, quarterly peer conference calls. Peer Helpers are required to complete six hours of continuing education annually.

4. Hiring Considerations

   If projects are able to support more than the hours suggested, they are highly encouraged to do so. If projects are below minimum hours suggested, discuss the reasons with your NAS consultant.

   Projects with a caseload of:

   1-1,000 = 10 - 20 hours per week of peer helper time
   1,001-2,000 = 20 - 30 hours per week of peer helper time
   2,001- 4,000 = 30 - 45 hours per week of peer helper time
   4,001- 8,000 = 45 - 60 hours per week of peer helper time
   8,001 – 25,000 = 100 - 150 hours per week of peer helper time
   Over 25,001 = 150 - 300 hours per week of peer helper time

113.6 Volunteers, Students and Interns

Volunteers, students, and interns may provide a resource for assisting on special projects at the clinic and with applicants and participants.

1. Minimum Qualifications
   - Follow local agency policy
   - Prefer student or intern with an interest in nutrition or breastfeeding, or public health programs, or a volunteer who is at least sixteen years old

2. Job Responsibilities
   Students and interns
   - Observe and/or perform the duties of a health professional under the direction of a WIC health professional

   Volunteers
   - Perform the duties assigned per the WIC director based on credentials, training and experience

3. Trainings and Meetings
   - Required: Civil rights, conflict of interest and confidentiality training, WIC System Security training
   - Optional: any skill development trainings, VENA training

113.7 Staff Meetings

Regularly scheduled staff meetings to communicate policy and procedure are required. Meeting minutes must be kept and circulated among those staff not present. Topics include outreach, breastfeeding, nutrition education, caseload, clinic flow and issues raised in All Project Letters, etc.

113.8 WIC Health Professional Orientation

Each project must develop and implement a written orientation plan for newly hired health professionals. This orientation must begin before the health professional is assigned risk assessment or food package prescription responsibilities. Newly hired health professionals must attend New Health Professional State training no later than three months after being hired.

Project-conducted orientation training must include:

a) review and discussion of pertinent sections of the State WIC Policy and Procedure Manual;

b) review and discussion of the project's high-risk plan and nutrition education plan and the health professional's responsibility for developing, implementing and evaluating these local project plans;

c) review and discussion of the Infant Feeding and Breastfeeding Support Policies of the Ohio Department of Health (ODH) WIC and CFHS Programs;

d) review and discussion of management tools/reports that may assist the health professional (e.g., management evaluations, project generated, computerized reports);

e) instruction and supervised practice concerning accurate and timely completion of all required WIC forms, including referral forms;

f) instruction and supervised practice concerning accurate and safe anthropometric and lab practices, when part of the health professional's assigned responsibilities;

g) explanation of relationships between project and State WIC and the project and local agencies used for referral; and

h) provision of additional training, when necessary, to update skills/knowledge in areas in which the orientee has no recent experience/training, for example:

- teen pregnancy
- toddler nutrition
- breastfeeding

Training Guidelines for WIC health professionals are in Appendix 100.

113.9 Staff Development

All staff should receive continuous opportunities for maintaining and increasing skills and knowledge necessary to perform assigned certification duties. WIC directors should plan budgets to allow for trainings and to purchase resources.

1. Monitoring

   Through clinic observation, WIC directors are responsible for monitoring that staff incorporates new techniques, procedural changes, and information received from the State WIC office.

2. Value Enhanced Nutrition Assessment (VENA)

   All employees are required to complete VENA training within six weeks of the hire date and before attending NHPT, NDT or SST. If circumstances require a delay, exceptions should be discussed with the NAS consultant. Documentation of completion of VENA training is placed on employees' *VENA Training and Observation Summary form*, found in Appendix 100.

   WIC directors are required to monitor all staff on VENA compliance once a year. The director or other designated personnel can complete the summary form.

   Use the *VENA Training and Observation Summary* form found in Appendix 100 to evaluate an employee's ability to provide services that encompass the components of VENA (Rapport Building, Cultural Awareness, Critical Thinking, and Teamwork). Only staff that has direct WIC participant contact must be monitored (e.g., an agency telephone operator who routes calls to WIC staff would not be evaluated. A WIC receptionist who routes calls would be evaluated.)

   WIC directors are evaluated using this form when regularly scheduled to work as support or health professional staff. Projects may request evaluation assistance from other project directors.

   To complete the VENA Training and Observation Summary form, the director or designated supervisory staff:
   - completes the heading;
   - observes employee interacting with WIC participants and coworkers;
   - uses the listed rating scale to evaluate the employee in the four VENA areas;
   - documents the rating score in the rating box, for each line item;

- enters supportive comments as appropriate
- develops a follow-up plan for any rating of "1"
- discusses findings with employee;
- captures signatures; and
- use the same form and a different color ink for follow-up observation, if needed.

Completed forms must be kept for review on management evaluations and per WIC retention policy. During the management evaluation process, WIC directors will be audited on completion and retention of the VENA Training and Observation Summary forms and required follow-up documentation.

113.10 Conflict of Interest and Misuse or Illegal Use of Program Funds, Assets, or Property

Conflict of Interest
Local projects must ensure that there is no conflict of interest in certifying WIC program applicants and participants. To prevent a conflict of interest, the following practices are prohibited:

- certifying oneself,
- certifying relatives or friends, or
- one employee determining eligibility for all certification criteria and issuing coupons for the same participant.

The local WIC project director must establish separation of duties among staff to prevent the occurrence of conflict of interest. One employee must not be solely responsible for determining the eligibility of an applicant for all certification requirements and for issuing coupons to that participant.

In the event that a practical circumstance exists, such as having only one staff person to conduct WIC clinic operations, the project director or a WIC supervisor must review the certification records and coupon issuance for that clinic to ensure eligibility and coupon issuance were completed correctly.

Misuse or Illegal Use of Program Funds, Assets, or Property
WIC program funds, assets, or property must be used for WIC purposes only. USDA has set a financial penalty for misuse or illegal use of program funds, assets, or property at $25,000.

Employee Understanding of Conflict of Interest and Misuse or Illegal Use of Program Funds, Assets, or Property

To ensure that all WIC staff knows the requirements related to conflict of interest and misuse or illegal use of program funds, assets, or property, each WIC staff member must review and sign the *Ohio WIC Program Employee Conflict of Interest and Misuse or Illegal Use of Program Funds, Assets, or Property Understanding* form in Appendix 100. The form must be signed on an annual basis by the beginning of the annual WIC grant cycle which begins on October 1st each year. The form is maintained on file at the local project.

114. State Trainings

The Ohio WIC program provides various trainings to ensure consistent and quality services in WIC clinics. The following sections provide a brief overview of the training opportunities offered by the State WIC office. Some trainings that have previously been offered on-site may instead be offered through webinars depending on funding availability.

114.1 New Directors Training

This one-day training is designed to provide new WIC directors with an overview of the WIC program requirements ranging from Request for Proposal (RFP) preparation to vendor relations. All new WIC directors must attend this training. New WIC directors with at least one month experience as WIC directors are eligible to attend. The training is also open to all WIC directors who are interested in a refresher on the topics. New Directors Training is offered at least twice each fiscal year, or more often as needed. To arrange for this training, project directors should contact their Nutrition and Administrative Services Consultant.

114.2 New Health Professional Training

Health professional trainings are offered to provide a general overview of the certification process, nutrition education and counseling, breastfeeding education and promotion activities, and food issuance. Continuing education credits are generally offered for these mandatory trainings.

State WIC New Health Professional Training includes:

(1) general overview of certification, nutrition counseling and education, breastfeeding promotion and support activities, and food issuance; and

(2) familiarization with State WIC resources and fiscal policies related to continuing education and ordering nutrition education materials and equipment.

To arrange for this training, project directors can either contact State WIC with the name of a new health professional immediately upon hire, or WIC directors can complete and submit the mandatory Certifying Health Professional/Breastfeeding

Coordinator Resume form located in Appendix 100 indicating choice of training date. Maximum class size is 20 and only new health professionals with at least one month service in Ohio WIC are eligible to attend.

Health professionals who have left WIC employment for an extended period of time (two years or more) and return to work for the WIC program should be encouraged to attend this training in order to update their skills.

114.3 Continuing Health Professional Training

Continuing Health Professional Training may be offered, as needed, as a refresher for all WIC Health Professionals. This training is not mandatory, but is strongly recommended for all health professionals. Continuing education credits are generally offered.

114.4 Grow and Glow Breastfeeding Training

This breastfeeding training is offered online through Ohio Train. It is offered to all local WIC staff, including support staff and local non-WIC staff who influence WIC participants' infant feeding decisions. The training covers the basics of breastfeeding management and promotion including using the Three Step Counseling Technique to discuss breastfeeding, creating a breastfeeding friendly clinic, communicating with other health care professionals about breastfeeding issues, helping mothers position and latch their babies on correctly, and referring for problems. Continuing education credits are generally offered.

114.5 Statewide Breastfeeding Coordinators Meeting

This is an annual meeting mandatory for local WIC Breastfeeding Coordinators. Current information about breastfeeding issues and Ohio WIC breastfeeding policy and procedure are communicated at the meeting. Local WIC Breastfeeding Coordinators receive an opportunity to share information about breastfeeding challenges and successes they have experienced throughout the year. Continuing education credits are generally offered. This meeting is dependent on funding availability.

114.6 Support Staff Training

This training offers all support staff the opportunity to gain a better understanding of various aspects of the Ohio WIC program policies and procedures. Support staff training will address a variety of topics including, but not limited to, outreach, referral, policy updates, the certification process, and other clinic functions such as voter registration, scheduling, and inventory. The training also focuses on core customer service principles of the WIC program. Contact your Nutrition and Administrative Services Consultant for more information.

114.7 System Training

System related trainings will be provided when needed as determined by system development and enhancements.

WIC University

WIC University is a one-day training designed to familiarize users with basic WIC system software functions. Trainees should have at least one month, and less than six months, WIC program experience. Maximum class size for WIC University is 16. Contact your Nutrition and Administrative Services Consultant to register.

114.8 Vendor Training

Vendors are required to attend a face to face training prior to becoming an authorized vendor. Information is provided for owners, operators, and cashiers, and about the coupon redemption and payment processes. Training schedules are issued to prospective vendors and posted on the ODH WIC vendor website for each contracting period. Local WIC project directors are encouraged to attend vendor trainings when conducted in their region of the state.

In addition, the following training options are provided to vendors throughout the contracting period:

- Webinar trainings
- Individual corporate trainings
- Additional face to face training as requested
- Train the trainer

114.9 Grants Services Related Trainings

The Grants Services Unit of the Ohio Department of Health provides several trainings for local subgrantee agencies. A representative from each subgrantee agency is **required** to attend trainings. Per program requirements, the **WIC director is required** to attend the Grants Management Information System (GMIS) trainings, as well as other Grants Services related trainings as needed.

114.10 VENA Training

USDA requires that all WIC staff receive Value Enhanced Nutrition Assessment (VENA) training. This is to be completed through the WIC Works Resources System. New employees must complete the required topics within six weeks of the date of hire unless circumstances require a delay. Exceptions should be discussed with your NAS consultant. New health professionals, new directors and new support staff are required to complete all necessary VENA training modules **before** attending New Health Professional Training, New Directors Training and Support Staff Training, respectively. See Appendix 100 *VENA Training Protocol*.

114.11 Other State Trainings

In collaboration with local WIC programs, the State WIC office may provide a WIC Symposium. A WIC Symposium offers workshops and training pertinent to job duties and is open to all WIC program staff. Continuing education credits are generally offered. A Symposium is dependent on funding availability.

115. Management Evaluations

The Ohio WIC program conducts management evaluations to monitor and evaluate the local WIC project's provision of services. Each local project is evaluated biennially by State WIC staff according to the standards outlined in the WIC Onsite Review Guide.

115.1 Purpose and Expectation

The purpose of the WIC Management Evaluation is to ensure that federal and state regulations and policies are followed and to improve WIC services by identifying program strengths and weaknesses in relation to established standards. In addition, the management evaluation serves to correct identified weaknesses through the implementation of a locally developed and State agency approved corrective action plan that includes time frames and responsible parties. Management evaluations are also used to make recommendations for more effective program functioning and to identify needed changes in State operations (i.e., policy and procedures). The evaluation process may reveal ideas to share with other local projects.

Serving as a communication, information, and compliance tool, the management evaluation can be used to demonstrate progress local projects have made and provide State staff with another method of updating and training local project staff.

During the evaluation, local project staff will be expected to meet and discuss requirements with State staff, as well as demonstrate compliance with requirements through use of appropriate reports, files, and actual observance of clinic operations. Specific details of the site visit are jointly agreed upon, documented in the previsit letter, and discussed at the entrance conference.

115.2 Areas Reviewed During Management Evaluations

The biennial evaluations include all aspects of the local project's operations that correspond to the WIC Onsite Review Guide. Evaluations generally cover a three day period, except in cases of larger projects where the time period may be extended. A minimum of 20% of the project's clinics must be reviewed or at least one clinic, whichever is greater. This 20% may or may not include subcontractor sites. Local project directors and State WIC consultants may decide to review more clinics than the 20% minimum, depending on the local project's needs.

The management evaluation (ME) consists of an entrance conference, actual review of clinic procedures, and an exit conference where the results of the review are communicated to the local WIC agency staff. A copy of the completed WIC Onsite Review Guide is provided to the local WIC director via email attachment within 45 days of the exit conference. The following outlines the areas that are reviewed during the ME.

- General Administration: Requirements in this portion of the evaluation cover State correspondence, the WIC grant application, record retention procedures, caseload management, outreach and referral mechanisms, staffing and clinic operations, civil rights compliance, and employee fraud, fair hearing and participant abuse procedures and documentation.

- Financial Management: Requirements in this portion of the evaluation cover all fiscal procedures, reports, documentation, and inventories.

- System Administration: Requirements in this portion of the evaluation cover all WIC system operations, reports, and electronic handling of food benefits.

- Certification: Requirements in this portion of the evaluation cover all procedures and policies that relate to certifying an applicant for the WIC program including voter registration procedures.

- Nutrition Education: Requirements in this portion of the evaluation cover all standards and procedures for nutrition and breastfeeding education and policies governing high-risk participants.

- Food Issuance: Requirements in this portion of the evaluation cover the issuance of special formulas, food package assignment, managing returned and donated formula, and handling of food benefits.

- Breastfeeding: Requirements in this portion of the evaluation cover all standards and procedures for promoting breastfeeding, supporting participants and their families, training, pump issuance, as well as the Breastfeeding Peer Helper Program.

115.3 Follow-up to the Management Evaluation

- Management Evaluation Letter

  The State WIC office will issue a written letter to the local project containing the corrective actions and recommendations cited in the WIC Onsite Review Guide within 45 days of the end of the review.

- Management Evaluation Response

  The local project is required to provide a written response to all corrective actions and recommendations contained in the WIC Onsite Review Guide within 45 days of receipt. Corrective actions require that an action be taken to resolve any issues; Recommendations require a response but are optional for the project to incorporate into its clinic environment. Responses to corrective actions should be specific, measurable, and time- and action-oriented. The local project must use the 'Project Response' portion of the WIC Onsite Review Guide to respond to all corrective actions and recommendations.

- Approval Letter

  An approval letter stating acceptance of the local agency's response to the Management Evaluation Letter will be sent by the State WIC office within 15 days of receipt. If the local agency's response letter is satisfactory, the management evaluation process is considered complete.

  Should the State WIC office disapprove any corrective actions taken or time frames implemented, State staff will contact the project and discuss needed changes. A letter will be sent to the local agency recording these concerns. The local agency will again be required to submit a written response to these concerns within 15 days. Upon State WIC approval of the resubmitted action plan, an approval letter will be issued and the management evaluation process will be considered complete.

116. Local Agency Standards

The standards by which local WIC agencies are evaluated include federal regulatory requirements and State requirements as set forth in the Ohio WIC Policy and Procedure Manual and All Projects Letters (APLs). Local program objectives as set forth in the local WIC project application and budget (ODH Request for Proposal [RFP]), the State Plan, and local agency standards as issued by the State WIC office are also evaluated.

116.1 Local Agency Standards

The following Requirements (R) are contained in the WIC Onsite Review Guide and used to evaluate all local WIC projects.

GENERAL ADMINISTRATION

R 1. The Record Retention Policy must be followed.

R 2. Project provides outreach and referral services.

R 3. Coordination of services must exist between WIC and other health and human services through a referral network and coordination of appointments when possible.

R 4. Staffing management is appropriate to ensure that all program functions are administered as required.

R 5. All civil rights requirements must be followed.

R 6. Employee Fraud, Fair Hearing, and Participant Abuse procedures must be followed and documented.

R 7. Local Subgrantee Projects manage and monitor subcontractors appropriately.

FINANCIAL MANAGEMENT

R 1. Expenditures are processed and paid according to Grants Administration Policy and Procedure.

R 2. Financial reports and all supporting documentation must be completed according to ODH Grants Administration Policy and Procedure and maintained on file for review.

R 3. Equipment and equipment inventory lists must be maintained as required.

SYSTEM ADMINISTRATION

R 1. All system functions must be completed properly within established deadlines.

CERTIFICATION

R 1. The WIC Program Application must be completed as required.

R 2. A comprehensive explanation of the WIC program and services offered must be given to each applicant/participant**.**

R 3. Staff performs anthropometrics and hematological procedures according to policy.

R 4. Health and Nutrition History information is available via State WIC form or readily accessible medical chart.

R 5. Health Professionals assess, assign, and document supportive information for appropriate risk codes.

R 6. The Welcome To WIC (WTW) Letter is accurately completed and reviewed with the participant.

R 7. Certification appointment reminders must be completed and provided to participants as required along with supportive documentation.

R 8. Notification of termination must be timely, accurate, and provided in writing to the participant. Chart documentation must support termination.

R 9. Notification of ineligibility must be provided to applicants who fail to meet any of the eligibility criteria. Supportive documentation must be maintained in the participant's chart.

NUTRITION EDUCATION

R 1. All adult participants, parents or caretakers must be provided with nutrition education at each certification. This contact must be documented.

R 2. The project complies with the approved nutrition education strategies.

R 3. All participants or caretakers must be offered at least one midcertification nutrition education contact during each certification period. This contact must be documented.

R 4. The Health Professional documents nutrition care plans relevant to the participant's mutually agreed upon goal.

R 5. The effectiveness of the nutrition education and materials being provided must be evaluated.

FOOD ISSUANCE

R 1. Participants must receive a full explanation of how to use their benefits.

R 2. WIC Nutrition Cards must be received, stored, inventoried and issued according to Ohio WIC policy.

R 3. All food packages must be individualized and assigned by health professionals.

R 4. Prescriptions for all special formulas and applicable foods must be appropriate and supported by required documentation.

R 5. Returned formula distribution is monitored.

BREASTFEEDING

R 1. Local project promotes breastfeeding to participants and their families.

R 2. Local project supports breastfeeding participants and their families.

R 3. Local project coordinates breastfeeding promotion and support efforts in the community.

R 4. Participants are educated about milk removal and issued breast pumps appropriately.

R 5. Trained WIC staff issues pumps to participants, provide follow-up, and manage pump inventory.

R 6. Local projects with a breastfeeding peer helper program follow policy.

117. Caseload Management

The Ohio WIC program receives federal funding largely based on the numbers of participants served. The State agency assigns each local WIC project an annual caseload number based on the project's share of total statewide caseload. Caseload at the state and federal levels is primarily used to manage food costs. Managing caseload at the local level assists in determining staffing levels, number of clinics needed, and clinic flow. The following sections discuss caseload directives and management techniques.

117.1 Caseload Directives

State WIC sets caseload as part of the annual Request for Proposal (RFP) grant funding process. Caseload is based on the most recent actual average number of participants. Typically, the first four fiscal-year closeout months (i.e., September to December, plus January and February initial) are used to calculate average monthly participation. For example, if statewide average monthly participation was 270,000 and a project's share of this total was three percent, the assigned caseload for that project would be 8,100 (270,000 x 3%). The statewide caseload is subdivided among the approved local projects to serve participants in all 88 Ohio counties. Participants are "counted" if food benefits have been assigned and issued. The participant is "counted" in the clinic where the certification or midcertification occurs. Participants that transfer to another in-state clinic remain "counted" in the original clinic until the receiving clinic issues benefits. Note: receiving clinics are **not** to reissue benefits to affect caseload numbers.

Local project caseload is assigned in an attachment, *FY__ Local Project Funding and Caseload Plan*, to the grant at the beginning of the fiscal year. By submitting the grant, the local project must comply with the assigned caseload. State WIC may allow local projects to serve more or less than the assigned caseload and may reallocate caseload slots in conjunction with grant level adjustments as deemed necessary such as when more or less federal funding becomes available.

117.2 Caseload Management Techniques

In order to serve the highest number of assigned participants, local project directors must use all of the following techniques:

- maintain an outreach plan that addresses reaching potentially eligible participants and partnering with referral agencies;

- hire knowledgeable staff, provide support for training, and monitor staff performance;
- incorporate and follow customer service guidelines;
- implement an engaging and enjoyable nutrition and breastfeeding education and support program;
- monitor scheduling, show rates, and missed food benefit activity;
- utilize multiple participant reminder techniques; and
- resolve any dual participation errors.

Techniques to monitor scheduling, show rates, missed food benefit activity; utilize multiple participant reminder techniques; and resolve any dual participation errors are discussed in the following policy sections.

117.3 Reducing No-show Rates

A. Scheduling

Participants are scheduled through the WIC System for all types of appointments. Note: Food benefit pick up and nutrition education (NE) can be scheduled separately as needed. To assist with show rate calculation, always schedule a participant for NE. Attempt to schedule all family members together, unless requested not to do so. The following guidelines may vary considerably depending on what position is assigned different duties (CPA review, anthropometrics, benefit issuance, explanation of program, immunization review, etc.)

Guidelines for scheduling:

- Allow staff a few minutes to turn on computers and ready the clinic for participants.
- Schedule last participant so there is enough time to fully process the appointment without mandating overtime for staff.
- Allow a few minutes at the end of the day to turn off computers and lock clinic site.
- Number of appointment slots/day
  - One support staff person can process about two participants for each one participant processed by a health professional (HP). (Application and anthropometric processing takes less time than assessment and education.)
  - Certification appointments usually take longer than recertification or midcertification appointments.
  - Group class uses less of HP time, but possibly more schedule time.

- Type of nutrition education activity affects the schedule.
- *Generally*, an individual appointment can be scheduled about every 15 minutes. Certification appointments may need to be scheduled every 30 minutes.
- *Generally*, if two HPs are scheduled, twice as many participants can be scheduled for the same time slot.
- Less appointments may be scheduled if staff has been allotted clinic time for special functions like outreach visits, breastfeeding planning, nutrition plan development, etc.

Allow time for walk-in requests, phone calls, formula changes, appointment requests, reissuance of benefits, transfers, etc. Scheduling and clinic flow are influenced by how well staff work together to serve and move participants through the clinic.

B. Monitoring Show Rate

Definitions for determining show rate:

- **Show**: a participant who attends a scheduled appointment.
- **No-show**: a blank appointment slot due to a participant not showing for a scheduled appointment. Only those appointments where the participant did not come in for the scheduled appointment count towards the no-show rate; therefore, you will not know that a participant appointment is a no-show until that appointment time has passed.
- **Reschedule**: Participants who rescheduled are not counted in that day's tally for show rate as they have a new appointment date. A rescheduled appointment does not count towards a no-show appointment. There will be instances where a participant calls to reschedule prior to her appointment time which could allow for that appointment slot to be refilled by another participant calling requesting services for that same day; only the refilled appointment counts toward the show rate.
- **Walk-in**: A participant who appears at a clinic without being scheduled for that day. Hospital certifications and preliminary infants are considered walk-ins. The number of walk-ins is an indicator of the level of activity in the clinic; therefore, trends with walk-ins may be a factor used in determining staffing needs and the number of available appointment slots incorporated into the master schedule during peak walk-in times.

Trends may be determined by monitoring show rates. Clinics that serve many walk-ins generally have a lower show rate than those that serve fewer walk-ins. Larger clinics or those with a very transient population may see lower show rates.

Projects should target an 80% show rate for high-risk appointments and 75% for all other types of appointments.

C. Reducing No-show Rates

WIC directors must monitor show rates monthly. Monthly documentation will be reviewed during the management evaluation. Use the *Show Rate and Instruction Worksheet* in Appendix 100 or other Nutrition and Administrative Services approved documentation.
A low show rate may indicate the project needs to:

- add appointment slots to the master schedule such as double or triple booking during slower periods;
- use additional methods for reminding participants of appointments like appointment cards, telephone calls, texting, or emails;
- change the timing of scheduled appointments (less at 8:00 am, more at 9:30 am; use early time slots to issue benefits for participants that could not be issued at a previous nutrition education appointment, update bulletin boards, call physicians, read policy updates, write reminders, and other necessary clinic functions.); or
- offer alternative methods of nutrition education, or revise current lesson plans for group nutrition education sessions.

D. Missed Food Benefits

Missed food benefits information is reported on the Quarterly Activity Report. The project runs the *Participants Currently Certified Without Current Food Benefits* on the first of the month following the report month to contact participants in order to maintain them on caseload. These are participants that have been certified and need to return for a midcertification appointment. Projects should run this report each month or sooner, make contact with the participants to reschedule, and provide benefits to increase caseload levels.

117.4 WIC Automated Appointment Reminder System

The automated Appointment Reminder System (ARS) can be used to remind participants of upcoming appointments. Staff schedules a participant for automated calls by completing the checkbox on the scheduling tab in the WIC System after receiving participant approval. Clinics receive a report of appointment calls made by reviewing the ARS report in Cognos.

The schedule of calls is:

Appointment day	Automated call is made
Monday	Friday
Tuesday	Friday
Wednesday	Monday
Thursday	Tuesday
Friday	Wednesday

117.5 Dual Participation

Dual participation means simultaneous participation in the Ohio WIC program at more than one Ohio WIC clinic. Listing as a dual participant occurs when the same first name, last name and date of birth appear on two or more separate computer records, at clinics in different projects or at separate clinics within the same local project.

- Local clinics must investigate and resolve potential dual participation within 24 hours of notification.

- Local clinic staff must review the *Potential Dual Participant Report* received with the *Clinic Communication Summary*. (The potential dual participation will continue to be reported until it has been resolved.)

- The clinic that receives the dual participation listing is responsible for investigating the issue and making a decision about which clinic should retain the active status computer record of the participant.

- See *Resolving Dual Participants in the WIC System* in Appendix 100.

Dual participation also includes simultaneous participation in an Ohio WIC clinic and any other state WIC clinic. WIC staff operating clinics in service areas located across state borders will contact the neighboring clinic and the State WIC office when there is suspicion that an individual may be participating in more than one WIC program. Resolution guidance will be provided by the State WIC office per interstate dual participation prevention agreements.

RESERVED 118-119

120. Outreach

120.1 Outreach Definition and Purpose

Outreach is the systematic process of promoting and advertising the WIC program to targeted groups and individuals. The purpose of outreach is to find and educate potential participants and community partners, serve high priority populations, maintain/increase caseload, and promote positive messages about WIC.

120.2 Outreach Requirements

Each clinic must publicize the availability of WIC services a minimum of twice a year, and conduct outreach with physicians at least once a year as part of the outreach plan. Outreach efforts must be documented. The following strategies will assist local projects in developing their outreach plan.

State WIC recommends focusing on four target audiences:

- Potentially-Eligible Individuals
- Service Providers and Community Agencies
- Employers
- Media

There are three principle activities that should be performed by each WIC clinic to ensure effective outreach:

A. Publicizing Availability of WIC
Several techniques that can be used to publicize the availability of WIC services include news releases, newspaper feature stories, social media/internet, mass emails, posters, flyers, pamphlets, and other related marketing strategies.

B. Build and Maintain an Effective Outreach Network
Community agencies and organizations that serve similar populations make up your outreach network. Some examples include health and medical organizations, hospitals, clinics, physicians, community assistance and unemployment agencies, social service agencies, religious organizations, advocacy groups, educational institutes, food banks, and child care programs. The purpose of this network is to ensure that community agencies appropriately direct potentially eligible applicants to the WIC program.

Organizations in your outreach network should be provided with written materials and program application information for WIC.

Continuous education about the WIC program to the organizations in your outreach network is essential. Update partners by visiting in person, emails, telephone calls, letters, presentations, texts, etc. Community agencies should maintain a stock of posters and pamphlets describing the WIC program with the address and telephone number of the nearest WIC office so they can be distributed to potentially eligible applicants.

C. Coordinating Referrals with Other Community Partners

Contact other community partners to establish a referral system. Some examples include Family Planning/Planned Parenthood, Head Start, La Leche League, Medicaid, and Mental Health Services. Once programs are aware of each other's scope and eligibility criteria, an ongoing referral system may be established.

120.3 Outreach Documentation

A documentation system must be developed and maintained to keep track of all outreach. State WIC will review outreach activities during the management evaluation. Listed below are examples of activities that may be documented:

- Outreach materials placed in businesses, doctors' offices and laundromats
- Articles included in quarterly or annual reports
- Participants used to refer family and friends
- "Congratulations on the birth of your new baby" cards mailed weekly
- Christmas cards sent to social service agencies/physicians in county
- Packets of WIC information, including income guidelines, distributed to local daycare centers to be given to parents

120.4 Customer Service Guidelines

The customer service guidelines in this section have been developed for WIC project directors to use in managing their WIC projects. By emphasizing the importance of good customer service, creating policies with a customer service focus, and monitoring employees to see that good customer service practices are followed, WIC directors can ensure that all customers feel comfortable while in the WIC clinic and have a positive experience.

One of the most important questions to ask is, "Who are my customers?" Customers are the people that we interact with every day. Participants are the most obvious customers, but customers also include coworkers, other employees in the agency, delivery drivers, mailmen, and others. Goals and objectives that accompany each guideline are found in *Customer Service Guidelines* in Appendix 100.

120.5 State and Local WIC Outreach Materials

Refer to the Appendix 100 *Outreach Material Examples* for a variety of outreach materials like those listed below. The materials may be used to assist in developing local outreach materials. **Locally developed outreach materials must be approved by State WIC before use.**

Outreach Material Examples

- Brochure/ Pamphlet/Information about the WIC program
- Feature Story
- Letters to Referral Agency
- Newsletter
- News Release
- Postcard
- Poster
- Presentation
- Public Service Announcement/ Tweets/Facebook Posts/Texts

State WIC requirements of all outreach materials:

- Do not use the word "free" on materials.
- Add breastfeeding promotion language or the breastfeeding logo in support of breastfeeding.
- Include the current WIC logo.
- Include the nondiscrimination statement – See PPM section 111.1.
- The text of the nondiscrimination statement must be in print size no smaller than the smallest text in the materials.

120.6 Media Use

As part of the outreach plan, prepare a list of local media contacts, develop a media kit and meet with media members as applicable. See Appendix 100 *Media Use*.

Regular contact with local media about WIC activities promotes ongoing coverage. See Appendix 100, *Meeting the Local Media* for more information. Some types of media include:

- Print media – newspapers, magazines, ad bags, billboards, cash register receipts
- Broadcast media – radio and television
- Social media – Facebook, Twitter, You Tube, Pinterest, Instagram, Skype, Google +
- Electronic media - email, websites, texting, webinars, DVDs, Power Point presentations

Purchased television, radio, print (newspapers, newsletters, and magazines), internet, and other related advertising must be approved in advance by State WIC. All media contacts should be reported on the quarterly activity reports.

1. Social Media

The use of social media can be an inexpensive and effective method of communication. General guidance documents, *Ohio WIC Facebook Guidance* and *Ohio WIC General Social Media Guidance*, are found in Appendix 100. These documents do not give specific information about the type of social media that should be used or who should take part. These are all topics that should be decided upon at the local level. This guidance focuses on confidentiality and customer service. Local projects must read and review **both** documents before moving forward with any type of social media. Local agency policies regarding the use of social media must be adhered to first before considering State WIC's guidance.

Once a social media outlet has been established, local projects need to promote and maintain it. For example, on Facebook, the more 'likes' a page has the more searchable it becomes. Therefore, the page needs to be advertised to be effective. Advertise social media platforms in any of the following ways:

- Create sticker labels that promote the site and place on envelopes or other WIC materials.

- Craft a flyer to give out at all appointments.
- Promote the site on already existing local agency pages.
- Discuss the opportunities the site provides in nutrition education, prenatal, and breastfeeding classes.
- Create a bulletin board that addresses the site and how participants could enjoy or benefit from it.

2. News Releases

News releases cover specific information or general features about interesting people, programs, or services. Has your local WIC project recently coordinated services with another community program? Have you recently established a new WIC clinic site in your county? Are you providing anything unique in your education activities? Are you offering nutrition education classes which are open to the general public? Has your caseload increased? Are you planning special events for WIC Awareness Week as well as related awareness weeks (Alcohol and Other Drug-Related Birth Defects, Immunization, and Breastfeeding Awareness Week)? If so, write a news release and submit it to the local newspaper. The internet has become a popular way people receive their information. Exploring news releases through blogs and other social media methods is an important option.

3. Newsletter Articles

Writing an article on the WIC program for newsletters distributed by other community agencies and organizations is another effective outreach tool. State-issued health professional and physician newsletters can be forwarded to entities in the local community.

4. Media Interviews

Media interviews can be used to broadcast information to many different people at one time, in the form of either radio or television interviews. See Appendix 100 *Media Interviews.*

5. Feature Stories

Has your WIC project performed an unusual service or developed a project that filled public need, such as community nutrition lectures? Or, is there some dramatic viewpoint about the WIC program on which you can focus? If so, you may have a feature story on your hands. See Appendix 100 *Feature Stories.*

6. Public Service Announcements (PSAs)
Some radio and television stations provide a certain amount of air time free of charge to nonprofit organizations. Since many organizations submit public service announcements (PSAs), competition requires that the PSA be well written and utilize the correct format. See Appendix 100 *Public Service Announcements.*

7. Letters to the Editor
Letters to the editor offer a way of calling attention to a worthy cause or enlisting support for a matter of public concern. Such letters are sometimes used to convey thanks for public support, participants' support, or the paper's support and that of the staff members with whom you have worked.

Letters to the editor may also be used to bring attention to misinformation about the WIC program or nutrition issues printed in the newspaper. If you intend to identify your workplace, be sure to obtain approval from your supervisor before the letter is sent.

120.7 – 120.9 Reserved

120.10 Ohio WIC Mobile Unit

The Ohio WIC mobile unit is an excellent tool to bring services to communities and showcase WIC services. It is suitable for events including, but not limited to, health and county fairs, breastfeeding education and promotion, FMNP benefits distribution, WIC family fun activities, WIC outreach, nutrition education, and WIC temporary clinic.

The Ohio WIC Mobile Unit is maintained and operated by the Cuyahoga County WIC program. If you would like to request the unit for your event, See *Things to Know about the Ohio WIC Mobile Unit* and *Ohio WIC Mobile Unit Request Form* in Appendix 100 for additional information.

121. Reserved

122. Confidentiality of Participant Information

All WIC staff must restrict the disclosure and use of confidential applicant and participant information to persons directly connected with the administration and enforcement of the WIC program, who are determined to have a need to know the information for WIC program purposes. These persons include, but are not limited to, personnel from USDA and the office of the Comptroller General of the United States, personnel from Ohio WIC local projects and other WIC State and local projects; persons under contract with USDA or State WIC to perform research about the WIC program; persons conducting WIC program audits; and persons investigating or prosecuting WIC program violations under federal, state or local law.

122.1 Participant Information Defined

Participant information is **any** information about an applicant or participant, obtained from the applicant or participant; another source; or generated as a result of a WIC application, certification, or participation, that individually identifies an applicant or participant and family members. Applicant and participant information is confidential, regardless of original source and the source's confidentiality rules that may be set by other federal, state or local laws; for example, federal Health Insurance Portability and Accountability Act (HIPAA) rules.

122.2 Information Access for Applicants and Participants

WIC staff must provide applicants and participants access to all information they have provided to the WIC program. This usually consists of the application form, health histories, and verification documentation, if copied. In the case of an applicant or participant who is an infant or child, the access may be provided to the parent or guardian, assuming that any issues regarding custody or guardianship have been settled. Access is provided by copying the requested information for the applicant or participant.

WIC staff need not provide the applicant or participant (or the infant's or child's parent or guardian) access to any other information in the file or record such as documentation of income provided by third parties and staff assessments of the participant's condition or behavior. The local project director, upon reviewing such items, has discretion to provide them, or not. If the information supports a State or local WIC decision that is being appealed by the applicant or participant, then the information should be provided.

122.3 Information Sharing for Non-WIC Purposes

WIC staff may share specified confidential applicant and participant information in the administration of its agency's other programs and with other public organizations that serve persons eligible for WIC when the following requirements are met.

1. The Director of the Ohio Department of Health must designate the permitted non-WIC uses of the information and the names of the organizations to which the information may be shared.

2. The WIC applicant or participant must be notified at the time of application about the use of information and participation in the WIC program for non-WIC purposes. The notice must indicate that the information will be used by State and local WIC agencies and designated public organizations only in the administration of programs that serve persons eligible for WIC.

3. The State or local agency sharing the information must enter into a written agreement with the other public organization or, in the case of non-WIC use by a State or local WIC agency, the unit of the State or local agency that will be using the information.

122.4 Interprogram and Interagency Agreements

A list of all organizations, including units of the State agency or local agencies such as Immunization, Child and Family Health Services, and Lead, with which the State agency has a signed written agreement, will be published in the annual Ohio WIC State Plan of Operations. The written agreements include requirements that the receiving organizations may use the confidential applicant and participant information only for:

1. establishing the eligibility of WIC applicants or participants for the programs identified that the organization administers;

2. conducting outreach to WIC applicants and participants for the identified programs;

3. enhancing the health, education, or well-being of WIC applicants or participants who are currently enrolled in the programs, including the reporting of known or suspected child abuse or neglect that is not otherwise required by state law;

4. streamlining administrative procedures in order to minimize burdens on staff, applicants, or participants in either the receiving program or the WIC program; and

5. assessing and evaluating the responsiveness of a state's health system to participants' health care needs and health care outcomes.

The agreement must contain the receiving organization's assurance that it will not use the information for any other purpose or disclose the information to a third party.

122.5 Notice of Information Sharing to Applicants and Participants

At each application and recertification, WIC staff must provide participants with the *Information Sharing in the WIC Program HEA4416* brochure, which provides the required explanation for understanding what information may be shared with any or all of the programs listed in the brochure.

122.6 Release of Information

For individuals or organizations not addressed throughout section 122, WIC staff may share confidential applicant and participant information only if the applicant or participant signs a release form authorizing the sharing and specifying the parties to which the information may be provided. For private physicians and other health care providers, the *Welcome to WIC Letter – Consent for Sharing Information* section may be used to obtain the applicant's or participant's consent.

For other requests that are not initiated by the participant, for example, a request from a preschool or day care provider, the *WIC Interagency Referral and Follow-Up Form,* or a similar, locally developed form must be provided. These other requests for consent must take place after the application and certification process is completed so it is not viewed as a condition of WIC eligibility. Just as with the two WIC forms noted, locally developed forms must contain wording that meets the following program requirements:

- to permit applicants and participants the right to refuse to sign the release form,
- to inform them that signing the form is not a condition of eligibility, and
- that refusing to sign the form will not affect processing their application or participation in the WIC program.

122.7 Reporting Child Abuse and Neglect

WIC staff, as an "other health care professional," is required by state law, Ohio Revised Code section 2151.421, to report known or suspected child abuse or neglect to the local Public Children's Services Agency (PCSA). Staff may disclose confidential applicant

and participant information without the consent of the participant or applicant to the extent necessary to comply with the child abuse and neglect reporting law. This disclosure allowance includes testifying at a PCSA court hearing based on the report filed by the WIC staff.

If the PCSA requests information from WIC staff, when a report was not filed by WIC staff, then the WIC confidentiality rules must be followed; information cannot be provided without the applicant or participant's consent or an enforceable court ordered subpoena.

122.8 Subpoenas

Subpoenas are legal requests for information, do not require the automatic surrender of information, and typically have a time frame and location indicated for a response. When presented with a valid subpoena, WIC staff must respond following these required procedures:

1. Upon receiving the subpoena, immediately notify the State WIC office.

2. Consult with the local project's legal counsel and determine whether the information requested is in fact confidential under WIC rules and prohibited from being used or disclosed as stated in the subpoena.

3. If the local project's legal counsel determines that the information is confidential and prohibited from being used or disclosed as stated in the subpoena, then an attempt must be made to quash the subpoena unless the State or local project determines that disclosing the confidential information is in the best interest of the program. The determination to disclose confidential information "in the best interest of the program" without attempting to quash the subpoena should be an infrequent occurrence.

4. If the local project's legal counsel seeks to quash the subpoena, or decides that disclosing the confidential information is in the best interest of the program, the court or the receiving party must be informed that this information is confidential and the project must seek to limit the disclosure by:

    - providing only the specific information requested in the subpoena and no other information, and

    - limiting to the greatest extent possible the public access to the confidential information disclosed.

122.9 Search Warrants

Search warrants are of an immediate law enforcement nature. In responding to a search warrant for confidential information, the WIC staff must use the following procedures:

1. Upon receiving the search warrant, immediately notify the State WIC office.

2. Immediately notify the local project's legal counsel.

3. Comply with the search warrant, and inform the individual serving the search warrant that the information being sought is confidential and seek to limit the disclosure by:

   - providing only the specific information requested in the search warrant and no other information; and

   - limiting to the greatest extent possible the public access to the confidential information disclosed.

122.10 Participant Abuse and Confidentiality

In the event that an applicant or participant becomes verbally or physically abusive to WIC staff resulting in a safety risk to either or both staff and other participants, law enforcement authorities may be called to resolve the issue. WIC confidentiality rules do not prohibit WIC staff from contacting law enforcement if applicants or participants become verbally or physically abusive.

In addition, if an applicant or participant is suspected of stealing either WIC program property or personal items from employees or other individuals in the clinic, law enforcement authorities may be called to resolve the issue.

Only the minimum demographic information (name and contact information) should be provided to assist authorities in resolving the issue.

122.11 Requests for WIC Statistical Data/WIC Studies – Data Stewardship

Requests for data by colleges, universities, students, and other agencies to conduct studies of various aspects of the Ohio WIC program will be referred to the

Data Operations Unit Supervisor Data Steward. Any proposed study must clearly benefit the Ohio WIC program and its vested responsibilities in delivery of program services. Because of the lengthy time demands of such endeavors, and, frequently, the subject matter involves confidential participant information, the following guidelines will be used for determining the feasibility of study requests.

1. A study proposal must be provided which explains the nature of the study, why the study may need to be conducted, who or what is to be studied, when the study will begin and end, and where the study will be conducted. In addition, the proposal must include the resources for carrying out the study, including both financial and staff resources.

2. Data needs must be clearly defined so that BNS can determine if the data is readily available, or if the data needs will require special data services runs or it needs to be retrieved from actual case files. In conjunction with federal WIC program regulations**,** BNS can share data in summary or aggregate form without any personal identifying information about participants.

3. Personal identifying information of participants is confidential per federal WIC program regulations. It is critical that item two be resolved to determine if there will be confidentiality issues. Any type of request that ties personal identifying information of a participant to the study is a confidentiality issue. This can occur with longitudinal studies or studies that require a match of WIC program information with that of another program or vital statistics information. Depending on the nature of the issue, a signed, release of information may be required by each participant to participate in a study, a confidentiality clause may need to be included in the study agreement, and ODH Legal Services and Institutional Review Board review and approval are required.

4. The WIC program confidentiality rules in Title 7 of the Code of Federal Regulations subsection 246.26 (d) shall be followed in the determination of confidentiality issues.

5. Study results must be published in terms of aggregate program participation data; no personal identifying information may be published. In addition, federal program copyright rules must be followed.

6. The study must not interfere with the day-to-day operations of the WIC program at the local level. Local WIC project staff is not available to carry out any aspect of the study unless the State WIC office deems this as necessary.

7. No study may begin without the written approval of the Chief of the Bureau of Nutrition Services via a written agreement. This approval will be provided only after review and approval of the study request by the Ohio Department of Health Office of Legal Services and Institutional Review Board through the completed ODH Institutional Review Board Application process.

8. A request for and submission of a study proposal does not guarantee that approval will be granted. The study must have outcomes that will be beneficial to the operation and improvement of the Ohio WIC program or another legitimate public health purpose. In addition, it will be screened to ensure that a similar study is not already in progress through USDA.

9. The Bureau of Nutrition Services must be provided an opportunity to review and comment on the final results of the study before publication and must receive copies of the final results and report of the study.

122.12 Confidentiality of Vendor Information

Confidential vendor information is any information about a vendor (whether it is obtained from the vendor or another source) that individually identifies the vendor, except for vendor's name, address, telephone number, web site/e-mail address, store type, and authorization status. The disclosure of confidential vendor information is restricted to:

1. persons directly connected with the administration or enforcement of the WIC or Ohio Food Assistance (Supplemental Nutrition Assistance Program (SNAP) program) who the State WIC office determines has a need to know the information for purposes of administering these two programs. These persons include personnel from USDA, the office of the Comptroller General of the United States, local WIC projects, other WIC State and local agencies, auditors, and persons investigating or prosecuting WIC or SNAP violations under federal, state, or local law;

2. persons directly connected with the administration or enforcement of any federal, state, or local law or ordinance whereby the State WIC office has entered into a written agreement with the requesting party specifying that the information may not be used or redisclosed except for purposes directly connected to the administration or enforcement of a federal, state, or local law;

3. a vendor that is subject to an adverse action, including a claim, to the extent that the confidential information concerns the vendor and is related to the adverse action; and

4. all authorized vendors and vendor applicants concerning vendor sanctions which have been imposed. The information shared is limited to the vendor's name, address, length of the disqualification or amount of the civil money penalty, and a summary of the reasons for sanctions as provided in the notice of adverse action. This information may be disclosed only after completing all administrative and judicial reviews in which the State WIC office has prevailed the sanction imposed on the vendor, or the time period for requesting review by the vendor has expired.

Except as allowed in this section, the State WIC office restricts the use or disclosure of information about retailers obtained from SNAP.

123. Fair Hearings

An applicant/participant who has been denied participation, assessed a claim, or disqualified from the program has the right to a fair hearing.

123.1 Right to a Hearing

An applicant/participant who has been denied participation, assessed a claim, or disqualified from the program (affected party) for program abuse must be provided a fair hearing (hereinafter referred to as "hearing") as follows:

A. The local WIC project shall inform each applicant during the WIC program certification of the right to appeal any decision made by the local project regarding the applicant's eligibility.

B. Whenever a local agency determines during a certification visit that an applicant or current participant is not eligible to continue participation in the WIC program, the local agency shall deny the participant's continued participation and complete the ineligibility letter (Notice: The WIC Program Cannot Serve You HEA 4462), which outlines the reason for the determination of ineligibility and the right to a hearing.

C. Whenever an adverse action (i.e., denial, disqualification, or claim) is being taken against a participant, notification of the hearing rights must be included with the notice of the adverse action and must also include:
   1. the methods by which a hearing can be requested; the time limit to request
   2. a hearing, which is sixty (60) days from the date the notice was received by the applicant/participant; and
   3. the allowance of positions or arguments to be presented on behalf of the applicant or participant in person or by a designated representative (e.g., legal counsel, relative, spokesperson) at the hearing.

123.2 Hearing Request

To request a hearing, the following steps are required:

A. The affected party or her designated representative (e.g., legal counsel, relative, spokesperson) who was subject to an adverse action (i.e., denied participation, disqualified or assessed a claim) must ask the local project or

State WIC office for a hearing. The request for a hearing must be made within sixty (60) days of receipt of notice of the adverse action.

B. The hearing request may be made verbally or in writing. If the request is made verbally, the local or State WIC office must immediately document the request in writing.

C. The State WIC office or local project, whichever receives the hearing request, must keep a record of the date on which it received the request. To meet this requirement, the individual receiving the request must sign and indicate the date of receipt on the request or on the written record documenting the verbal request.

D. All written requests and all written records of verbal requests must include the name, address and telephone number of both the person whose WIC participation is the subject of the hearing and the person's designated representative (if applicable).

E. If the local project receives a hearing request, it must notify the State WIC office within two business days.

123.3 Denial or Dismissal of the Hearing Request

The filing of a request shall not prevent the affected party from withdrawing the request or the local project or State WIC office from reversing its determination or otherwise resolving the matter without a hearing. Notice of a reversal or settlement must be provided to the State WIC office by the local project.

The State WIC office or local project may deny or dismiss a hearing request only under the following circumstances:

- the request is not received within sixty (60) days of receipt by the affected party or representative;
- the affected party or representative, in writing, withdraws the request for the hearing;
- the affected party fails, without good cause, to appear at the scheduled hearing; or
- the affected party has been denied participation by a previous hearing and cannot provide evidence that circumstances relevant to program eligibility have changed in such a way as to justify a hearing.

123.4 Rescheduling Hearings

The State WIC office or local agency shall determine if a hearing is to be rescheduled based upon the following guidelines:

A. If the affected party fails to appear for a scheduled hearing, the State WIC office or local project must decide whether the affected party had good cause for failing to appear.

If the affected party shows good cause, the agency shall schedule a second hearing in accordance with these rules. A hearing regarding WIC eligibility must be rescheduled within ten days of the original hearing date.

B. The affected party and the local project or State WIC office each shall have one opportunity to reschedule the hearing date upon specific request to the Hearing Officer. Any other postponements shall be by mutual agreement of the agency, the affected party and the Hearing Officer. If the postponement will prevent the decision from being issued within the forty-five day decision period, the Hearing Officer shall deny the postponement unless the affected party waives the right to a decision within that period. The waiver must be received in writing.

123.5 Setting and Notice of Hearing

If the local project has denied participation or disqualified an applicant/participant, the local project shall conduct the hearing unless the State WIC office determines otherwise. When the State WIC office has assessed a claim or disqualified a participant, the State WIC office will be responsible for conducting the hearing. The agency responsible for conducting the hearing shall set the hearing date, time and place.

A. The hearing date shall be within twenty-one days from the date a request for a hearing is received by the agency responsible for the hearing.

B. The location of the hearing shall be accessible to the participant.

C. The agency conducting the hearing shall notify the affected party whose WIC participation is the subject of the hearing (or if a minor, the parent or guardian) of the date, time, and hearing location. The notice shall be sent certified mail, return receipt requested. If the person whose WIC

participation is the subject of the hearing has a designated representative (other than a parent or guardian), then a copy of the notice shall also be sent certified mail, return receipt requested, to that designated representative.

D. The notice must be mailed certified mail, return receipt requested, at least ten days prior to the hearing and must state that the affected party has the following rights to:
   1. examine, prior to and during the hearing, the documents and records presented to support the decision under appeal;
   2. be assisted or represented by legal counsel or other persons;
   3. bring witnesses;
   4. advance arguments without undue interference;
   5. question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses; and
   6. submit evidence to establish all pertinent facts and circumstances in the case.

E. A copy of these Fair Hearing procedures in "D" shall be sent with the notice.

123.6 Hearing Procedures

An impartial Hearing Officer designated by the local project or by the State WIC office, whichever is providing the hearing, will conduct the hearing. The Hearing Officer must have no personal stake or involvement in the decision and must not have participated in making the determination which is the subject of the hearing.

A. The Hearing Officer shall:
   1. administer oaths or affirmations;
   2. ensure that all relevant issues are considered;
   3. request, receive and make part of the hearing record all evidence determined necessary to decide the issues being raised;
   4. regulate the conduct and course of the hearing consistent with due process to ensure an orderly hearing;
   5. order, where relevant and necessary, an independent medical assessment or professional evaluation from a source mutually satisfactory to the affected party and the local project or State WIC office; and
   6. render a hearing decision which will resolve the dispute.

B. The affected party and her designated representative, if any, may:
   1. examine the documents and records presented to support the decision under appeal;
   2. present witnesses;
   3. question or refute any testimony or evidence and confront and cross-examine adverse witnesses;
   4. submit evidence to establish all pertinent facts and circumstances in the case; and
   5. advance arguments without undue interference.

C. Whichever agency, State or local, that conducts the hearing must provide, for the record and for the use of the Hearing Officer, a recording or verbatim transcript of the hearing. A verbatim transcript may be made from a recording.

D. If the Hearing Officer orders an independent medical assessment, the assessment or evaluation shall be completed within ten days of the order, and the hearing shall be reconvened within five days after completion of the assessment or evaluation.

123.7 Hearing Decision

When the hearing is completed, the Hearing Officer shall make a decision to resolve the dispute based solely on the hearing record.

A. The hearing record to that point shall consist of all papers and requests filed in the proceeding, the verbatim transcript or recording of testimony and exhibits of an official report containing the substance of what transpired at the hearing.

B. The decision shall comply with federal and state law, regulations and policy.

C. The decision shall be in writing, shall summarize the facts of the case, shall state the reasons for the decision and shall identify the supporting evidence and the pertinent regulations or policy.

D. The affected party and her designated representative, if any, must be notified in writing of the Hearing Officer's decision and of the reasons for the decision within 45 days from the date of the request from the hearing. The notification must be sent by certified mail, return receipt requested.

123.8 Continuation of Benefits

The following scenarios outline the allowable receipt of benefits during the hearing process:

A. If a WIC participant, whose participation is disqualified, requests a hearing within the 30-day notice period, defined in the Participant Abuse section, shall continue to receive benefits until the Hearing Officer reaches a decision. If a WIC participant, whose participation is disqualified, files a timely hearing request, after the 30-day notice period, then the participant shall not continue to receive benefits until the Hearing Officer makes a decision in favor of the affected party.

B. Applicants for participation who are denied benefits at initial certification or at subsequent certifications may appeal the denial, but shall not receive benefits while awaiting the hearing.

C. If the decision of the Hearing Officer is in favor of the affected party and benefits were denied or discontinued, benefits must begin immediately.

D. If the decision of the Hearing Officer is in favor of the agency, as soon as is administratively feasible, any continued benefits must be terminated as decided by the Hearing Officer.

123.9 Documentation and Record Retention

The following outlines the hearing documentation retention policy:

A. The written decision of the Hearing Officer and a copy of the notification of the decision shall become part of the record of the hearing.

B. Whichever agency, State or local, conducting the hearing, shall have the responsibility of preserving the complete written record of the hearing for a period of three years following the date of submission of the final expenditure report for the period in which the hearing decision was made. Whichever agency conducted the hearing must provide the agency which did not conduct the hearing with a copy of the written record. During the three year period, the record must be available to the affected party or her representative for copying and inspection at the office of both the State and local WIC agencies during the agency's normal business hours.

C. All State and local WIC agency records and decisions must be available for public inspection and copying, provided the names and addresses of participants and other members of the public (except representative of the State and local WIC agency) are kept confidential.

123.10 Appeals

The notification of the local Hearing Officer's decision shall explain the appeal right and shall state how and when the affected party may request an appeal hearing. The following outlines the process for appealing a local level decision:

A. The decision of a Hearing Officer at the local level is binding on the local agency and the State agency unless it is appealed to the State level and overturned by the State Hearing Officer.

B. If a local project conducts a hearing, the affected party may appeal the decision from that hearing to the State WIC office.

C. The appeal request must be made to the State WIC office, in the manner described in Section 123.2, within fifteen days of the mailing date of the hearing decision notification from the first hearing.

D. If a state level decision upholds the local agency action and the affected party expresses an interest in pursuing a higher review of the decision, the State agency shall explain that the State agency decision is final.

124. Participant Abuse

An applicant/participant who makes false or misleading statements; misrepresents, conceals, or withholds facts to obtain benefits; or fails to meet participant responsibilities is subject to specific sanctions based on program violations.

State WIC and local projects must impose disqualifications, repayment of benefits, or take other actions depending upon the offense. When appropriate, State WIC must refer participants who violate program requirements to federal, state, or local authorities for prosecution under applicable laws.

124.1 Classifications of Participant Violations

Participant violations include, but are not limited to, the following actions of the participant, parent or caretaker of an infant or child participant, or alternate:

A. Intentionally making false or misleading statements or intentionally misrepresenting, concealing, or withholding facts to obtain benefits;
B. Exchanging WIC or FMNP food instruments, or supplemental foods for one or more of the following:
    1. cash or credit;
    2. nonfood items; e.g., diapers, baby wipes;
    3. unauthorized food items; e.g., purchasing powdered formula when concentrate is listed on the food instrument, unauthorized brands of cereal; and
    4. supplemental foods in excess of those listed on the participant's food instrument;
C. Selling any WIC benefit; e.g., formula, food, breast pumps, via the internet or by other means; e.g., Craigslist, eBay, direct sale;
D. Redeeming WIC or FMNP food instruments that were previously reported as lost or stolen;
E. Failure to return loaned breastpumps upon request from the local WIC office;
F. Participation in the program in more than one WIC clinic; or
G. Verbally abusing, threatening, or physically harming clinic, farmer or vendor staff, or other applicants or participants.

124.2 Procedures for Addressing Violations 124.1 A-E When the Violation Value Equals $99 or Less, and It Is a First Claim

The following steps are taken for these violations:

A. An account of the violations and supporting documents must be sent to the State WIC office.

B. Once the violations are verified, the State WIC office must determine the value of the claim based on the Not To Exceed amount or face value of the involved food instruments or the amount paid for the involved breastpump. The State WIC office must establish a claim via certified letter notifying the participant that within 30 days, full restitution or a repayment schedule mutually agreed on by the State office and the participant must be made. Additionally, the letter must include notice that failure to pay in full must result in a disqualification for a period of one year to begin no earlier than 30 days after receipt of the letter, at the end of the valid period of previously-issued coupons, or upon failure to make agreed upon payments, whichever is later. Notice of fair hearing rights and procedures must be included in the letter. A copy of the letter will be forwarded to the appropriate WIC project.

C. If full restitution is not made within 30 days or a payment schedule is not mutually agreed upon by the participant and State WIC, the final begin date of disqualification must be established.

D. If the participant is no longer on the program, State WIC must flag the participant's record in the system as "disqualified" to ensure program participation does not occur for the established disqualification period.

124.3 Procedures for Addressing Violations 124.1 A-E When the Violation Value is $100 or More, or It Is a Second or Subsequent Claim.

The following steps are taken for these violations:

A. An account of the violations and supporting documents must be sent to the State WIC office.

B. Once the violations are verified, the State WIC office must determine the value of the claim based on the Not To Exceed amount or face value of the involved food instruments or the amount paid for the involved breast pump.

C. The State WIC office must establish a claim via certified letter notifying the participant that within 30 days, full restitution or a repayment schedule mutually agreed on by the State office and the participant must be established. Additionally, the letter must include notice of disqualification for a period of one year to begin no earlier than 30 days after receipt of the letter, at the end of the valid period of previously-issued coupons, or upon failure to make agreed upon payments, whichever is later. Notice of fair hearing rights and procedures must be included in the claim letter. A copy of the letter will be forwarded to the appropriate WIC project.

D. If the claim does not total $1,600 or more, no additional claim actions must be taken if a response is not received from the participant. However, if the claim totals $1,600 or more, and the participant defaults on the payment plan or no response is received, the claim must be referred to the Ohio Attorney General's office for collection.

E. Once the final date of disqualification is established based on the receipt date of the letter or the valid period of previously-issued coupons, State WIC must terminate and flag the participant in the system as "disqualified" to ensure program participation does not occur for the established disqualification period.

F. If the participant is no longer on the program, State WIC must flag the participant's record in the system as "disqualified" to ensure program participation does not occur for the established disqualification period.

124.4 Procedures for Addressing Violation 124.1 F

The following steps are taken for this violation:

A. Within 120 days of detecting dual participation, the State WIC office must establish a claim based on the Not To Exceed amounts or face value of food instruments issued by the nonprimary clinic and must notify the participant that within 30 days, full restitution or a repayment schedule agreed on by the State office and the participant must be made. Additionally, the letter must include notice of disqualification for a period of one year to begin no earlier than 30 days after receipt of the letter, or at the end of the valid period of previously-issued coupons, whichever is later. Notice of fair hearing rights and procedures must be included in the letter. A copy of this letter will be forwarded to the clinics of participation.

B. Once the final date of disqualification is established, State WIC must terminate and flag the participant in the system as "disqualified" to ensure program participation is not approved for the length of the disqualification.

C. If the claim totals $1,600 or more, and the participant defaults on the payment plan or no response is received, the claim must be referred to the Ohio Attorney General's office for collection.

124.5 Procedures for Addressing Violation 124.1 G

The following steps are taken for this violation:

A. Depending on the severity of the situation, sanctions taken will be imposed at the discretion of the local project director in consultation with the State WIC office. Potential sanctions include a warning letter, disqualification for up to one year, and/or referral to law enforcement or other authorities for prosecution.
   1. A warning letter may be imposed for the first violation or for an abuse which is not clearly documented.
   2. A disqualification can be imposed for a period of up to one year for an abuse which is severe and clearly documented or for a repeat offense.

3. A referral to law enforcement or other authorities for prosecution can be made when the severity of the violation warrants intervention; for example, the safety of local WIC staff, applicants or participants appears to be in danger. Participant information related to this violation may be released only to law enforcement or prosecutorial entities; release of information to agency security or other personnel is not permitted.

B. Once the appropriate sanction has been determined, the local project must notify the participant via certified letter of a warning or disqualification. A disqualification letter must include notice of fair hearing rights and procedures. A copy of this warning or disqualification letter must be maintained in the participant's chart with a second copy forwarded to the State office.

128. WIC Disaster Plan

As defined by USDA, the WIC program is not a disaster assistance program and is not considered a first responder. However, WIC policies allow State agencies flexibility in program design and administration to support continuation of benefits to participants during times of pandemic, natural, or other disasters. This section outlines assumptions, limitations, communication, operating principles, and allowance for suspension of some certification policies and procedures that can be applied to Ohio disaster circumstances.

128.1 Assumptions

Key assumptions that the Ohio WIC program will be operating under during a pandemic, natural, or other disaster are:

- The workforce and population may be homebound, displaced, or hospitalized.
- There may be a critical need for people to remain in their homes to help contain the spread of disease.
- A disaster or pandemic may arrive and spread in several waves over the course of a lengthy period of time; for example, one-two years.
- The Ohio Department of Health (ODH) is the lead agency for providing information on the arrival of a pandemic disaster and its spread across the state.
- Local WIC projects need to become familiar with specific disaster preparedness in their communities via local health departments and the Emergency Management Agencies.
- During an emergency, there may be a local agency need for WIC program staff to be deployed temporarily to other job assignments to ensure the health and safety of all community members.
- The cost of protective gloves, masks, etc. is allowable. These items should be used to help prevent the spread of illness and disease in the clinic on an as-needed basis; for example, during regular cold and flu season.
- Local WIC projects will assist in helping people remain in their homes during peak disaster waves.
- Local WIC projects must maintain a supply of paper documents for determining participant eligibility when electrical power is disrupted.
- The WIC program will maintain or reestablish program services during an emergency. WIC will continue to provide WIC coupons to purchase supplemental food for those eligible as is feasible.

- The WIC program considers infants the most vulnerable WIC participants in that the breastfeeding support or formula provided by WIC is frequently their only food source.

128.2 Limitations

The following are limitations of the WIC program in any type of disaster-related emergency.

- The WIC program is not a first responder in an emergency. It is not a provider of emergency food. It does not distribute food or infant formula to emergency group facilities or evacuation centers.
- The issuance of WIC coupons to participants is reasonable only when food delivery systems are in place. For example, if there are no retail food stores open or if there is no food on the shelf to purchase, the family may be better served when referred to a food distribution site than given a coupon they cannot use.

128.3 Communication – Disaster Contact Phone Tree

To ensure continuity of WIC business in a disaster that closes ODH or a local WIC clinic, a Disaster Contact Phone Tree is established to share information with State and local WIC staff as quickly as possible within available communication systems and current knowledge about the disaster.

"Disaster" is used in a broad sense that includes closure due to power outages, tornadoes, blizzards and other inclement weather, systems destruction, fire, building collapse, and pandemic disease outbreak.

ODH Business Interruption

When information is received that the business of ODH is interrupted due to a disaster, the Bureau of Nutrition Services (BNS) Disaster Contact Phone Tree is activated and the following steps will be taken.

The Executive Office and Administrative Support Unit staff will contact the following BNS supervisors, local WIC Regional Representatives, and USDA Midwest Region office:

Executive Office Contacts:
Program Operations Supervisor
Program Development Unit/Data Operations Supervisor
Program Analysis Supervisor
Northwest Regional Representative
Northeast Regional Representative
USDA MWRO Director

Administrative Support Contacts:
Vendor Management Supervisor
Nutrition and Administrative Services Supervisor
Central Regional Representative
Southeast Regional Representative
Southwest Regional Representative

The BNS supervisors will contact their respective staff. If communication systems allow, all staff should update daily voice mail messages with closure status information.

The regional representatives or alternates will contact the project directors in the counties within their respective region.

Local Business Interruption

When a disaster occurs locally that interrupts WIC business in the community, the project director calls the assigned Nutrition and Administrative Services (NAS) consultant to report the incident. If the NAS consultant is not available, the project director may call any BNS staff person on the State staff phone and email list.

In some cases, depending on the time and nature of the disaster, the State WIC office may initiate contact to local projects, using the local WIC project emergency contact telephone listing, to determine impact on local clinics and services.

Based on information provided, the NAS consultant will assess the problem and project needs and report to the NAS supervisor and BNS chief.

The BNS chief will call in other needed supervisors and staff to assist in bringing the clinic into operation. This may result in having portable PCs deployed in temporary clinics, deploying the WIC mobile clinic van to the

community, and delivery of clinic supplies and forms that may have been lost in the disaster. Depending on the severity, the BNS chief may implement a temporary suspension of policies and procedures as outlined in this WIC Disaster Plan.

128.4 Operating Principles

Key operating principles in disaster circumstances include the following:

- A **refugee** is a person who has been forced to leave his or her home country and seek refuge elsewhere. In establishing eligibility, refugee status is not considered, and it is not necessary to determine whether or not an applicant is a refugee. Legal residency and United States citizenship are not requirements for participation in WIC.

- An **evacuee** is a person from an area in the United States where a weather-related or other type of disaster has occurred or is about to occur, and has been asked or required to leave home with very little advance notice.

    - Evacuees have been designated as being at special nutrition risk and receive high priority for certification.
    - Evacuees do not have to present proof of identity, residency or income that is normally required (that is, if you had to leave home in such a hurry that you were unable to bring the necessary documents with you, or if those documents were destroyed).

- Infants and children are among the most vulnerable victims of natural or human-induced emergencies.

    - Mother's milk is the safest food for infants during emergencies.
    - Interrupted breastfeeding and inappropriate complementary feeding heighten the risk for malnutrition, illness, and death.
    - Uncontrolled distribution of breastmilk substitutes can lead to early and unnecessary cessation of breastfeeding.
    - For the vast majority of infants, emphasis should be on protecting, promoting, and supporting breastfeeding and ensuring timely, safe, and appropriate complementary feeding.
    - See Appendix 400 for *Breastfeeding Support in Disasters Resources.*

128.5 Temporary Suspension of Policies and Procedures

During a disaster, there may be a temporary suspension of specific policies and procedures to help participants to continue to receive benefits while meeting overall public health needs that could include remaining at home to minimize the spread of disease. BNS will notify local projects when the temporary suspension begins and will provide a second notification when the temporary suspensions end. These temporary suspensions may be on a project-by-project basis depending on the disaster location, and they may be on-again, off-again depending on the number of waves of disaster.

Certification
Upon instruction from the State WIC office, the following certification policies and procedures may be implemented:

- Certification Periods for Breastfeeding Women, Infants, and Children: Within the parameters of section 246.7(g) (3) of the WIC regulations, the certification period may be extended by a period not to exceed 30 days.

- Physical Presence: Section 203.1 Exceptions to Physical Presence – Disabled, will be assumed and applied due to "a serious illness that may be exacerbated by coming into clinic." There may be barriers to physically accessing the clinic in severe weather circumstances.

- Certification can be completed via mailing of paperwork and documentation and/or telephone interview and completing the WIC system tabs.

- The documentation requirements for income, residence, identity, height, weight, and hemoglobin may be temporarily suspended when the BNS chief determines that the documentation requirement during the disaster presents an unreasonable barrier to participation or is needed to help families stay in their homes as an illness prevention measure. Reassess certification to extent possible; blood test, height or length, and weight measurements can be deferred for 90 days.

Food Package Assignment
Ready-to-Feed formula may need to be issued in circumstances where the water supply may be contaminated or is unavailable for mixing.

Medical Documentation for Exempt Infant Formulas and WIC-eligible Medical Foods
Participants presenting another state's food instrument that specifies an exempt infant formula or WIC-eligible medical food may be issued food instruments for the specified item up to the end of their certification period.

Participants without a food instrument, but who can provide the name of the exempt infant formula or WIC-eligible medical food that the individual was receiving before relocating, may be issued a one-month food instrument for that specific item.

Applicants who were not participants prior to the disaster must obtain medical documentation prior to issuing exempt infant formula or eligible medical foods. The medical documentation may be provided as an original written, electronic, or facsimile document. Medical documentation may be accepted by telephone by a health professional, who documents the information and keeps it on file. Telephone documentation may be used until written confirmation is received and only when necessary. The local clinic must obtain the written documentation within two weeks time after accepting the medical documentation by telephone. The written documentation is kept on file with the telephone documentation.

Refer individuals with serious medical conditions that require use of an exempt infant formula or eligible medical food to local medical providers to ensure that the participant is linked to the health care system.

Nutrition Education
Nutrition Education can be by telephone, internet, or mail as noted in Section 332, Mailing Coupons/Fruit and Vegetable Vouchers, and according to Chapter 400. If the telephone, internet, or mail systems are disrupted, then nutrition education is deferred until the next on-site appointment with participants.

Food Issuance
Coupons may be mailed to participants as allowed by Section 332, Mailing Coupons/Fruit and Vegetable Vouchers. During a pandemic, illness is presumed and prevention of further spread of illness by remaining home is critical. Local projects need to pay close attention to community business circumstances caused by the disaster where the mail, stores, and pharmacies may be slowed or shut down.

Replacement of WIC Coupons/FVVs
Coupons/FVVs lost or destroyed in a disaster may be reissued per PPM section 330.4, Void/Reissue.

128.6 Ohio WIC Disaster Plan of Action

The State WIC office will provide guidance based on the nature of the disaster by issuing the *Ohio WIC Disaster Plan of Action* to all local WIC projects. The action plan provides for a statement of disaster, which projects are affected, covered time frame, persons affected, and a checklist of actions that are being put in place. The *Ohio WIC Disaster Plan of Action* form is in Appendix 100 for reference.

CHAPTER 200

Introduction to Chapter 200 - Certification and Program Requirements

This chapter provides policy and procedure necessary for determining WIC program eligibility. The policy and procedure presented in this chapter must be used by local WIC projects in determining eligibility at the initial application and for each subsequent recertification. Title 7 of the Code of Federal Regulations Part 246.7 serves as the regulatory basis for the policy and procedure in this chapter. In addition, Food and Nutrition Service (FNS) Instruction Letters and WIC Policy Memorandums were used in the development of this chapter.

This chapter is organized to provide policy and procedure in the order in which the local WIC project will need to know or refer to information for certifying applicants/participants. The general organization of the Certification and Program Requirements chapter is as follows.

- Sections 201 through 259 provide policy and procedure for accepting and processing the WIC application, and for the six WIC eligibility requirements: physical presence, identification, categorical, residential, income, and medical/nutritional risk. Voter Registration and Immunization Coordination requirements are in sections 207 and 235, respectively.

- Sections 260 through 269 provide the supportive medical data and medical procedure requirements related to the certification process.

- Sections 270 through 279 provide the steps which must be taken following the eligibility determination. These steps include processing initially ineligible applicants and eligible applicants. In addition, procedures are provided for processing participants applying for recertification and participants who have changes in categorical status, including terminations and transfers.

- Sections 280 through 285 provide policy and procedure for special certification cases which include waiting lists, migrant farmworkers, foreign students and aliens, coordination of WIC and other health services, certification without charge, and participant file maintenance.

Every person in need of WIC program assistance must apply for the program and meet all of the eligibility requirements established by federal laws and regulations and Ohio WIC policies and procedures, as provided in this chapter. Likewise, the local WIC project must meet requirements as specified in this chapter for determining eligibility, obtaining necessary verification, documenting that eligibility requirements are met, notifying applicants/participants of their rights and responsibilities, reporting information to State WIC, and recordkeeping.

201. Ohio WIC Program Application Forms

Ohio WIC provides two application forms: (1) the *WIC Program Application* in section 201.1, and (2) the *WIC Application Addendum* in section 201.2. A third application form, the Ohio Department of Medicaid (ODM 07216) *Application for Health Coverage & Help Paying Costs* in section 201.3, may be accepted with rescreening requirements

201.1 *WIC Program Application* (HEA 4460)

Initial WIC applicants complete the *WIC Program Application* (HEA 4460). This form may be provided at the application appointment, mailed in advance of the application appointment, or printed and completed by the applicant from the WIC website.

- Each applicant must answer all questions on the application form as a preliminary step in the eligibility determination process.
- Questions relate to the identification, including gender, ethnicity, and race; categorical, residential, and income eligibility requirements.
- The applicant must sign and date the application form.
- WIC staff may complete the form if the applicant is not able to complete it, and sign and date in the space provided as the person who helped complete the form.
- A single application form may be used for a woman applicant and her children. The single application form should be maintained in the youngest child's WIC chart. Staff must cross-reference in other family members' charts by recording on the health history form "Location of CPA" space the full name of the child whose chart contains the application.

The *WIC Program Application* form contains a fill-in, check-off Agency Use Only section for documenting categorical, identification, physical presence, income, and residence verification information. Local WIC staff documents all verification information, signs (at least first initial and last name), and dates in the designated blocks. Application and documentation information must match information entered into the WIC system Demographics tab.

201.2 *WIC Application Addendum* (HEA 4466)

Participants requesting that WIC services be continued beyond their initial eligibility period can have eligibility recertified through the *WIC Application Addendum* (HEA 4466). This addendum form is for updating the original application information rather than having participants complete a new form.

The addendum is used for reviewing and updating the WIC system Demographics tab with the participant. Physical presence, identification, categorical, residential, income, and medical or nutritional risk requirements must be met at each WIC recertification.

- The participant must check the box indicating a request for continued WIC benefits, that the information has been reviewed and updated since the last application, and then sign and date the form.

- The "Confirmed or other information" section must be used to note changes made to previous information. For example, "income increased," "married - EU size changed from 3-4," or "no changes."

- Staff documents all verification information, signs (at least first initial and last name), and dates in the designated blocks in the Agency Use Only section. Documentation information must match information entered into the WIC system Demographics tab.

- Once completed, this form is placed in the participant's record with the original application. If a single application was used for a mother and her children, a single addendum is completed, filed, and cross-referenced per section 201.1

The addendum is for recertification only. As long as a participant continues to be recertified, a new addendum form may be used at each recertification. For example, a participant who has been recertified twice after initial application may have an original application and two addendums on file.

The addendum cannot be used to add a newborn infant or any other additions of children or a pregnant mother to an existing family group. Each new applicant for the WIC program must complete a *WIC Program Application*.

If a participant has been terminated from the program, a new *WIC Program Application* form must be completed; the addendum is not used to reinstate a former WIC participant.

201.3 *Application for Health Coverage & Help Paying Costs* (ODM 07216)

A referral to WIC on an Ohio Department of Medicaid (ODM) *Application for Health Coverage & Help Paying Costs* form must be processed as a WIC application as follows:

- Staff must try to contact the applicant within five working days of the stamped in date. Contact may be by telephone or letter with the contact date noted in the blank space at bottom of first application page; e.g., "telephone call on 11-6-15" or "letter sent 10-22-15."

- Once contact is made, staff sets up a clinic appointment for the applicant. The application processing time frame begins when the applicant comes into the WIC clinic according to section 201.4 Application Processing Time Frames.

- Due to differences in questions on the ODM form with respect to WIC eligibility requirements, staff **must rescreen** the applicant for:

  - ✓ household members: (note on ODM form, any members reported that should not be included in WIC economic unit; add any excluded members with their required WIC information by using a *WIC Program Application* as an attachment);
  - ✓ ethnicity and race: (have the applicant complete missing information on the ODM form);
  - ✓ other income: (have applicant report missing child support, veteran's payments, Ohio Works First, or SSI by using the "Other Income" space on the ODM form); and
  - ✓ deductions, if reported: (explain to applicant that federal tax deduction items are not applicable in WIC income eligibility determination).

- Once rescreening is completed, staff determines WIC eligibility.

- Documentation for WIC physical presence, identification, pregnancy, residence, and income requirements is completed using and attaching either a *WIC Program Application* or *WIC Application Addendum* form and entering information, signing (at least first initial and last name), and dating the Agency Use Only section.

- Application and documentation information must match information entered into the WIC system Demographics tab.

If the applicant does not respond to the contact attempt or follow through with a scheduled appointment, the local WIC project must keep the ODM referral application form in an "Inactive ODM Referral File" for a period of one calendar year.

201.4 Application Processing Time Frames

Application processing time frames begin when the applicant visits the local WIC project during clinic hours to make a request for program services. Staff must record the applicant's name, address, and the date of application at this initial visit on an application form.

Processing time frames for individuals telephoning for an appointment to apply for WIC services begin when the individual actually comes into the clinic, not the day of the telephone request.

Prenatal applicants, infants less than six months of age, and migrant farmers are considered expedited service participants. These expedited service participants must be notified of their eligibility or ineligibility within 10 calendar days of the initial date of request for services. All other applicants shall be notified of their eligibility within 20 calendar days of the date of the first request for services.

If individuals come to a clinic which may not be scheduled again within the 10 or 20 day requirements (such as a satellite clinic), the following must occur.

- The person's application should be processed that day.

- If the application cannot be processed that day, an appointment must be offered at a different location within the10 and 20 day requirements.

- If the individual does not choose to or cannot make an appointment at a different clinic, then an appointment must be scheduled for the next time the clinic is held at that location. The local WIC project must document the circumstances in the individual's chart.

202. Overview of WIC Eligibility Requirements

To be certified or recertified as an eligible participant for the Ohio WIC program, six eligibility requirements must be met.

1. Physical Presence - The applicant/participant must be physically present in the local WIC project clinic at the initial and each subsequent certification visit.

2. Identification -The applicant/participant must provide personal identifying information to the local WIC project.

3. Categorical - The applicant/participant must be a member of one of the five categorical groups served by the WIC program: a pregnant, postpartum, or breastfeeding woman; an infant from birth to one year of age; or a child from one up to five years of age.

4. Residential - The applicant must live in the state of Ohio.

5. Income - The applicant/participant must have income within the Ohio WIC income guidelines.

6. Medical/Nutritional - The applicant/participant must be determined to be at medical or nutritional risk by a health professional at the local WIC project.

An applicant/participant must meet all six of these requirements to be eligible for the Ohio WIC program. The sections which follow provide detailed policies and procedures for establishing eligibility under each of these six requirements.

203. Physical Presence Requirement

An applicant must be physically present in the local WIC project clinic at the initial WIC certification visit and at each subsequent recertification visit, except in certain limited circumstances described in subsection 203.1. Physical presence is a key public health practice for providing nutrition and health assessment, observing and gathering objective and subjective information about the applicant, tailoring food packages to an individual's needs, and promoting active participation in nutrition and breastfeeding education. Physical presence also helps with making clear recommendations and referrals to other agency or on-site services such as immunizations or lead screening. In addition, physical presence facilitates meeting other eligibility requirements including identity, residence, and income.

203.1 Exceptions to Physical Presence

In certain, limited situations, an applicant/participant, or the parents or guardians of the applicant/participant, may be exempted from meeting the physical presence requirement at the certification or recertification clinic visit. Although the applicant/participant's physical presence may be exempted by criteria described in this section, all other eligibility requirements must be met. The information and documents required to meet the remaining eligibility requirements may be provided by a parent, guardian, or authorized representative as described in subsection 203.2. The allowed exceptions to physical presence are as follows:

1. Disabled: This exception is for an applicant/participant with a physical or mental impairment (disability) that substantially limits one or more major life activities such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Under the Americans with Disabilities Act and the Rehabilitation Act, WIC projects must provide reasonable accommodations for persons with disabilities. However, in the case of an applicant or participant (or parent, guardian, or caretaker of an applicant or participant) who has disabilities that make it difficult to come into a WIC clinic for certification, the applicant/participant may be certified without being physically present. This does not mean that all persons with disabilities are automatically exempt, but only those whose disabilities create a current barrier to being physically present in the WIC clinic.

Disabled persons may also include those who have a temporary current condition such as:

- a medical condition that necessitates the use of medical equipment that is not easily transportable,
- a medical condition that requires confinement to bed rest, or
- a serious illness that may be exacerbated by coming into the clinic.

2. Unreasonable Barrier to Participation: This exception is for certain infants or children in the following circumstances in which physical presence would present an unreasonable barrier to participation. The circumstances are:

    - an infant or child who was present at the initial WIC certification, and was physically present at one recertification visit within the past 12 months, and who has working parents, guardians, or caretakers whose working status presents a barrier to bringing the infant or child into the WIC clinic during available clinic hours. In a two-parent household, both parents must be working. An example of this is working parents whose children are in daycare, and the distances and time needed away from work to pick up the children and meet the appointment may jeopardize employment status.

3. Infants Born to Women Participants: Infants born to women who participated in WIC during their pregnancies are considered to be medically or nutritionally eligible for WIC services and may be certified without being physically present at the time of certification. In this circumstance, the certification visit type for the infant certification must be a Preliminary "P" visit.

    Infants born to women who participated in WIC during their pregnancies and who are not physically present at their initial certification may not be certified as visit type Certification "C" because this will allow three months of food issuance and provide six months of eligibility. These infants are permitted by federal regulations to be certified for six weeks only, pending their physical presence in the WIC clinic.

The certification procedure for a "P" visit, as for any certification, must include a completed Combined Programs Application (CPA), Welcome to WIC letter (WTW), accurately plotted growth chart, and WIC Health History form. The WIC Health History form must be completed as much as possible at this time to document assessment of infant feeding practices (such as breastfeeding or formula preparation). The CPA and WTW letter require the signature of the infant's parent or guardian. The health professional must assess and sign the WIC Health History form. Only a health professional may assign medical/nutrition risk codes and the food package. The parent or caretaker shall be provided appropriate nutrition education.

When not physically seen at the time of certification, the infant must be given an appointment to be seen in the clinic by six weeks of age. At this Follow-up "K" visit, the growth chart must be updated with current anthropometric measurements and follow-up nutrition counseling must be provided. Additional risk codes and follow-up nutrition counseling must be updated on the initial WIC Health History form. The remaining benefits for the three-month period will be issued at this time.

In some instances, an infant is hospitalized for an extended period of time, or has a medical condition which prevents the infant from being seen in the clinic by six weeks of age. If the infant is in the hospital, there is no need for immediate certification since the infant's food needs are being met in the hospital. Once the infant is released from the hospital, certification may occur. If the infant is out of the hospital, but has a medical condition that prevents physical presence at the WIC clinic by six weeks of age, the exemption should be documented on the Health History form and the remaining benefits for the three-month period may be issued.

If the infant is not brought into the clinic by six weeks of age and is not exempt from the physical presence requirement for any other reason, food instruments must be withheld until the infant is seen in the clinic.

203.2 Time Limit on Physical Presence Exemption

Limits on the length of time an applicant/participant may be exempt from the physical presence requirement must be handled on an individual case basis. The exception is only applicable to the certification period for which it was provided. Need for further exemptions must be reassessed at each subsequent certification.

203.3 Authorized Representative

When the applicant/participant is not able to be physically present in the clinic, or the parent or guardian of the applicant/participant is not able to be physically present in the clinic, an authorized representative may be designated to act in the applicant's/participant's behalf. The authorized representative, in acting on the applicant's/participant's behalf, will provide the clinic with the applicant's/participant's information to determine eligibility, including identity, categorical, residence, income, and medical or nutritional risk documentation.

When parents or guardians have asked an individual to serve as an authorized representative, the forms needed for certification must be sent ahead of the visit for the parent to read, complete, sign, and return with supporting documentation (for example, pay stubs, Healthy Start card, birth certificates) with the authorized representative. When the clinic is not forewarned that there will be an authorized representative, the appointment should be completed to the extent possible and the needed forms provided to the representative to take to the parents or guardians for completing, signing, and returning to the clinic. These forms include the Combined Programs Application, appropriate health histories, Welcome to WIC letter, and Voter Registration.

The parents or guardians must provide the WIC clinic with either a telephone number where they can be contacted to confirm that the person appearing is the authorized representative, or a currently dated note signed by the parents or guardians indicating that the person is the authorized representative. The signed, dated note may simply state: "I have asked (Authorized Representative) to represent me and to bring my children (Names of Children) to this WIC appointment. If you have any questions, please call me at: (telephone)." The *WIC Authorized Representative Letter* in Appendix 200 may also be used to fulfill this requirement. The signed

authorization letter from the participant is only valid for the current certification period.

203.4 Documentation of Physical Presence

An indication that the applicant/participant was either physically present or has an exception to the physical presence requirement must be documented in the Agency Use Only section of the application by checking either a "P" for Present or an "E" for Exempt next to the applicant's name. If an "E" is checked, one of the following allowed exception reasons must be written next to the "E." For example, "E – newborn infant or E - work."

- newborn infant
- disabled
- medical condition - confinement
- medical condition - equipment
- serious illness
- barrier to participation due to work

204. Identification Requirement

As an initial step in the certification and recertification process, the local WIC project must check and document the identification of each applicant/participant.

Documentation on the application form must include:

- type of identification seen, and
- date the identification is checked.

Examples of documents used to identify women applicants/participants include:

- driver's license or Ohio ID card,
- employee identification card,
- Social Security card, (Do not write Social Security Numbers on the application form.)
- Public assistance identification card,
- Medicaid card,
- voter's registration,
- insurance policies, and
- WIC ID or VOC card. (The WIC ID cannot be used at an initial certification appointment.)

Examples of documents used to identify infants and children include:

- immunization record,
- birth certificate,
- hospital record,
- crib card,
- day care or nursery school record,
- Social Security card (Do not write Social Security Numbers on the application form.), and
- WIC ID or VOC card. (The WIC ID cannot be used at an initial certification appointment.)

Once the documentation presented by the parent or guardian for the infant's or child's identification has been recorded in the WIC chart, the infant's or child's documents do not need to be presented again at recertification visits.

205 Categorical Requirement

An applicant/participant must be a member of one of the following categorical groups to participate in WIC.

- Women Pregnant - Women determined through an objective medical assessment to have one or more embryos or fetuses in the uterus, or the WIC certifying health professional's assessment that the applicant appears to be pregnant

  Postpartum - Women who have terminated a pregnancy within the last six months by birth, miscarriage, or abortion

  Breastfeeding - Women up to one year postpartum who are feeding mother's breast milk to their infants on the average of at least once a day

- Infants Person under one year of age

- Children Persons who have had their first birthday but who have not yet had their fifth birthday

205.1 Women Certified as Pregnant

Verification of pregnancy for a woman applicant who claims or appears to be pregnant is required within 60 days after certification in one of the following two ways:

(1.) An objective medical assessment such as the results of a blood or urine test or an ultrasound, by an appropriate medical authority (e.g., a physician or Planned Parenthood staff nurse), or

(2.) A notation by the WIC certifying health professional that, based on the applicant's statement and the health professional's assessment, the applicant appears to be pregnant.

Immediate proof of pregnancy is not a condition of eligibility for WIC; the applicant's statement of pregnancy is sufficient for 60 days. Applicants not providing verification of pregnancy at certification must provide the local project with verification of pregnancy within 60 days after certification. If verification is not provided within 60 days, the local project must terminate the woman's participation in the program.

The verification of pregnancy must be documented on the application. Acceptable verification includes reference to the participant's medical chart in the prenatal clinic, a written statement from the health professional who performed the pregnancy assessment, or documentation of a telephone conversation with the health professional. Documentation of a telephone conversation must include the name of the contact person, the date, and a confirming statement about the pregnancy.

Procedure When Verification of Pregnancy Is Not Available

An applicant who does not have verification of pregnancy or who cannot be determined as appearing to be pregnant may receive WIC benefits for 60 days without such verification. The local WIC project enters an "N" (No) in the Pregnancy Verification field on the WIC system Pregnancy Info tab. A warning message will appear as a reminder that pregnancy verification is required within 60 days.

When the participant provides the verification, the "N" on the Pregnancy Info tab must be changed to "Y" (Yes). If the "N" is not changed to indicate that pregnancy has been verified, then issuance of food after two months will be prohibited in the system. A warning message will appear indicating that pregnancy verification is required.

205.2 Women Certified as Postpartum

Verification of delivery, miscarriage, or abortion is required for women who are certified as postpartum. Verification for women who are certified as postpartum is determined either from an attending medical authority or by the WIC certifying health professional that, based on the applicant's statement and the health professional's assessment, the applicant is postpartum.

205.3 Women Certified as Breastfeeding

Verification of breastfeeding is required for women who are certified as breastfeeding. Verification for women who are certified as breastfeeding is determined either from an attending medical authority or the WIC certifying health professional that, based on the applicant's statement and the health professional's assessment, the applicant is breastfeeding.

205.4 Certifying Infants and Children

Verification is required for categorical eligibility of infants (0-12 months of age) and children (one year up to five years of age). The documentation must indicate the birth date of the infant or child. Examples of documents include an immunization record, birth certificate, hospital record, crib card, day care or nursery school record. Once the documentation presented by the parent or guardian for the infant's or children’s categorical eligibility has been recorded in the WIC chart, the documents do not need to be presented again at recertification visits.

206. Residence Requirement

An applicant/participant must live in the state of Ohio to receive Ohio WIC program services. The applicant/participant does not have to live in the state for any minimum time limit to be considered an Ohio resident. The local WIC project must see proof of residence and document it in the Agency Use Only section of the application form at initial and subsequent certifications. Proof of residence of the parents/guardians serves as proof for infants and children.

Examples of documents used to prove residence include Ohio driver's license or identification card, utility or credit card bills, WIC appointment reminder cards received through the mail, or any document that bears the name and current address of the applicant/participant. The address reported on the application must match the address appearing on the document used for proof of residence.

If the applicant/participant has no proof of residence, a statement must be signed by the applicant/participant attesting to residence. Since the application and its addendum contain a statement affirming that the information on the application is correct and the applicant signs the form, this can serve as the required statement. The local WIC project must make a notation as to the reason the applicant/participant could not produce proof of residence in the Agency Use Only section of the application. For example, staff may write: "Applicant moved recently; address stated on application," or, "Participant's records lost in flood; address stated on application."

Participants generally receive services in the county where they reside. Participants may request services in a *nonresidence* county due to transportation issues, healthcare location, convenience, or any other stated barriers.

- Local staff in *nonresidence* counties must inform individuals of the availability of services in their residence county. If the individual desires to receive services in the county of residence, provide the individual with the name, address, and telephone number of the local WIC project which serves that county. If the individual desires service in the *nonresidence* county, provide services.

- Staff is not to encourage individuals to seek services outside of their residence county, but is to facilitate WIC services.

206.1 Residents of Institutions, Group Homes, and Shelters

Applicants/participants residing in institutions, group homes, emergency shelters, or homeless shelters may be eligible to receive WIC services and benefit from WIC in the same manner as any other person requesting or receiving WIC services. There are circumstances that may cause individuals to take temporary residence in shelters for battered women, shelters for the homeless, and homes for unwed mothers, etc. An application for residents of institutions, group homes, and shelters must be processed with the following considerations.

(1) Statement of Address - The local project must review the circumstances of each applicant/participant on an individual basis. Eligibility may not be denied due to lack of a permanent address. The applicant's/participant's written statement of address on the application serves as documentation for the residence requirement. Persons, who reside in institutions, group homes, or emergency shelters, may list the institution, group home, or emergency shelter address. Persons who reside in temporary shelters, battered women's shelters, and/or are in transit from day to day may not be able to provide the project with a specific address. The applicant/participant should enter the city, county, and state of residence on the application.

Use the following procedures when entering data into the WIC System:

- Record "No Permanent Address" in the Address field and the appropriate name and zip code of the local WIC project's city or town in the City and Zip Code fields.

- Select the appropriate code which pertains to the applicant/participant in the Residence Status field (Res Status). A participant cannot be classified as "Homeless" if the participant has maintained a temporary accommodation in the residence of another individual for a period that exceeds 365 days prior to the application date.

(2) Income Verification - Local WIC projects must attempt to verify income of applicants/participants residing in institutions, group homes, or emergency shelters. When income documentation does not exist, the application may be processed based on the individual's statements as long as there is no evidence or facts to cast doubts on the applicant's/participant's income declaration.

(3) Benefit Issuance - WIC foods for persons residing in a temporary residence must be prescribed in the same manner as foods for any other person participating in WIC. Storage facilities for food products must be considered when prescribing food packages and participants are to be informed that these foods are not to be used for communal feedings.

(4) Information and Referral - Local WIC projects must provide applicants and participants residing in a temporary residence with information about other health care and human service programs available within the community as described in the section headed Coordination of WIC and other Health Care Services.

207. **Voter Registration Requirement**

Each WIC applicant must receive a *Voter Registration Form* and a *Designated Voter Registration Agency Notice of Rights* form at the time of application and recertification. The National Voter Registration Act (NVRA) of 1993, Public Law 103-31, and Amended Substitute Senate Bill 300 of the 120th Ohio General Assembly required that WIC project sites serve as voter registration assistance sites throughout Ohio. These laws also have designated county departments of job and family services, public schools, libraries, mental health agencies, developmental disabilities agencies, and vocational rehabilitation agencies as voter registration sites. The purpose of these two laws is to increase opportunities for voter registration and voting among eligible citizens. The following subsections provide an explanation and the procedures for conducting voter registration as part of the WIC application process.

207.1 Voter Registration Coordinator

Each WIC project must designate a staff person to serve as the project's voter registration coordinator. In conjunction with the Secretary of State's (SOS) Voter Registration Instruction Manual, the voter registration coordinator will be responsible for:

1. completing and submitting the local WIC project check-off *Voter Registration Assistance Plan* or update by the annual grant application date established by the State WIC office,

2. training staff who will be assisting in voter registration activities,

3. ensuring that instructional materials received from the State WIC office or the SOS are distributed to staff,

4. ensuring that all voter registration forms and informational materials designated by the SOS are available in local project clinic sites,

5. ensuring that the registration forms are transmitted to the County Board of Elections as determined in the local plan, and

6. serving as the contact person and coordinating with the County Board of Elections, the SOS office, and the State WIC office to resolve any voter registration issues as they arise.

207.2 Voter Registration Assistance Plan

Each local WIC project must complete the check-off *Voter Registration Assistance Plan* or update request provided by the State WIC office in the annual grant application. The plan includes:

1. the name of the project's voter registration coordinator and the locations of all the local clinic sites as requested in the grant application;
2. an assurance that the project will follow Ohio WIC Policy and Procedure Manual (PPM) section 207 to conduct voter registration at each application and recertification;
3. an assurance that each applicant receives the *Designated Voter Registration Agency Notice of Rights* form at the time of application;
4. an assurance that staff giving out and accepting voter registration forms will be trained according to PPM section 207 and the SOS Voter Registration Instruction Manual; and
5. the method by which the local WIC project has agreed upon with the County Board of Elections for transmitting the voter registration forms.

This plan will be filed through the Ohio WIC office with the SOS by the required annual due date specified in Ohio Administrative Code Rule 111-10-02.

207.3 WIC Staff Responsibilities in Voter Registration

Local WIC project staff is responsible for providing each program applicant, both initially and at recertification, an opportunity to register or decline to register to vote. This opportunity is provided by giving the applicant a *Voter Registration Form* and a *Designated Voter Registration Agency Notice of Rights* form together with all other WIC program application forms. The applicant is to complete the registration form or decline registration. If the applicant requests assistance with completion of the form, project staff must provide that assistance just as with any of the WIC application forms. In providing the opportunity to register or decline, or in providing assistance with completing the registration form, local WIC project staff must not:

- directly or indirectly seek to influence the applicant's political preference or party enrollment,
- display or demonstrate any political preference or party allegiance, or preference or support for any state or local ballot issues inclusive of local tax levies and bond proposals,

- make any statement to an applicant or take any action which would have as its purpose or effect to discourage the applicant from registering to vote, and

- make any statement to an applicant which would have as its purpose or effect to lead the applicant to believe that a decision to register or decline to register has any bearing on the availability of WIC services or benefits.

207.4 Voter Registration Form

The SOS *Voter Registration Form* specifies requirements to register to vote and instructions for completion of the form. It is a preaddressed mailing form, if the applicant chooses to take the form home to complete. It is also used by the applicant for a voter address or name change. The local project must obtain supplies of the *Voter Registration Form* from its County Board of Elections or print its own supply since it is not a State WIC stocked form. A copy of the form and the *Bilingual (English/Spanish) Voter Registration* form appear in Appendix 200.

If a non-WIC applicant requests a voter registration form at a WIC clinic, it must be provided and received in the same manner as a WIC applicant's form. Requests such as this may occur if a friend or relative is at the WIC clinic with the WIC applicant.

207.5 Treatment of Voter Registration Forms

When a *Voter Registration Form* is returned to the intake desk, it is treated according to the manner in which it is completed as follows:

1. If it is completed, then date stamp it or write in ink a date as received that does not identify the WIC program. This is to ensure that the registering voter is not identified as a WIC participant on “public” voter registration records. The date stamp or written date must be placed in a blank space on the form so as to not interfere with reading the form.

2. If it is returned blank, then it is considered a "declination" to register to vote.

3. If the applicant takes the form home, no further action is required of the local project.

4. If a form is taken home, completed, and returned to the WIC office later, then treat it according to the information in item 1 above.

5. Transmit completed forms to the County Board of Elections within five days according to procedures established by the local project voter registration coordinator.

207.6 Designated Voter Registration Agency Notice of Rights Form

The SOS *Designated Voter Registration Agency Notice of Rights* form provides applicants with their rights in responding to the *Voter Registration Form.* This form must be given to the applicant with the *Voter Registration Form* initially and at recertification. The local WIC project prints its own supply of this form because it requires specific county information. Before printing this form, the local WIC project must fill in the "agency name" line at the top of the form; the name, address, and telephone number of the county prosecutor; and the telephone number of the County Board of Elections in designated spaces. A copy of the form appears in Appendix 200.

207.7 Agency Based Registration Voter Registration Transmission Form

The completed *Voter Registration Forms* must be forwarded to the County Board of Elections within five days of receipt. All forms collected between Monday and Friday can be sent to the Board of Elections once each week, by the end of the day on Friday. The local project voter registration coordinator is responsible for coordinating the transmittal of the forms to the County Board of Elections. The transmittal takes place using the *Agency Based Registration Voter Registration Transmission Form* as follows:

1. Complete the information requested on the form, including "agency name, address, and transmission date."
2. Complete the “number of registration forms" line. These are batched and sent with the transmittal form.
3. Complete the "agency designee signature, title, and phone number" lines; and, if needed, the “comments” lines.
4. Forward the transmittal form with the registration forms to the County Board of Elections in which the local project is located in the manner agreed upon in the local voter registration plan; that is, by mail, courier, Board of Elections pickup, or other delivery method.

The local project must print its own supply of the transmittal forms since it is not a State WIC stocked form. A copy of the form appears in Appendix 200.

207.8 Voter Registration Record Keeping and Reporting

The SOS has designated the County Boards of Elections as responsible for maintaining the voter registration forms and accompanying transmittal forms received from local WIC projects. The County Boards of Elections are responsible for reporting the numbers of voter registrations received from WIC to the SOS for the Federal Elections Commission.

Since the County Boards of Elections have the responsibility of maintaining voter registration records and statistical reporting, local WIC projects are not required to maintain any copies of voter registration forms or transmittal forms.

210. Income Requirement

An applicant/participant must meet specific income guidelines to participate in WIC. The sections which follow contain the Ohio WIC program income guidelines and definitions of an economic unit, earned income, and unearned income. These sections provide information about determining applicable income. This information includes treatment of public assistance income, income that is not counted, verification of earned and unearned income, and calculating countable income.

211. Ohio WIC Program Income Guidelines

Ohio WIC program income guidelines are based on FNS income guidelines for reduced-priced school meals established under Section 9 of the National School Lunch Act. FNS adjusts its income guidelines on or before July 1st of each year based on annual adjustments in the revised poverty income guidelines issued by the United States Department of Health and Human Services (HHS). FNS multiplies the HHS poverty income guidelines and increment for each additional economic unit member by a factor of 1.85, and rounds the results upward to the nearest whole dollar amount. As a result of using this formula, the Ohio WIC program income guidelines are equal to185% of the HHS poverty income guidelines.

In order to be eligible for WIC, the gross countable income of the economic unit, of which the applicant/participant is a member, must be less than or equal to the Ohio WIC program income guidelines for economic unit size provided in the chart on the following page.

OHIO WIC PROGRAM INCOME GUIDELINES

Economic Unit	Annual	Monthly	Twice Monthly	Biweekly	Weekly
1	$21,775	$1,815	$ 908	$ 838	$ 419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
9	83,343	6,946	3,473	3,206	1,603
10	91,039	7,587	3,794	3,502	1,751
11	98,735	8,228	4,114	3,798	1,899
12	106,431	8,870	4,435	4,094	2,047
13	114,127	9,511	4,756	4,390	2,195
14	121,823	10,152	5,076	4,686	2,343
15	129,519	10,794	5,397	4,982	2,491
16	137,215	11,435	5,718	5,278	2,639

212. Definition of an Economic Unit

The local WIC project must establish the size of the economic unit of which the applicant/participant is a member. The total gross countable income of all individuals living together in the single economic unit of which the applicant/participant is a member is counted to determine income eligibility. Determination of economic unit size is based on the number of individuals living together with consideration given to relationship and/or legal responsibility among members of the household.

An economic unit (EU) is an individual or a group of related or nonrelated individuals who are:

- not residents of an institution,
- usually living together, and
- sharing income and or other household goods and services.

The following subsections provide guidelines to establish EU size. A basic principle which carries through each subsection is that it is possible that two or more separate EUs can live together under the same roof.

212.1 Related Individuals with Legal Responsibility

Related individuals who live together and who have legal responsibility for some or all of the other individuals through marriage, birth, adoption, placement for adoption, or legal guardianship are considered to be a single EU. Examples include:

- Expectant couple
- Two parents with minor children
- Single parent with minor children
- A legal guardian with children

Following are some specific circumstances which involve determining a child's membership as part of an EU.

1. Child of Divorced or Separated Parents

   - Count the child in the EU of the parent or guardian with whom the child lives.
     Example: A mother and child live together and receive child support payments from the father who is remarried and lives in the same town. Count mother and child as EU of two and count child support payment as part of income.

- Count the child in the EU of the parent with whom the child lives the majority (over one-half) of the time for joint custody situations.

- In equal share (50/50) joint custody arrangements, the parents must mutually agree on the EU of which the child is a member. If the joint custody is set up on clearly defined time frames (e.g., six months with the father and six months with the mother), then count the child as a member of the EU where he lives during the specified time period.

- If there is not clearly defined time frames and the parents cannot agree on EU membership for the child, the income eligibility is based on both of the parents' EUs, regardless of where the parents reside.

2. Pregnant Minor or Minor Mother Living at Home

   A pregnant minor or minor mother is less than 18 years old. Count the pregnant minor or minor mother in the EU in which she lives. (e.g., lives with parents, a single parent, or legal guardian)

   - In some circumstances, a pregnant minor or minor mother may claim that she is totally supporting herself and infant. Children under the age of 18 are the legal responsibility of their parents. If the pregnant minor or minor mother lives with her parents, she is counted in her parent's EU regardless of statements of self sufficiency.

   - The infant born to a minor mother, who lives in the home of the minor mother's parents or guardians, is counted in the total EU of the minor mother. Income provided for the infant is counted as part of the total EU income. (The infant may be considered a separate EU under special circumstances. See Section 212.2.)

3. Minor Father with Custody of his Infant or Child

   Count the infant/child in the minor father's EU.

4. Pregnant Woman's EU

   Count the fetus or number of fetuses as part of the woman's EU.
   Example: A pregnant woman carrying twins and living with her husband and two older children is counted as an EU of six.

212.2 Related Individuals Without Legal Responsibility

Individuals who are related and who live together, but who have no legal responsibility for each other, are considered to be a single EU only when they consider themselves as a single EU.

Examples of related individuals who live together, but who have no legal responsibility for each other include:

- parents with adult children (18 years of age and older)
- grandparents who care for grandchildren
- adult sisters or brothers who live together

If the applicant/participant states that all of the related individuals live together as an EU, then all of the individuals are treated as one EU. If the applicant/participant states that the related individuals make up different EUs, then the local WIC project determines EU size and income based on the composition of the EU of which the applicant/participant is a member.

- A Minor Mother's Infant as a Separate Economic Unit

  When a minor mother and her infant live with the minor mother's parents, the minor mother's parents may state that they are not providing financial support or will not provide financial support for the infant. As grandparents, they are not legally responsible for the financial support of their grandchild. The infant can be considered an EU of one provided there is a separate, verifiable source of financial support for the infant, or currently has "zero" financial support but is being assisted through in-kind support from the grandparents or other family members.

  - Examples of financial support include child support payments, public assistance payments, or the minor mother's earned income.

  - Examples of in-kind support include housing, health insurance coverage via the grandparent's employer, clothing, or food.

  - The project must document the "zero income" circumstance and in-kind support, and should provide information to the minor mother about the public assistance programs, child support enforcement, and other available services in the community.

212.3 Foster Child

- Count as an EU of one a foster child who is living with a foster family, but who remains the legal responsibility of welfare or other agency.

- The payments made by the welfare agency or from any other source for the care of that child are considered as the income of that foster child. The income of other members of the foster family does not apply as income available to the foster child.

212.4 Nonrelated Individuals as EUs

Nonrelated individuals who live together are usually not considered to be an EU unless they consider themselves to be a single EU. The local WIC project must accept the statement of the applicant/participant who lives with the other individuals.

- If the applicant/participant states that all of the individuals live together as an EU, then all of the individuals are treated as one EU.

- If the applicant/participant states that the nonrelated individuals make up different EUs, then the local WIC project determines economic unit size and income based on the composition of the EU of which the applicant/participant is a member.

212.5 Unmarried Couple Expecting or Who Have a Common Child

- An unmarried couple who lives together and who is expecting or who has a common child is considered to be a single economic unit. The economic unit size consists of the unmarried expectant couple plus number of fetuses, or the unmarried couple and the common child, and any other individual living with the unmarried couple for whom either or both have legal responsibility.

- An unmarried couple who lives together and who is expecting or who has a common child is not treated according to Section 212.4, Nonrelated Individuals as Economic Units. Even though unmarried, the couple shares a common relationship and legal responsibility to the child.

212.6 A Child Living Away from Home

If a child resides in a school or institution for part of the year and the child's support is being paid for by a parent or guardian, the child is counted in the economic unit of that parent or guardian. Even though the child may be living apart from the family or guardian for the majority of the time, the child is counted as part of the economic unit, since the family continues to provide the economic support for the child.

212.7 Military Families as EUs

To determine the economic unit size of military families when military personnel are serving overseas or assigned to a military base and temporarily absent, the following three options are provided in order of preference:

1. Military personnel serving overseas or assigned to a military base, even though not living with their families, should be considered members of the same economic unit. Use of this option is dependent on what the local project can reasonably determine, based on available data, as the total gross income of the economic unit.

2. If the total gross income of the economic unit that includes the assigned military personnel cannot be determined, and the spouse and children have their own source of documented income (for example, spouse and children allotments), then the spouse and children may be counted as a separate economic unit.

3. In some cases, the children may be residing with other relatives or friends. In these circumstances, the children may be counted:

   a. As part of the economic unit of the absent military parents if the total gross income of the entire economic unit can be determined, or

   b. As a separate economic unit if there is a children's military pay allotment that is being received to meet the needs of the children during the military assignment.

   c. When options (a) or (b) are not applicable, count the children as part of the economic unit of the persons with whom they are residing.

213. Income Eligibility for Public Assistance Recipients

A WIC applicant/participant who is certified as a fully eligible recipient of one of the following Ohio Department of Job and Family Services (ODJFS) public assistance programs meets the WIC income eligibility requirements.

- Ohio Works First (OWF) (Temporary Assistance for Needy Families [TANF])
- Food Assistance program (Supplemental Nutrition Assistance Program [SNAP] formerly known as Food Stamps)
- Medicaid program which includes, but is not limited to, Healthy Start, Healthy Families, and Expedited Medicaid
- Refugee Resettlement program
- Financial Disability Assistance program (ODJFS safety net program for those not eligible for other federal and state programs such as OWF)

In addition, a WIC applicant/participant who is a member of an economic unit consisting of any of the following public assistance recipients is adjunctively income eligible:

- Ohio Works First recipient
- pregnant woman recipient of Medicaid (Medicaid for pregnant women extends to 60 days postpartum)
- infant recipient of Medicaid (Infants born to mothers on Medicaid are deemed eligible for full Medicaid until the end of the month of the first birthday.)

Public Assistance Adjunctive Eligibility Summary

	Medicaid	**Ohio Works First**	**Food Assistance***
Pregnant Woman	Self and economic unit members	Self and economic unit members	Self and economic unit members
Infant	Self and economic unit members	Self and economic unit members	Self and economic unit members
Child	Self	Self and economic unit members	Self and economic unit members

***** The Food Assistance program identifies a head of household to receive Food Assistance benefits for all household members. Usually, infants and children would not receive benefits individually.

Due to the difference in the way economic unit size and income are counted in public assistance programs and Healthy Start Medicaid income eligibility at 200 percent of the federal poverty level, a public assistance recipient may have income exceeding the Ohio WIC Income Guidelines. A public assistance recipient who has income exceeding the Ohio WIC income guidelines is income eligible for WIC services based on adjunctive public assistance program eligibility.

The local WIC project must verify and document the applicant/participant's participation in a public assistance program on an Ohio WIC Program Application form, and must enter the corresponding public assistance codes in the Public Assistance and Proof on File fields on the demographics screen.

Allowed Public Assistance Verification

The following are allowed verifications of public assistance participation:

- current month's Medicaid card (some Medicaid categories provide monthly cards)
- printout accessed by participant from benefits account at: www.odjfsbenefits.ohio.gov
- benefits notice letter or CRIS-E computer system "Proof of Eligibility" and benefits printout
- current Medicaid status from Medicaid Provider Information Line at 1-800-686-1516 or Medicaid Information Technology System (MITS)
- current Food Assistance status from the Ohio EBT Cardholder Portal at https://www.ebt.acs-inc.com/ebtcard/ohebt/index.jsp This portal can only be accessed by the participant who can share the view with local WIC staff. The portal will show the EBT cardholder's name and address and the last three months of transactions including Food Assistance deposits. The screen can be printed.
- documentation of a telephone conversation with the public assistance eligibility determiner

Documentation of the Medicaid card, Medicaid Provider Information Line or MITS, OWF, Food Assistance, or other benefits notice, or printout must include the type of public assistance program, identifying case or billing number, and issue date or current effective date.

Documentation of a telephone conversation must include the name of the contact person, the date, the type of program and identifying case or billing number, and a confirming statement of public assistance eligibility.

Not Allowed as Public Assistance Verification
The following are **not allowed** as public assistance verification because they do not contain sufficient information which identifies an individual as a current public assistance recipient:

- health maintenance organization (HMO) or managed care organization card, website, or staff conversation; these organizations do not determine Medicaid eligibility
- Ohio Directions Electronic Benefits Transfer (EBT) card
- public assistance picture identification card

Income Recording for Verified Public Assistance Participants
When public assistance is verified and documented, the income source, amount, and frequency reported on the application need not be verified nor documented in the Agency Use Only section of an Ohio WIC Program Application. However, an income amount must still be recorded in the WIC system and on the application for demographic reporting.

Staff determines the income amount to record in the WIC system by the following steps:

1. Review for accuracy and completeness all economic unit income amounts and frequency reported in the income section on an Ohio WIC Program Application.

2. Clarify any missing information with the applicant/participant.

3. Enter each full income amount, both dollars and cents, separately into the WIC system income field and select the frequency for each income amount from the income frequency drop down box.

4. Allow system to calculate the income and record the final total amount on the application. The final amount that remains in the system is rounded down for 49 cents and below and rounded up for 50-99 cents.

214. Reserved

215. Income - General Principles

Income earned or received by the applicant/participant's economic unit must be considered in determining eligibility for the WIC program. Specific types of income are excluded from consideration in determining eligibility and are addressed in the section headed Income Exclusions.

Income for purposes of the WIC program means gross cash income before deductions for income taxes, employees' social security taxes, insurance premiums, bonds, etc. Income is entered into the WIC system according to section headed Determining Countable Income.

The economic unit's current income that is received within the month prior to application (past 30 days) is the basis for the income eligibility determination. If the applicant/participant is employed, then income eligibility is based on current gross earnings. If the applicant/participant is currently unemployed or on strike, the income eligibility is based on the current income which may be unemployment compensation, public assistance, or strikers' benefits.

In some instances, past income may need to be computed and verified to determine an average income estimate. Examples of such instances include a person who works fluctuating hours or a person who has earnings from self-employment.

215.1 Need-Based Program

The determination of eligibility for WIC is based upon the amount of income available to the applicant/participant's economic unit. Since WIC is a need-based program, there must be an established need for assistance. Economic units, who have income in excess of the Ohio WIC program income guidelines, at the date of application or due to a change during the WIC eligibility period, are not eligible for WIC, even though the other eligibility requirements are met. If during the certification period the participant's income increases to a level which exceeds the Ohio WIC program income guidelines, the participant must be removed from the program with notice provided according to the section headed Terminations.

Per the section headed Income Eligibility for Public Assistance Recipients, a public assistance recipient who has income exceeding the Ohio WIC income guidelines is income eligible for WIC services based on adjunctive public assistance program eligibility.

215.2 Availability of Income

In most cases, only currently available income is considered in determining need. Availability depends upon the date of receipt, who receives the income, and the time frame the income is intended to cover. It may be necessary in certain instances to apportion income to a future time frame. For example, an employee who works on a contract basis would have the income from the contract averaged over the time covered under the contract. Such income is current income for the time to which it is apportioned.

Income received by any member of the applicant/participant's economic unit is considered available to all members. If income is received jointly by a member of the economic unit and one or more persons not in the economic unit, the member's portion to be considered as available income is the prorated share, unless evidence is produced to the contrary.

215.3 Income Reporting Responsibility

The applicant/participant, including the parent, legal guardian, or foster care agency responsible for an infant or child in WIC, is responsible for giving information necessary to determine income eligibility. This information is reported in the income section of an Ohio WIC application form. The applicant/participant or individual responsible for the infant or child is also responsible for reporting any changes in the economic unit income during the WIC eligibility period.

215.4 Verification of Income

All income of the applicant/participant's economic unit must be verified. Statements as to the amount and source of income must be verified and documented on an Ohio WIC application form. The applicant/participant and any economic unit member whose income affects the income eligibility determination are required to submit verification as requested by local staff.

Verification of income is not required when an economic unit reports income on the Application which clearly exceeds the Ohio WIC program income guidelines, or if some other factor of eligibility is clearly not met. If the other factor of eligibility is only questionable and is not yet resolved, income may be verified. If

local staff suspects over reporting of income, causing the applicant to be disqualified, the income may be verified.

215.5 Applicants with No Income and No Proof of Income

When there is a response on the application that no income is received, or previously reported income has stopped, local staff must review the applicant/participant's circumstances with the individual. Local staff may determine there is WIC income eligibility on the basis that there is "zero income." The local staff must document the circumstances as to why there is no income at the current time and how basic living necessities such as food, shelter, medical care, and clothing are met. Examples of questions to ask are:

- How does your family pay for rent, clothing, and other living expenses?
- Where is your family getting food?
- Where is your family living?
- How long has the family been without income?
- Where does the family expect to receive income from and when?

It is the individual's responsibility to provide evidence to substantiate the income declaration. In some rare instances verification may not be available, and the applicant/participant has cooperated in trying to obtain verification. Rare instances include being a victim of theft; loss in recent move; fire, flood, or other natural disaster; a homeless individual or family; a migrant farm worker; a refugee; or an evacuee due to disaster. In these rare instances, the application may be processed based on the individual's statements as long as there is no evidence or facts to cast doubt on the income declaration.

The documentation for no income and no proof of income may be written on the "Confirmed or other information" Agency Use Only section on the Ohio WIC Program Application or Addendum, or on the *Ohio WIC Program No Proof Form* in Appendix 200. Reviewing and documenting the participant's current circumstances as indicated above must take place at each certification period.

The applicant/participant should be referred to the county department of job and family services for unemployment and the Ohio Works First, Food Assistance, and Medicaid programs.

216. Types of Income

There are two types of income: unearned and earned income. Each income type has distinguishing characteristics, but is treated exactly the same in determining countable income. Gross cash unearned and earned income is counted. The following subsections provide characteristics of unearned and earned income to assist in documentation and verification of WIC income eligibility.

216.1 Unearned Income

Unearned income is all income that is not wages or net earnings from self-employment. All income which does not meet the definition of earned income is considered unearned income.

Eligibility for an unearned payment does not, by itself, affect the amount of unearned income to be counted; actual receipt is the key factor. The applicant's economic unit must actually receive the payment to have it included as income. The amount of unearned income to be counted is usually the amount of income received. In many cases, unearned income is paid on a monthly benefit basis. Examples of common types of unearned income follow:

- public assistance payments, e.g., Ohio Works First (OWF)
- Supplemental Security Income (SSI)
- unemployment compensation
- alimony or child support payments
- workers' compensation benefits
- disability benefits
- other cash income including, but is not limited to, cash amounts received or withdrawn from any source such as savings, investments, trust accounts, and other resources which are readily available to the economic unit
- regular cash contributions from persons not living in the household
- dividends or interest on savings or bonds
- Retirement, Survivors and Disability Insurance (RSDI, i.e., Social Security)
- income from estates or trusts
- government civilian employee or military pensions or retirement benefits
- Veterans Administration (VA) benefits
- private pensions or annuities
- net royalties
- Railroad Retirement or railroad unemployment benefits

216.2 Earned Income

Earned income is payment received for services performed as an employee, or as a result of being engaged in self-employment. Earned income includes wages, salary, commissions, fees, or net profit from farm and nonfarm self-employment. Generally, wages include all remunerations from employment.

Earned income with respect to farm or nonfarm self-employment means the net profit from a business enterprise resulting from a comparison of the gross receipts with the business expenses directly related to producing the goods or services.

Where the economic unit has both employed and self-employed earnings, the gross earned income will consist of the wages plus the proceeds from self-employment minus operating expenses.

The local staff shall determine the gross amount of earnings to compare to the Ohio WIC program income guidelines according to the sections headed Determining Gross Earned Income, Self-Employment Earnings, Income Exclusions, and Determining Countable Income:

The following are examples of common types of earned income:

- wages and salaries
- commissions and fees
- back pay, bonuses, and awards paid by employer
- severance pay
- payments for work training and on-the-job training programs
- sick leave, annual leave, holiday and vacation pay received in the form of wages
- cash allowances to personnel for housing (Military housing allowances are excluded. See the section headed Income Exclusion.)
- net income received for providing room and board, or board only
- net rental income

217. Verification of Unearned and Earned Income

Verification of unearned and earned income is required at initial application, recertification, and whenever discrepancies in income information are discovered or wage amounts change.

Special attention should be paid to those types of unearned income which may be increased due to cost-of-living increases that are issued across the board to all recipients of specific benefits. Verification of public assistance program income administered by the Ohio Department of Job and Family Services is treated according to the section headed Income Eligibility for Public Assistance Recipients.

Most forms of unearned income may be verified by viewing an award letter or by a written statement or telephone conversation from the agency, organization, or a person administering the payment. Most forms of earned income may be verified by pay stubs, by a written statement signed by the employer or representative of the employer, or by a telephone conversation with the employer.

The verification must be documented on an Ohio WIC Program Application or Addendum. The documentation must show the gross amount and frequency of the benefit or earnings, the source of the benefit or earnings, the date of the award letter or pay stubs, the date of the telephone conversation, name of contact person, and the confirming statement if verified by telephone. Some other examples of verification which may be used include the following:

- viewing of the payment/benefit check
- military leave and earnings statement (LES)
- divorce or dissolution decree
- savings account, checking account, or certificate of deposit books
- tax records or federal tax forms for self-employed persons
- business receipts
- accounting records
- W-2 form
- lease or contract
- employment contract

218. Lump Sum Payments

Lump sum payments are classified in two ways: (1) as reimbursements for lost assets or injuries, and (2) as “new money” that is intended for income.

1. Lump sum payments that represent "reimbursements" must not be counted as income. Examples include reimbursements received from insurance companies for loss or damage of real or personal property, such as home or auto; payments intended for a third party to pay for a specific expense, such as payment of medical bills resulting from an accident or injury; and back pay such as in the case of SSI, Social Security Disability, or pension.

   Income tax returns must not be counted since income tax is not an allowable deduction in WIC income eligibility determination; the amount paid for taxes has already been counted.

2. Lump sum payments that represent "new money" intended to be used as income must be counted as **annual** income. Examples include gifts, inheritances, death benefits, lottery winnings, worker’s compensation for lost income, sign-on bonus for new job or land mineral rights/fracking, and severance pay.

3. When the intended purpose of the lump sum payment has both features, treat the lump sum payment accordingly for the portion that is a reimbursement and the remaining portion that is new income.

219. RESERVED

220. Determining Gross Earned Income

The number of hours an individual works sometimes fluctuates or the individual is employed seasonally and income must be averaged to arrive at an amount to be converted to a standard amount for the frequency (weekly, biweekly, twice monthly, and monthly) in which payment is received. Local project staff will need to be alert to the number of hours per week which the individual is expected to work as a normal workweek.

1. If the individual works a set workweek; e.g., 35 hours a week, that number is used in determining the amount of gross income.

2. If the individual works fluctuating hours each week, at least three current pay stubs must be used to arrive at an average gross amount for frequency received. This average is considered gross income for the frequency received until the next recertification of eligibility unless the individual reports a change in circumstances which requires a redetermination of income.

3. In some cases pay stubs reflect year-to-date earnings. This is an acceptable means of determining average gross income for the frequency received. This method may be used as an alternative to using three current pay stubs for individuals who work fluctuating hours. In using this method, local staff must determine when the payments began through the current payment and then divide by the number of frequencies received.

4. In several situations, the individual may have a change in employment which must be reported to the local WIC project. In these situations, the gross income must be recalculated to determine financial need.
   - The individual has an increase in hourly wage.
   - The individual is working increased hours.
   - The individual is working a set workweek instead of fluctuating hours.
   - The individual has changed employers.
   - The individual has moved from part-time to full-time employment.

5. If the individual has earnings from new employment, the available pay stubs or a statement from the employer may be used to calculate average gross income.

221. Self-Employment Earnings

An applicant/participant or other member of the economic unit who owns a farm or business has earnings from self-employment. The net profit from self-employment is included as countable gross income for the WIC program. Generally, it is necessary for the self-employed individual to estimate current income. Estimates are usually based on the tax return filed for the previous year or current business records.

The net profit is calculated by subtracting operating expenses from gross receipts. Operating expenses are the costs of producing the goods and services and without which the goods or services could not be produced. Gross receipts are the total proceeds from the sale of the goods or services.

221.1 Allowable Operating Expenses

For purposes of determining net profit from self-employment in the WIC program, allowable operating expenses include those items listed as "deductions" on the following Internal Revenue Service (IRS) tax forms.

- 1040 Schedule C-Profit or Loss from Business
- 1040 Schedule F-Profit or Loss from Farming
- Form 4835 -Farm Rental Income and Expenses

The following are examples of items which may be subtracted from gross receipts as operating expenses:

- cost of renting land, buildings, machinery, and equipment necessary for the operation of the business or farm
- cost of utilities for business or farm buildings
- cost of office supplies
- amount of real property taxes (except special assessment taxes that increase the value of the property) on business or farm land owned or being purchased by the individual
- cost of employees' wages and benefits and the employer's share of the employees' Social Security taxes

- cost of repairs and maintenance of business or farm property (including buildings, machinery, equipment, trucks, etc.) owned or being purchased by the individual, if such expenditures do not appreciably add to the value of the property
- interest portion of business and farm loans or mortgages
- insurance on business and farm property (including buildings, machinery, livestock, cars, trucks, etc.)
- business-related travel expenses
- business license
- cost of gas and oil for business or farm vehicles
- cost of feed, fertilizer, seeds, plants, and farm supplies
- cost of breeding fees, veterinary fees, and livestock medicines
- cost of advertising
- postage and shipping costs
- cost of tools purchased for business
- cost of tax return preparation
- wholesale cost of products sold
- attorney fees related to the business
- cost of business transportation (including parking expenses)

221.2 Nonallowable Operating Expenses

The following items may not be subtracted from gross receipts to determine net profit:

- monies paid to purchase capital assets, equipment, machinery, and other durable goods
- payments on the principal of mortgages on income-producing real property
- any amount claimed as a net loss sustained in any prior period
- any amount claimed as the applicant/participant's own federal, state, local, and social security taxes
- any amount claimed as personal business and entertainment expense and personal transportation

221.3 Allocating Self-Employment Income

Local staff must estimate net profit and allocate this figure across the taxable year, even if the business is seasonal. The estimated amount of net profit from self-employment may be determined from the tax return filed for the previous year or current business records. Local staff must use one of the following four methods to determine the most accurate estimate of current and future earnings:

1. When the individual has been carrying on the same trade or business for more than one year, income is determined as the net profit as shown on the tax return for the preceding taxable year.

2. When the individual has been self-employed for only a part of the preceding tax year, income is determined by prorating net profit as shown on the tax return for the preceding year. For example, an individual self-employed for five months would have monthly income determined as one-fifth of the preceding year's net profit.

3. When the individual can estimate annual net profit based on past or current business records, the local WIC project may use the individual's best estimate.

4. When the individual has been self-employed on a sporadic basis, and has not maintained business records and/or declared the self-employment earnings on his income tax return, then the individual's statement as to self-employment earnings is used to estimate income on the frequency stated. Operating expenses are not subtracted from the individual's statement of self-employment income when business or tax records are not provided.

222. Income Exclusions

In determining income eligibility, the following items are excluded:

- income-in-kind is any benefit which is not received in cash. Free room and board is an example of income-in-kind. Any benefit received as income-in-kind is exempt from the determination of WIC income eligibility;

- loans, not including amounts to which the applicant has constant or unlimited access;

- military housing allowances: Basic Allowance for Housing (BAH), Family Separation Housing (FSH), Overseas Housing Allowance (OHA);

- military Family Supplemental Subsistence Allowance **(**FSSA) from the Department of Defense (Public Law 109–163, sec.608);

- military Overseas Continental US Cost of Living Adjustment **(**OCONUS COLA);

- military combat pay for personnel deployed to a designated combat zone: Hostile Fire/Imminent Danger Pay (HFP/IDP); Hardship Duty Pay (HDP, HDP-L, HDP-M, or SAVE PAY); and

- military garnishment for support or debt (SUPPORT/COMM DEBT or PRIOR SPT/COMM) when it appears both in the entitlement and deductions sections of the leave and earnings statement.

Payments or benefits provided under certain federal programs or acts are excluded by law from consideration as income. These programs include, but are not limited to:

1. Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (Public Law 91-646, Section 216), 42 U.S.C. 4636;

2. Any payments to volunteers under Title I (VISTA and others) and Title II (RSVP, Foster grandparents, and others) of the Domestic Volunteer Service Act of 1973(Public Law 93-113, Section 404(g), 42 U.S.C. 5044(g) to the extent excluded by that act);

3. Payment to volunteers under section 8(b)(l)(B) of the Small Business Act (SCORE and ACE) (Public Law 95-510, Section 101, 15 U.S.C. 637 (b(1)(D));

4. Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94–114, sec. 6, 25 U.S.C. 459e);

5. Payments received under the Job Training Partnership Act (Public Law 97–300, sec. 142(b), 29 U.S.C. 1552(b));

6. Income derived from the disposition of funds to the Grand River Band of Ottawa Indians (Public Law 94–540, sec. 6);

7. Payments received under the Alaska Native Claims Settlement Act (Public Law 100–241, sec. 15, 43 U.S.C. sec. 1626(c));

8. The value of assistance to children or their families under the National School Lunch Act, as amended (Public Law 94–105, sec. 9(d), 42 U.S.C. sec. 1760(e)), the Child Nutrition Act of 1966 (Public Law 89–642, sec. 11(b), 42 U.S.C. sec. 1780(b)), and the Food and Nutrition Act of 2008 (Public Law 95–113, sec. 1301, 7 U.S.C. sec. 2017(b));

9. Payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (Public Law 95–433, sec. 2, 25 U.S.C. 609c–1);

10. Payments to the Passamaquoddy Tribe and the Penobscot Nation or any of their members received pursuant to the Maine Indian Claims Settlement Act of 1980 (Public Law 96–420, sec. 6, 9(c), 25 U.S.C. 1725(i), 1728(c));

11. Payments under the Low-income Home Energy Assistance Act, as amended (Public Law 99–125, sec. 504(c), 42 U.S.C. sec. 8624(f));

12. Student financial assistance received from any program funded in whole or part under Title IV of the Higher Education Act of 1965, including the Pell Grant, Supplemental Educational Opportunity Grant, State Student Incentive Grants, National Direct Student Loan,* PLUS, College Work Study, and Byrd Honor Scholarship programs, which is used for costs described in section 472 (1) and (2) of that Act (Public Law 99–498, section 479B, 20 U.S.C. 1087uu). The specified costs set forth in section 472 (1) and (2) of the Higher Education

Act are tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, and including the costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution. The specified costs set forth in section 472 (1) and (2) of the Act are those costs which are related to the costs of attendance at the educational institution and do not include room and board and dependent care expenses;

(* Additional Student Loan Information: The U.S. Department of Education administers three student loan programs: the Federal Perkins Loan Program [formerly called National Direct Student Loans], the William D. Ford Federal Direct Loan (Direct Loan) Program and the Federal Family Education Loan (FFEL[sm]) Program. The Direct Loan Program[sm] comprises Direct Stafford Loans, Direct PLUS Loans and Direct Consolidation Loans. The FFEL Program comprises FFEL Stafford Loans, FFEL PLUS Loans and FFEL Consolidation Loans.)

13. Payments under the Disaster Relief Act of 1974, as amended by the Disaster Relief and Emergency Assistance Amendments of 1989 (Public Law 100–707, sec. 105(i), 42 U.S.C. sec. 5155(d));

14. Effective July 1, 1991, payments received under the Carl D. Perkins Vocational Education Act, as amended by the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1990 (Public Law 101–392, sec. 501, 20 U.S.C. sec. 2466d);

15. Payments pursuant to the Agent Orange Compensation Exclusion Act (Public Law 101–201, sec. 1);

16. Payments received for Wartime Relocation of Civilians under the Civil Liberties Act of 1988 (Public Law 100–383, sec. 105(f)(2), 50 App. U.S.C. sec. 1989b– 4(f)(2));

17. Value of any child care payments made under section 402(g)(1)(E) of the Social Security Act, as amended by the Family Support Act (Public Law 100–485, sec. 301, 42 U.S.C. sec. 602 (g)(1)(E));

18. Value of any ‘‘at-risk’’ block grant child care payments made under section 5081 of Public Law 101–508, which amended section 402(i) of the Social Security Act;

19. Value of any child care provided or paid for under the Child Care and Development Block Grant Act, as amended (Public Law 102–586, Sec. 8(b)), 42 U.S.C. 9858q);

20. Mandatory salary reduction amount for military service personnel which is used to fund the Veteran’s Educational Assistance Act of 1984 (GI Bill), as amended (Public Law 99–576, sec. 303(a)(1), 38 U.S.C. sec. 1411 (b));

21. Payments received under the Old Age Assistance Claims Settlement Act, except for per capita shares in excess of $2,000 (Public Law 98–500, sec. 8, 25 U.S.C. sec. 2307);

22. Payments received under the Cranston-Gonzales National Affordable Housing Act, unless the income of the family equals or exceeds 80 percent of the median income of the area (Public Law 101–625, sec. 522(i)(4), 42 U.S.C. sec. 1437f nt);

23. Payments received under the Housing and Community Development Act of 1987, unless the income of the family increases at any time to not less than 50 percent of the median income of the area (Public Law 100–242, sec. 126(c)(5)(A), 25 U.S.C. sec. 2307);

24. Payments received under the Sac and Fox Indian claims agreement (Public Law 94–189, sec. 6);

25. Payments received under the Judgment Award Authorization Act, as amended (Public Law 97–458, sec. 4, 25 U.S.C. sec. 1407 and Public Law 98–64, sec. 2(b), 25 U.S.C. sec. 117b(b));

26. Payments for the relocation assistance of members of Navajo and Hopi Tribes (Public Law 93–531, sec. 22, 22 U.S.C. sec. 640d-21);

27. Payments to the Turtle Mountain Band of Chippewas, Arizona (Pub.L. 97–403, sec. 9);

28. Payments to the Blackfeet, Grosventre, and Assiniboine tribes (Montana) and the Papago (Arizona) (Public Law 97–408, sec. 8(d));

29. Payments to the Assiniboine Tribe of the Fort Belknap Indian community and the Assiniboine Tribe of the Fort Peck Indian Reservation (Montana) (Public Law 98–124, sec. 5);

30. Payments to the Red Lake Band of Chippewas (Public Law 98–123, sec. 3);

31. Payments received under the Saginaw Chippewa Indian Tribe of Michigan Distribution of Judgment Funds Act (Public Law 99–346, sec. 6(b)(2));

32. Payments to the Chippewas of Mississippi (Public Law 99–377, sec. 4(b)); and

33. Payments received by property owners under the National Flood Insurance Program (Public Law 109–64).

223. Determining Countable Income

Countable income is the amount of income which is compared to the Ohio WIC program income guidelines to determine income eligibility. The amount of the countable income determines whether the applicant/participant is financially eligible or ineligible for WIC. Steps to calculate countable income follow.

223.1 Conversion Factors and Computing Countable Income

There are five frequencies of income for comparing by economic unit (EU) size and income. The five frequencies and their respective conversion factors are weekly X 52, biweekly X 26, twice monthly X 24, monthly X 12, and annual. The WIC system will complete the income calculations and compare to the respective frequency as explained below.

1. If an EU has only one income source, or if all EU sources have the same frequency of income, there is no conversion factor use, but only frequency comparison. The WIC system compares the single source income, or the sum of the separate, same frequency incomes to the respective income frequency amount for EU size to determine income eligibility.

   For example, for a family of four where mom's gross biweekly earnings are $767.32 and dad's gross biweekly earnings are $659.16, since the incomes are both biweekly, the system adds them together for a total of $1,426.48 biweekly, rounds it down to $1,426 and compares it to the biweekly income guideline amount for an EU of four.

   In this example, local project staff verifies and documents the income on an Ohio WIC Program Application or Addendum, recording both amounts and checking the frequency for each as "biweekly." Staff enters each full income amount, both dollars and cents, separately into the WIC system income field and selects "biweekly" from the income frequency drop down box. The system will add the amounts and then compare the total to the biweekly income guideline amount for the EU size. While the full income amounts are used in the calculations, the final amount that remains in the system and local staff records on the application or addendum is rounded down for 49 cents and under and rounded up for 50 – 99 cents.

2. If an EU reports multiple income sources at more than one frequency, the WIC system will perform the following calculations:

   - annualize all full income amounts, both dollars and cents, by multiplying weekly income by 52, biweekly income by 26, twice monthly income by 24, and monthly income by 12;

   - add together all of the unrounded, converted values;

   - round the sum of all of the converted values down for 49 cents and under and up for 50 – 99 cents; and

   - compare the total to the annual income amount for the EU size to determine income eligibility.

   For example, for a family of four where dad is in the military and paid $758.57 biweekly, mom works part time and earns $211.32 weekly, and mom receives child support of $237.65 monthly, the system will multiply dad's income by 26 (biweekly conversion factor = $19,722.82), multiply mom's income by 52 (weekly conversion factor = $10,988.64), and multiply mom's child support by 12 (monthly conversion factor = $2,851.80), add the unrounded, annualized (converted) values together arriving at a total annualized income of $33,563.26, rounded down to $33,563 and compares it to the annual income amount for an EU of four.

   In this example, local project staff verifies and documents the income on an Ohio WIC Program Application or Addendum, recording all three income amounts and checking the frequency for each, respectively, as biweekly, weekly, and monthly. Staff enters each full income amount, both dollars and cents, separately into the WIC system income field and selects the frequency for each income amount from the income frequency drop down box. The system will annualize each amount, add the annualized amounts, and then compare the total to the annual income guideline amount for the EU size. While the full income amounts are used in the calculations, the final amount that remains in the system and local staff records on the application or addendum is rounded down for 49 cents and under and rounded up for 50 – 99 cents.

223.2 Fluctuating Income and WIC System Computation

The WIC system does not perform averaging calculations for situations where the EU has fluctuating earned income. Local project staff must complete an averaging calculation according to the section on Determining Gross Earned Income to arrive at the amount that will be entered into the system for the frequency of income receipt.

For example, an applicant who works fluctuating hours presents three weekly pay stubs and shows gross income for one in the amount of $378.62, a second for $228.37 and a third for $417.29. Once verified and documented on an Ohio WIC Program Application or Addendum, these three paychecks must be manually added together and divided by three ($1,024.28/3) to arrive at the weekly average income amount that is entered into the system; that amount is $341.43. That weekly average amount entered would compare in the system to the weekly amount for the EU size to determine income eligibility. The averaging calculations and total are documented on the application or addendum.

224. Examples of Income Computation

This section provides three examples of WIC income computation to illustrate practical application of some of the principles and concepts discussed in the preceding income eligibility sections.

1. Mrs. Smith applied for WIC for her three-month-old infant. The infant is a member of an economic unit which consists of five members: Mr. and Mrs. Smith and their three-month-old infant, and Mrs. Smith's two children from a previous marriage. Mrs. Smith is not employed, but receives $225 per month in child support. Mr. Smith works a different number of hours every pay period and has his last three biweekly pay stubs in the amounts of $475.27, $337.45, and $402.00. The economic unit's total gross monthly income is computed as follows:

   - There is fluctuating income, so project staff must average the three biweekly pay stubs to arrive at an average biweekly pay amount.

     $475.27 + $337.45 + $402.00 = $1,214.72 divided by 3 (number of pay stubs) = $404.91 average biweekly pay

   - There are two frequencies of income which the WIC system will annualize as follows:

     Child support calculation = $225 X 12 (monthly conversion factor) = $2,700.00

     Wages calculation = $404.91 X 26 (biweekly conversion factor) = $10,527.66

   - Total annualized income = $13,227.66, rounded up to $13,228 and compared to the annual income amount for a family of five.

2. Miss Day is 16 years old, two months pregnant and has applied for WIC. She lives with her mother, a twin sister, and three younger brothers. The economic unit size is seven. Miss Day works a 16-hour part-time job per week and earns $99.20. Her twin sister earns $116.32 every two weeks in a part-time job.

   Miss Day's mother earns $248.50 twice a month, and receives Social Security family survivor benefits in the amount of $835 per month and veteran's benefits of $139 per month. Miss Day's economic unit's total gross monthly income is computed by the WIC system as follows:

- There are five sources of income and four frequencies which the WIC system will annualize as follows:

  Social Security calculation = $835.00 X 12 (monthly conversion factor) = $10,020.00

  Veteran's Benefits calculation = $139.00 X 12 (monthly conversion factor) = $1,668.00

  Mother's income calculation = $248.50 X 24 (twice monthly conversion factor) = $5,964.00

  Sister's income calculation = $116.32 X 26 (biweekly conversion factor) = $3,024.32

  Miss Day's income calculation = $99.20 X 52 (weekly conversion factor) = $5,158.40

- Total annualized income = $25,834.72 rounded up to $25,835 and compared to the annual income amount for a family of seven.

3. The Star family consists of a 23-year-old daughter and her two-year-old child, the disabled mother of the daughter and the unemployed father. The daughter has applied for WIC for her two-year-old child. The four individuals pool their resources and income, and consider themselves to be a single economic unit. The daughter works for a temporary service company and reports weekly income of $128.00 and has provided proof of Medicaid Healthy Start for her child. She receives $117 per month in child support. The disabled mother receives a monthly disability check in the amount of $517.75. The father participates in the Job Training Partnership Program and receives a $75 per week stipend. The economic unit's total gross monthly income is computed as follows:

   - The daughter provided proof of Medicaid for her child so the child is adjunctively income eligible for WIC and Medicaid is entered in the proof on file field of the WIC system.

   - Since Medicaid is verified, the income amounts do not need to be verified, but are used as reported on the application form to arrive at an income amount to be recorded in the WIC system.

- The father's Job Training Partnership Program income is excluded as income per section 222.

- The income information as reported on the application is then entered into the system and computed by the system as follows:

  Daughter's income calculation = $128.00 X 52 (weekly conversion factor) = $6,656.00

  Daughter's child support calculation = $117.00 X 12 (monthly conversion factor) = $1,404.00

  Mother's disability calculation = $517.75 X 12 (monthly conversion factor) = $6,213.00

- Total annualized income recorded in the system is = $14,273.00 and compared to the annual income amount for a family of four. Even though the cash income is not the reason for income eligibility in the case of public assistance verification, the system still checks the total with the income guidelines.

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235. Immunization Coordination Requirement

Each infant/child's immunization record must be reviewed for immunizations received to date. Infants/children who are identified as deficient in immunizations must be referred to their appropriate immunization provider. (Staff is **not** required to refer for *optional* immunizations, i.e., flu shots.) WIC services such as certification, food issuance, and nutrition education may not be denied, interrupted, or terminated if an infant's/child's immunization record is not up-to-date or brought to the appointment, or the caregiver rejects immunizations.

The following subsections provide an explanation and the procedures for immunization review and referral as part of the WIC application process.

235.1 WIC Staff Responsibilities

Review the immunization status/shot record of each infant/child applicant, both at initial certification and at each recertification. The review can be completed by either the support or health professional staff, depending on clinic flow needs. In addition, immunization status can be reviewed any time a caregiver produces a shot record at follow-up appointments, high-risk visits, and education appointments.

Maintain a current list of immunization clinics/providers in the counties of service. The list of providers must include:

- name of the provider
- address/phone number of the provider
- dates/times/locations of immunization services

235.2 Instructions for Reviewing Shot Records

Review the participant's shot record and assess the status of immunizations through use of the Impact Statewide Immunization Information System (SIIS).

- Only the following documents can be used as a shot record/proof of current immunization:

- *ODH Immunization Record Card – Parent's Copy* (Appendix 200) or any other immunization record/shot record; and

- documentation from a physician or representative from a physician's office; i.e., physician letterhead with signature, or billing statement with either antigen listed or Current Procedural Terminology (CPT) codes listed.

- Computer procedures for the assessment of current immunization status and generation of the "grid view" and immunization reports are detailed in Appendix 200 in the following three manuals: *Impact SIIS User Training*, *Impact SIIS Key Master Training*, and *Impact SIIS Quick Guide.*

- Updating participant contact information in Impact SIIS is not required.

- Only dates recorded in the MM/DD/YYYY (01/26/2011) format can be entered in the Impact SIIS. If only month and year are recorded for a shot, do not enter that shot data. A complete immunization schedule is found in Appendix 200 titled *Recommended Immunization Schedule for Persons 0-6 years old*.

- Impact SIIS and the WIC Certification System are not linked. Users should log into Impact SIIS and minimize the application and then log into the WIC Certification System. This allows the user to toggle back and forth between the two applications.

- Users of Impact SIIS must sign the electronic *Security Agreement* on an annual basis. Impact SIIS will automatically prompt staff to read the *Security Agreement* and then click on the "I Agree" button. This action maintains user status and acknowledges that staff is still employed by WIC.

- Staff may use the following helpful resource, *Common Immunization Abbreviations*, located in Appendix 200.

235.3 Processing Screened Participants

All participants/caregivers must receive a printed reminder or "grid view" from Impact SIIS at each certification and recertification. The "grid view" is meant to be a reminder to the participant to keep shots up-to-date.

- If the immunization record is up-to-date:
  -No referral is necessary.
  -Note when the next shot is due.
  -Provide the caregiver with the "grid view."

- If the immunization record is not up-to-date:
  -Refer the parent/caregiver to the primary physician listed on the health history and/or the next immunization clinic available.
  -Document the referral on the risk tab in the WIC Certification System and with the "Add Referral to Immunization Provider" button in Impact SIIS. -Provide the caregiver with the "grid view."

- If the caregiver does not bring an immunization record:
  -Encourage these caregivers to bring the shot record to the next scheduled WIC appointment.

235.4 Exceptions to Processing Screened Participants

There are three exceptions to the procedure for providing the "grid view" at each certification and recertification. These are:

1. Ohio-born infants at their first WIC visit that occurs within one month of birth. (Do not create Impact SIIS records at all.)

2. Infants or children whose guardians did not bring an immunization record.

3. Infants or children whose guardians do not want the immunization information shared with other entities. (Do not enter the immunizations into Impact SIIS.)

235.5 Processing Participants at Clinic Sites without Access to the Internet or Ability to Duplicate the Shot Record

A. At WIC clinics where there is not access to the internet:

- Complete the *Update Participant Immunization Data* form located in Appendix 200 or copy the actual immunization record.
- Enter the data into Impact SIIS at the main WIC clinic site within five working days.
- Print the “grid view.”
- Mail the “grid view” or place the “grid view” into the participant chart with a critical message to provide at the next appointment.
    - Staff should highlight the "Due Now" section of the “grid view.” If an infant or child is past due for several shots, local agency staff is encouraged to call these caregivers and try to expedite the referral process.
- Document the referral on the risk tab in the WIC Certification System and with the “Add Referral to Immunization Provider” button in Impact SIIS.

B. At WIC clinics where there is not access to duplication services:

- Complete the *Update Participant Immunization Data* form located in Appendix 200.
- Enter the data into Impact SIIS at the main WIC clinic site within five working days.
- Print the “grid view.”

- Mail the “grid view” or place it in the participant’s chart with a critical message to provide it to the caregiver at the next appointment.

    - Staff should highlight the "Due Now" section of the “grid view.” If an infant or child is past due for several shots, local agency staff is encouraged to call these caregivers and try to expedite the referral process.

- Document the referral on the risk tab in the WIC Certification System and with the “Add Referral to Immunization Provider” button in Impact SIIS.

235.6 Optional Immunization Screening Process

Impact SIIS may be updated by immunization partners or WIC staff. In order to facilitate clinic flow and work with local immunization partners, the following screening process can be implemented:

1. WIC staff copy the immunization data provided and explain to the caregiver that the “grid view” will be provided at a later date.

2. WIC staff provides the immunization records in a confidential manner to the local immunization partner.

3. The local immunization partner inputs the data into Impact SIIS within five working days of the WIC appointment.

4. The local immunization partner prints the “grid view” and gives it to the WIC staff or tells the WIC staff that the shot information has been updated and a “grid view” can now be printed.

5. WIC staff mails the “grid view” or places it in the participant’s chart with a critical message to provide it to the caregiver at the next appointment.

    - Staff should highlight the "Due Now" section of the “grid view.” If an infant or child is past due for several shots, local agency staff is encouraged to call these caregivers and try to expedite the referral process.

WIC directors may elect to have WIC staff copy and enter the shot record after a participant appointment. Projects using this procedure must ensure that the information is entered within five working days of the WIC appointment. Additionally, the steps 4 and 5 outlined above must be followed.

235.7 Accuracy of the "grid view"

If local immunization providers question the assessment accuracy of Impact SIIS, refer them to the State Immunization consultant. (See Appendix 200 *ImpactSIIS: A Quick Guide for WIC Staff*.) If a WIC participant's parent/guardian questions the accuracy of the assessment data based on information from the immunization provider, tell the participant to follow the provider's advice and continue with the certification procedure. Brochures regarding immunization can also be used.

235.8 Immunizations and Nutrition Education

Information provided to the parent/caregiver about the importance of immunizations, the health benefits, and the risks involved when a child is not fully immunized can count as nutrition education when this information is incorporated into individual educational modules or used for midcertification nutrition education classes.

235.9 Confidentiality of Immunization Information

A. To share information with the local and State immunization programs, the parent/guardian reviews and gives permission by checking and initialing the Consent for Sharing Information section of the Welcome to WIC (WTW) letter. The copy of the signed WTW letter is maintained in the participant's file. The information shared is restricted to the information specified on the WTW letter.

- The Consent for Sharing Information section of the WTW letter must list specific names of individuals authorized to receive immunization information. "My doctor" or "my pediatrician" is not an acceptable release of information.

B. The parent/guardian has the right to withhold permission for sharing shot information. This is designated by not checking the Consent for Sharing Information on the WTW letter. If the parent/guardian refuses permission to share information, the local project must honor that request and ensure that the immunization information is not shared with any immunization program. (See 235.4 #3 above.) Refusal to share information has no effect on service eligibility and receipt of services from the WIC program.

235.10 Record Keeping and Reports

Five reports in Impact SIIS are specifically available for WIC use. *WIC/Impact Report Instructions* in Appendix 200 provides the instructions for how to access, view, and print the reports. It is not required that WIC reports be printed or maintained for WIC purposes.

A. Available reports:
- WIC Screenings – Detail Report: provides names of participants screened during a specified date range.
- WIC Screenings – Summary Report: provides total number of participants screened during a specified date range.
- WIC Referrals – Detail Report: provides names of participants referred to immunization providers during a specified date range.
- WIC Referrals – Summary Report: provides total number of participants referred to immunization providers during a specified date range.
- WIC Practice CoCASA Extract: provides information about participants' current immunization status (numbers and percent of participants that are current and not current with immunizations). Instructions to run the WIC Practice CoCASA Extract are **not** included in Appendix 200. Call the Regional Immunization Staff (found under Resources on the Impact SIIS Login page), if there is a need to run this report.

B. The screening report is populated with participant information when:
- A participant is selected and her screen is displayed, or
- A new participant is created and immunization dates are entered.

C. The referral report is populated when:
- Staff clicks on the "Add referral to Immunization Provider" button on the bottom of the participant's screen.

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243. Minimum Required Health Data

An applicant/participant must be determined to be at medical/nutritional risk to participate in WIC. This section describes minimum required health data and exceptions to the minimum health data requirements. The following data must be recorded at each certification visit on the appropriate screen of the WIC computer system.

- **Prenatal woman**: pregnancy weight record, prepregnancy weight, hematocrit or hemoglobin, expected date of delivery (EDD), and Health History form
- **Postpartum/breastfeeding women**: current height and weight, prepregnancy weight, hematocrit or hemoglobin, actual date of delivery, and Health History form
- **Infants 0-6 weeks**: birth weight and length, and Health History form which includes dietary intake
- **Infants 0-6 weeks born to women participants**: birth weight and length, assessment of health data, type of feeding, and an accurately plotted growth chart
- **Infants 6 weeks - 9 months**: birth weight and length, current weight and length, Health History form which includes dietary intake
- **Infants 9 months - 12 months**: birth weight, current weight and length, hematocrit or hemoglobin, and Health History form which includes dietary intake. **Exception:** If an infant is not due for a clinic visit between nine and twelve months of age, bloodwork taken between six and nine months of age is an allowable substitute as the initial bloodwork on a case-by-case basis. Documentation of this exception must appear on the infant's health history form.
- **Children**: current height and weight, hematocrit or hemoglobin, and Health History form. **Exception:** The hematocrit or hemoglobin test is not required for children two to five years of age who were determined to be within the normal range at the previous certification. However, the hematocrit or hemoglobin test shall be performed on such children at least once per year. To ensure certifying for the highest priority, it is strongly recommended that a hematocrit or hemoglobin test be performed on a child who does not otherwise qualify in Priority III, even if the bloodwork results were previously within a normal range.

Health data used to certify a participant must be taken either at the WIC clinic or provided to the WIC clinic by a health care provider in writing or by telephone. It is not acceptable for a parent or guardian to verbally convey the health data to the WIC clinic. Sources of documentation include the crib card, birth certificate, or hospital certificate.

If none of these are available, documentation including a health professional's signature must be obtained from the hospital nursery.

Health data used to certify participants must not be greater than 60 days old.

243.1 Exception to Minimum Required Health Data

In rare instances, an applicant/participant may refuse a hematocrit or hemoglobin test based upon religious or medical reasons. If an applicant's religious beliefs will not allow him or her to have blood drawn, a statement of the applicant's refusal to have blood drawn must be included in the individual's WIC chart. Likewise, if an applicant's medical condition will not allow him or her to have blood drawn, documentation from a physician of the medical condition must be included in the individual's WIC chart. If the condition is considered life long, such as hemophilia, a new statement from the physician is not necessary for subsequent certifications. An applicant refusing the hematocrit or hemoglobin test without citing a religious or medical reason will be denied WIC services.

243.2 Other Health Data

Local WIC projects must inquire during WIC nutrition screening if a child has had a blood lead screening test. If the child has had a blood lead screening test, the test result should be recorded in the WIC computer system and/or the Health History form. If the child has not had a blood lead screening test, the child must be referred to programs where a blood lead screening test can be obtained. Referral in this context does not require the completion of the WIC Interagency Referral and Follow-up Form. Verbal provision of lead contact information, or provision of written information with lead contact information, is adequate.

WIC funds can only be used to determine if an infant or child WIC participant or applicant has received a blood lead screening test, to record the blood lead screening test result, and to refer to local blood lead screening test programs available, as appropriate. WIC is not required nor allowed to spend WIC funds to conduct blood lead screening tests.

Children $\geq$ twelve months of age should be tested. Refer to Section 261 regarding the completion of the Health History form for more information. Information regarding the assignment of risk code 21, high blood lead may be found in Sections 245-249.

244. Nutritional Risk Priority System

The Federal Nutritional Risk Priority system shall be used to certify women, infants, and children for the program. This system prioritizes individuals by level of medical/nutritional risk. There are six priority levels in the system. Priority status is assigned by the system computer at the time of certification based on health and diet information assessed by a certifying health professional. The participant will be certified at the highest priority applicable.

The information in this section and following risk code sections (245-250) has been developed using currently acceptable medical criteria establishing nutritional need for women, infants, and children (see Risk Codes - Justifications and References located in Appendix 200).

The following list represents the six priorities ranked in order from highest to lowest:

I Pregnant women, breastfeeding women and infants at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented nutrition related medical conditions;

II Infants up to six months of age born to women who participate in the WIC program during pregnancy; infants up to six months of age born to women who did not participate during pregnancy but who would have been medically or nutritionally eligible;

III Postpartum women at nutritional risk as demonstrated by hematological or other documented nutrition-related high-risk medical conditions; children at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented nutrition-related medical conditions;

IV Pregnant women, breastfeeding women and infants at nutritional risk due to an inadequate dietary pattern; homelessness or migrancy; postpartum women at nutritional risk as demonstrated by documented high-risk conditions;

V Children at nutritional risk due to an inadequate dietary pattern; homelessness or migrancy; and

VI Postpartum women at nutritional risk as demonstrated by anthropometric measurements; inadequate or inappropriate dietary pattern; homelessness or migrancy.

245. Risk Criteria for Pregnant Women

Pregnant women can be certified in Priorities I and IV. This section provides a detailed description of the risk criteria for certifying pregnant women for the WIC program. An abbreviated resource of **all** risk criteria, *WIC Medical/Nutritional Risk Codes*, is located in Appendix 200.

The risk description is written on the Welcome to WIC (WTW) letter as the nutritional risk. To the left of the risk description is the identifying numerical code to be selected from the risk tab or recorded on the Nutrition Care Plan. **Select all applicable risk codes up to eight**. **Appropriate documentation to support the risk codes selected must appear in the WIC chart.** The computer system assigns the highest eligible priority from the risk codes selected. State mandated high-risk parameters are identified by an "H" located under each high-risk code description. **High-risk codes must be selected.** Required high-risk follow-up protocols are located in the Nutrition Education Chapter of the Policy and Procedure Manual.

In several risk codes, self reporting of a **diagnosed** condition or history of a **diagnosed** condition is allowed. 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 references to professional diagnosis. A self-reported medical diagnosis, “My doctor says that I have/my son or daughter has…,” should prompt the health professional to validate the presence of the condition or history of the condition by asking more pointed questions related to that diagnosis.

245.1 Priority I Risk Criteria for Pregnant Women

Pregnant women meeting one of the following risk criteria will be certified as Priority I participants.

10 Slow weight gain

Slow maternal weight gain is defined as:
A low rate of weight gain in the 2nd and 3rd trimesters, singleton pregnancies, such that:

- Underweight women gain < 1 pounds per week
- Normal weight women gain < .8 pounds per week
- Overweight women gain <.5 pounds per week
- Obese women gain < .4 pounds per week

Or
Low weight gain at any point in pregnancy such that: using an Institute of Medicine (IOM)-based weight gain grid, a pregnant woman's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective prepregnancy weight category.

Prepregancy Weight Groups:	Definition (BMI):	Total Weight Gain Range
Underweight	< 18.5	28-40 lbs
Normal Weight	18.5 to 24.9	25-35 lbs
Overweight	25.0 to 29.9	15-25 lbs
Obese	≥30.0	11-20 lbs

Multifetal pregnancies: The 2009 IOM Report provides provisional guidelines for total weight gain for multifetal gestations. See Risk Code Justifications & References in Appendix 200. This information is not used for risk code determination.

11 High weight gain

A high rate of weight gain, such that in the 2nd and 3rd trimesters, for singleton pregnancies:
-Underweight women gain > 1.3 pounds per week
-Normal weight women gain > 1 pound per week
-Overweight women gain > .7 pounds per week
-Obese women gain >.6 pounds per week

Or
High weight gain at any point in pregnancy, such that using an Institute of Medicine (IOM) based weight gain grid, a pregnant woman's weight plots at any point above the top line of the appropriate weight gain range for her respective prepregnancy weight category.

Prepregancy Weight Groups:	Definition (BMI):	Cut-off Value
Underweight	< 18.5	>40 lbs
Normal Weight	18.5 to 24.9	>35 lbs
Overweight	25.0 to 29.9	>25 lbs
Obese	≥30.0	>20 lbs

Multifetal pregnancies: The 2009 IOM Report provides provisional guidelines for total weight gain for multifetal gestations. See Risk Code Justifications & References in Appendix 200. This information is not used for risk code determination.

12 High weight before pregnancy

Prepregnancy BMI ≥ 25

13 Low weight before pregnancy

Prepregnancy BMI < 18.5

H BMI < 18.5 and not gaining recommended amounts during the second and third trimesters.

H BMI < 18.5 and smokes at least 20 cigarettes per day (one pack per day).

16 Lack of proper prenatal care

Prenatal care beginning after the 1st trimester (after 13th week), or based on the following chart:

Weeks of gestation	Number of prenatal visits
14-21	0 or unknown
22-29	1 or less
30-31	2 or less
32-33	3 or less
34 or more	4 or less

17 Slow fetal growth

Fetal Growth Restriction (FGR**)** (replaces the term Intrauterine Growth Retardation (IUGR) may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography.

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

20 Low iron

Hemoglobin (Hgb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hgb and Hct reflect the amount of functional iron in the body. Changes in Hgb concentration and Hct occur at the late stages of iron deficiency. While neither test is a direct measure of iron status, they are useful indicators of iron deficiency anemia.

First trimester of pregnancy

- Hematocrit less than 33%

H
- Hematocrit less than or equal to 30.0%

- Hemoglobin less than 11 grams per 100 milliliters

H
- Hemoglobin less than or equal to 10.0 grams per 100 milliliters

Second trimester of pregnancy

- Hematocrit less than 32%

H
- Hematocrit less than or equal to 30.0%

- Hemoglobin less than 10.5 grams per 100 milliliters

H
- Hemoglobin less than or equal to 10.0 grams per 100 milliliters

Third trimester of pregnancy

- Hematocrit less than 33%

H

- Hematocrit less than or equal to 30.0%
- Hemoglobin less than 11 grams per 100 milliliters

H

- Hemoglobin less than or equal to 10.0 grams per 100 milliliters

21 High blood lead

Blood lead levels of ≥10 micrograms per deciliter within the past 12 months

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under physician's orders

Cut off value is the current published guidance from the Centers for Disease Control and Prevention (CDC).

22 Had a large baby

Any history of birth of a large for gestational age infant, or history of birth of an infant weighing ≥ 9 pounds (4000 grams) or ≥90th percentile weight for gestational age at birth

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under physician's orders

23 Nutritional birth defect

Any history of having given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake

May be self reported by applicant/participant/caregiver or reported or documented by a physician or health care provider working under physician's orders

Examples of congenital or birth defects linked to inappropriate nutritional intake are:

- inadequate folic acid - neural tube defect
- excess vitamin A - cleft palate/lip
- inadequate zinc - low birth weight

39 Many pregnancies before age 20

Women under age 20 at date of conception who have had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome

May be self reported by applicant/participant/caregiver or reported or documented by a physician or health care provider working under physician's orders

40 Pregnant at a young age

- Conception ≤17 years of age

H

- Conception ≤15 years of age

42 Having more than one baby

More than one (> 1) fetus in a current pregnancy
May be self reported by applicant/participant/caregiver or reported or documented by a physician or health care provider working under physician's orders

43 Close pregnancies

Conception before 16 months postpartum in a current pregnancy

44 Conditions caused by pregnancy

- **Hyperemesis Gravidarum**
  Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic.

Presence of Hyperemesis Gravidarum as diagnosed by physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Nutrition risk is based on chronic condition, not single episodes.

H

- **Gestational Diabetes**
  Gestational diabetes mellitus (GDM) is defined as any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

  Presence of gestational diabetes diagnosed by physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **History of Gestational Diabetes**
  History of gestational diabetes mellitus (GDM) diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **History of Preeclampsia**
  History of preeclampsia diagnosed by physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Pregnancy Induced Hypertension**
  Presence of hypertension diagnosed by physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

45 **Past fetal loss**
(History of spontaneous abortion, fetal or neonatal loss)

- Any history of two or more spontaneous abortions (SAB); SAB is the spontaneous termination of a gestation at < 20 weeks gestation or at < 500 grams.
- Any history of a fetal death (death at ≥ 20 weeks gestation) or a neonatal death (death within 0-28 days of life)

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under physician's orders

46 **Smoking or Secondhand Smoke**

- Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigar

H day
- BMI <18.5 and smokes at least 20 cigarettes per (one pack per day)

- Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home. ETS is also known as passive, secondhand, or involuntary smoke.

47 **Alcohol use**

H Any alcohol use during current pregnancy

48 **Drug use**

H Any illegal drug use, i.e., marijuana, cocaine, crack, PCP, LSD, heroin, methamphetamine, etc., or the misuse of prescription drugs, i.e., oxycontin, methadone, valium, etc.

49 **Past early or small baby**

- Any history of the birth of an infant at ≤ 37 weeks gestation

- Any history of birth of an infant weighing ≤ 5 lb 8 oz (#2500 grams)

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by health care provider working under physician's orders

69 Breastfeeding while pregnant

Breastfeeding woman now pregnant

80 Transfer

Pregnant woman with current valid Verification of Certification (VOC) document from another state

91 Inborn Errors of Metabolism (IEM)

When using this risk code, enter the specific condition on the WTW letter as the nutritional risk.

H All the following conditions are high-risk:

Presence of inborn errors of metabolism diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat

Generally refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:

Amino Acid Metabolism Disorders
- PKU-Phenylketonuria (includes clinically significant hyperphenylalaninemia variants)
- Maple syrup urine disease
- Homocystinuria
- Tyrosinemia

Carbohydrate Disorders

- Galactosemia
- Glycogen storage disease types I-VI
- Fructose 1-phosphate aldolase deficiency

Fatty Acid Oxidation Defects

- MCADD - 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

Organic Acid Disorders (AKA organic aciduria or organic academia)

- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- Glutaric acidemia Type I and II
- 3-hydroxy-3-methylglutaryl coenzyme A lyase deficiency (3HMGCoA)
- Multiple carboxylase deficiency (Biotinidase deficiency, Holocarboxylase synthetase deficiency)
- Methylmalonic acidemia
- Propionic acidemia
- Beta-ketothiolase deficiency

Lysosomal Storage Diseases

- Fabry disease (α-galactosidase A deficiency)
- Gauchers disease (glucocerebrosidase deficiency)
- Pomp disease (glycogen storage disease Type II or α-glucosidase deficiency)

Mitochondrial Disorders

- Leber hereditary optic neuropathy
- Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)
- Mitochondrial neurogastrointestinal encephalopathy disease (MNGIE)

- Myoclonic epilepsy with raged-red fibers (MERRF)
- Neuropathy, ataxia, and retinitis pigmentosa (NARP)
- Pyruvate carboxylase deficiency

Peroxisomal Disorders

- Zellweger Syndrome Spectrum
- Adrenoleukodystrophy (x-ALD)

Urea Cycle Disorders

- Citrullinemia
- Argininosuccinic aciduria
- Carbamoyl phosphate synthetase l deficiency

Other IEM can be found at:
http://rarediseases.info.nih.gov/GARD

93 **Conditions that Affect Nutritional Status**
When using this risk code, enter the specific condition on the WTW letter as the nutritional risk.

In deciding to assign risk code 93, the condition, or treatment for the condition, must be severe enough to affect nutrition status unless the specific section allows for the history of a condition.

H All the following conditions are high-risk:

- **Cancer**
  A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biological restraints. The current condition, or treatment for the condition, must be severe enough to affect nutritional status.

  Presence of cancer diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Celiac Disease**
  Celiac Disease (CD) is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. More information about the definition of CD is found In Appendix 200 *Risk Codes – Justifications and References*.

  CD is also known as: Celiac Sprue, Gluten-sensitive Enteropathy, and Nontropical Sprue

  Presence of Celiac Disease diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Central Nervous System Disorders**
  Conditions which affect energy requirements, ability to feed self or alter nutritional status metabolically, mechanically, or both. Includes, but not limited to:

  - epilepsy
  - cerebral palsy (CP)
  - neural tube defects (NTD), such as: spina bifida or myelomeningocele
  - Parkinson's disease
  - multiple sclerosis

  Presence of central nervous system disorders diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Depression**
  Presence of clinical depression diagnosed by a physician or psychologist as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat**
  Developmental, sensory, or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs.

  Includes, but not limited to:

  - minimal brain function
  - feeding problems due to a developmental disability such as pervasive development disorder (PDD) which includes autism
  - birth injury
  - head trauma
  - brain damage
  - other disabilities

  May be self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under physician's orders.

- **Diabetes Mellitus**
  Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

  Presence of diabetes mellitus diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Drug Nutrient Interactions**
  Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization to an extent that nutritional status is compromised

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.

- **Eating Disorders**
  Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:

  - self-induced vomiting
  - purgative abuse
  - alternating periods of starvation
  - use of drugs such as appetite suppressants, thyroid preparations or diuretics
  - self-induced marked weight loss

  Presence of eating disorders diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Food Allergies**
  Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food.

  Presence of food allergies diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders.

- **Gastrointestinal Disorders**
  Diseases or conditions that interfere with the intake, digestion, and/or absorption of nutrients. The conditions include, but are not limited to:

- gastroesophageal reflux disease (GERD)
- peptic ulcer
- post-bariatric surgery
- short bowel syndrome
- inflammatory bowel disease, including ulcerative colitis or Crohn's Disease
- liver disease
- pancreatitis
- biliary tract diseases

Presence of gastrointestinal disorders diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Genetic and Congenital Disorders**
  Hereditary or congenital condition that causes physical or metabolic abnormality: The current condition must alter nutrition status metabolically, mechanically, or both. Includes, but not limited to:

  - cleft lip or palate
  - Down's syndrome
  - thalassemia major
  - sickle cell anemia (not sickle cell trait)

  Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Hypertension and Prehypertension**
  Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Hypoglycemia**
  Presence of hypoglycemia as diagnosed by a physician as self-reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Infectious Diseases**
  A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to:

  - tuberculosis
  - pneumonia
  - meningitis
  - parasitic infections
  - hepatitis
  - HIV (Human Immunodeficiency Virus infection)*
  - AIDS (Acquired Immunodeficiency Syndrome)*

  The infectious disease must be present *within the past six months*, and diagnosed by a physician.

  May be self-reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under physician's orders

  * It is strongly recommended that all pregnant women know their HIV status. Early treatment can decrease risk of transmission to the fetus.

- **Lactose Intolerance**
  Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.

Presence of lactose intolerance diagnosed by a physician as self-reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

A special formula for a pregnant woman with lactose intolerance is authorized only as specified in Chapter 300.

- **Nutrient Deficiency Diseases**
  Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micro nutrients. Diseases include, but are not limited to:
  - Protein Energy Malnutrition (PEM)
  - Scurvy
  - Rickets
  - Beri Beri
  - Hypocalcemia
  - Osteomalacia
  - Vitamin K Deficiency
  - Pellagra
  - Cheilosis
  - Menkes Disease
  - Xerophthalmia

  Presence of nutrient deficiency disease diagnosed by a physician as self-reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Recent Major Surgery, Trauma, Burns**
  Major surgery, trauma, or burns severe enough to compromise nutritional status
  Any occurrence:
  - within the past two ($\leq$ 2) months may be self reported

- more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician

- **Renal Disease**
  Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.

  Presence of renal disease diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Thyroid Disorders**
  Thyroid dysfunctions that occur in pregnancy, during fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following:

  Hypothyroidism – low secretion levels of thyroid hormone (can be overt or mild/subclinical). It is most commonly seen as chronic autoimmune thyroiditis (Hashimotos's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.

  Hyperthyroidism – excessive thyroid hormone production (most commonly known as Grave's disease and toxic multinodular goiter)

  Congenital hypothyroidism – infants born with underactive thyroid gland and presumed to have had hypothyroidism in-utero

  Congenital Hyperthyroidism – Excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation).

Presence of thyroid disorders diagnosed by a physician as self-reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Other Medical Conditions**
  Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but not limited to:

  - juvenile rheumatoid arthritis (JRA)
  - lupus erythematosus
  - cardiorespiratory diseases
  - heart disease
  - cystic fibrosis
  - Persistent asthma (moderate or severe) requiring daily medication

  Presence of medical conditions as diagnosed by a physician as self reported by applicant/ participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

94 Dental problems

Diagnosis of dental problems by a physician or by a health care provider working under the orders of a physician or adequate documentation by the health professional, including, but not limited to:

- Tooth decay, periodontal disease, tooth loss and or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality

- Gingivitis of pregnancy

245.2 Priority IV Risk Criteria for Pregnant Women

Pregnant women meeting one of the following risk criteria will be certified as priority IV participants, if no higher priority risk code is selected.

30 Unhealthy diet habits

- **Inappropriate or Excessive Intake of Dietary Supplements Including Vitamins, Minerals, and Herbal Remedies**
  Pregnant woman routinely takes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences including, but not limited to, ingestion of unprescribed, excessive, or toxic amounts of multi or single vitamins, mineral supplements, or herbal remedies.

- **Inadequate Vitamin/Mineral Supplementation**
  Pregnant woman does not routinely take a dietary supplement recognized as essential by national public health policy makers because diet alone cannot meet nutrient requirements.
  -pregnant women not taking her doctor-prescribed prenatal vitamins
  -consumption of <27 mg. of supplemental iron per day by pregnant women
  -consumption of <150 ug of supplemental iodine per day by pregnant women

- **Pica**
  Compulsively ingesting nonfood items including, but not limited to:

  - ashes
  - baking soda
  - burnt matches
  - carpet fibers
  - chalk
  - cigarettes
  - clay
  - dirt/dust

- large quantities of ice and/or freezer frost
- paint chips
- starch (laundry and cornstarch)

- **Eating foods that could be contaminated with pathogenic microorganisms**
  Potentially harmful foods:
  -Raw fish or shellfish, including oysters, clams, mussels, and scallops;
  -Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole;
  -Raw or undercooked meat or poultry;
  -Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot;
  -Refrigerated pâté or meat spreads;
  -Unpasteurized milk or foods containing unpasteurized milk;
  -Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as made with pasteurized milk;
  -Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog;
  -Raw sprouts (alfalfa, clover, and radish); or
  -Unpasteurized fruit or vegetable juices.

31 Needs Diet Guidance

Women who meet the eligibility requirements of income, categorical, and residency status may be presumed to be at nutritional risk based on failure to meet *Dietary Guidelines for Americans* (Dietary Guidelines). Failure to meet Dietary Guidelines is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans) based on an individual's estimated energy needs.

This risk may be assigned only to individuals (2 years or older) for whom a complete nutrition assessment (to include an assessment for risk codes 30-unhealthy diet habits and 35- limited diet) has been performed and for whom no other risks are identified.

35 Limited diet

Consuming a diet very low in calories and/or essential nutrients or impaired caloric intake or absorption of essential nutrients following bariatric surgery

- **Vegan diets**
  Consumption of plant origin foods only, an eating plan with no animal products (no meat, poultry, fish, eggs, milk, cheese, or other dairy products) and avoidance of foods made with animal product ingredients

- **Highly restrictive diets**
  Diets that are very low in calories, severely limit intake of important food sources of nutrients, or otherwise involve high-risk eating patterns (e.g., Macrobiotic diet)

66 At risk for poor diet

Pregnant woman who is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- ≤ to 17 years of age

- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)

- physically disabled to a degree which restricts or limits food preparation abilities, or

- currently using or having a history of abusing alcohol or other drugs

67 Needs WIC services

Battering within past six months as self-reported, or as documented by a social worker, health care provider or on another appropriate document, or as reported through consultation with a social worker, health care provider, or other appropriate personnel.

"Battering" generally refers to violent assaults on women.

95 Homeless or Migrant

- **Homeless** - A categorically eligible woman who lacks a fixed and regular nighttime residence, or whose primary nighttime residence is:
  - a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations;
  - an institution that provides a temporary residence for individuals intended to be institutionalized;
  - a temporary accommodation of not more than 365 days in the residence of another individual; or
  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
- **Migrant** - A categorically eligible woman who is a member of a family which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode

96 Foster care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months

246. Risk Criteria for Breastfeeding Women

Breastfeeding women can be certified in Priorities I and IV. This section provides a detailed description of the risk criteria for certifying breastfeeding women for the WIC program. An abbreviated resource of **all** risk criteria, *WIC Medical/Nutritional Risk Codes*, is located in Appendix 200.

The risk description is written on the Welcome to WIC (WTW) letter as the nutritional risk. To the left of the risk description is the identifying numerical code to be selected from the risk tab or recorded on the Nutrition Care Plan. **Select all applicable risk codes up to eight**. **Appropriate documentation to support the risk codes selected must appear in the WIC chart.** The computer system assigns the highest eligible priority from the risks selected. State-mandated high-risk parameters are identified by an "H" located to the left of each high-risk description. **High-risk codes must be selected.** Required high-risk follow-up protocols are located in the Nutrition Education Chapter of the Policy and Procedure Manual.

In several risk codes, self reporting of a **diagnosed** condition or history of a **diagnosed** condition is allowed. 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 references to professional diagnosis. A self-reported medical diagnosis, "My doctor says that I have/my son or daughter has…," should prompt the health professional to validate the presence of the condition or history of the condition by asking more pointed questions related to that diagnosis.

246.1 Priority I Risk Criteria for Breastfeeding Women

Breastfeeding women meeting one of the following risk criteria will be certified as Priority I participants.

11 High weight gain

Breastfeeding women (most recent singleton pregnancy only): total gestational weight gain exceeding the upper limit of the Institute of Medicine's (IOM) recommended range based on Body Mass Index (BMI), as follows:

Prepregancy Weight Groups	Definition (BMI)	Cut-off Value
Underweight	< 18.5	> 40 lbs
Normal Weight	18.5 to 24.9	> 35 lbs
Overweight	25.0 to 29.9	> 25 lbs
Obese	≥30.0	> 20 lbs

Multifetal pregnancies: The 2009 IOM Report provides provisional guidelines for total weight gain for multifetal gestations. See Risk Code Justifications & References in Appendix 200. This information is not used for risk code determination.

14 Low weight

- **Less than 6 months postpartum:**
  Prepregnancy or current Body Mass Index (BMI) <18.5

- **6 months to a year postpartum:**
  Current Body Mass Index (BMI) <18.5

H

- BMI <18.5 and smokes at least 20 cigarettes per day (one pack per day)

15 High weight

- **Less than 6 months postpartum:**
  Prepregnancy Body Mass Index (BMI) ≥ 25.0

- **6 months to a year postpartum:**
  Current Body Mass Index (BMI) ≥ 25.0

20 Low iron

Hemoglobin (Hgb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hgb and Hct reflect the amount of functional iron in the body. Changes in Hgb concentration and Hct occur at the late stages of iron deficiency. While neither test is a direct measure of iron status, they are useful indicators of iron deficiency anemia.

Breastfeeding Women

- <15 yrs - hematocrit less than 36.0%
  - hemoglobin less than 11.8 grams per 100 milliliters
- ≥15 yrs - hematocrit less than 36.0%
  - hemoglobin less than 12.0 grams per 100 milliliters
- For all ages:

H Hematocrit less than or equal to 33%

H Hemoglobin less than or equal to 11.0 grams per 100 milliliters

21 High blood lead

Blood lead level of ≥10 micrograms per deciliter within the last 12 months

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Cut off value is the current published guidance from the Centers for Disease Control and Prevention (CDC).

22 Had a large baby

Birth of a large for gestational age infant during most recent pregnancy, or history of birth of an infant weighing ≥ 9 pounds (4000 grams) or ≥ 90th percentile weight for gestational age at birth

Presence or history of large for gestational age infant

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

23 Nutritional birth defect

Giving birth in the most recent pregnancy to an infant who has a congenital or birth defect linked to inappropriate nutritional intake
May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Examples of congenital or birth defects linked to inappropriate nutritional intake are:
- inadequate folic acid - neural tube defect
- excess vitamin A - cleft palate/lip
- inadequate zinc - low birth weight

39 Many pregnancies before age 20

Women under age 20 at date of conception who have had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome. For breastfeeding women, the most recent pregnancy is at least the fourth pregnancy.

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

40 Pregnant at a young age

- Conception when ≤ 17 years of age for most recent pregnancy

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- ≤ 15 years of age at conception for most recent pregnancy

42 Having more than one baby

Breastfeeding woman with more than one fetus in most recent pregnancy

43 Close pregnancies

Breastfeeding women with conception prior to 16 months postpartum for most recent pregnancy

44 Conditions caused by pregnancy

- **History of Gestational Diabetes**
  History of gestational diabetes mellitus (GDM) diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **History of diagnosed preeclampsia**
  Presence of preeclampsia diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

45 Past fetal loss

- For a breastfeeding woman, a spontaneous abortion (SAB) that occurred during the most recent pregnancy whose outcome resulted in one or more live births. SAB is the spontaneous termination of a gestation at < 20 weeks gestation or at < 500 grams.

- For a breastfeeding woman, fetal death or neonatal loss during most recent pregnancy with one or more infants still living. A fetal death (death at ≥20 weeks gestation) or a neonatal death (death within 0-28 days of life)

  May be self reported by applicant/participant/ caregiver or documented by a physician or by a health care provider working under a physician's orders

46 Smoking or Secondhand Smoke

- Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigars

H

- BMI <18.5 and smokes at least 20 cigarettes per day

- Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home. ETS is also known as passive, secondhand, or involuntary smoke.

47 Alcohol use**

- Routine, current use of more than 2 drinks per day. A serving or standard sized drink is: 1 can of beer (12 fluid ounces); 5 ounces wine; 1½ fluid ounces of liquor (1 jigger gin, rum, vodka, whiskey (86-proof), vermouth, cordials or liqueurs)

- Binge drinking - drank 5 or more drinks on the same occasion on at least one day in the past 30 days

- Heavy drinking - drank 5 or more drinks on the same occasion on five or more days in the past 30 days

H

- Consumes an average of three ounces of hard liquor or six mixed drinks per day, or three 12 ounce beers, or three 4 ounce servings of wine per day

****Breastfeeding is contraindicated only on occasions when a woman uses alcohol as defined above.

48 Drug use**

H Any illegal drug use, such as marijuana, cocaine, crack, PCP, LSD, heroin, methamphetamine, etc. or misuse of prescription drugs such as oxycontin, methadone, valium, etc.

**Breastfeeding is contraindicated for a woman using illegal drugs or misusing prescription drugs.

49 Past early or small baby

- Preterm delivery - birth of an infant at less than or equal to 37 weeks gestation as outcome of most recent pregnancy

- Birth of an infant weighing less than or equal to 5 pounds 8 ounces (≤ 2500 grams) as outcome of most recent pregnancy

74 Breastfeeding issues

H A breastfeeding woman with any of the following complications or potential complications for breastfeeding:

- Severe breast engorgement
- Recurrent plugged ducts
- Mastitis (fever or flu-like symptoms with localized breast tenderness)
- Flat or inverted nipples
- Cracked, bleeding or severely sore nipples
- Age ≥ to 40 year
- Failure of milk to come in by four days postpartum
- Tandem nursing (breastfeeding two siblings who are not twins)

80 Transfer

Breastfeeding woman with current, valid Verification of Certification (VOC) document from another state

91 Inborn Errors of Metabolism (IEM)
(When using this risk code, enter the name of the specific condition on the WTW letter as the nutritional risk.)

H All the following conditions are high-risk:

Presence of inborn errors of metabolism diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under physician's orders

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat

Generally refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:
Amino Acid Metabolism Disorders
- PKU-Phenylketonuria (includes clinically significant hyperphenylalaninemia variants)
- Maple syrup urine disease
- Homocystinuria
- Tyrosinemia

Carbohydrate Disorders
- Galactosemia
- Glycogen storage disease types I-VI
- Fructose 1-phosphate aldolase deficiency

Fatty Acid Oxidation Defects
- MCADD - 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

Organic Acid Disorders (AKA organic aciduria or organic academia)
- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- Glutaric acidemia Type I and II
- 3-hydroxy-3-methylglutaryl coenzyme A lyase deficiency (3HMGCoA)
- Multiple carboxylase deficiency (Biotinidase deficiency, Holocarboxylase synthetase deficiency)
- Methylmalonic acidemia
- Propionic acidemia
- Beta-ketothiolase deficiency

Lysosomal Storage Diseases
- Fabry disease (α-galactosidase A deficiency)
- Gauchers disease (glucocerebrosidase deficiency)
- Pomp disease (glycogen storage disease Type II or α-glucosidase deficiency)

Mitochondrial Disorders
- Leber hereditary optic neuropathy
- Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)
- Mitochondrial neurogastrointestinal encephalopathy disease (MNGIE)
- Myoclonic epilepsy with raged-red fibers (MERRF)
- Neuropathy, ataxia, and retinitis pigmentosa (NARP)
- Pyruvate carboxylase deficiency

Peroxisomal Disorders
- Zellweger Syndrome Spectrum
- Adrenoleukodystrophy (x-ALD)

Urea Cycle Disorders
- Citrullinemia
- Argininosuccinic aciduria
- Carbamoyl phosphate synthetase l deficiency

Other IEM can be found at:
http://rarediseases.info.nih.gov/GARD

93 **Conditions that Affect Nutritional Status**
When using this risk code, enter the name of the specific condition on the WTW letter as the nutritional risk.

In deciding to assign risk code 93, the condition, or treatment for the condition, must be severe enough to affect nutrition status unless the specific section allows for the history of a condition.

H All the following conditions are high-risk:

- **Cancer**
  A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biological restraints. The current condition, or treatment for the condition, must be severe enough to affect nutritional status.

  Presence of cancer diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Celiac Disease**
  Celiac Disease (CD) is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. More information about the definition of CD is found In Appendix 200 *Risk Codes – Justifications and References*.

  CD is also known as: Celiac Sprue, Gluten-sensitive Enteropathy, and Nontropical Sprue

  Presence of celiac diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Central Nervous System Disorders**
  Conditions which affect energy requirements, ability to feed self or alter nutritional status metabolically, mechanically, or both. Includes, but not limited to:

  - epilepsy
  - cerebral palsy (CP)
  - neural tube defects (NTD), such as: spina bifida or myelomeningocele
  - Parkinson's disease
  - multiple sclerosis

  Presence of central nervous system disorder as diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Depression**
  Presence of clinical depression as diagnosed by a physician or psychologist as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat**
  Developmental, sensory or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs.

  Includes, but not limited to:
  - minimal brain function
  - feeding problems due to a developmental disability such as pervasive development disorder (PDD), which includes autism
  - birth injury
  - head trauma
  - brain damage
  - other disabilities

Presence of developmental, sensory or motor delay or disability affecting the ability to eat, as diagnosed by a physician as self reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Diabetes Mellitus and Pre-Diabetes**
  Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

  Impaired fasting glucose (IFG) and/or impaired glucose tolerance (IGT) are referred to as pre-diabetes. These conditions are characterized by hyperglycemia that does not meet the diagnostic criteria for diabetes mellitus.
  Presence of diabetes mellitus or pre-diabetes as diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Drug Nutrient Interactions**
  Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised

  Possible nutrition-related side effects of drugs include, but are not limited to:

  - altered taste sensation
  - gastric irritation
  - appetite suppression
  - altered GI motility
  - altered nutrient metabolism and function, including enzyme inhibition, vitamin antagonism, and increased urinary loss.

- **Eating Disorders**
  Eating disorders (anorexia nervosa and bulimia) are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:

  - self-induced vomiting
  - purgative abuse
  - alternating periods of starvation
  - use of drugs such as appetite suppressants, thyroid preparations or diuretics
  - self-induced marked weight loss

  Presence of eating disorder as diagnosed by a physician as self-reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

  Or evidence of such disorder as documented by the certifying health professional

- **Food Allergies**
  Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food.

  Presence of food allergy as diagnosed by a physician as self-reported by the applicant/participant/ caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Gastrointestinal Disorders**
  Diseases or conditions that interfere with the intake, digestion, and/or absorption of nutrients. The conditions include, but are not limited to:
  - gastroesophageal reflux disease (GERD)
  - peptic ulcer

- post-bariatric surgery
- short bowel syndrome
- inflammatory bowel disease, including ulcerative colitis or Crohn's disease
- liver disease
- pancreatitis
- biliary tract diseases

Presence of gastrointestinal disorder as diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Genetic and Congenital Disorders**
  Hereditary or congenital condition that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. May include, but is not limited to:

  - cleft lip or palate
  - Down's syndrome
  - thalassemia major
  - sickle cell anemia (not sickle cell trait)

  Presence of genetic or congenital disorder as diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Hypertension and Prehypertension**
  Presence of hypertension or prehypertension diagnosed by a physician as self reported by the applicant/participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Hypoglycemia**
  Presence of hypoglycemia as diagnosed by a physician as self-reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Infectious Diseases**
  A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to:

  - tuberculosis
  - pneumonia
  - meningitis
  - parasitic infections
  - hepatitis
  - HIV (Human Immunodeficiency Virus infection)*
  - AIDS (Acquired Immunodeficiency Syndrome)*

  The infectious disease must be present *within the past six months* as diagnosed by a physician.
  - May be self reported by applicant/participant/ caregiver or documented by a physician or by a health care provider working under a physician's orders

  * Breastfeeding is contraindicated for a woman with this condition

- **Lactose Intolerance**
  Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.

Presence of lactose intolerance as diagnosed by a physician as self-reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

A special formula for a breastfeeding woman with lactose intolerance is authorized only as specified in Chapter 300.

- **Nutrient Deficiency Diseases**
  Diagnosis of nutritional deficiency or a disease caused by insufficient dietary intake of macro and micro nutrients. Diseases include, but are not limited to:
  - protein energy malnutrition (PEM)
  - scurvy
  - rickets
  - beri beri
  - hypocalcemia
  - osteomalacia
  - vitamin K deficiency
  - pellagra
  - cheilosis
  - Menkes disease
  - xerophthalmia

  Presence of nutrient deficiency disease as diagnosed by a physician

- **Recent Major Surgery, Trauma, Burns**
  Major surgery (including C-sections), trauma, or burns severe enough to compromise nutritional status

Any occurrence
- within the past two (≤ 2) months may be self reported
- more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician

- **Renal Disease**
  Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.

  Presence of renal disease as diagnosed by a physician as self-reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Thyroid Disorders**
  Thyroid dysfunctions that occur in pregnancy and postpartum women, during fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following:

  Hypothyroidism – low secretion levels of thyroid hormone (can be overt or mild/subclinical). It is most commonly seen as chronic autoimmune thyroiditis (Hashimotos's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.

  Hyperthyroidism – excessive thyroid hormone production (most commonly known as Grave's disease and toxic multinodular goiter)

  Congenital hypothyroidism – infants born with underactive thyroid gland and presumed to have had hypothyroidism in-utero

Congenital Hyperthyroidism – excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation)

Postpartum Thyroiditis – Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous.

Presence of thyroid disorder as diagnosed by a physician as self-reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Other Medical Conditions**
  Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but not limited to:

  - juvenile rheumatoid arthritis (JRA)
  - lupus erythematosus
  - cardiorespiratory diseases
  - heart disease
  - cystic fibrosis
  - persistent asthma (moderate or severe) requiring daily medication

  Presence of medical condition as diagnosed by a physician as self-reported by the applicant/ participant/caregiver, or as reported or documented by a physician or someone working under physician's orders

94 Dental problems

Dental problems as diagnosed by a physician or a health care provider working under the orders of a physician, or adequate documentation by the health professional, including, but not limited to:

- tooth decay
- periodontal disease
- tooth loss
- ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality

246.2 Priority IV Risk Criteria for Breastfeeding Women

Breastfeeding women meeting one of the following risk criteria will be certified as priority IV participants, if no higher priority risk code is selected.

30 Unhealthy diet habits

- **Inappropriate or Excessive Intake of Dietary Supplements, including Vitamin, Minerals and Herbal Remedies**
  The breastfeeding woman routinely takes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences, including but not limited to ingestion of unprescribed excessive or toxic amounts of multi or single vitamins, mineral supplements, or herbal remedies.

- **Inadequate Vitamin/Mineral Supplementation**
  The breastfeeding woman does not routinely take a dietary supplement recognized as essential by national public health policy makers because diet alone cannot meet nutrient requirements.
  -A breastfeeding woman with low iron is not taking her doctor-prescribed iron supplement.

-Consumption of < 150 ug of supplemental iodine per day by breastfeeding women
-Consumption of < 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant women

- **Pica**
  Compulsively ingesting nonfood items including, but not limited to:

  - ashes
  - baking soda
  - burnt matches
  - carpet fibers
  - chalk
  - cigarettes
  - clay
  - dirt/dust
  - large quantities of ice and/or freezer frost
  - paint chips
  - starch (laundry and cornstarch)

- **Eating foods that could be contaminated with pathogenic microorganisms**
  Potentially harmful foods:
  -Raw fish or shellfish, including oysters, clams, mussels, and scallops;
  -Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole;
  -Raw or undercooked meat or poultry;
  -Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot;
  -Refrigerated pâté or meat spreads;
  -Unpasteurized milk or foods containing unpasteurized milk;
  -Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as made with pasteurized milk;

-Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog;
-Raw sprouts (alfalfa, clover, and radish); or
-Unpasteurized fruit or vegetable juices.

31 Needs Diet Guidance

Women who meet the eligibility requirements of income, categorical, and residency status may be presumed to be at nutritional risk based on failure to meet *Dietary Guidelines for Americans* (Dietary Guidelines). Failure to meet Dietary Guidelines is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans) based on an individual's estimated energy needs.

This risk may be assigned only to individuals (2 years or older) for whom a complete nutrition assessment (to include an assessment for risk codes 30-unhealthy diet habits, 35- limited diet, and 63-prevention) has been performed and for whom no other risks are identified.

35 Limited diet

Consuming a diet very low in calories and/or essential nutrients or impaired caloric intake or absorption of essential nutrients following bariatric surgery

- **Vegan diets**
  Consumption of plant origin foods only, an eating plan with no animal product (no meat, poultry, fish, eggs, milk, cheese, or other dairy products) and avoidance of foods made with animal product ingredients

- **Highly restrictive diets**
  Diets that are very low in calories, severely limit intake of important food sources of nutrients, or otherwise involve high-risk eating patterns (e.g., Macrobiotic diet)

63 Prevention

A participant who has previously been certified eligible for the program may be considered to be at nutritional risk in the next certification period if the health professional determines there is a possibility of regression in nutritional status without the benefits that the WIC program provides. Code 63 can be used only at recertification. **This code must be used by itself and only if no other risk code has been identified.** This risk code may be used once in succession after a risk code. It can be used after any appropriate risk code.

66 At risk for poor diet

Breastfeeding woman who is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- ≤ 17 years of age
- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)
- physically disabled to a degree which restricts or limits food preparation abilities, or
- currently using or having a history of abusing alcohol or other drugs

67 Needs WIC services

Battering within past six months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel.

"Battering" generally refers to violent assaults on women.

70 Breastfeeding a WIC baby

A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk

The infant's risk code must be identified in the "BF Infant Risk" section of the mother's Health History form.

95 Homeless or Migrant

- **Homeless** - A categorically eligible woman who lacks a fixed
and regular nighttime residence, or whose primary nighttime residence is:

  - a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations

  - an institution that provides a temporary residence for individuals intended to be institutionalized

  - a temporary accommodation of not more than 365 days in the residence of another individual

  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings

- **Migrant** - A categorically eligible woman who is a member of a family which contains at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode

96 Foster care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months

247. Risk Criteria for Postpartum Women

Postpartum women can be certified in Priorities III and VI. This section provides a detailed description of the risk criteria for certifying postpartum, nonbreastfeeding women for the WIC program. An abbreviated resource of **all** risk criteria, *WIC Medical/Nutritional Risk Codes*, is located in Appendix 200.

The risk description is written on the Welcome to WIC (WTW) letter as the nutritional risk. To the left of the risk description is the identifying numerical code to be selected from the risk tab or recorded on the Nutrition Care Plan. **Select all applicable risk codes up to eight**. **Appropriate documentation to support the risk codes selected must appear in the WIC chart.** The computer system assigns the highest eligible priority from the risk codes selected. State mandated high-risk parameters are identified by an "H" located under each high-risk code description. **High-risk codes must be selected.** Required high-risk follow-up protocols are located in the Nutrition Education Chapter of the Policy and Procedure Manual.

In several risk codes, self reporting of a **diagnosed** condition or history of a **diagnosed** condition is allowed. 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 references to professional diagnosis. A self-reported medical diagnosis, "My doctor says that I have/my son or daughter has…," should prompt the health professional to validate the presence of the condition or history of the condition by asking more pointed questions related to that diagnosis.

247.1 Priority III Risk Criteria for Postpartum Women

Postpartum women meeting one of the following risk code criteria will be certified as Priority III participants.

20 Low iron

Hemoglobin (Hgb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hgb and Hct reflect the amount of functional iron in the body. Changes in Hgb concentration and Hct occur at the late stages of iron deficiency. While neither test is a direct measure of iron status, they are useful indicators of iron deficiency anemia.

Postpartum Women

- <15 yrs - hematocrit less than 36.0%
  - hemoglobin less than 11.8 grams per 100 milliliters
- ≥15 yrs - hematocrit less than 36.0%
  - hemoglobin less than 12.0 grams per 100 milliliters
- For all ages:

H Hematocrit less than or equal to 33%

H Hemoglobin less than or equal to 11.0 grams per 100 milliliters

21 High blood lead

Blood lead level of ≥ 10 micrograms per deciliter within the last 12 months

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Cut off value is the current published guidance from the Centers for Disease Control and Prevention (CDC).

80 Transfer

Postpartum woman with current valid Verification of Certification (VOC) document from another state.

91 Inborn Errors of Metabolism (IEM)
(When using this risk code, enter the name of the specific condition on the WTW letter as the nutritional risk.)

H All of the following conditions are high-risk:

Presence of inborn errors of metabolism diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat

Generally refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:

Amino Acid Metabolism Disorders
- PKU-Phenylketonuria (includes clinically significant hyperphenylalaninemia variants)
- Maple syrup urine disease
- Homocystinuria
- Tyrosinemia

Carbohydrate Disorders
- Galactosemia
- Glycogen storage disease types I-VI
- Fructose 1-phosphate aldolase deficiency

Fatty Acid Oxidation Defects
- MCADD - 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

Organic Acid Disorders (AKA organic aciduria or organic academia)
- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- Glutaric acidemia Type I and II

- 3-hydroxy-3-methylglutaryl coenzyme A lyase deficiency (3HMGCoA)
- Multiple carboxylase deficiency (Biotinidase deficiency, Holocarboxylase synthetase deficiency)
- Methylmalonic acidemia
- Propionic acidemia
- Beta-ketothiolase deficiency

Lysosomal Storage Diseases

- Fabry disease (α-galactosidase A deficiency)
- Gauchers disease (glucocerebrosidase deficiency)
- Pomp disease (glycogen storage disease Type II or α-glucosidase deficiency)

Mitochondrial Disorders

- Leber hereditary optic neuropathy
- Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)
- Mitochondrial neurogastrointestinal encephalopathy disease (MNGIE)
- Myoclonic epilepsy with raged-red fibers (MERRF)
- Neuropathy, ataxia, and retinitis pigmentosa (NARP)
- Pyruvate carboxylase deficiency

Peroxisomal Disorders

- Zellweger Syndrome Spectrum
- Adrenoleukodystrophy (x-ALD)

Urea Cycle Disorders

- Citrullinemia
- Argininosuccinic aciduria
- Carbamoyl phosphate synthetase l deficiency

Other IEM can be found at:
http://rarediseases.info.nih.gov/GARD

93 Conditions that Affect Nutritional Status

When using this risk code, enter the name of the specific condition on the WTW letter as the nutritional risk.

In deciding to assign risk code 93, the condition, or treatment for the condition, must be severe enough to affect nutrition status unless the specific section allows for the history of a condition.

H All of the following conditions are high-risk:

- **Cancer**
  A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biological restraints. The current condition, or treatment for the condition, must be severe enough to affect nutritional status.

  Presence of cancer as diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Celiac Disease**
  Celiac Disease (CD) is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. More information about the definition of CD is found In Appendix 200 *Risk Codes – Justifications and References*.

  CD is also known as: Celiac Sprue, Gluten-sensitive Enteropathy, and Nontropical Sprue

  Presence of celiac disease as diagnosed by a physician as self-reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Central Nervous System Disorders**
  Conditions which affect energy requirements, ability to feed self or alter nutritional status metabolically, mechanically, or both. Includes, but not limited to:
  - epilepsy
  - cerebral palsy (CP)
  - neural tube defects (NTD), such as: spina bifida or myelomeningocele
  - Parkinson's disease
  - multiple sclerosis

Presence of central nervous system disorder as diagnosed by a physician as self-reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Depression**
  Presence of clinical depression as diagnosed by a physician or psychologist as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat**
  Developmental, sensory or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs. Includes, but not limited to:

  - minimal brain function
  - feeding problems due to a developmental disability such as pervasive development disorder (PDD), which includes autism
  - birth injury
  - head trauma
  - brain damage
  - other disabilities

  Presence of developmental, sensory or motor delay or disability affecting the ability to eat, as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Diabetes Mellitus or Pre-Diabetes**
  Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

Impaired fasting glucose (IFG) and/or impaired glucose tolerance (IGT) are referred to as pre-diabetes. These conditions are characterized by hyperglycemia that does not meet the diagnostic criteria for diabetes mellitus.

Presence of diabetes mellitus or pre-diabetes as diagnosed by a physician as self reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Drug Nutrient Interactions**
  Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization to an extent that nutritional status is compromised

  Possible nutrition-related side effects of drugs include, but are not limited to:
  - altered taste sensation
  - gastric irritation
  - appetite suppression
  - altered GI motility
  - altered nutrient metabolism and function, including enzyme inhibition, vitamin antagonism, and increased urinary loss

- **Eating Disorders**
  Eating disorders (anorexia nervosa and bulimia) are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:

  - self-induced vomiting
  - purgative abuse
  - alternating periods of starvation
  - use of drugs such as appetite suppressants, thyroid preparations or diuretics
  - self-induced marked weight loss

Presence of eating disorder as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Or evidence of such disorder as documented by the certifying health professional

- **Food Allergies**
  Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food.

  Presence of food allergy as diagnosed by a physician as self-reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Gastrointestinal Disorders**
  Diseases or conditions that interfere with the intake or absorption of nutrients. The conditions include, but are not limited to:

  - gastroesophageal reflux disease (GERD)
  - peptic ulcer
  - post-bariatric surgery
  - short bowel syndrome
  - inflammatory bowel disease, including ulcerative colitis or Crohn's disease
  - liver disease
  - pancreatitis
  - biliary tract diseases

  Presence of gastrointestinal disorder as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Genetic and Congenital Disorders**
  Hereditary or congenital condition that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. Includes, but not limited to:

  - cleft lip or palate
  - Down's syndrome
  - thalassemia major
  - sickle cell anemia (not sickle cell trait)

  Presence of genetic or congenital disorder as diagnosed by a physician as self-reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Hypertension and Prehypertension**
  Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Hypoglycemia**
  Presence of hypoglycemia as diagnosed by a physician as self-reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Infectious Diseases**
  A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to:
  - tuberculosis
  - pneumonia
  - meningitis
  - parasitic infections

- hepatitis
- HIV (Human Immunodeficiency Virus infection)
- AIDS (Acquired Immunodeficiency Syndrome)

The infectious disease must be present *within the past six months,* as diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders.

- **Lactose Intolerance**
  Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.

  Presence of lactose intolerance as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

  A special formula for a postpartum woman with lactose intolerance is authorized only as specified in Chapter 300.

- **Nutrient Deficiency Diseases**
  Diagnosis of nutritional deficiency or a disease caused by insufficient dietary intake of macro and micro nutrients. Diseases include, but not limited to:

  - protein energy malnutrition (PEM)
  - scurvy
  - rickets
  - beri beri

- hypocalcemia
- osteomalacia
- vitamin K deficiency
- pellagra
- cheilosis
- Menkes disease
- xerophthalmia

Presence of nutrient deficiency disease as diagnosed by a physician as self reported by applicant/ participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Recent Major Surgery, Trauma, Burns**
  Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status

  Any occurrence

  - within the past two ($\leq$ 2) months may be self reported

  - more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician

- **Renal Disease**
  Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.

  Presence of renal disease as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Thyroid Disorders**
  Thyroid dysfunctions that occur in pregnancy and postpartum women, during fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following:

  Hypothyroidism – low secretion levels of thyroid hormone (can be overt or mild/subclinical). It is most commonly seen as chronic autoimmune thyroiditis (Hashimotos's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.

  Hyperthyroidism – excessive thyroid hormone production (most commonly known as Grave's disease and toxic multinodular goiter)

  Congenital hypothyroidism – infants born with underactive thyroid gland and presumed to have had hypothyroidism in-utero

  Congenital Hyperthyroidism – excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation)

  Postpartum Thyroiditis – Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous.

  Presence of thyroid disorder as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **Other Medical Conditions**
  Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but not limited to:

  - juvenile rheumatoid arthritis (JRA)
  - lupus erythematosus
  - cardiorespiratory diseases
  - heart disease
  - cystic fibrosis
  - persistent asthma (moderate or severe) requiring daily medication

  Presence of medical condition as diagnosed by a physician as self reported by applicant/participant/ caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

94 Dental problems

Dental problems as diagnosed by a physician or a health care provider working under the orders of a physician, or adequate documentation by the health professional, including, but not limited to:

- tooth decay
- periodontal disease
- tooth loss
- ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality

247.2 Priority VI Risk Criteria for Postpartum Women

Postpartum women meeting one of the following risk criteria will be certified as priority VI participants, if no higher priority risk code is selected.

11 High weight gain

Postpartum women (most recent singleton pregnancy only): total gestational weight gain exceeding the upper limit of the Institute of Medicine's (IOM) recommended range based on Body Mass Index (BMI), as follows:

Prepregancy Weight Groups	Definition(BMI)	Cut-off Value
Underweight	< 18.5	> 40 lbs
Normal Weight	18.5 to 24.9	> 35 lbs
Overweight	25.0 to 29.9	> 25 lbs
Obese	≥ 30.0	> 20 lbs

Multifetal pregnancies: The 2009 IOM Report provides provisional guidelines for total weight gain for multifetal gestations. See Risk Code Justifications & References in Appendix 200. This information is not used for risk code determination.

14 Low weight

Prepregnancy or current Body Mass Index (BMI) <18.5

15 High weight

Prepregnancy Body Mass Index (BMI) ≥ 25.0

22 Had a large baby

Birth of a large for gestational age infant during most recent pregnancy or history of birth of an infant weighing ≥ 9 pounds (4000 grams) or ≥ 90th percentile weight for gestational age at birth

Presence or history of large for gestational age infant
- May be self reported by applicant/participant/caregiver
- May be reported or documented by a physician or by a health care provider working under a physician's orders

23 Nutritional birth defect

Giving birth in the most recent pregnancy to an infant who has a congenital or birth defect linked to inappropriate nutritional intake

May be self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

Examples of congenital or birth defects linked to inappropriate nutritional intake are:

- inadequate folic acid - neural tube defect
- excess vitamin A - cleft palate/lip
- inadequate zinc - low birth weight

30 Unhealthy diet habits

- **Inappropriate or Excessive Intake of Dietary Supplements, including Vitamins, Minerals and Herbal Remedies**
  The postpartum woman routinely takes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences, including, but not limited to, ingestion of unprescribed excessive or toxic amounts of multi or single vitamins, mineral supplements, or herbal remedies.

- **Inadequate Vitamin/Mineral Supplementation**
  The postpartum woman does not routinely take a dietary supplement recognized as essential by national public health policy makers because diet alone cannot meet nutrient requirements.
  -A postpartum woman with low iron is not taking her doctor-prescribed iron supplement.
  -Consumption of < 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant women

- **Pica**
  Compulsively ingesting nonfood items including, but not limited to:

  - ashes
  - baking soda
  - burnt matches
  - carpet fibers
  - chalk
  - cigarettes
  - clay
  - dirt/dust
  - large quantities of ice and/or freezer frost
  - paint chips
  - starch (laundry and cornstarch)

- **Eating foods that could be contaminated with pathogenic microorganisms**
  Potentially harmful foods:
  -Raw fish or shellfish, including oysters, clams, mussels, and scallops;
  -Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole;
  -Raw or undercooked meat or poultry;
  -Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot;
  -Refrigerated pâté or meat spreads;
  -Unpasteurized milk or foods containing unpasteurized milk;
  -Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as made with pasteurized milk;
  -Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog;
  -Raw sprouts (alfalfa, clover, and radish); or
  -Unpasteurized fruit or vegetable juices.

31 Needs Diet Guidance

Women who meet the eligibility requirements of income, categorical, and residency status may be presumed to be at nutritional risk based on failure to meet *Dietary Guidelines for Americans* (Dietary Guidelines). Failure to meet Dietary Guidelines is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans) based on an individual's estimated energy needs.

This risk may be assigned only to individuals (2 years or older) for whom a complete nutrition assessment (to include an assessment for risk codes 30-unhealthy diet habits 35- limited diet, and 63-prevention) has been performed and for whom no other risks are identified.

35 Limited diet

Consuming a diet very low in calories and/or essential nutrients or impaired caloric intake or absorption of essential nutrients following bariatric surgery

- **Vegan diets**
  Consumption of plant origin foods only, an eating plan with no animal products (no meat, poultry, fish, eggs, milk, cheese, or other dairy products) and avoidance of foods made with animal product ingredients

- **Highly restrictive diets**
  Diets that are very low in calories, severely limit intake of important food sources of nutrients, or otherwise involve high-risk eating patterns (e.g., Macrobiotic diet)

39 Many pregnancies before age 20

Women under age 20 at date of conception who have had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome. For postpartum women, the most recent pregnancy is at least the fourth pregnancy.
- May be self reported by applicant/participant/caregiver
- May be reported or documented by a physician or by a health care provider working under a physician's orders

40 Pregnant at a young age

- Conception when ≤ 17 years of age for most recent pregnancy

H
- Women ≤ 15 years of age at time of conception for most recent pregnancy

42 Having more than one baby

Postpartum woman with more than one fetus in most recent pregnancy

43 Close pregnancies

Postpartum woman with conception prior to 16 months postpartum for most recent pregnancy

44 Condition caused by pregnancy

- **History of Gestational Diabetes**
  History of gestational diabetes mellitus (GDM) diagnosed by a physician as self reported by applicant/ participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

- **History of diagnosed preeclampsia**
  Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver or reported or documented by a physician or by a health care provider working under a physician's orders

45 Past fetal loss

- A spontaneous abortion (SAB) during the most recent pregnancy. SAB is the spontaneous termination of a gestation at < 20 weeks gestation or at < 500 grams.

- For a postpartum woman, fetal death or neonatal loss during most recent pregnancy. A fetal death (death at ≥ 20 weeks gestation) or a neonatal death (death within 0-28 days of life)

  - May be self reported by applicant/participant or caregiver
  - May be reported or documented by a physician or by a health care provider working under a physician's orders

46 Smoking or Secondhand Smoke

- Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigars

H

- BMI <18.5 and smokes at least 20 cigarettes per day

- Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home. ETS is also known as passive, secondhand, or involuntary smoke.

47 Alcohol use

- Routine, current use of more than 2 drinks per day. A serving or standard sized drink is : 1 can of beer (12 fluid ounces); 5 ounces wine; and 1 ½ fluid ounces of liquor (1 jigger gin, rum, vodka, whiskey (86-proof), vermouth, cordials or liqueurs)

- Binge drinking - drank 5 or more drinks on the same occasion on at least one day in the past 30 days

- Heavy drinking - drank 5 or more drinks on the same occasion on five or more days in the past 30 days

H

- Consumes an average of three ounces of hard liquor or six mixed drinks per day, or three 12 ounce beers, or three 4 ounce servings of wine per day

48 Drug use

H Any illegal drug use, such as marijuana, cocaine, crack, PCP, LSD, heroin, methamphetamine, etc. or misuse of prescription drugs such as oxycontin, methadone, valium, etc.

49 Past early or small baby

- Preterm delivery - birth of an infant at less than or equal to 37 weeks gestation as outcome of most recent pregnancy

- Birth of an infant weighing less than or equal to 5 pounds 8 ounces (≤ 2500 grams) as outcome of most recent pregnancy

63 Prevention

A participant who has previously been certified eligible for the program may be considered to be at nutritional risk in the next certification period if the health professional determines there is a possibility of regression in nutritional status without the benefits that the WIC program provides.

Code 63 can be used only at recertification. This code must be used by itself and only if no other risk code has been identified. This risk code may be used once in succession after a risk code. It can be used after any appropriate risk code.

66 At risk for poor diet

Postpartum woman who is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- ≤ 17 years of age
- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)
- physically disabled to a degree which restricts or limits food preparation abilities
- currently using or having a history of abusing alcohol or other drugs

67 Needs WIC services

Battering within past six months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel

"Battering" generally refers to violent assaults on women.

95 Homeless or Migrant

- **Homeless** - A categorically eligible woman who lacks a fixed and regular nighttime residence, or whose primary nighttime residence is:

  - a supervised, publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations

  - an institution that provides a temporary residence for individuals intended to be institutionalized

  - a temporary accommodation of not more than 365 days in the residence of another individual

  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings

- **Migrant** - A categorically eligible woman who is a member of a family which contains at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode

96 Foster care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months

248. Risk Criteria for Infants

Infants can be certified as Priorities I, II, and IV. This section provides a detailed description of the risk criteria for certifying infants for the WIC program. An abbreviated resource of **all** risk criteria, *WIC Medical/Nutritional Risk Codes*, is located in Appendix 200.

The risk description is used on the Welcome to WIC (WTW) letter as the nutritional risk. To the left of the risk description is the identifying numerical code to be selected from the risk tab or recorded on the Nutrition Care Plan. **Select all applicable risk codes up to eight**. **Appropriate documentation to support the risk codes selected must appear in the WIC chart.** The computer system assigns the highest eligible priority from the risk codes selected. State mandated high-risk parameters are identified by an "H" located under each high-risk code description. **High-risk codes must be selected.** Required high-risk follow-up protocols are located in the Nutrition Education Chapter of the Policy and Procedure Manual.

In several risk codes, self reporting of a **diagnosed** condition or history of a **diagnosed** condition is allowed. 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 references to professional diagnosis. A self-reported medical diagnosis, “My doctor says that I have/my son or daughter has…,” should prompt the health professional to validate the presence of the condition or history of the condition by asking more pointed questions related to that diagnosis.

248.1 Priority I Risk Criteria for Infants

Infants meeting one of the following risk criteria will be certified as Priority I participants.

20 Low iron - age 6 through 11 months

Hemoglobin (Hgb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hgb and Hct reflect the amount of functional iron in the body. Changes in Hgb concentration and Hct occur at the late stages of iron deficiency. While neither test is a direct measure of iron status, they are useful indicators of iron deficiency anemia.

- Hematocrit less than 33%

H
- Hematocrit less than or equal to 30%

- Hemoglobin less than 11 grams per 100 milliliters

H
- Hemoglobin less than or equal to 10 grams per 100 milliliters

21 High blood lead

Blood lead level of ≥ greater than or equal to 10 micrograms per deciliter within the past 12 months, as self reported by caregiver, or as reported or documented by a physician or someone working under physician's orders

Cut off value is the current published guidance from the Centers for Disease Control and Prevention (CDC).

46 Secondhand Smoke

Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home. ETS is also known as passive, secondhand, or involuntary smoke.

50 Born early **

Infant born at ≤ to 37 weeks gestation

51 Low birth weight **

Birth weight ≤ 5 pounds 8 ounces (≤ 2500 grams)

H ≤ 37 weeks gestation **and** ≤ 2500 grams or 5 pounds 8 ounces

52 Short for age **

≤ 2.3rd percentile length for age* based on Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts

*Based on 2006 World Health Organization international growth standards. The cut off for short infants is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

**** Note**: The assignment of these risk code criterion for premature infants must include a growth chart plotted using adjusted gestational age. **See Calculating Gestation-Adjusted Age – Chart 248.1.**

Calculating Gestation-Adjusted Age – Chart 248.1

Plotting growth charts for risk codes 50 (born early), 51 (low birth weight), 52 (short stature) and 55 (at risk for short stature) for premature infants must be based on adjustment for gestational age calculated for infants as follows:

- Document the infant's gestational age in weeks. (Mother/caregiver can self-report, or referral information from the medical provider may be used.)
- Subtract the infant's gestational age in weeks from 40 weeks (gestational age of term infant) to determine the adjustment for prematurity in weeks.
- Subtract the adjustment for prematurity in weeks from the infant's chronological postnatal age in weeks to determine the infant's gestation-adjusted age.

Example:
Randy was born prematurely on March 19, 2001. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2001 clinic visit, his chronological postnatal age is 12 weeks.

30 = gestational age in weeks
40 – 30 = 10 weeks adjustment for prematurity
12 – 10 = 2 weeks gestation-adjusted age

His measurements would be plotted on a growth chart as a 2-week-old infant.

Special situations regarding the use of Adjusted Gestational Age (AGA):

* When to change from the 0-24 month growth chart to the 2-5 year old growth charts:

  When the child has reached **2 years AGA**, she should be changed to the standing measurements and the corresponding 2-5 year old growth charts.

* Premature infants/children in a normal growth pattern:

  Regardless of growth status, it has been decided to apply AGA for all premature infants and children so that any code 50 infant/child less than 24 months (**adjusted age**) will be plotted and assessed using AGA.

* When AGA is a negative number (e.g., minus two weeks), and the measurement cannot be plotted:

  These issues are addressed in section 265.4 of the WIC Policy and Procedure Manual. The risk codes 52 and 55(short for age) cannot be used. Staff must document "unable to plot" on the growth chart or health history at paper clinics.

*Adapted from the Centers for Disease Control and Disease Prevention (CDC) internet training module: "Overview of the CDC Growth Charts"; www.cdc.gov/nccdphp/dnpa/growthcharts/trainingmodules/module2/text/page5itext.

53 Underweight

- $\leq 2.3^{rd}$ percentile weight for length* based on Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts

  *Based on 2006 World Health Organization international growth standards. The cut off for underweight infants is 2.3; however, for ease of use, CDC labels it as the 2^{nd} percentile on the hard copy growth charts.

54 High weight for length

- ≥97.7th percentile weight for length* based on CDC Birth to 24 months gender specific growth charts

  *Based on 2006 World Health Organization international growth standards. The cut off for high weight for height infants < 24 months is ≥97.7th ; however, for ease of use, CDC labels it as the 98th percentile on the hard copy growth charts.

55 At risk for growth problems
When using this code, list the applicable definition on the WTW letter.

- *At risk for short for age**:*
  > 2.3rd percentile and ≤5th percentile length for age* based on CDC Birth to 24 months gender specific growth charts

  *Based on 2006 World Health Organization international growth standards. The cut off for short infants is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

  ****Note**: The assignment of this risk code for premature infants must include a growth chart plotted using adjusted gestational age. **See Calculating Gestation-Adjusted Age – Chart 248.1.**

- *At risk for underweight:*
  >2.3rd and ≤5th percentile weight for length* based on CDC Birth to 24 months gender specific growth charts

  *Based on 2006 World Health Organization international growth standards. The cut off for underweight infants is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

- *At risk for high weight for length:*

  - Being < 12 months of age and born to a woman with a BMI ≥ 30 at time of conception or at any point in the first trimester of the pregnancy. BMI must be based on the mother's self reported preconception weight and height or on a measured weight and height documented by a health care provider.

  - Being < 12 months of age and having a biological father with a BMI ≥ 30 at the time of certification. BMI must be based on the father's self reported weight and height or on weight and height measurements taken by staff at the time of certification.

56 Slow growth

H All of the following conditions are high-risk:

- Presence of failure to thrive (FTT) diagnosed by a physician
  - May be self reported by caregiver
  - May be reported or documented by a physician or health care provider working under the physician's orders

- An inadequate rate of weight gain as defined by the following. (Refer to *WIC Health Professional Guide to Support Normal Breastfeeding in the Birth Month* in Appendix 400.)

  A. Infants from birth to one month of age:
  - excessive weight loss after birth (> ½ pound or >8% weight loss from birth)

  - not back to birth weight by two weeks of age

B. Infants from 1 to 6 months of age:

- Based on two weights taken at least one month apart, the infant's actual weight gain is less than the calculated expected minimal weight gain based on the following table.

Age	Average Weight Gain	
Birth-1 mo	4 ½ oz/wk	19 oz/mo
1-2 mos	6 ¼ oz/wk	27 oz/mo
2-3 mos	4 ½ oz/wk	19 oz/mo
3-4 mos	4 oz/wk	17 oz/mo
4-5 mos	3 ½ oz/wk	15 oz/mo
5-6 mos	3 oz/wk	12 oz/mo

C. Infants from 6 months to 12 months

Based on weights taken at least 3 months apart, the infant's actual weight gain is less than the calculated expected weight gain based on the table below:

Age	Average Weight Gain	
6-12 mos	2 ¼ oz/wk	9 ½ oz/mo

57 Small at birth

- Small for gestational age diagnosed by a physician
  - May be self reported by caregiver
  - May be reported or documented by a physician or health care provider working under the physician's orders

58 Small head size**

≤2.3rd percentile head circumference for age based on CDC Birth to 24 months gender specific growth charts

*Based on 2006 World Health Organization international growth standards. The cut off for small head size is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

Use of this code is at the discretion of the local project. The head circumference can be measured by the project staff or based on information in a readily accessible medical chart or as self reported by the caregiver. Document the head circumference in the appropriate space on the infant's Health History form.

Note: The assignment of this risk code criterion for premature infants must include a growth chart plotted using adjusted gestational age. **See Calculating Gestation-Adjusted Age – Chart 248.1.**

59 Large at birth

- Birth weight ≥ 9 pounds (≥4000 grams) or ≥ 90th percentile weight for gestational age at birth, or

- Large for gestational age diagnosed by a physician
  - May be self reported by caregiver
  - May be reported or documented by a physician or health care provider working under the physician's orders

65 At risk for poor growth

- Infant born to a woman diagnosed with mental retardation by a physician or psychologist
  - May be self reported by caregiver
  - May be reported or documented by a physician, psychologist or health care provider working under the physician's orders

- Infant born to a woman with any documented or self reported use of alcohol or illegal drugs or misuse of prescription drugs during most recent pregnancy

68 Fetal Alcohol Syndrome

- Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.

- FAS diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

74 Breastfeeding issues

H A breastfed infant with any of the following complications or potential complications for breastfeeding:

- jaundice
- weak or ineffective suck
- difficulty latching onto mother's breast
- inadequate stooling (for age, as determined by physician or other health care professional) and/or fewer than six wet diapers per day

80 Transfer

Infant with current valid Verification of Certification (VOC) document from another state

81 Infant transfer

Infant with current valid Verification of Certification (VOC) document from another state. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits.

In some cases, an infant transferring from another state may have been certified for a period extending up to the infant's first birthday. Infants such as these who transfer into the Ohio WIC program must be brought into the clinic for

height, weight, hematocrit/hemoglobin, and nutrition counseling at six months after the certification date.

However, the infant shall not be reassigned a new risk code and remains in Priority I status even if the infant no longer qualifies with a risk code. Food issuance cannot be delayed for failure to bring the infant into the clinic for evaluation.

91 Inborn Errors of Metabolism (IEM)
When using this risk code, enter the specific condition on the WTW letter as the nutritional risk.

H All of the following conditions are high-risk:

Presence of inborn errors of metabolism diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders.

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat

Generally refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:

Amino Acid Metabolism Disorders
- PKU-Phenylketonuria (includes clinically significant hyperphenylalaninemia variants)
- Maple syrup urine disease
- Homocystinuria
- Tyrosinemia

Carbohydrate Disorders
- Galactosemia
- Glycogen storage disease types I-VI
- Fructose 1-phosphate aldolase deficiency

Fatty Acid Oxidation Defects
- MCADD - 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

Organic Acid Disorders (AKA organic aciduria or organic academia)

- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- Glutaric acidemia Type I and II
- 3-hydroxy-3-methylglutaryl coenzyme A lyase deficiency (3HMGCoA)
- Multiple carboxylase deficiency (Biotinidase deficiency, Holocarboxylase synthetase deficiency)
- Methylmalonic acidemia
- Propionic acidemia
- Beta-ketothiolase deficiency

Lysosomal Storage Diseases

- Fabry disease (α-galactosidase A deficiency)
- Gauchers disease (glucocerebrosidase deficiency)
- Pomp disease (glycogen storage disease Type II or α-glucosidase deficiency)

Mitochondrial Disorders

- Leber hereditary optic neuropathy
- Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)
- Mitochondrial neurogastrointestinal encephalopathy disease (MNGIE)
- Myoclonic epilepsy with raged-red fibers (MERRF)
- Neuropathy, ataxia, and retinitis pigmentosa (NARP)
- Pyruvate carboxylase deficiency

Peroxisomal Disorders
- Zellweger Syndrome Spectrum
- Adrenoleukodystrophy (x-ALD)

Urea Cycle Disorders
- Citrullinemia
- Argininosuccinic aciduria
- Carbamoyl phosphate synthetase l deficiency

Other IEM can be found at:
http://rarediseases.info.nih.gov/GARD

93 Conditions that Affect Nutritional Status

When using this risk code, enter the specific condition on the WTW letter as the nutritional risk.

In deciding to assign risk code 93, the condition, or treatment for the condition, must be severe enough to affect nutritional status unless the specific section allows for the history of a condition.

H All of the following conditions are high-risk:

- **Cancer**

  A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biological restraints. The current condition, or treatment for the condition, must be severe enough to affect nutritional status.

  Presence of cancer diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Celiac Disease**
  Celiac Disease (CD) is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. More information about the definition of CD is found In Appendix 200 *Risk Codes – Justifications and References*.

  CD is also known as: Celiac Sprue, Gluten-sensitive Enteropathy, and Nontropical Sprue

  Presence of Celiac Disease diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Central Nervous System Disorders**
  Conditions which affect energy requirements, ability to feed self or alter nutritional status metabolically, mechanically, or both. Includes, but not limited to:

  - epilepsy
  - cerebral palsy (CP)
  - neural tube defects (NTD), such as: spina bifida or myelomeningocele
  - Parkinson's disease
  - multiple sclerosis

  Presence of central nervous system disorders diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat**
  Developmental, sensory or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs. Includes, but not limited to:

- minimal brain function
- feeding problems due to developmental delays such as pervasive development disorder (PDD), which includes autism
- birth injury
- head trauma
- brain damage
- other disabilities

Presence of condition diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Diabetes Mellitus**
  Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

  Presence of diabetes mellitus diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Drug Nutrient Interactions**
  Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised

  Possible nutrition-related side effects of drugs include, but are not limited to:

  - altered taste sensation
  - gastric irritation
  - appetite suppression
  - altered GI motility
  - altered nutrient metabolism and function, Including

- enzyme inhibition
- vitamin antagonism
- increased urinary loss.

- **Food Allergies**
  Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food.

  Presence of food allergies diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Gastrointestinal Disorders**
  Diseases or conditions that interfere with the intake, digestion, and/or absorption of nutrients. The conditions include, but are not limited to:
  - gastroesophageal reflux disease (GERD)
  - peptic ulcer
  - post-bariatric surgery
  - short bowel syndrome
  - inflammatory bowel disease, including ulcerative colitis or Crohn's Disease
  - liver disease
  - pancreatitis
  - biliary tract diseases

  Presence of gastrointestinal disorders diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Genetic and Congenital Disorders**
  Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. Includes, but not limited to:

- cleft lip or palate
- Down's syndrome
- thalassemia major
- sickle cell anemia (not sickle cell trait)

Presence of genetic and congenital disorders diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Hypertension and Prehypertension**
  Presence of hypertension or prehypertension diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Hypoglycemia**
  Presence of hypoglycemia diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Infectious Diseases**
  A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but not limited to:

  - tuberculosis
  - pneumonia
  - meningitis
  - parasitic infections
  - hepatitis
  - bronchiolitis (three episodes in the last six months)
  - HIV (Human Immunodeficiency Virus infection)
  - AIDS (Acquired Immunodeficiency Syndrome)

The infectious disease *must be present within the past six months*, and diagnosed by a physician, as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

- **Lactose Intolerance**
  Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.

  Presence of lactose intolerance diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

  A special formula for infants with lactose intolerance is authorized only as specified in Chapter 300.

- **Nutrient Deficiency Diseases**
  Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micro nutrients. Diseases include, but are not limited to:
  - Protein Energy Malnutrition (PEM)
  - Scurvy
  - Rickets
  - Beri Beri
  - Hypocalcemia
  - Osteomalacia
  - Vitamin K Deficiency
  - Pellagra
  - Cheilosis
  - Menkes Disease
  - Xerophthalmia

Presence of nutrient deficiency disease diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Recent Major Surgery, Trauma, Burns**
  Major surgery, trauma, or burns severe enough to compromise nutritional status

  Any occurrence:

  - within the past two (≤ 2) months may be reported by caregiver
  - more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician

- **Renal Disease**
  Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.

  Presence of renal disease diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Thyroid Disorders**
  Thyroid dysfunctions that occur during fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following:

Hypothyroidism – low secretion levels of thyroid hormone (can be overt or mild/subclinical). It is most commonly seen as chronic autoimmune thyroiditis (Hashimotos's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.

Hyperthyroidism – excessive thyroid hormone production (most commonly known as Grave's disease and toxic multinodular goiter)

Congenital hypothyroidism – infants born with underactive thyroid gland and presumed to have had hypothyroidism in-utero

Congenital Hyperthyroidism – excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation)

Presence of thyroid disorders diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Other Medical Conditions**
  Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but not limited to:

  - juvenile rheumatoid arthritis (JRA)
  - lupus erythematosus
  - cardiorespiratory diseases
  - heart disease
  - cystic fibrosis

Presence of medical conditions diagnosed by a physician as self reported by the caregiver, or as reported or documented by a physician or someone working under physician's orders

NOTE: In infants, asthma-like symptoms are usually diagnosed as bronchiolitis with wheezing which is covered under Infectious Diseases.

94 Dental problems

Diagnosis of dental problems by a physician or health care provider working under the orders of a physician or adequate documentation by the health professional. Includes, but not limited to:

- Presence of nursing or baby bottle caries, smooth surface decay of the maxillary anterior and the primary molars

248.2 Priority II Risk Criteria for Infants

Infants meeting one of the following risk codes will be certified as Priority II participants, if no higher priority risk code is selected.

61 Baby born to WIC eligible mom

An infant less than six months of age whose mother was a WIC program participant during pregnancy:
- The infant's Health History Form indicating that the mother was on WIC serves as documentation for the risk code.

An infant less than six months of age whose mother was not on WIC during the pregnancy, but whose medical records document that the woman was at nutritional risk during pregnancy because of detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions. Any of the following is acceptable documentation for code use:

- Information documented in the woman's medical records
- Information captured on the WIC Health History Form
- Anthropometric records
- Information captured on the CPA

Document the prenatal risk code that would have been assigned to her in the "Notes" section of the infant's Health History Form.

248.3 Priority IV Risk Criteria for Infants

Infants meeting one of the following risk criteria will be certified as Priority IV, if no higher priority risk code is selected.

30 Unhealthy diet habits

- **Inappropriate or Excessive Intake of Dietary Supplements Including Vitamins, Minerals, and Herbal Remedies**
  Infant routinely takes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences. Includes, but not limited to: ingestion of unprescribed, excessive, or toxic amounts of multi or single vitamins, mineral supplements, or herbal remedies

- **Inadequate Vitamin/Mineral Supplementation**
  Infant does not routinely take a dietary supplement recognized as essential by national public health policy makers because diet alone cannot meet nutrient requirements.

Examples include, but not limited to:
-Infants greater than or equal to (≥) six months not taking 0.25 milligrams (mg) of fluoride daily when the water supply contains less than 0.3 parts per million (ppm) of fluoride
-Breastfed infants who are ingesting less than 1 liter (or 1 quart) per day of Vitamin D-fortified formula and are not taking a supplement of 400 IU of vitamin D
-Nonbreastfed infants who are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula and are not taking a supplement of 400 IU of vitamin D

- **Feeding foods that could be contaminated with harmful microorganisms or toxins**
  Examples of potentially harmful foods:
  - Unpasteurized fruit or vegetable juice;
  - Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese;
  - Honey (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.);
  - Raw or undercooked meat, fish, poultry, or eggs;
  - Raw vegetable sprouts (alfalfa, clover, bean, and radish); or
  - Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).

31 Needs Diet Guidance

An infant who has begun to or is expected to begin to 1) consume complementary foods and beverages, 2) eat independently, 3) be weaned from breastmilk or infant formula, or 4) transition from a diet based on infant foods to one based on the *Dietary Guidelines for Americans*, is at risk of inappropriate complementary feeding.

This risk may be assigned only to infants for whom a complete nutrition assessment (to include an assessment for risk codes 30-unhealthy diet habits, 35- limited diet, 36-improper bottle or cup use, 38-inappropriate infant feeding, and 63-prevention) has been performed and for whom no other risks are identified.

35 Limited diets

- **Vegan Diets**
  Consumption of plant origin foods only, an eating plan with no animal products (no meat, poultry, fish, eggs, milk, cheese, or other dairy products) and avoidance of foods made with animal product ingredients

- **Highly Restrictive Diets**
  Diets that are very low in calories, severely limit intake of important food sources of nutrients, or otherwise involve high-risk eating patterns (e,g., Macrobiotic Diet)

36 Improper bottle or cup use

When using this code, enter the specific improper feeding practice on the WTW letter as the nutrition risk.

Routine use of the bottle to feed liquids other than breastmilk, formula, or water. This includes:

- fruit juice
- soda
- soft drinks
- gelatin water
- corn syrup solutions
- milk
- other sugar-containing beverages
- diluted cereal or other solid foods

Allowing the infant to fall asleep at naps or bedtime with the bottle

Allowing the infant to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier

Propping the bottle

Allowing the infant to carry around and drink throughout the day from a covered or training cup

38 Improper infant feeding
When using this code, enter the specific improper feeding practice on the WTW letter as the nutrition risk.

- **Inappropriate Infant Feeding Practices**
  Routine use of any of the following:

  - infant not fed breastmilk or iron-fortified infant formula as primary source of nutrients during the first six months of life and as the primary fluid consumed during the second six months of life (includes infants prescribed low iron formula without iron supplementation)

  - feeding goat's milk, sheep's milk, imitation milks, substitute milks (rice- or soy-based beverages, non-dairy creamer) or other "homemade concoctins" in place of breastmilk or FDA-approved infant formula during the first year of life

  - not supporting an infant's need for growing independence with self feeding (e.g., solely spoon-feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils)

- feeding an infant with inappropriate textures based on his developmental stage (e.g., feeding primarily pureed or liquid foods when the infant is ready and capable of eating mashed, chopped or appropriate finger foods)

- feeding solids in a bottle (including enlarging the nipple to accommodate thickened liquid)

- adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier

- using a syringe-action nipple feeder

- feeding foods of inappropriate consistency, size, or shape, that put the infant at risk of choking

- inappropriate, infrequent or highly restrictive feeding schedules, or forcing an infant to eat a certain type and/or amount of food. For example, consumption of less than 20 ounces of formula per day in the first six months of life for nonbreastfeeding infants or consumption of less than 16 ounces of formula per day in the second six months of life for nonbreastfeeding infants, assuming adequate intake of solid foods

- feeding any amount of honey to infant under one year of age (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.)

- feeding >10 oz./day of full strength juice

- **Early Introduction of Solid Foods**
  Addition of solid foods into the daily diet before four (<4) months of age

- **Feeding Cow's Milk During First 12 Months**
  Feeding whole, low-fat, reduced fat, skim, or non-fat milk (fresh, canned, evaporated or sweetened condensed), or recipes using any of these products as the primary source of milk before the first birthday (<12 months)

- **No Dependable Source of Iron for Infants at Six Months of Age or Later**
  No routine age-appropriate iron source after six months of age, such as: iron-fortified cereals, iron-fortified infant formula, meats, or oral iron supplements

  - For example, consumption of less than 5-6 tablespoons of dry cereal, 20 ounces of iron fortified formula, .3 milliliters of iron drops, or 1/4 teaspoon of ferrous sulfate or elixir per day

- **Improper Dilution of Formula**
  Routine over dilution or under dilution of formula (failure to follow manufacturer's dilution instructions or specific instructions accompanying a prescription)

- **Feeding Other Foods Low in Essential Nutrients**
  Infants routinely consuming foods low in essential nutrients and high in calories, or caffeine-containing foods or beverages that replace or are in addition to age-appropriate nutrient dense foods needed for growth and development. This includes excessive feeding of water.

  - A total of four to eight 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.

- **Lack of Sanitation in Preparation and Handling of expressed breastmilk or formula**
  Lack of knowledge or access to facilities to ensure that water, bottles, and nipples used for feeding infants have been properly sanitized. This includes:

  - no access to a safe water supply, stove for sterilization, or refrigeration or freezer for storage
  - failure to practice appropriate sanitation techniques in preparing bottles
  - failure to properly handle expressed breastmilk/prepared formula, such as:
  - feeding expressed breastmilk/formula held at room temperature longer than two hours or longer than recommended by the manufacturer
  - feeding expressed breastmilk/prepared formula held in refrigerator longer than 48 hours
  - refeeding expressed breastmilk/formula remaining from an earlier feeding

63 Prevention

A participant who has previously been certified eligible for the program may be considered to be at nutritional risk in the next certification period if the health professional determines there is a possibility of regression in nutritional status without the benefits that the WIC program provides.

Code 63 can be used only at recertification. This code must be used by itself, and only if no other risk code has been
identified. This risk code may be used once in succession after a risk code. It can be used after any appropriate risk code.

66 At risk for poor diet

Infant whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- less than or equal to 17 years of age
- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)
- physically disabled to a degree which restricts or limits food preparation abilities
- currently using or having a history of abusing alcohol or other drugs

67 Needs WIC services

Battering or child abuse/neglect within past six months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel

Child abuse/neglect: Any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of an infant or child by a parent or caretaker

Ohio law requires health professionals to report known or suspected child abuse or neglect; therefore, WIC staff must release such information to appropriate officials.

71 Breastfed by a WIC mom

Breastfeeding infant of woman at nutritional risk

The mother's risk code must be identified in the "Mom's Code" section of the infant's Health History form.

75 Needs breastfed more often

The fully breastfed infant (i.e., consuming no solid foods) who is routinely taking:

- fewer than 8 feedings in 24 hours if < 2 months of age, or
- fewer than 6 feedings in 24 hours if ≥ 2 months of age
- scheduled feedings instead of demand feedings

95 Homeless or Migrant

- **Homeless** - A categorically eligible infant who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:
  - a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations;
  - an institution that provides a temporary residence for individuals intended to be institutionalized;
  - a temporary accommodation of not more than 365 days in the residence of another individual; or
  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

- **Migrant** - A categorically eligible infant who is a member of a family which contains at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode

96 Foster care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months

249. Risk Criteria for Children

Children can be certified as Priorities III and V. This section provides a detailed description of the risk criteria for certifying children for the WIC program. An abbreviated resource of **all** risk criteria, *WIC Medical/Nutritional Risk Codes*, is located in Appendix 200.

The risk description is written on the Welcome to WIC (WTW) letter as the nutritional risk. To the left of the risk description is the identifying numerical code to be selected from the risk tab or recorded on the Nutrition Care Plan. **Select all applicable risk codes up to eight**. **Appropriate documentation to support the risk codes selected must appear in the WIC chart.** The computer system assigns the highest eligible priority from the risk codes selected. State mandated high-risk parameters are identified by an "H" located under each high-risk code description. **High-risk codes must be selected.** Required high-risk follow-up protocols are located in the Nutrition Education Chapter of the Policy and Procedure Manual.

In several risk codes, self reporting of a **diagnosed** condition or history of a **diagnosed** condition is allowed. 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 references to professional diagnosis. A self-reported medical diagnosis, “My doctor says that I have/my son or daughter has…,” should prompt the health professional to validate the presence of the condition or history of the condition by asking more pointed questions related to that diagnosis.

249.1 Priority III Risk Criteria for Children

Children meeting one of the following risk criteria will be certified as Priority III participants.

20 Low iron

Hemoglobin (Hgb) and hematocrit (Hct) are the most commonly used tests to screen for iron deficiency anemia. Measurements of Hgb and Hct reflect the amount of functional iron in the body. Changes in Hgb concentration and Hct occur at the late stages of iron deficiency. While neither test is a direct measure of iron status, they are useful indicators of iron deficiency anemia.

12 months through less than two years of age

- Hematocrit < 33.0%

H • Hematocrit ≤ to 30%

- Hemoglobin < 11 grams per 100 milliliters

H • Hemoglobin ≤ 10 grams per 100 milliliters

Two years to five years of age

- Hematocrit less than 33%

H • Hematocrit less than or equal to 30%

- Hemoglobin less than 11.1 grams per 100 milliliters

H • Hemoglobin less than or equal to 10 grams per 100 milliliters

21 High blood lead

Blood lead level of greater than or equal to 10 micrograms per deciliter within the past 12 months
- May be self reported by caregiver
- May be reported or documented by a physician or health care provider working under the physician's orders

Cutoff value is the current published guidance from the Centers for Disease Control and Prevention (CDC).

46 Secondhand Smoke

Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home. ETS is also known as passive, secondhand, or involuntary smoke.

50 Born early **
Use for children less than 24 months of age only.

Child born at ≤ to 37 weeks gestation

51 Low birth weight **
Use for children less than 24 months of age only.

Birth weight ≤ 5 pounds 8 ounces (≤2500 grams)

52 Short for age **

- 1 to <2 years of age and ≤ 2.3rd percentile length for age* based on Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts

- ≥ 24 months and less than 5 years of age and ≤ to the 5th percentile stature per age based on the 2000 CDC age/gender specific growth charts

*Based on 2006 World Health Organization international growth standards. The cut off for short children < 24 months is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

****Note**: For children age 12-24 months with a history of prematurity, the assignment of these risk codes criterion must include a growth chart plotted using adjusted gestational age. **See Calculating Gestation-Adjusted Age -Chart 249.1.**

Calculating Gestation-Adjusted Age - Chart 249.1

Plotting growth charts for risk codes 50 (born early), 51 (low birth weight), 52 (short stature) and 55 (at risk for short stature) for children age 12-24 months with a history of prematurity must be based on adjustment for gestational age calculated for infants as follows:

- Document the infant's gestational age in weeks. (Mother/caregiver can self-report, or referral information from the medical provider may be used.)

- Subtract the infant's gestational age in weeks from 40 weeks (gestational age of term infant) to determine the adjustment for prematurity in weeks.

- Subtract the adjustment for prematurity in weeks from the infant's chronological postnatal age in weeks to determine the infant's gestation-adjusted age.

Example:

Randy was born prematurely on March 19, 2001. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2001 clinic visit, his chronological postnatal age is 12 weeks.

30 = gestational age in weeks
40 – 30 = 10 weeks adjustment for prematurity
12 – 10 = 2 weeks gestation-adjusted age

His measurements would be plotted on a growth chart as a 2-week-old infant

*Adapted from the Centers for Disease Control and Disease Prevention (CDC) internet training module: "Overview of the CDC Growth Charts"; www.cdc.gov/nccdphp/dnpa/growthcharts/trainingmodules/module2/text/page5itext.

53 Underweight

- 1 to <2 years of age and ≤ 2.3rd percentile weight for length* based on Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts

- ≥ 24 months and less than 5 years of age and ≤ to the 5th percentile Body Mass Index (BMI) based on the 2000 CDC age/gender specific growth charts

*Based on 2006 World Health Organization international growth standards. The cut off for underweight children < 24 months is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

54 High weight for height

- 1 to <2 years of age and ≥97.7th percentile weight for length* based on CDC Birth to 24 months gender specific growth charts

H

- ≥ 24 months and less than 5 years of age and at ≥ the 95th percentile BMI** for age based on the 2000 CDC age/gender specific growth charts

*Based on 2006 World Health Organization international growth standards. The cut off for high weight for height children < 24 months is ≥97.7th ; however, for ease of use, CDC labels it as the 98th percentile on the hard copy growth charts.

**The cut off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk.

55 At risk for growth problems
When using this code, list the applicable definition on the WTW letter.

- *At risk for short for age*
  - 1 to <2 years of age and > 2.3rd percentile and ≤5th percentile length for age* based on CDC Birth to 24 months gender specific growth charts

  - ≥ 24 months and less than 5 years of age and >5th percentile and ≤10th percentile stature per age based on the 2000 CDC age/gender specific growth charts

*Based on 2006 World Health Organization international growth standards. The cut off for short children < 24 months is 2.3; however, for ease of use, CDC labels it as the 2nd percentile on the hard copy growth charts.

Note: For children age 12-24 months with a history of prematurity, assignment of this code criterion must include a growth chart plotted using adjusted gestational age. **See Calculating Gestation –Adjusted Age -Chart 249.1.**

- *At risk for underweight*
  - 1 to <2 years of age and >2.3 rd and $\leq 5^{th}$ percentile weight for length* based on CDC Birth to 24 months gender specific growth charts
  - 2 to 5 years of age and > 5^{th} and $\leq 10^{th}$ percentile Body Mass Index (BMI) for age based on the 2000 CDC age/gender specific growth charts

  *Based on 2006 World Health Organization international growth standards. The cut off for underweight children < 24 months is 2.3; however, for ease of use, CDC labels it as the 2^{nd} percentile on the hard copy growth charts.

- *At risk for high weight for height*
  - Being ≥ 24 months of age and ≥ 85^{th} and < 95^{th} percentile BMI based on the 2000 CDC age/gender specific growth charts (i.e., standing height)

  - Being ≥ 12 months of age and having a biological mother with a BMI ≥ 30 at the time of certification. (BMI must be based on self-reported weight and height, or on weight and height measurements taken by staff at the time of certification. If the mother is pregnant or has had a baby within the past 6 months, use her preconception weight to assess for obesity since her current weight will be influenced by pregnancy-related weight gain.)

- Being ≥ 12 months of age and having a biological father with a BMI ≥ 30 at the time of certification. (BMI must be based on the father's self-reported weight and height or on weight and height measurement taken by staff at the time of certification.)

*Based on National Center for Health Statistics/Centers for Disease Control and Prevention (2000) age specific growth charts, or defined for overweight on revised Body Mass Index (BMI) growth charts

Note: The first bullet in this definition cannot be used for children 24-36 months with a recumbent length measurement, since these recommended CDC cut-offs for BMI and WFS are based on standing height measurements.

56 Slow growth

H • Presence of failure to thrive (FTT) diagnosed by a physician as self reported by caregiver, or as reported or documented by a physician or someone working under the physician's orders

H • An inadequate rate of weight gain as defined below:

Based on two weights taken at least 3 months apart, the child's actual weight gain is less than the calculated expected weight gain based on the table below.

Age	Average Weight Gain	
12-59 mos	0.6 oz/wk	2.7 oz/mo

57 Small at birth

For children less than two years of age only.

- Presence of small for gestational age diagnosed by a physician
  - May be self reported by caregiver
  - May be reported or documented by a physician or health care provider working under the physician's orders

68 Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.

Presence of FAS diagnosed by a physician
- May be self reported by caregiver
- May be reported or documented by a physician or health care provider working under the physician's orders

80 Transfer

Child with current valid Verification of Certification (VOC) document from another state

91 Inborn Errors of Metabolism (IEM)
When using this risk code, enter the specific condition on the WTW letter as the nutritional risk.

H All of the following conditions are high-risk:

Presence of inborn errors of metabolism diagnosed by a physician.
- May be self-reported by applicant/participant/ caregiver
- May be reported or documented by a physician
- May be reported or documented by health care provider working under physician's orders

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat

Generally refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to:

Amino Acid Metabolism Disorders
- PKU-Phenylketonuria (includes clinically significant hyperphenylalaninemia variants)
- Maple syrup urine disease
- Homocystinuria
- Tyrosinemia

Carbohydrate Disorders
- Galactosemia
- Glycogen storage disease types I-VI
- Fructose 1-phosphate aldolase deficiency

Fatty Acid Oxidation Defects
- MCADD - 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

Organic Acid Disorders (AKA organic aciduria or organic academia)
- Isovaleric acidemia
- 3-Methylcrotonyl-CoA carboxylase deficiency
- Glutaric acidemia Type I and II
- 3-hydroxy-3-methylglutaryl coenzyme A lyase deficiency (3HMGCoA)

- Multiple carboxylase deficiency (Biotinidase deficiency, Holocarboxylase synthetase deficiency)
- Methylmalonic acidemia
- Propionic acidemia
- Beta-ketothiolase deficiency

Lysosomal Storage Diseases

- Fabry disease (α-galactosidase A deficiency)
- Gauchers disease (glucocerebrosidase deficiency)
- Pomp disease (glycogen storage disease Type II or α-glucosidase deficiency)

Mitochondrial Disorders

- Leber hereditary optic neuropathy
- Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)
- Mitochondrial neurogastrointestinal encephalopathy disease (MNGIE)
- Myoclonic epilepsy with raged-red fibers (MERRF)
- Neuropathy, ataxia, and retinitis pigmentosa (NARP)
- Pyruvate carboxylase deficiency

Peroxisomal Disorders

- Zellweger Syndrome Spectrum
- Adrenoleukodystrophy (x-ALD)

Urea Cycle Disorders

- Citrullinemia
- Argininosuccinic aciduria
- Carbamoyl phosphate synthetase l deficiency

Other IEM can be found at:
http://rarediseases.info.nih.gov/GARD

93 Conditions that Affect Nutritional Status

When using this risk code, enter the specific condition on the WTW letter as the nutritional risk.

In deciding to assign risk code 93, the condition, or treatment for the condition, must be severe enough to affect nutritional status unless the specific section allows for the history of a condition.

H All of the following conditions are high-risk:

- **Cancer**
  A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biological restraints. The current condition, or treatment for the condition, must be severe enough to affect nutritional status.

  Presence of cancer diagnosed by a physician as self reported by caregiver, or as reported or documented by a physician, or someone working under physician's orders

- **Celiac Disease**
  Celiac Disease (CD) is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. More information about the definition of CD is found In Appendix 200 *Risk Codes – Justifications and References*.

  CD is also known as: Celiac Sprue, Gluten-sensitive Enteropathy, and Nontropical Sprue

  Presence of Celiac Disease diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Central Nervous System Disorders**
  Conditions which affect energy requirements, ability to feed self or alter nutritional status metabolically, mechanically, or both. Includes, but not limited to:

- epilepsy
- cerebral palsy (CP)
- neural tube defects (NTD), such as: spina bifida or myelomeningocele
- Parkinson's disease
- multiple sclerosis

Presence of central nervous system disorders as self reported by caregiver or as reported or documented by a physician or someone working under physician's orders

- **Depression**
  Presence of clinical depression diagnosed by a physician or psychologist as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat**
  Developmental, sensory or motor disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs. Includes, but not limited to:

  - minimal brain function
  - feeding problems due to developmental disability such as pervasive development disorder (PDD), which includes autism
  - birth injury
  - head trauma
  - brain damage
  - other disabilities

  Presence of condition diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Diabetes Mellitus**
  Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

  Presence of diabetes mellitus diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Drug Nutrient Interactions**
  Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised

  Possible nutrition-related side effects of drugs include, but are not limited to:

  - altered taste sensation
  - gastric irritation
  - appetite suppression
  - altered GI motility
  - altered nutrient metabolism and function, including
    - enzyme inhibition
    - vitamin antagonism
    - increased urinary loss

- **Food Allergies**
  Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food.

  Presence of food allergies diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Gastrointestinal Disorders**
  Diseases or conditions that interfere with the intake, digestion, and/ or absorption of nutrients. The conditions include, but are not limited to:

  - gastroesphageal reflux disease (GERD)
  - peptic ulcer
  - post-bariatric surgery
  - short bowel syndrome
  - malabsorption syndromes
  - inflammatory bowel disease, including ulcerative colitis or Crohn's Disease
  - liver disease
  - pancreatitis
  - biliary tract diseases

  Presence of gastrointestinal disorders diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Genetic and Congenital Disorders**
  Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. Includes, but not limited to:

  - cleft lip or palate
  - Down's syndrome
  - thalassemia major
  - sickle cell anemia (not sickle cell trait)

  Presence of genetic and congenital disorders diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Hypertension and Prehypertension**
  Presence of hypertension or prehypertension diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Hypoglycemia**
  Presence of hypoglycemia diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Infectious Diseases**
  A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but not limited to:

  - tuberculosis
  - pneumonia
  - meningitis
  - parasitic infections
  - hepatitis
  - bronchiolitis (three episodes in the last six months)
  - HIV (Human Immunodeficiency Virus infection)
  - AIDS (Acquired Immunodeficiency Syndrome)

  The infectious disease must be present within the past six months, and diagnosed by a physician as self reported by caregiver, or as reported or documented by a physician or someone working under physician's orders

- **Lactose Intolerance**
  Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.

  Presence of lactose intolerance diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

  A special formula for a child with lactose intolerance is authorized only as specified in Chapter 300.

- **Nutrient Deficiency Diseases**
  Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micro nutrients. Diseases include, but not limited to:

  - Protein Energy Malnutrition (PEM)
  - Scurvy
  - Rickets
  - Beri Beri
  - Hypocalcemia
  - Osteomalacia
  - Vitamin K Deficiency
  - Pellagra
  - Cheilosis
  - Menkes Disease
  - Xerophthalmia

  Presence of nutrient deficiency disease diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Recent Major Surgery, Trauma, Burns**
  Major surgery, trauma, or burns severe enough to compromise nutritional status

  Any occurrence:
  - within the past two (≤ 2) months may be self reported
  - more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician

- **Renal Disease**
  Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Thyroid Disorders**
  Thyroid dysfunctions that occur during fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following:

  Hypothyroidism – low secretion levels of thyroid hormone (can be overt or mild/subclinical). It is most commonly seen as chronic autoimmune thyroiditis (Hashimotos's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.

  Hyperthyroidism – excessive thyroid hormone production (most commonly known as Grave's disease and toxic multinodular goiter)

Congenital hypothyroidism – infants born with underactive thyroid gland and presumed to have had hypothyroidism in-utero

Congenital Hyperthyroidism – excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation)

Presence of thyroid disorders diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

- **Other Medical Conditions**
  Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but not limited to:

  - juvenile rheumatoid arthritis (JRA)
  - lupus erythematosus
  - cardiorespiratory diseases
  - heart disease
  - cystic fibrosis
  - persistent asthma (moderate or severe requiring daily medication)

  Presence of medical conditions diagnosed by a physician as self reported by the caregiver or as reported or documented by a physician or someone working under physician's orders

94 Dental problems

Dental problems as diagnosed by a physician or health care provider working under the orders of a physician, or adequate documentation by the health professional including, but not limited to:

- Presence of nursing or baby bottle caries, smooth surface decay of the maxillary anterior and the primary molars

- Tooth decay, periodontal disease, tooth loss and or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality

249.2 Priority V Risk Criteria for Children

Children meeting one of the following risk criteria will be certified as Priority V participants, if no higher priority risk code is selected.

30 Unhealthy diet habits

- **Inappropriate or Excessive Intake of Dietary Supplements Including Vitamins, Minerals, and Herbal Remedies**
  Child routinely takes inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences. Includes, but not limited to ingestion of unprescribed, excessive, or toxic amounts of multi or single vitamins, mineral supplements, or herbal remedies.

- **Inadequate Vitamin/Mineral Supplementation**
  Child does not routinely take a dietary supplement recognized as essential by national public health policy makers when diet alone cannot meet nutrient requirements. Examples include, but not limited to:
  -children less than 36 months not taking 0.25 milligrams (mg) of fluoride daily when their water supply contains less than 0.3 ppm (parts per million) of fluoride

-children 36-60 months of age not taking 0.50 mg of fluoride daily when their water supply contains less than 0.3 ppm (parts per million) of fluoride
-Not providing 400 IU of vitamin D if a child consumes less than 1 liter (or 1 quart) of vitamin D fortified milk or formula

- **Pica**
  Routine ingestion of nonfood items including, but not limited to:

  - ashes
  - baking soda
  - carpet fibers
  - cigarettes or cigarette butts
  - clay
  - dust/dirt
  - foam rubber
  - large quantities of ice
  - paint chips
  - starch (laundry and cornstarch)

- **Feeding foods that could be contaminated with harmful microorganisms or toxins**
  Examples of potentially harmful foods:
  - Unpasteurized fruit or vegetable juice;
  - Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese;
  - Raw or undercooked meat, fish, poultry, or eggs;
  - Raw vegetable sprouts (alfalfa, clover, bean, and radish); or
  - Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).

31 Needs Diet Guidance

- A child (12 through 23 months) who has begun to or is expected to begin to 1) consume complementary foods and beverages, 2) eat independently, 3) be weaned from breastmilk or formula, or 4) transition from a diet based on toddler foods to one based on the *Dietary Guidelines for Americans*, is at risk of inappropriate complementary feeding.

- Children two years of age and older who meet the eligibility requirements of income, categorical, and residency status may be presumed to be at nutritional risk based on failure to meet Dietary Guidelines for Americans (Dietary Guidelines). Failure to meet Dietary Guidelines is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans) based on an individual's estimated energy needs.

  This risk may be assigned only to children for whom a complete nutrition assessment (to include an assessment for risk codes 30-unhealthy diet habits, 35- limited diet, 36-improper bottle use, 37-inappropriate feeding practices for children, and 63-prevention) has been performed and for whom no other risks are identified.

35 Limited diet

- **Vegan Diets**
  Consumption of plant origin foods only, an eating plan with no animal products (no meat, poultry, fish, eggs, milk, cheese, or other dairy products) and avoidance of foods made with animal product ingredients

- **Highly Restrictive Diets**
  Diets that are very low in calories, severely limit intake of important food sources of nutrients, or otherwise involve high-risk eating patterns (e.g., macrobiotic diets)

36 Improper bottle or cup use

When using this code, enter the specific improper use of the bottle on the WTW letter as the nutrition risk.

Routine use of the bottle to feed liquids other than breastmilk, formula, or water. This includes:

- fruit juice
- soda
- soft drinks
- gelatin water
- corn syrup solutions
- milk
- other sugar-containing beverages
- diluted cereal or other solid foods

Allowing the child to fall asleep at naps or bedtime with the bottle

Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier

Propping the bottle

Use of a bottle for feeding or drinking beyond 14 months of age

Using a pacifier dipped in sweet agents such as sugar, honey, or syrups

Allowing the child to carry around and drink throughout the day from a covered or training cup

37 Inappropriate Feeding Practices for Children

When using this code, enter the specific improper feeding practice on the WTW letter as the nutrition risk.

- Too much juice: routine consumption or feeding of 12 or more ounces of fruit juice per day

- Too many sweet drinks: Routinely feeding (2 or more servings per day) a child any sugar-containing fluids including: soda, soft drinks, gelatin water, corn syrup solutions, and sweetened tea

- Use of imitation milks: for example, inadequately or unfortified rice- or soy-based beverages, non-dairy creamers, or "homemade concoctions"

- Missing feeding readiness cues
  -Using feeding practices that disregard the developmental needs or stages of the child, examples include:

  -Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's requests for appropriate foods)
  -Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking
  -Not supporting a child's need for growing independence with self-feeding (e.g., solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils)
  -Feeding a child food with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily pureed or liquid food when the child is ready and capable of eating mashed, chopped or appropriate finger foods)

- Using foods and beverages low in essential nutrients and high in calories to replace age-appropriate nutrient dense foods needed for growth and development

-Too many sweets: 3 or more servings of cake, cookies, pies, candy, sweet desserts, pop, soda, or sugared drinks, per day

-Too many high fat foods: 3 or more servings of mayonnaise, salad dressings, chips, cheese curls, fried snack foods, French fries, fast foods, lunchmeat, hot dogs, bacon, or sausage, per day

-Too many fats and sweets: 3 or more servings per day of any of the sweets and fats listed in the prior two bullets

- Using non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk as the primary milk source

63 Prevention

A participant who has previously been certified eligible for the program may be considered to be at nutritional risk in the next certification period if the health professional determines there is a possibility of regression in nutritional status without the benefits that the WIC program provides.

Code 63 can be used only at recertification. **This code must be used by itself and only if no other risk code has been identified.** This risk code may be used once in succession after a risk code. It can be used after any appropriate risk code.

66 At risk for poor diet

Child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- less than or equal to 17 years of age

- mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)

- physically disabled to a degree which restricts or limits food preparation abilities

- currently using or having a history of abusing alcohol or other drugs

67 Needs WIC services

Battering or child abuse/neglect within past six months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel.

Child abuse/neglect: Any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of an infant or child by a parent or caretaker.

Ohio law requires health professionals to report known or suspected child abuse or neglect; therefore, WIC staff must release such information to appropriate officials.

95 Homeless or Migrant

- **Homeless** - A categorically eligible child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

  - a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living quarters;

  - an institution that provides a temporary residence for individuals intended to be institutionalized;

- a temporary accommodation of not more than 365 days in the residence of another individual; or

- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

- **Migrant** - A categorically eligible child who is a member of a family which contains at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode

96 Foster care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months

250. Summary of Medical Codes for WIC Nutrition Risk Criteria

The chart that follows summarizes the nutritional risk criteria for women, infants and children. The chart is organized according to category of participant (pregnant, breastfeeding and postpartum women, infants, children), priority and corresponding medical codes. The Spanish translations of the risk criteria are written on the Welcome To WIC letter for the Spanish-speaking participants, as appropriate. The chart is designed to be used as a tool for the identification of priority and medical codes for all eligible participants.

The complete descriptions of the nutritional risk criteria must be used to determine eligibility. High-risk medical/nutritional identification is not included in this summary.

Category	Priority	Medical Code	
Pregnant Women	I	10-	Slow weight gain Lento aumento de peso
		11-	High weight gain Mucho aumento de peso
		12-	High weight before pregnancy Peso elevado antes del embarazo
		13-	Low weight before pregnancy Peso reducido antes del embarazo
		16-	Lack of proper prenatal care Falta de cuidado prenatal adecuado
		17-	Slow fetal growth Crecimiento fetal retardado
		20-	Low iron Bajo en hierro
		21-	High blood lead Alto contenido de plomo en la sangre
		22-	Had a large baby Tuvo un bebè grande

Category	Priority	Medical Code	
Pregnant Women	I	23-	Nutritional birth defect Defecto nutricional congènito
		39-	Many pregnancies before age 20 Varios embarazos antes de los 20 años de edad
		40-	Pregnant at a young age Embarazada a temprana edad
		42-	Having more than one baby Embarazada con màs de un bebè
		43-	Close pregnancies Embarazos cerca uno del otro
		44-	Conditions caused by pregnancy Afecciones mèdicas producidas por el embarazo
		45-	Past fetal loss Pèrdida fetal en el pasado
		46-	Smoking and/or Secondhand Smoke Fumar/Humo de segunda mano
		47-	Alcohol use Consumo de alcohol
		48-	Drug use Consumo de estupefacientes (drogas)
		49-	Past early or small baby Bebè pequeño o prematuro en el pasado
		69-	Breastfeeding while pregnant Amamantando durante su embarazo

Category	Priority	Medical Code	
Pregnant Women	I	80-	Transfer Traslado
		91-	Inborn Errors of Metabolism (List specific condition- no Spanish Translation)
		93-	Conditions that affect nutrition status (List specific condition- no Spanish translation)
		94-	Dental problems Problemas dentales
Pregnant Women	IV	30-	Unhealthy diet habits Hàbitos dietèticos nocivos
		31-	Needs diet guidance Necesita Guía para Alimentación
		35-	Limited diet Dieta restringida
		66-	At risk for poor diet En riesgo por dieta deficiente
		67-	Needs WIC services Necesita los servicios de WIC
		95-	Homeless or Migrant Indigente o Migrante
		96-	Foster care Cuidado adoptivo temporal
Breastfeeding Women	I	11-	High weight gain Mucho aumento de peso

Category	Priority	Medical Code	
Breastfeeding Women	I	14-	Low weight Peso reducido
		15-	High weight Peso elevado
		20-	Low iron Bajo en hierro
		21-	High blood lead Alto contenido de plomo en la sangre
		22-	Had a large baby Tuvo un bebè grande
		23-	Nutritional birth defect Defecto nutricional congènito
		39-	Many pregnancies before age 20 Varios embarazos antes de los 20 años de edad
		40-	Pregnant at a young age Embarazada a temprana edad
		42-	Having more than one baby Embarazada con màs de un bebè
		43-	Close pregnancies Embarazos cerca uno del otro
		44-	Conditions caused by pregnancy Afecciones mèdicas producidas por el embarazo
		45-	Past fetal loss Pérdida fetal en el pasado
		46-	Smoking and/or Secondhand Smoke Fumar/Humo de segunda mano

Category	Priority	Medical Code	
Breastfeeding Women	I	47-	Alcohol use Consumo de alcohol
		48-	Drug use Consumo de estupefacientes (drogas)
		49-	Past early or small baby Bebè pequeño o prematuro en al pasado
		74-	Breastfeeding issues Asuntos relacionados con la lactancia materna
		80-	Transfer Traslado
		91-	Inborn Errors of Metabolism (List specific condition -no Spanish translation)
		93-	Conditions that affect nutrition status (List specific condition-no Spanish translation)
		94-	Dental problems Problemas dentales
Breastfeeding Women	IV	30-	Unhealthy diet habits Hàbitos dietèticos nocivos
		31-	Needs diet guidance Necesita Guía para Alimentación
		35-	Limited diet Dieta restringida
		63-	Prevention Prevenciòn
		66-	At risk for poor diet En riesgo por dieta deficiente

Category	Priority	Medical Code	
Breastfeeding Women	IV	67-	Needs WIC services Necesita los servicios de WIC
		70-	Breastfeeding a WIC baby Amamantando un bebè bajo el programa WIC
		95-	Homeless or Migrant Indigente o Migrante
		96-	Foster care Cuidado adoptivo temporal
Postpartum Women	III	20-	Low iron Bajo en hierro
		21-	High blood lead Alto contenido de plomo en la sangre
		80-	Transfer Traslado
		91-	Inborn Errors of Metabolism (List specific condition- no Spanish translation)
		93-	Conditions that affect nutrition status (List specific condition- no Spanish translation)
		94-	Dental problems Problemas dentales
Postpartum Women	VI	11-	High weight gain Mucho aumento de peso
		14-	Low weight Peso reducido
		15-	High weight Peso elevado

Category	Priority	Medical Code	
Postpartum Women	VI	22-	Had a large baby Tuvo un bebè grande
		23-	Nutritional birth defect Defecto nutricional congènito
		30-	Unhealthy diet habits Hàbitos dietèticos nocivos
		31-	Needs diet guidance Necesita Guía para Alimentación
		35-	Limited diet Dieta restringida
		39-	Many pregnancies before age 20 Varios embarazos antes de los 20 años de edad
		40-	Pregnant at a young age Embarazada a temprana edad
		42-	Having more than one baby Embarazada con màs de un bebè
		43-	Close pregnancies Embarazos cerca uno del otro
		44-	Conditions caused by pregnancy Afecciones mèdicas producidas por el embarazo
		45-	Past fetal loss Pèrdida fetal en el pasado
		46-	Smoking and/or Secondhand Smoke Fumar/Humo de segunda mano
		47-	Alcohol use Consumo de alcohol

Category	Priority	Medical Code	
Postpartum Women	VI	48-	Drug use Consumo de estupefacientes (drogas)
		49-	Past early or small baby Bebè pequeño o prematuro en el pasado
		63-	Prevention Prevenciòn
		66-	At risk for poor diet En riesgo por dieta deficiente
		67-	Needs WIC services Necesita los servicios de WIC
		95-	Homeless or Migrant Indigente o Migrante
		96-	Foster care Cuidado adoptivo temporal
Infants	I	20-	Low iron Bajo en hierro
		21-	High blood lead Alto contenido de plomo en la sangre
		46-	Secondhand Smoke Fumar/Humo de segunda mano
		50-	Born early Nacido prematuramente
		51-	Low birth weight Poco peso al nacer
		52-	Short for age Bajo de estatura para su edad

Category	Priority	Medical Code	
Infants	I	53-	Underweight Peso insuficiente
		54-	High weight for length Exceso de peso para su largo
		55-	At risk for growth problems En riesgo por problemas de crecimiento
			-At risk for short for age -En riesgo por bajo de estatura para su edad
			-At risk for underweight -En riesgo por peso insuficiente
			-At risk for high weight for height -En riesgo por exceso de peso para su estatura
		56-	Slow growth Retardo en el crecimiento
		57-	Small at birth Pequeño al nacer
		58-	Small head size De cabeza pequeña
		59-	Large at birth Grande al nacer
		65-	At risk for poor growth En riesgo por crecimiento deficiente
		68-	Fetal Alcohol Syndrome (No Spanish translation)
		74-	Breastfeeding issues Asuntos relacionados con la lactancia materna
		80-	Transfer Traslado

Category	Priority	Medical Code	
Infants	I	81-	Infant transfer Traslado de infante
		91-	Inborn Errors of Metabolism (List specific condition-no Spanish translation)
		93-	Conditions that affect nutrition status (List specific condition-no Spanish translation)
		94-	Dental problems Problemas dentales
Infants	II	61-	Baby born to WIC eligible mom Bebè de una madre con derecho al programa WIC
Infants	IV	30-	Unhealthy diet habits Hàbitos dietèticos nocivos
		31-	Needs diet guidance Necesita Guía para Alimentación
		35-	Limited diets Dieta restringida
		36-	Improper bottle or cup use (List specific improper use of the bottle.) -Other foods in the bottle -Otro tipa de alimentos en el biberòn -Sleeps or naps with bottle -Duerme o dormita con el biberón -Bottle used as a pacifier -Utiliza el biberón como chupete

Category	Priority	Medical Code	
Infants	IV	36-	Continued -Propping the bottle -Inclinar el biberón -Training cup used like a bottle -Taza de entrenamiento usada como una botella
		38-	Improper infant feeding (List specific improper feeding practice.) -Inappropriate infant feeding practices -Pràcticas de alimentaciòn infantil inadecuadas -Early introduction of solid foods -Introducciòn temprana de alimentos sòlidos -Feeding cow's milk during first 12 months -Alimentaciòn con leche de vaca durante los primeros 12 meses -No dependable source of iron for infants at six months of age or later -Sin una fuente de hierro confiable para niños de seis meses o más -Improper dilution of formula -Dilución inadecuada de la fórmula (leche especial para bebés) -Feeding other foods low in essential nutrients -Alimentación con otros productos bajos en elementos nutritivos esenciales -Lack of sanitation in preparation and handling of nursing bottles -Falta de higiene en la preparaciòn y el manejo de los biberones

Category	Priority	Medical Code	
Infants	IV	63-	Prevention Prevenciòn
		66-	At risk for poor diet En riesgo por dieta deficiente
		67-	Needs WIC services Necesita los servicios de WIC
		71-	Breastfed by a WIC mom Amamantado por una madre inscrita en el programa WIC
		75-	Needs breastfed more often Necesita que le amamanten con más frecuencia
		95-	Homeless or Migrant Indigente o Migrante
		96-	Foster care Cuidado adoptivo temporal
Children	III	20-	Low iron Bajo en hierro
		21-	High blood lead Alto contenido de plomo en la sangre
		46-	Secondhand Smoke Fumar/Humo de segunda mano
		50-	Born early Nacido prematuramente
		51-	Low birth weight Poco peso al nacer
		52-	Short for age Bajo de estatura para su edad

Category	Priority	Medical Code	
Children	III	53-	Underweight Peso insuficiente
		54-	High weight for height Exceso de peso para su estatura
		55-	At risk for growth problems En riesgo por problemas de crecimiento -At risk for short for age -En riesgo por bajo de estatura para su edad -At risk for underweight -En riesgo por peso insuficiente -At risk for high weight for height -En riesgo por exceso de peso para su estatura
		56-	Slow growth Retardo en el crecimiento
		57-	Small at birth Pequeño al nacer
		68-	Fetal Alcohol Syndrome (No Spanish translation)
		80-	Transfer Traslado
		91-	Inborn Errors of Metabolism (List specific condition-no Spanish translation)
		93-	Conditions that affect nutrition status (List specific condition-no Spanish translation)
		94-	Dental problems Problemas dentales

Category	Priority	Medical Code	
Children	V	30-	Unhealthy diet habits Hàbitos dietèticos nocivos
		31-	Needs diet guidance Necesita Guía para Alimentación
		35-	Limited diet Dieta restringida
		36-	Improper bottle or cup use (List specific improper use of the bottle.) -Other foods in the bottle -Otro tipo de alimentos en el biberòn -Sleeps or naps with bottle -Duerme o dormita con el biberón -Bottle used as a pacifier -Utiliza el biberón como chupete -Propping the bottle -Inclinar el biberón -Using bottle after 14 months old -Usando la botella despues de 14 meses de nacido -Using a pacifier dipped in sweets -Uso del bobo/chupete mojado en dulces -Training cup used like a bottle -Taza de entrenamiento usada como una botella

Category	Priority	Medical Code	
Children	V	37-	Inappropriate feeding practices for children (List specific improper feeding practice.) -Too much juice -Demasiado jugo - Too many sweet drinks -Demasiadas bebidas dulces - Use of imitation milks -Uso de imitación de leches -Missing feeding readiness cues -Pérdida de señales de estado de preparación para comer -Too many sweets -Demasiados dulces -Too many high fat foods -Demasiados alimentos de elevado contenido graso -Too many fats and sweets -Demasiados alimentos dulces y de elevado contenido graso -Not using whole milk -Falta del uso de leche con grasa
		63-	Prevention Prevenciòn
		66-	At risk for poor diet En riesgo por dieta deficiente
		67-	Needs WIC services Necesita los servicios de WIC

Category	Priority	Medical Code	
Children	V	95-	Homeless or Migrant Indigente o Migrante
		96-	Foster care Cuidado adoptivo temporal

251.-259. Reserved

260. Required Supportive Data for Nutritional Risk Factors

This section provides guidelines for obtaining health information and assessing the nutritional status of WIC participants. For purposes of the WIC program, nutritional assessment is defined as the interpretation of information recorded from biochemical and anthropometric measurements and health history forms. If comprehensive nutritional status or health history information is recorded in a readily available medical chart, the local project may make a cross reference to the information in the WIC chart. The following sections describe methods for obtaining health and dietary habit information; measuring length, height, and weight and evaluating this data; and completing blood work analysis.

261. Procedures for Obtaining Health Histories and Completing the Nutrition Care Plan

There are four health history forms which can be used in collecting health history information on WIC applicants/participants. These are:

- WIC Health History for Infants (HEA 4448)
- WIC Health History for Children (HEA4450)
- WIC Health History for Pregnant Women (HEA 4455), and
- WIC Health History for Breastfeeding and Postpartum Women (HEA 4449).

The health history form for all participant categories serves as a tool to gain information on factors related to health and nutritional status. The nutrition care plan form serves as the record of the health professional's documentation of subjective, objective (as needed), assessment, plan information, and miscellaneous participant contacts. The health history form may be completed by the participant, parent/guardian or interviewer and is designed to gather information regarding the participant's general health condition and dietary habits. The resulting information is used in conjunction with hematologic and anthropometric results to assess the participant's overall health status. Certain health history questions will require follow-up questions and may require referral to health care services.

- Complete a health history and nutrition care plan form for each participant at certification unless the health history information is available in a readily accessible medical chart, and the information can be reviewed before or at the time of certification.

- The health history forms for infant, child, and breastfeeding/postpartum participants may be used twice for active participants. If a project uses a health history form twice, the health professional must document the current date, review all the questions, and update the health history form with a different color pen. A new nutrition care plan form must be completed for every certification.

- Indicate the location of the Combined Programs Application in the top, left, shaded box of the health history form, if the application is not in the participant's chart. If the application is in another family member's chart, record the complete name of that person in the box.

- In addition to written data, a brief visual examination of the participant should be completed. The physical signs of undernutrition lack specificity because abnormal physical characteristics result from both nutritional and nonnutritional factors, and nutrient deficiencies are usually multiple. Consequently, diagnosis of specific nutrient deficiencies is difficult. Physical characteristics must be interpreted along with dietary, biochemical, and anthropometric data as well as other factors such as age, sex, and environmental conditions.

  The following table from Krause's Food, Nutrition and Diet Therapy, L. Kathleen Mahan, MS, RD, CDE, and Sylvia Escott-Stump, MA, RD, W.B. Saunders Company, 2000 provides a summary of the physical signs indicative or suggestive of undernutrition.

Nutrition-Focused Physical Assessment

System	Normal Findings	Abnormal Findings
General survey	weight for height appropriate, well-nourished, alert, and cooperative	loss of weight, muscle mass and fat stores, growth retardation excess fat stores fatigue, anemia
Skin	pink, soft, moist, turgor with instant recoil, smooth appearance	poor wound healing, ulcers dry with fine lines and shedding, scaly (xerosis) spinelike plaques around hair follicles on buttocks, thighs, or knees (follicular hyperkeratosis) pellagrous dermatitis (hyperpigmentation of skin exposed to sunlight) pallor yellow pigmentation poor skin turgor petechiae, ecchymoses
Nails	smooth, translucent, slightly curved nail surface and firmly attached to nail bed; nail beds with brisk capillary refill	spoon-shaped (koilonychia) dull, lackluster pale, mottled
Scalp	pink, no lesions, tenderness; fontanels without softening, bulging	softening or craniotabes open anterior fontanel (usually closes by ~18 months of age)
Hair	natural shine, consistency in color and quantity, fine to coarse texture	lack of shine and luster, thin, sparse easily pluckable alternating bands of light and dark hair in young children (flag sign)
Face	skin warm, smooth; dry, soft, moist with instant recoil	diffuse depigmentation, swollen pallor moon face bilateral temporal wasting
Eyes	evenly distributed brows, lids, lashes; conjunctiva pink without discharge sclerae, without spots; cornea clear; skin without cracks or lesions	pale conjunctiva night blindness dry , grayish, yellow or white foamy spots on whites of eyes (Bitot's spots) dull, milky, or opaque cornea (corneal xerosis) dull, dry, rough appearance to whites of eyes and inner lids (conjunctival xerosis) softening of cornea (keratomalacia)

		cracked and reddened corners of eyes (angular palpebritis)
Nose	uniform shape, septum slightly to left of midline, nares patent bilaterally, mucosa pink and moist, able to identify smells	scaly, greasy, with gray or yellowish material around nares (nasolabial seborrhea) inflammation, redness of sinus tract, discharge, obstruction or polyps
Lips/mouth	pink, symmetrical, smooth intact	bilateral cracks, redness of lips (angular stomatitis) vertical cracks of lips (cheilosis)
Tongue	pink, moist, midline, symmetrical with rough texture	magenta smooth, slick, loss of papillae (atrophic filiform papillae) beefy red color, atrophied taste buds, and mucosa red and swollen decreased taste (hypoguesia)
Gums	pink, moist without sponginess	spongy, bleeding, receding
Teeth	repaired, no loose teeth; color may be various shades of white	missing, poor repair, caries, loose white or brownish patches (mottled)
Cranial nerves	intact	Abnormal
Gag reflex	intact	Absent
Jaw	proper alignment, movement from side to side	improper alignment and movement
Parotid gland	located anterior to earlobe, no enlargement	bilateral enlargement
Neck nodules	trachea midline, freely movable without enlargement or nodules	enlarged thyroid
Chest/lungs	anterior and posterior thorax; adequate muscle and fat stores, respirations even and unlabored, symmetrical rise and fall of chest during inspiration and expiration, lung sounds clear	somatic muscle- and fat – wasting; labored respirations; breath sounds such as crackles, rhonchi, and wheezing: evaluate for fluid status versus tenacious secretions that may labor breathing and increase energy expenditure; also consider increased rate and depth, decreased rate and depth
Heart	rhythm regular and rate within normal range; S1 and S2 heart sounds	irregular rhythm pounding pulse small, weak pulse palpitations tachycardia enlarged heart
Vascular access devices intact	no swelling, redness, drainage	purulent drainage, swelling, excessive redness
Abdomen	soft, nondistended, symmetrical, bilateral without masses, umbilicus in midline, no ascites, bowel sounds	generalized symmetrical distention protruding, everted umbilicus, tight glistening appearance (ascites)

	present and normoactive; tympanic on percussion; feeding device intact without redness, swelling	scaphoid appearance increased bowel sounds high-pitched tinkling decreased bowel sounds
Kidney, ureter, bladder	urine golden yellow (ranges from pale yellow to deep gold), clear without cloudiness, adequate output	decreased output, extremely dark, concentrated
Musculoskeletal	full range of motion without joint swelling or pain, adequate muscle strength	inability to flex, extend, and rotate neck adequately decreased range of motion, swelling, impaired joint mobility of upper extremities; muscle wasting on arms, legs; skin folding on buttocks swollen, painful joints enlargement of epiphyses at wrist, ankle, or knees bowed legs beading of ribs pain in calves, thighs
Neurologic	alert, oriented, hand-to-mouth coordination; no weakness or tremors cranial nerves intact: primary nutritionally focused ones include trigeminal, facial, glossopharyngeal, vagus, and hypoglossal reflexes (biceps, brachioradialis patella, and Achilles common in exam), functioning within normal range of 2+ + hypoactive reflexes	decreased or absent mental alertness; inadequate or absent hand-to-mouth coordination psychomotor changes, confusion, peripheral neuropathy tetany hyperactive reflexes hypokalemia hypoactive achilles, patellar reflex

261.1 Instructions for Completion of the WIC Health History for Infants

- Anthropometric and hematological data may either be recorded in the top, shaded boxes of the front page or on the growth chart. The data is always recorded in the computer.
- Parent/guardian (P/G) completes the heading information (name, birth date, etc.) and questions.
- The health professional may record subjective data in the space to the right of each question or on the Nutrition Care Plan form.
- Health professional reviews and discusses the completed form with the P/G and records any clarifications of significant information. The health professional indicates by initials, checkmarks, asterisks, or other manner any adverse health outcomes, whether the issue is addressed at the current appointment or not.
- Health professional circles all risk code numbers, if the risk code is assigned.
- The caregiver of an infant should be encouraged to have the infant tested for elevated blood lead levels at twelve months of age.

261.2 Instructions for Completion of the WIC Health History for Children

- Anthropometric and hematological data may either be recorded in the top, shaded boxes of the front page or on the growth chart. The data is always recorded in the computer.
- Parent/guardian (P/G) completes heading information (name, birth date, etc.) and questions.
- The health professional may record subjective data in the space to the right of each question or on the Nutrition Care Plan form.
- Health professional reviews and discusses the completed form with the P/G and records any clarifications of significant information. The health professional indicates by initials, checkmarks, asterisks, or other manner any adverse health outcomes, whether the issue is addressed at the current appointment or not.
- Health professional circles all risk code numbers, if the risk code is assigned.

- Children greater than or equal to twelve months of age should be tested for elevated blood lead levels. If a child greater than twelve months of age has not been tested, refer the child to a program that provides blood lead screening tests. Indicate in the "Referral" box on the Nutrition Care Plan (NCP) where the child was referred and indicate the referral in the WIC System. Referral in this context does not require the completion of the Interagency Referral and Follow-up Form. Provision of verbal or written lead contact information is adequate.

261.3 Instructions for Completion of the WIC Health History for Pregnant Women

- Anthropometric and hematological data may either be recorded in the top, shaded boxes of the front page or on the Pregnancy Weight Record. The data is always recorded in the computer.

- Participant completes heading information and questions.

- The health professional may record subjective data in the space to the right of each question or on the Nutrition Care Plan form.

- Health professional reviews and discusses the completed form with the participant/guardian and records any clarifications of significant information. The health professional indicates by initials, checkmarks, asterisks, or other manner any adverse health outcomes, whether the issue is addressed at the current appointment or not.

- Health professional circles all risk code numbers, if the risk code is assigned.

- If a woman appears to have a high risk for lead exposure (type of work, child or home identified with high lead levels, requests information, etc.) and has not been tested for elevated blood lead, verbally refer the woman to her doctor. Indicate that referral was made in the "Referral" box on the NCP and in the WIC System. Referral in this context does not require the completion of the Interagency Referral and Follow-up Form. Health professionals are **not** required to routinely ask women about lead exposure.

261.4 Instructions for Completion of the WIC Health History for Breastfeeding and Postpartum Women

- Anthropometric and hematological data may be recorded in the top, shaded boxes of the front page. The data is always recorded in the computer.

- Breastfeeding and nonbreastfeeding participants complete heading information (note, the "Date of last doctor visit" entry seeks the date of the woman's last OB/GYN care visit; e.g., six-week follow-up visit) and questions.

- If the postpartum woman has had a miscarriage, abortion, still birth, or infant death, enter a critical message in the WIC Certification System. The message will warn staff to refrain from providing a blank health history form to the woman at her appointment. The health professional can complete the health history form with the participant by asking questions appropriate to the woman's situation. A *Sample WIC Health History for Fetal/Infant Loss* is found in Appendix 200.

  Many women suffering from the loss of a baby find comfort in donating their breast milk to a milk bank to help other infants in need. Depending on the prenatal infant feeding plan, weeks gestation prior to miscarriage, and in the instance of a still birth or infant death, WIC staff should inform the woman about the opportunity to donate her breast milk to the Mothers' Milk Bank of Ohio. The milk bank can be contacted by phone at (614) 544-0813 or by email at milkbank@ohiohealth.com.

- The health professional may record subjective data in the space to the right of each question or on the Nutrition Care Plan form.

- Health professional reviews and discusses the completed form with the P/G and records any clarifications of significant information. The health professional indicates by initials, checkmarks, asterisks, or other manner any adverse health outcomes, whether the issue is addressed at the current appointment or not.

- Health professional circles all risk code numbers, if the risk code is assigned.

- If a woman appears to have a high risk for lead exposure (type of work, child or home identified with high lead levels, requests information, etc.) and has not been tested for elevated blood lead, verbally refer the woman to her doctor. Indicate that referral was made in the "Referral" box on the NCP and in the WIC System. Referral in this context does not require the completion of the Interagency Referral and Follow-up Form. Health professionals are **not** required to routinely ask women about lead exposure.

261.5 Instructions for Completing the Nutrition Care Plan (NCP) Form

- The full name of the participant is recorded on the top, blank line. Recording the participant identification number (ID#) is optional.

- Health professional records any additional subjective or objective (as needed) data in the block marked "S/O." "Bruises noted, but woman does not admit to battery or social issues" and other sensitive information can be documented in this area. Health professionals must document dietary information gathered during the certification process that is **not** written on the Health History form. Samples include: "Drinks 48 ounces of juice per day," "Eats one or less servings of vegetables per day," and "Uses no milk or dairy products." Health professionals must record only the information that will be needed or used to make the targeted diet assessment.

- Health professional records a risk code and a targeted diet assessment in the block marked "A." An example is as follows: "20, diet low in iron rich foods." A targeted diet assessment means asking questions and reviewing one or two areas of the participant's diet. In the above example, the health professional only asked questions about the intake of iron rich foods and made the assessment that the diet was low in this one area. Further questions regarding diet habits were not necessary at this time.

  For participants that are tubefed or receive a supplement and are assigned risk code 56, 91, or 93, the following **must** be documented in the Assessment area of the NCP:

  - amount of feeding or supplement consumed per day (average);
  - tolerance or complications of the feeding;
  - concerns, if any, regarding the caregiver's ability to provide the feeding or compliance issues; and
  - contact with the physician, if necessary, to change amount or type of feeding.

  The same documentation is required whether the information is received at certification, recertification, midcertification, or walk-in appointments, but the information is recorded under "Notes" for midcertification or walk-in appointments.

- The space marked "Previous objective met?" is an assessment tool that must be marked by the health professional. The health professional may provide additional, brief documentation addressing how the goal was met, why the goal was not met, or other appropriate information.

- Mark the high-risk (HR) block if participant meets high-risk criteria. Space is provided in the block for special notation as determined by the local project.

- Place a check mark in the "Referral" space to indicate referral made and document in the computer.

- Since the nutrition care plan form is used for all of the participant categories, health professionals should only complete the following boxes on the form when required.

    - Mom BMI and Dad BMI spaces need only be completed when this information is easily available and the health professional is using Risk Code 55. Staff is not required to obtain this information as a routine part of the infant's or child's certification.

    - Health professional records mom's risk code in the "Mom's Risk" box when required to substantiate the use of one of the infant's risk codes, i.e., when using code 71 or code 61.

    - Health professional records the breastfed infant's risk code in the "BF Infant Risk" box when required to substantiate the use of one of the mom's risk codes, i.e., when using code 70.

- Health professional records the plan in block marked "P." Based on a mutual agreement between the participant and the health professional, the plan contains simple, specific objectives including, when relevant, types and amounts of food, including WIC items, and frequency of recommended use. It is acceptable, specifically for participants who are not ready to commit to major dietary changes, to write goals such as: "Participant will read sippy cup pamphlet and consider decreasing use of sippy cups." It is also acceptable to write plans that do not have a nutrition component as long as the plan/goal was selected by the participant. For example, "Mary will call the smoke-free hotline and join the smoke-free quit group by next week" and "Susan will make an appointment with the prenatal clinic by next week" are acceptable plans. The plan can also be written as a positive statement, "Cheyanne will continue to attend obesity clinic exercise program." This plan should be consistent with the goal written on the WTW letter. Since health professionals are completing targeted (looking at one or two areas of diet) nutrition assessments, rarely would the plan "Diet within Normal Limits" or "Diet – OK" be written.

- Health professional must record signature (first initial, last name and credentials) in block marked "Signature."

- Health professional records date of visit in the block marked "Date."

- Health professional documents subsequent contacts; e.g., telephone, food package changes, physician contact, etc., in the area marked "Notes."

262. Obtaining Dietary Habit Information

The food frequency and 24-hour recalls are the most common tools used to obtain dietary intake information. It has been determined by the Institute of Medicine (IOM) that dietary record tools such as these are not effective in accurately assessing true dietary risk within the realm of WIC services. The 1996 IOM Report has determined 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." From this assessment, Food and Nutrition Service (FNS) has added the presumptive eligibility code which replaces most of the dietary risk codes that were previously determined using the food frequency. This code can only be used, however, after inappropriate nutrition practices have been evaluated and ruled out.

Health professionals must approach the certification process as a conversation and goal setting encounter with the participant to produce positive health outcomes versus an appointment to find risk codes. To allow sufficient time for rapport building and critical thinking, health professionals complete a targeted diet assessment. A targeted diet assessment means asking questions and reviewing one or two areas of the participant's diet.

An integral part of the WIC health screening process is the acquisition of information regarding nutritional status. The interviewer must be skilled in soliciting accurate and complete information from the participant. Appropriately asked questions can provide information regarding factors which affect food intake such as culture, finance, religion, living style, and occupation. For example, rather than asking the participant to name foods not liked, ask the participant to name foods avoided. There are many reasons other than food preference or taste for not eating a food. There may be a food allergy, religious taboo or problem with availability of that food. Be careful not to use terms like breakfast, lunch, or dinner. A participant's food habits may not fit into these definitions. Instead, the participant may snack often during the day or eat only one or two meals at unusual times. Questions should be open-ended, requiring more than a yes or no answer. With careful probing and attention paid to cues from the participant, much useful information can be solicited.

Additional probing questions must be asked based on each participant's current nutritional health status. Section 402 of Chapter 400 covers the nutrition practice guidelines for each category. Using this information along with a review of the health history forms, the health professional will individualize the interview session for each participant. The health professional should ask open ended questions using the participant's current health status and the information collected from the health history. Responses to these questions will help the health professional to make a nutritional

assessment. Pertinent nutrition practices information obtained from the interview is to be documented on the health history forms.

Health professionals have the following tools available to screen for certain nutrition practices and begin conversation with the participant.

-Health History forms
-Sample Discussion Starters Using the WIC Food Package
-Portion plates and food models

Occasionally, the health professional may not find any targeted diet assessment after reviewing the health history form and asking clarifying questions. In this instance, the health professional must use the Sample Discussion Starters Using the WIC Food Package found in Appendix 200 to begin reviewing the MyPlate food groups to assess the diet. The health professional will not need to cover every food group unless probing questions reveal that serving sizes and frequency of consumption are correct. If a health professional identifies a participant with a perfect diet, it is acceptable to write a positive assessment such as, “Eating appropriate diet for pregnancy,” or “Following a balanced diet.”

The Nutrition Practice Guide located in Appendix 200 is a flow chart that indicates how a participant can present with several possible dietary habit concerns based upon answers on the health history form and the medical data collected. From there, the health professional formulates additional open ended medical and dietary habit questions and determines possible areas for discussion. Through discussion with the participant, a mutual goal will be set. This goal may or may not be related to what the health professional sees as a priority during the interview process. The Nutrition Practice Guide is a visual picture of the critical thinking process the health professional uses to individualize every WIC visit.

263. Measurement Techniques for Height and Length

Growth patterns can be one determinant of adequate nutrition and good health. Accuracy of length and height measurements depends upon the use of proper techniques and appropriate equipment. Correct data entry is crucial for accurate computer plotted growth charts.

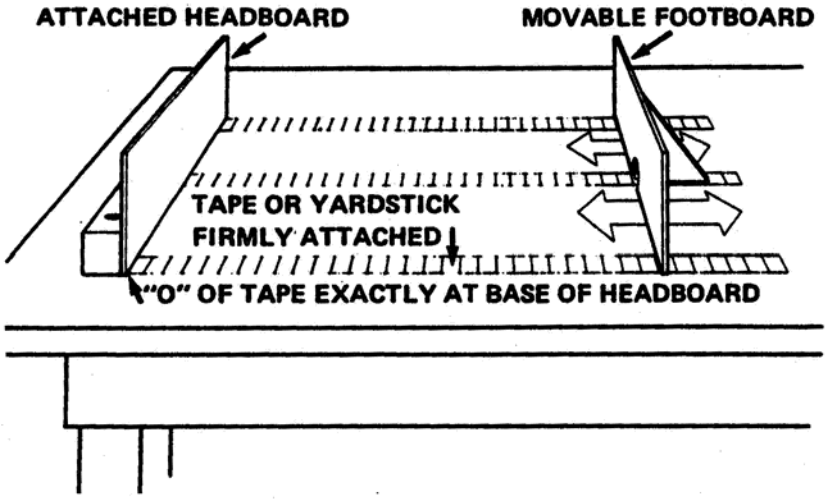
Infants and children up to 2 years of age must be measured in the recumbent position. Older children are measured while standing. The appropriate growth chart for the child's age and sex will be plotted by the WIC System.

263.1 Recumbent Length

Until the child is 24 months of age, the child should always be measured lying on his back. The following equipment is necessary for obtaining and documenting recumbent length for computer plotted growth charts.

- A measuring board with headboard and movable footboard attached at right angles to the measuring surface (See Figure 263.1A)
- A nonstretchable tape which adheres to the board

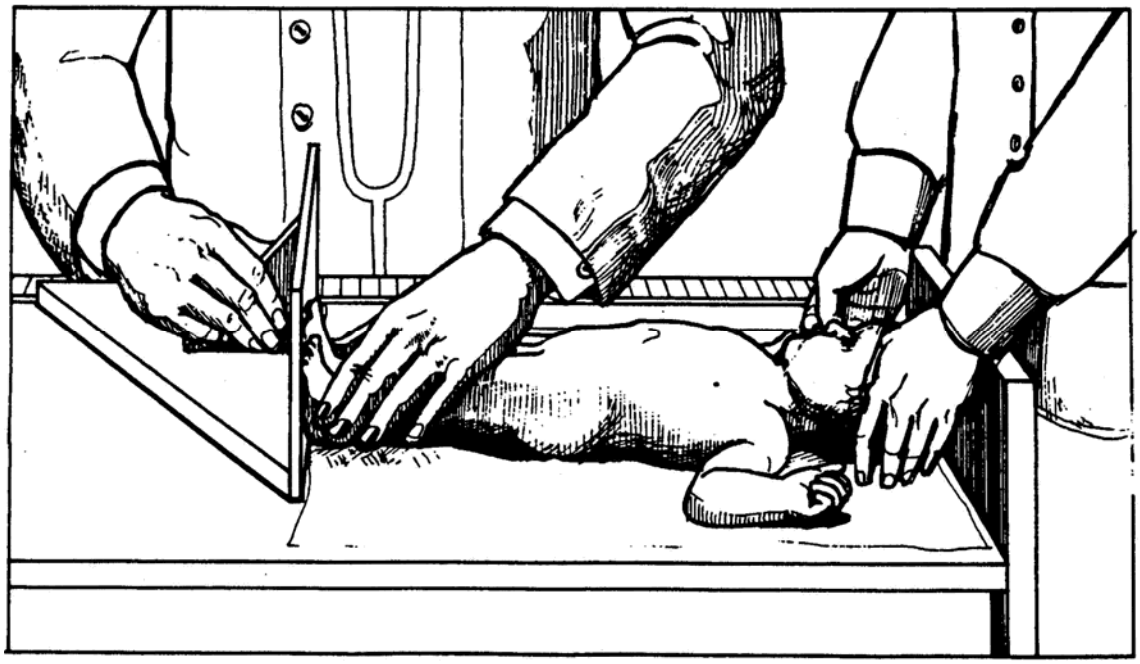
Figure 263.1A Recumbent Board



The following procedures should be utilized to obtain accurate measurements:

- Remove shoes and any bulky clothing from the infant or child.
- Lay infant or child on measuring board with the head against headboard. Head must be facing upward with the line of vision perpendicular to the board.
- One person holds the head in the proper position by gently placing both hands on either side of the head over the ears while the other straightens both legs and gently presses down on the knees until flat against the backboard and moves the footboard until the feet are flat against it.
- Check to see that the head is straight and even with the headboard. Be sure that the body and legs are in a straight line with the head (See Figure 263.1B).
- Read the measurement and record immediately.
- It is recommended that you repeat the measurement to validate the accuracy. Repeat a third time if a difference of greater than 1/4 inch is found.

Figure 263.1B Measuring the Child



Each of the following could be a source of error when measuring and plotting recumbent length:

- The head is in an incorrect position.
- The legs are bent or the body is arched.
- Both feet are not flat against the board.
- The infant is wearing hair clips or braids.
- The infant or child is on a padded surface.
- The infant is wearing shoes.

263.2 Child and Adult Stature

All children over 24 months of age must be measured in the standing position. Heights for all women must also be taken in this manner. If a woman is taller than the WIC staff member obtaining the measurement, then the staff member should use a footstool to read the height measurement at eye level.

The following equipment is necessary to obtain and document child and adult heights for computer plotted growth charts and weight gain grids.

- A nonstretchable measuring tape or stick adhered to a flat vertical surface such as a wall, partition or door (See Figure 263.2A)
- A right angle block or movable headboard

The following procedures must be used to obtain accurate measurements:

- Remove shoes.
- The child or woman should stand with their back to the measuring device on the wall, knees and feet together and line of vision perpendicular to the wall. Upper back, buttocks and heels should touch the wall as much as possible (See Figure 263.2B).

- A block flush at a right angle to the wall or a movable headboard should be brought to the top of the head (See Figure 263.2C). Do not use the sliding measuring rod on the scale.

- The child or woman should step away and the stature read to the nearest 1/4 inch.

- It is recommended that the measurement be repeated to validate its accuracy. Repeat a third time if the measurements differ by more than 1/4 inch.

- Record and plot the measurement as appropriate.

Each of the following could be a source of error when measuring and plotting child or adult heights:

- head not properly positioned;

- knees bent or feet raised from the floor;

- upper back, buttocks, or heels not touching the wall;

- knees or feet not together;

- right angle not firmly placed on the participants head;

- woman or child wearing hair clips or braids;

- measuring while standing on a padded surface (i.e., carpet);

- inaccurate attachment of measuring device to the wall; or

- woman or child wearing shoes.

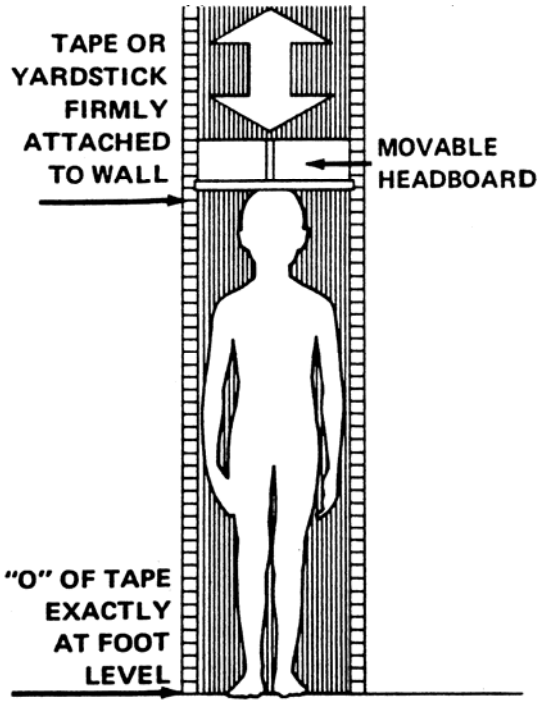


Figure 263.2A - Appropriate Measuring Device

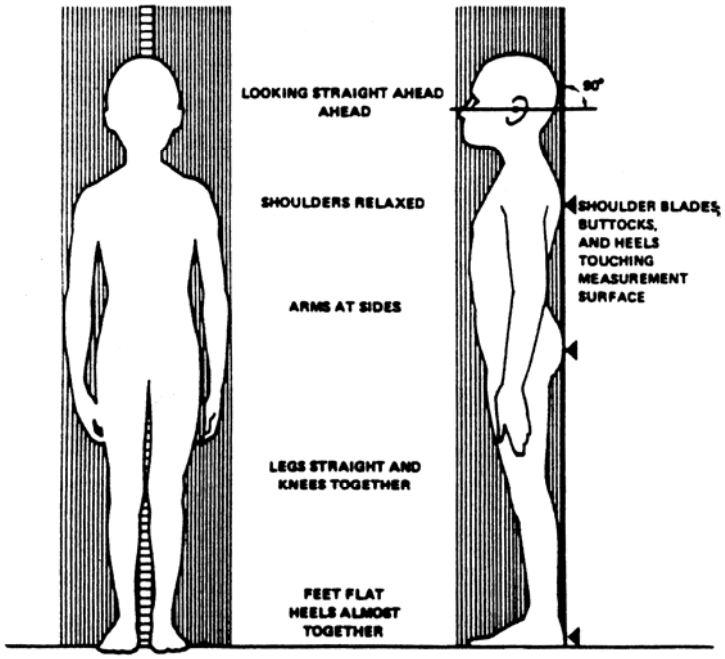


Figure 263.2B - Stature Measurements Techniques for Child and Adult

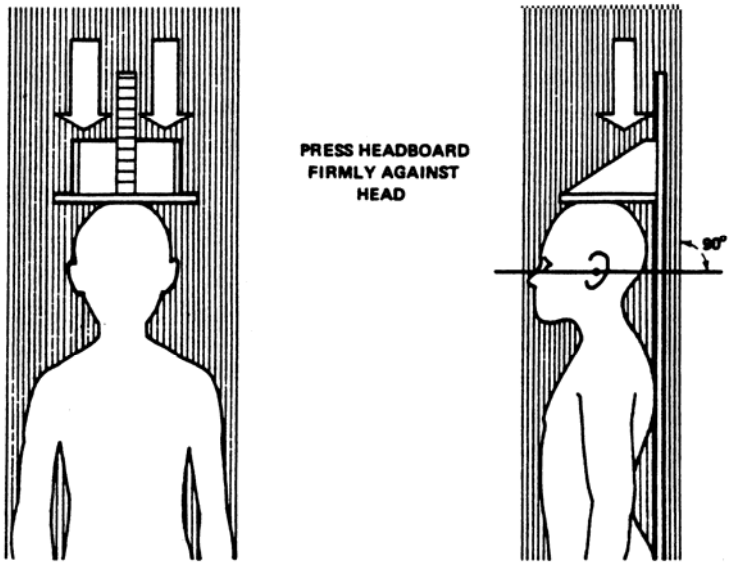


Figure 263.2C - Using a Right Angle

263.3 Measurement of Height/Length for a Participant with a Missing Limb, Disability, or Cast

If the individual's missing limb, disability, or cast prevents measurement of height/length, document this on the Health History form or Nutrition Care Plan. If a height/length measurement as described in sections 263.1 and 263.2 cannot be performed, the individual must not be certified for short for age, underweight or overweight for height or risk of these conditions unless the condition can be documented by the individual's primary health care provider.

An alternate technique of obtaining height/length, such as segmental measurement, can be performed. These measurements may suggest loss of height/length, especially if the disabled individual's limbs or trunk have contracted more since the last measurement. In these cases, the health professional must rely on professional judgment to assess the individual's progress and to monitor growth.

263.4 Measurement of Height/Length for a Participant with One Leg Shorter than the Other

If a child is less than two years of age and one leg is shorter than the other, fully extend both legs. Record the measurement of the longer leg. Participants two years of age and older should be able to stand. Document the procedure used on the Health History form or Nutrition Care Plan.

263.5 Measurement of Length for a Child Who Is Unable to Stand

Children over two years old who cannot stand without support should be measured lying down. If the child is longer than the recumbent board, then use a nonstretchable measuring tape attached to a table, desk-top, or floor in place of the recumbent board. Care should be taken when interpreting the 2 to 5 years growth chart of a child measured lying down. The child's length will plot taller on the growth chart because of the recumbent measurement. The percentile obtained in this manner can only be used to assess the child's growth over time.

Since the height measurement as described in section 263.2 cannot be performed, the individual must not be certified for short for age, underweight for height or risk of these conditions unless the condition can be documented by the individual's primary health care provider. Document the procedure used on the Health History form or Nutrition Care Plan.

264. Techniques for Determining Weight

Weight is an important determinant of health and nutritional status. Proper techniques and equipment are necessary for accurate results. Scales must be calibrated and sealed/certified by an authorized agency at least annually. The breastfeeding infant scales also must be calibrated at least once a year using the ten pound weight that came with them. If these scales are moved often, they may need to be calibrated more frequently. Correct data entry is crucial for accurate computer plotted growth charts.

264.1 Infant and Child (Under 2 Years of Age) Weight

Infants and children under 2 years of age must be weighed on the infant scale. The following equipment is necessary to obtain and document an infant's weight for computer plotted growth charts and weight grids.

- An infant balance beam scale with nondetachable weights or a medical grade digital infant scale
- A disposable pad or paper on the scale so that the infant is not laid directly on the scale to prevent infection and decrease exposure to fungus, virus, bacteria, etc.

The following procedures must be used to obtain accurate measurements using a balance beam scale:

- Zero balance the scale by bringing the main and fractional sliding beam weights directly over their respective zeros. Move the zeroing weight until the balance indicator is centered. Zero balance the scale with the pad or paper on the scale.
- Remove outer and/or bulky clothing as well as shoes from the infant. Have the diaper changed if wet or soiled. (It may be helpful to remind the caregiver to bring a change of diapers for the infant.)
- Place the infant on the center of the scale.
- To read the scale, move the main sliding beam until it indicates too heavy, then move it back one notch. Move the weight on the fractional indicator back and forth until the indicator is centered.

- The measurement should be read when the child or infant is not moving. If the child or infant is being restless, the measurement will not be accurate. When this is the case, record in the chart that the infant or child was restless and that the measurement may be imprecise.

- It is recommended that the measurement be repeated to validate the accuracy. If the measurements differ by more than 1/4 pound, repeat the procedure.

- Return the sliding beams to zero. Always zero balance the scale before weighing another infant.

Follow the manufacturer's instructions in order to obtain accurate measurements using a digital scale.

Each of the following could be a source of error when weighing an infant and plotting the weight measurement:

- scale not zero balanced,

- infant/child not placed on the center of the scale,

- infant wearing heavy clothes or a wet or soiled diaper, or

- infant/child uncooperative.

264.2 Child and Adult Weight

Children can be weighed on the adult scales when they are 2 years of age. If the child is weighed by this method, be certain to use the growth charts for boys or girls 2-5 years of age. All women are weighed by this method.

The following tools are necessary to obtain and document child or adult weight for computer plotted growth charts and weight gain grids.

- A balance beam scale with nondetachable weights (no bathroom scales or spring scales) or a medical grade adult digital scale

- A disposable pad or paper on the scale so that the child's or adult's feet do not directly touch the scale to prevent infection and decrease exposure to fungus, virus, bacteria, etc.

The following procedures must be used to obtain accurate weights using a balance beam scale:

- Zero balance the scale by bringing the main and fractional sliding beam weights directly over their respective zeros. Move the adjusting device until the balance indicator is centered. Zero balance the scale with the pad or paper on the scale.

- Have child or adult remove shoes and outer or bulky clothing. Have the diaper changed if wet or soiled.

- Have the participant stand on the center of the scale facing the beam in the middle of the scale.

- To read the scale, move the main sliding beam until it indicates too heavy, then move it back one notch. Move the weight on the fractional indicator back and forth until the indicator is centered.

- Record the weight to the nearest 1/4 pound on the growth chart. (1/4 pound = 4 oz.).

- It is recommended that the measurement be repeated to validate its accuracy. If the measurement differs by more than 1/4 pound, repeat the procedure.

- Return the sliding beams to zero. Always zero balance the scale before weighing another person.

Follow the manufacturer's instructions in order to obtain accurate measurements using a digital scale.

Each of the following could be a source of error when weighing a child or adult and plotting the weight measurement:

- Scale is not zero balanced,

- Heavy clothing, shoes, or a wet or soiled diaper are not removed,

- Participant is not centered on the scale, or

- Child is holding onto the scale.

264.3 Determining Weight of a Participant with a Missing Limb

- Weigh the individual.
- Document the physical problem on the prenatal grid, the Health History form or Nutrition Care Plan.

It is important to note that the growth percentiles for weight for height, weight for age, and Body Mass Index (BMI) will not be accurate. The individual must not be certified as underweight or risk of underweight, unless the condition can be documented by the individual's primary health care provider. Plotting the individual's weight gain over time will be useful in assessing growth.

264.4 Determining Weight for a Participant with a Cast

- Weigh the individual.
- Document the physical problem on the prenatal grid, the Health History form or Nutrition Care Plan.

It is important to note that the growth percentiles for weight for height, weight for age, and Body Mass Index (BMI) will not be accurate. The individual must not be certified as overweight or risk of overweight unless the condition can be documented by the individual's primary health care provider. Plotting the individual's weight gain over time will be useful in assessing growth.

264.5 Determining Weight for a Participant with a Physical Disability

Physically disabled children who are over two years of age or too heavy for the infant scale, and cannot be weighed by themselves on the adult scales may be weighed by having an adult hold them. The total weight for both persons is recorded. The adult is then weighed alone and his/her weight is subtracted from the combined weight. The remaining number represents the child's weight. Document the procedure used and the physical problem on the Nutrition Care Plan in the "Notes" section.

Physically disabled women who cannot be weighed in the WIC clinic, and for whom no current weight is available from a medical provider, cannot be certified for any weight-related risk code. The circumstances must be documented on the Nutrition Care Plan in the "Notes" section.

264.6 Head Circumference Measurement

Head circumference is a procedure used on infants from birth to 12 months of age as a screening measurement for nonnutrition related abnormalities (micro and macrocephaly).

Performance of this assessing measurement is at the discretion of the local project. The use of risk code 58, low head circumference, can be based on head circumference as measured by WIC project staff or based on information in a readily accessible medical chart or as self-reported by the caregiver.

The following tools are necessary to obtain and document head circumference for computer plotted head size.

- An insertion tape or disposable paper tape is needed to obtain a head circumference measurement (see Figure 264.6A)

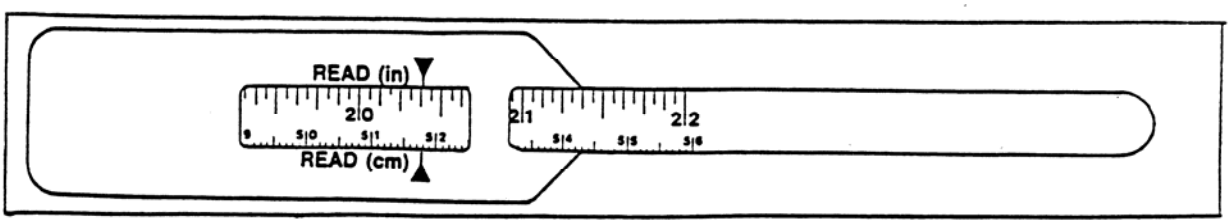


Figure 264.6A Insertion Tape

The following procedures must be used to obtain accurate measurement:

- Thread insertion tape before positioning it on the child's head by inserting the small or narrow end of the tape from the back or bottom side of the surface. Then thread through the second opening, going downward. Bring the tape upward through the third opening.

- The measurement can be taken with the infant lying down on his back or in the sitting position. If the child is restless, it may be necessary to hold the child's head while taking the measurement.

- Place the tape on the infant's head just above the edges of the eyebrows, above the ears, and over the fullest or most prominent portion of the back of the head.

- Position the tape so that you can read it on the side of the head. This gives a clear view of the position of the tape (See figure 264.6B). NOTE: Do not place the tape over ribbons, barrettes, pony tails or braids. These will distort the measurement.

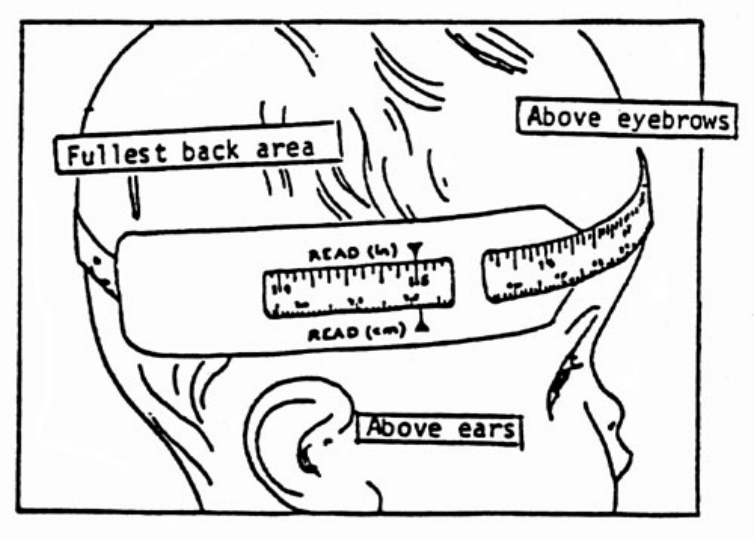


Figure 264.6B Positioning of Tape

- Pull the free end of the tape until it fits snugly around the head. Check to see that it is still properly positioned.

- Take the measurement reading by recording the number shown by the arrow point (See Figure 264.6C).

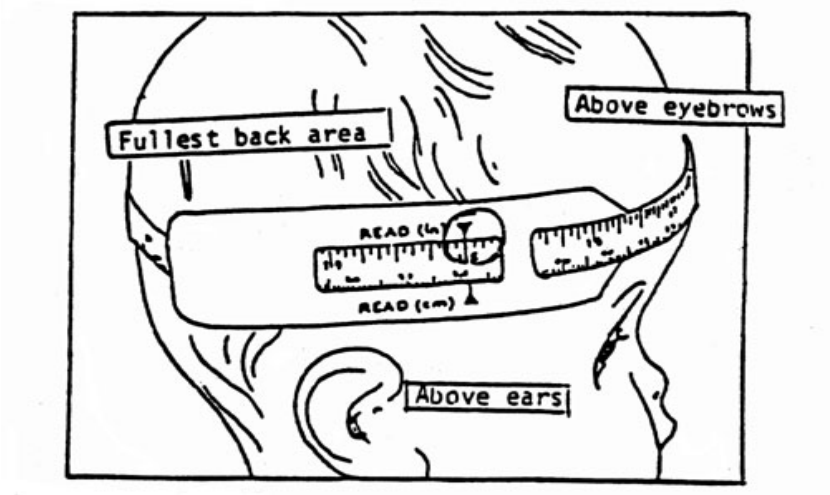


Figure 264.6C Reading the Tape

- Repeat the adjustment of the head circumference tape and remeasure until 2 readings agree within 2/16 of an inch.

- Record the confirming measurement on the WIC Health History Form. Record at 1/16 or 1/8 inch intervals (type of measuring tape determines inch increment intervals). Write values in inches and fractions of an inch for example, 13 11/16 or 15 5/8.

264.7 Body Mass Index

Body Mass Index (BMI) expresses the relationship between a person's standing weight and height. BMI is a measure that takes into account a person's weight and height to gauge total body fat in children and adults.

For WIC certification, a BMI of less than 19.8 for adult women is an indicator of underweight; a BMI equal to or more than 26.1 is an indicator of overweight.

As children grow, their body fatness changes over the years. The interpretation of BMI depends on the child's age. Additionally, girls and boys differ in their body fatness as they mature. Therefore, BMI for age is plotted according to sex-specific charts.

The following formula, the *CDC Tables for Calculated BMI Values for Selected Heights and Weights for Ages 2-20*, or the *Use and Interpretation of CDC Growth Charts* located on Appendix 200 can be used to determine children's and women's BMI.

Formula for determining BMI: Weight in pounds
Divided by height in inches
Divided by height in inches multiplied by 703

Example: 127 pounds, 5 feet 1 inch (61 in.) woman

127 lbs. divided by 61 in. divided by 61 in. X 703 = 23.9

265. Growth Chart Evaluation

Accurate height or length and weight measurements must be plotted correctly on the appropriate growth charts (the current CDC Growth Charts) before evaluating the data. Evaluation and determination of underweight, overweight, short stature or erratic pattern of growth can then be made. Short stature for an infant or child up to age two with a history of prematurity requires additional calculations of adjusted gestational age. See Calculating Gestation-Adjusted Age – Charts 248.1 and 249.1. The weight and height of an individual with a physical disability or congenital or metabolic disorder cannot be compared to the reference population. Therefore, the CDC growth charts will not be accurate. Sections 265.1 through 265.7 discuss the evaluation of growth charts for infants and children. Plotting the individual personal growth curve over a period of time is very helpful in assessing growth rate and providing appropriate nutrition counseling.

The WIC Certification System will plot the growth achieved through use of length or height, weight, date of visit, gender, and age entered as part of the certification process. BMI and Gestation-Adjusted Age are calculated as appropriate prior to plotting. The WIC Certification System uses plotting symbols (length or stature = **x**, weight = ●, AGA length = ■, and AGA weight = ♦) to assist the health professional's evaluation. Refer to the key on each growth chart. Staff is not required to print growth charts. Paper growth charts should only be used at clinics with no access to the WIC Certification System or in emergency situations when the WIC Certification System is not functioning. Blank growth charts are located in Appendix 200 and a few copies of each chart must be available in the clinic for emergency purposes.

265.1 Determination of Underweight

1. An infant or child (<2 years old) is considered underweight if the weight for length plots at or below the 2nd percentile on the age appropriate CDC Growth Chart for Boys or Girls (See Figure 265.1a)

Example: Length - 29 inches Weight - 16 pounds
Weight for length plots below the 2nd percentile.

2. A child (≥2 years old) is considered underweight if the BMI for age ≤5th percentile on CDC growth chart for Boys or Girls (See Figure 265.1b).

Example: BMI - 13 Age - 3 years
BMI for age plots below the 5th percentile.

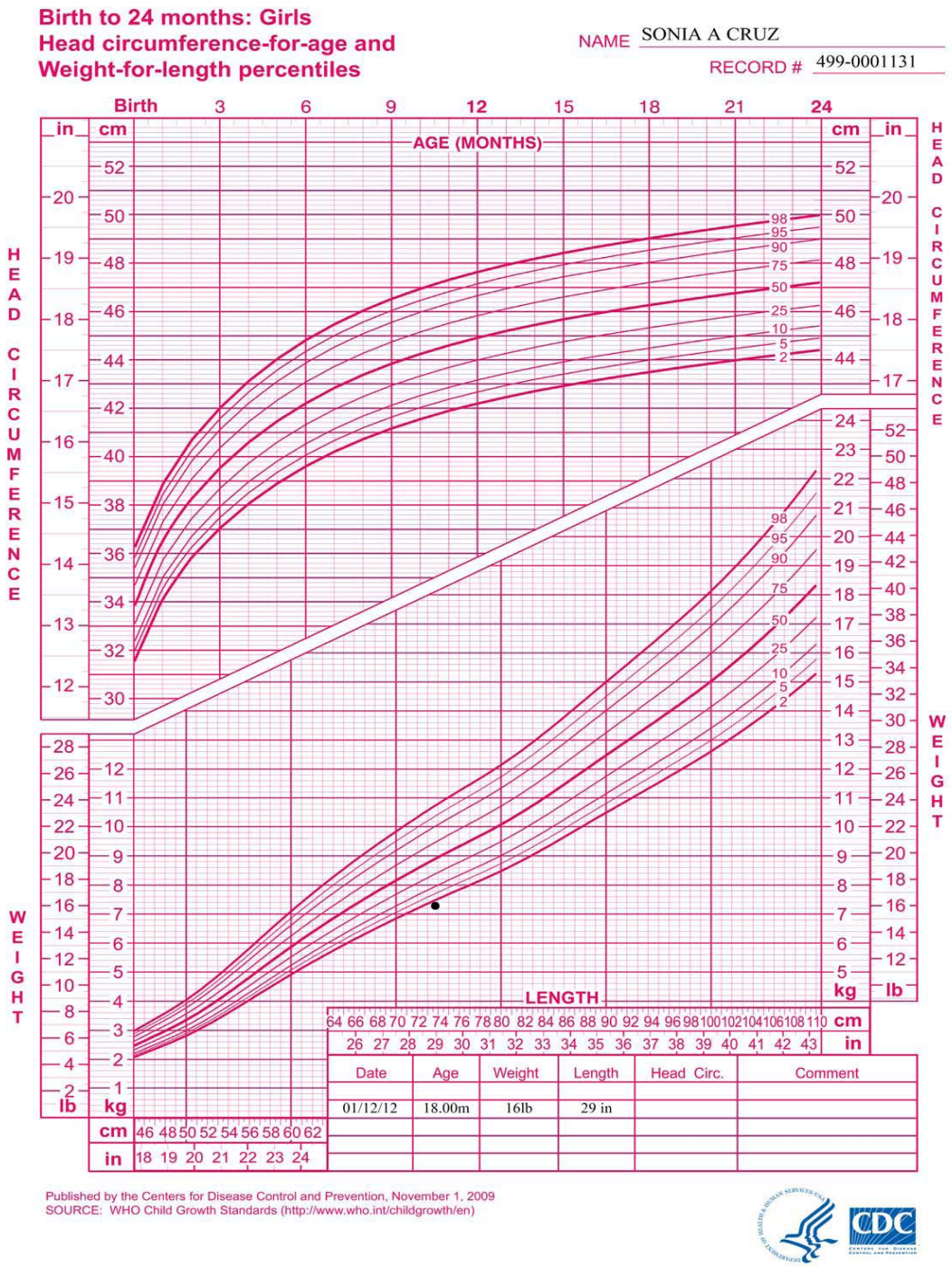


Figure 265.1a Plotting of Weight for Length for Determination of Underweight

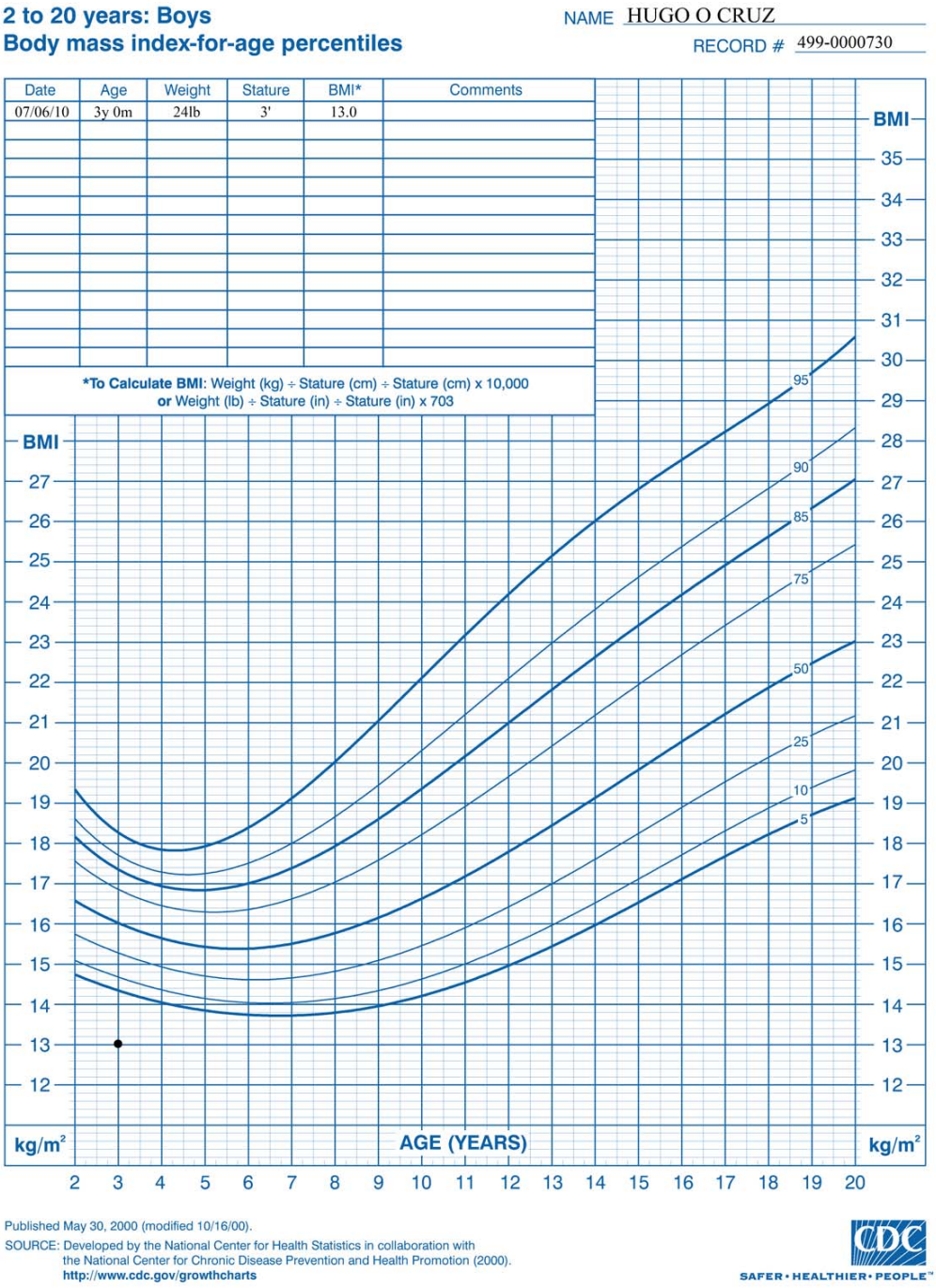


Figure 265.1b Plotting of BMI for Determination of Underweight

265.2 Determination of High Weight for Length/Height

1. An infant or child (< 2 years old) is considered high weight for length if the weight for length plots at or above the 98th percentile on the age appropriate CDC Growth Chart for Boys or Girls (See Figure 265.2a)

Example: Length - 35 inches Weight - 35 pounds
Weight for length plots above the 98th percentile.

2. A child (≥ 2 years old) is considered high weight for height if the BMI for age plots at or above the 95th percentile on the age appropriate CDC Growth Chart for Boys or Girls (See Figure 265.2b)

Example: BMI - 19 Age - 3
BMI for age plots above the 95th percentile.

265.3 Determination of At Risk for Growth Problems

1. At Risk for Short for Age

- An infant that plots at >2nd and ≤5th percentile length for age. (See Figure 265.3a)

Infant Example: Length - 26 inches Age - 9 months
Length plots on the 5th percentile.

- A child ≥ 12 months and < 24 months of age that plots at >2nd and ≤5th percentile length for age. (See Figure 265.3b)

Child Example: Length - 30 ½ inches Age - 18 months
Length plots between the 2nd and ≤5th percentile.

- A child 2 to 5 years of age that plots > 5th and ≤10th percentile height for age. (See Figure 265.3c)

Child Example: Height - 36 ½ inches Age - 3 years 8 months
Height plots >5th and ≤10th percentile.

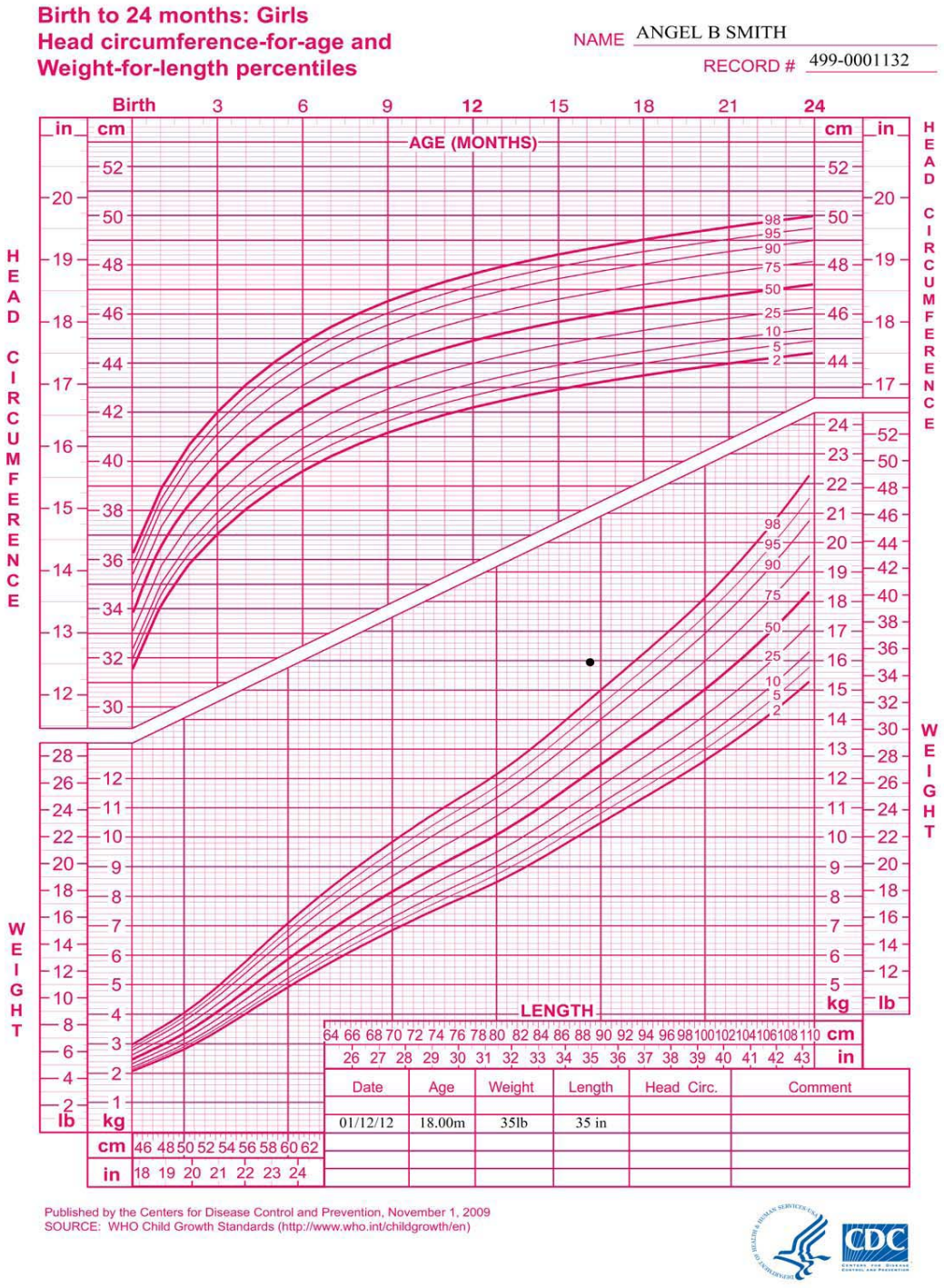


Figure 265.2a Plotting of Weight for Length for Determination of High Weight for Length

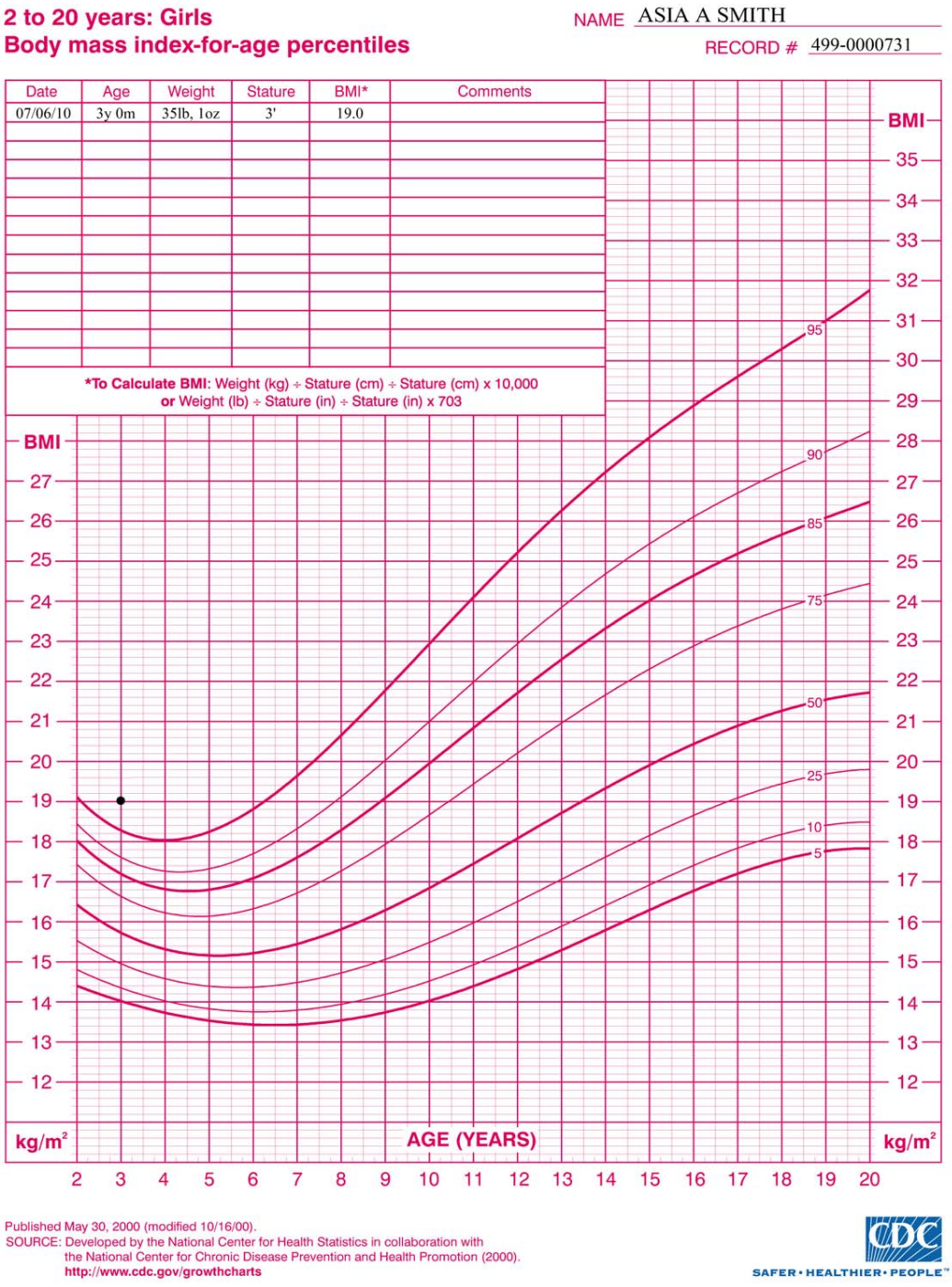


Figure 265.2b Plotting of BMI for Determination of High Weight for Height

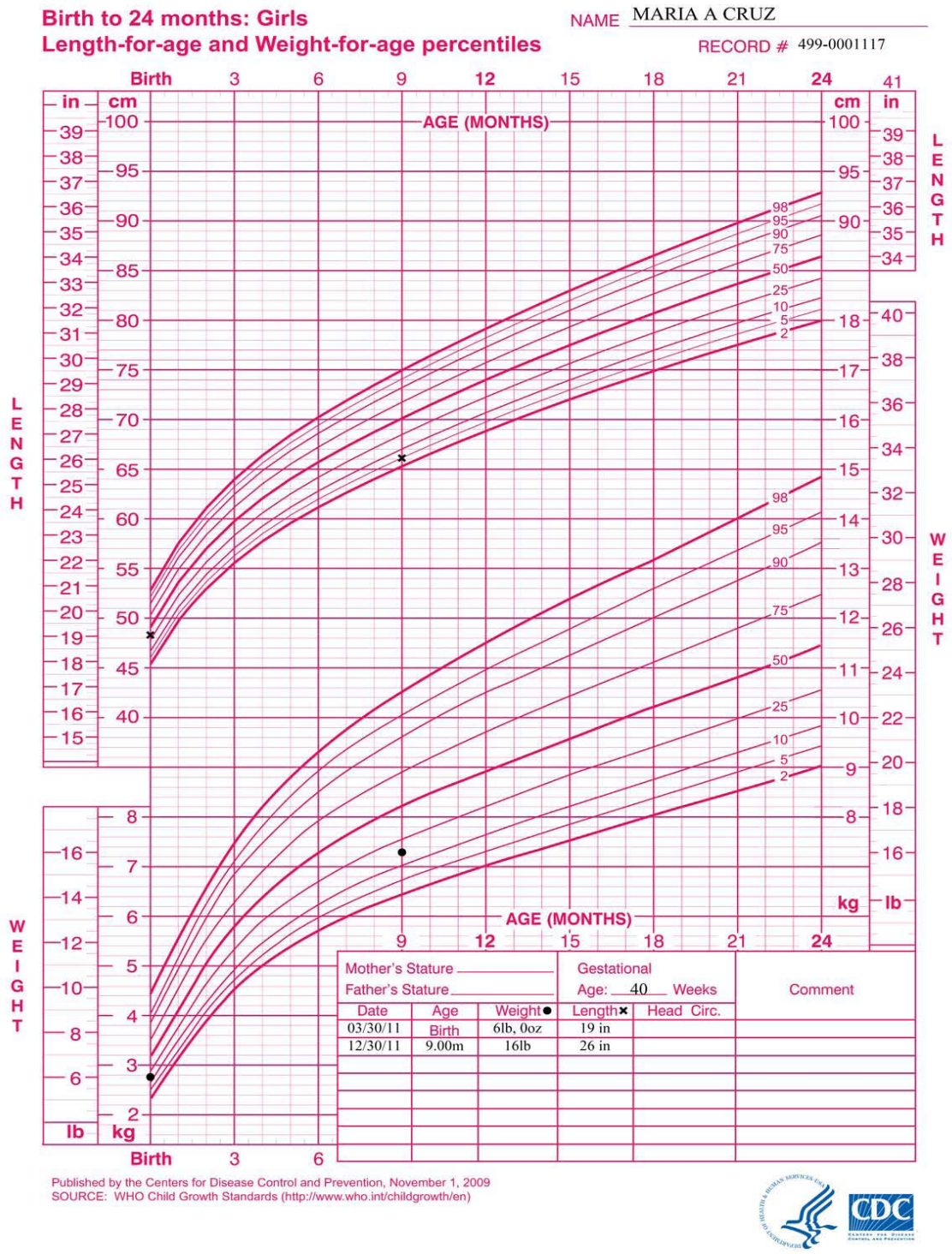


Figure 265.3a Plotting of Length for Age for Determination of At Risk for Short for Age (infant)

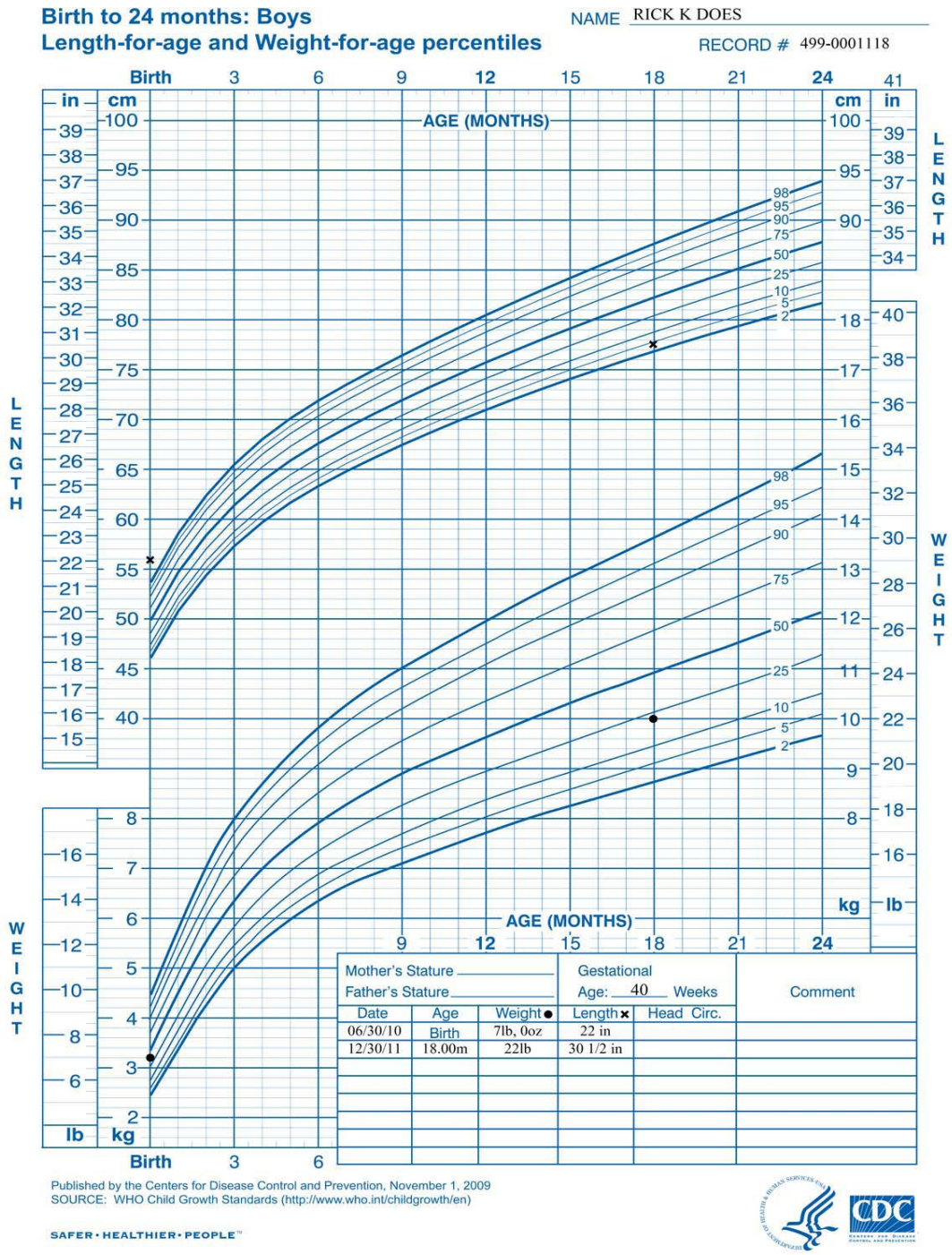


Figure 265.3b Plotting of Length for Age for Determination of At Risk for Short for Age (child 1 - <2years old)

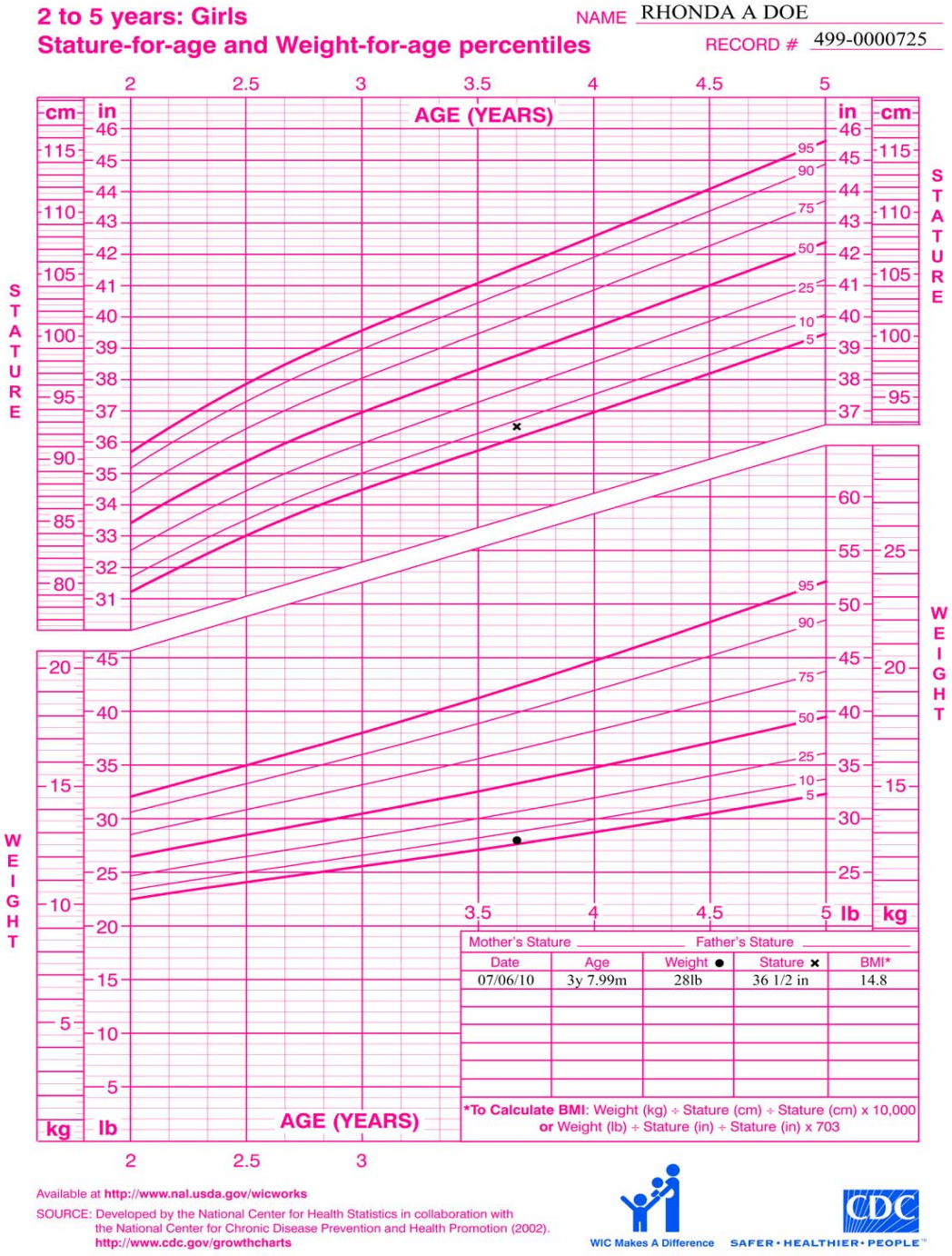


Figure 265.3c Plotting of Height for Determination of At Risk for Short for Age (child 2-5 years old)

2. At Risk for Underweight

- An infant that plots >2nd and ≤5th percentile weight for length (See Figure 265.3d.)

  Infant Example: Length - 24 inches Weight - 12 pounds
  Weight plots between 2nd and 5th percentile.

- A child ≥ 12 months and < 24 months of age that plots >2nd and ≤5th percentile weight for length (See Figure 265.3e.)

  Child Example: Length - 31 inches Weight - 19 3/4 pounds
  Weight plots at the 5th percentile.

- A child (2-5 years old) that plots at >5th and ≤10th percentile Body Mass Index (BMI) for age. (See Figure 265.3f.)

  Child Example: BMI - 14 Age - 4 ½ years old
  Weight plots between the 5th and 10th percentile.

3. At Risk for High Weight for Height

- A child ≥ 24 months of age and ≥ 85th and < 95th percentile BMI for age (See Figure 265.3g.)

Note: This determination does not apply to children with a recumbent length measurement since these recommended CDC cut-offs for BMI are based on standing height measurements.

Example: BMI - 18 Age - 3 years
BMI for age plots between 85th and 95th percentiles.

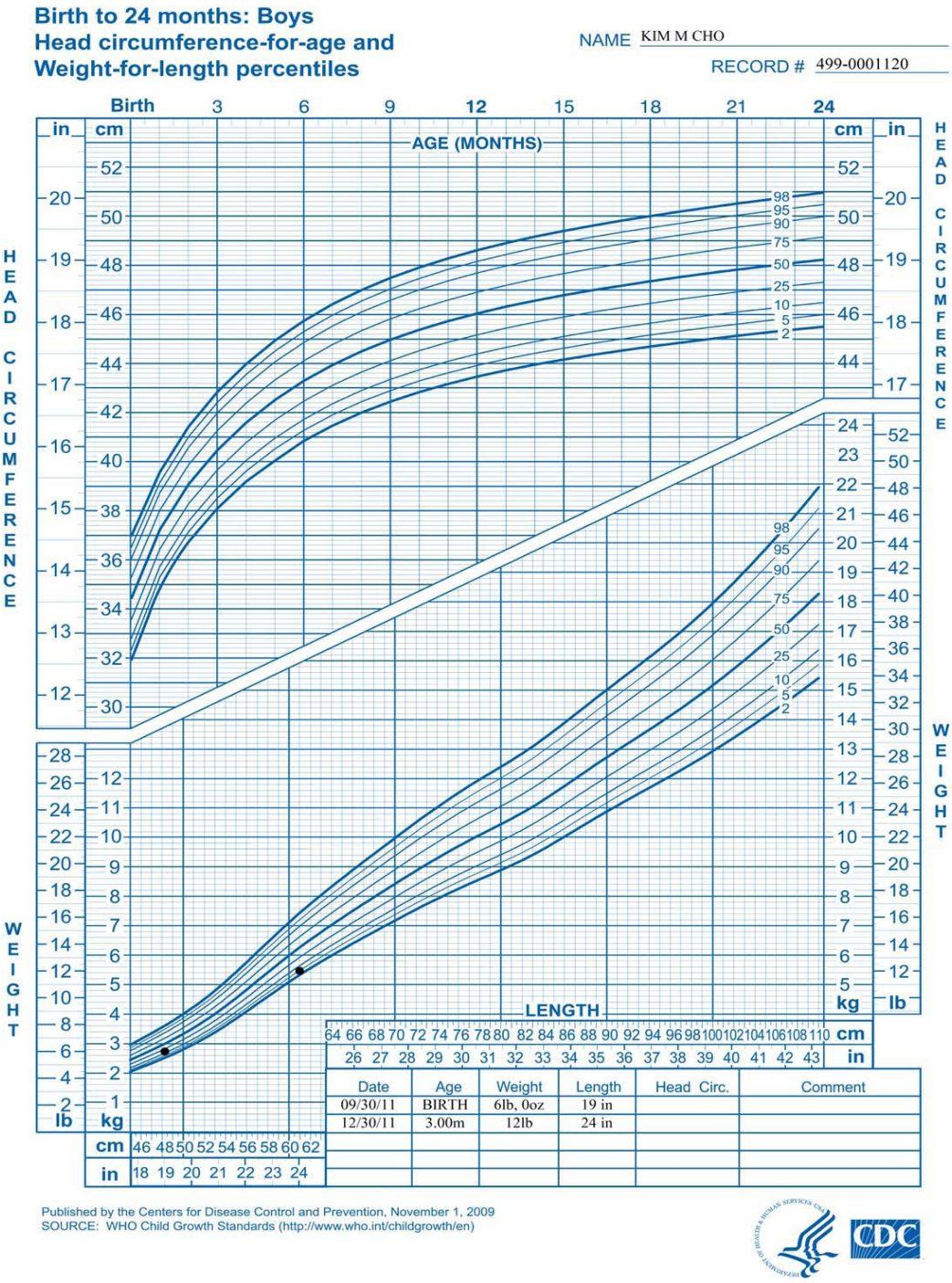


Figure 265.3d Plotting of Weight for Length for Determination of At Risk for Underweight (infant)

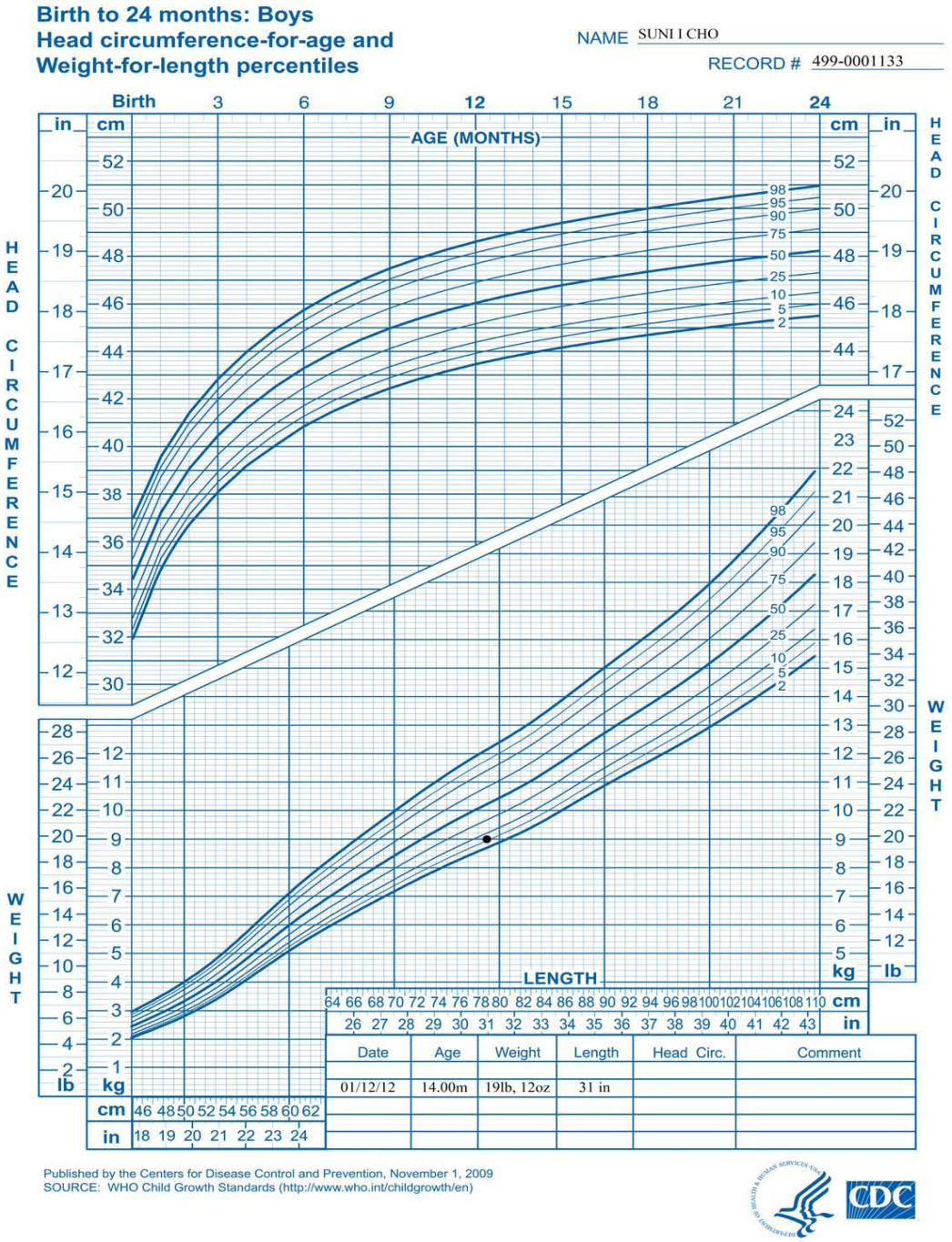


Figure 265.3e Plotting of Weight for Length for Determination of At Risk for Underweight (child 1 - <2 years old)

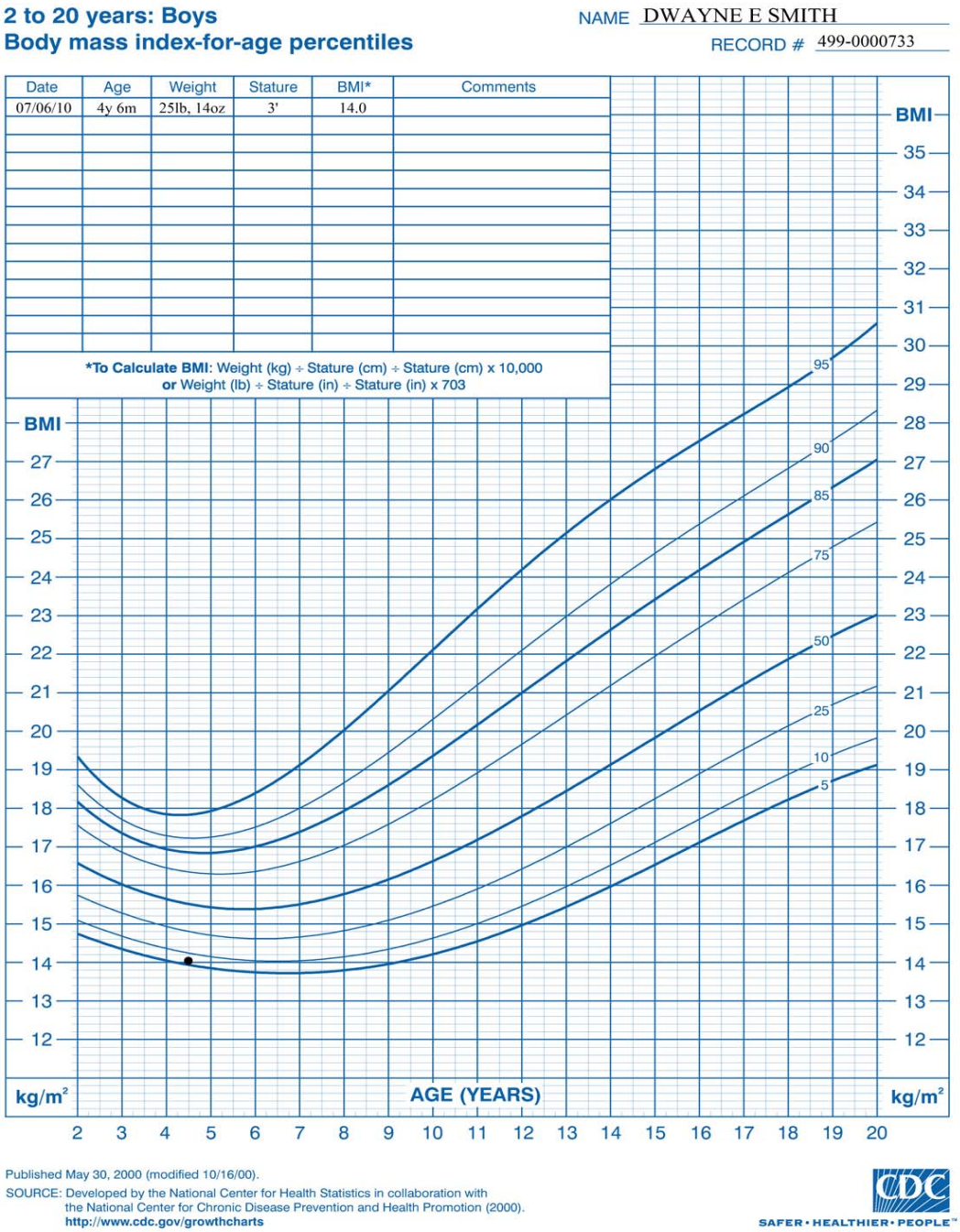


Figure 265.3f Plotting of BMI for Determination of At Risk for Underweight (child 2-5 years old)

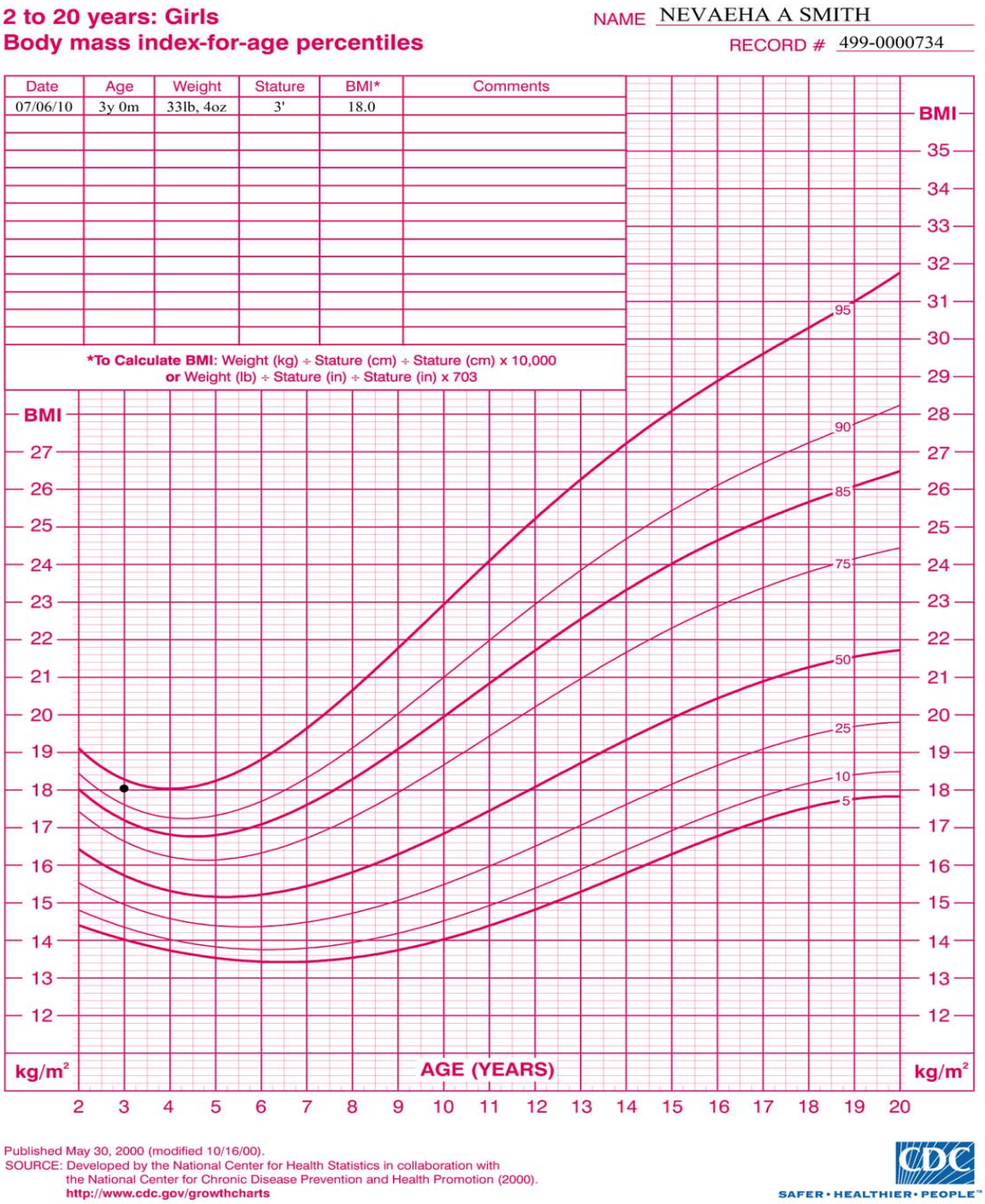


Figure 265.3g Plotting of BMI for Determination of At Risk for High Weight for Height

265.4 Determination of Shortness (Short for Age)

- An infant that plots ≤2nd percentile length for age on the CDC growth charts for boys and girls. (See Figure 265.4a.)

Infant Example Length - 26 inches Age – 9 months
Length plots below the 2nd percentile

- A child (≥12 months and <24 months old) that plots ≤2nd percentile length for age on the CDC growth charts for boys and girls. (See Figure 265.4b.)

Child Example Length – 29 inches Age – 18 months
Length plots below the 2nd percentile

- A child (2-5 years old) that plots ≤5th percentile on the CDC growth charts for boys and girls. (See Figure 265.4c.)

Child Example: Height - 34 inches Age - 3 years old
Height plots below the 5th percentile

Premature examples:

a. Randy Length - 18 inches Chronological age - 1 week
Gestational age - 30 weeks
Calculations: 40 (term) weeks – 30 (gestational age) weeks = 10 weeks
1 week (chronological age) – 10 weeks = -9 weeks
Randy cannot be plotted on the growth chart (See Figure 265.4d). Note that the computer does not print "plotted" on the legend to indicate this situation. (The risk code *cannot* be assigned since the information cannot be extrapolated on the chart.)

b. Roger Length - 27 ¾ inches Chronological Age - 62 weeks (14 ½ months)
Gestational age - 30 weeks
Calculations: 14 ½ months = 52 weeks (1 year) + 10 weeks (2 ½ months)
(use 52 weeks for whole years and 4 weeks/month)
40 (term) weeks – 30 (gestational age) weeks = 10 weeks
62 weeks (chronological age) – 10 weeks = 52 weeks
Roger plots on the 2nd percentile (See Figure 265.4e). Note that the computer prints "plotted" on the legend in this example. Risk code 52 must be assigned.

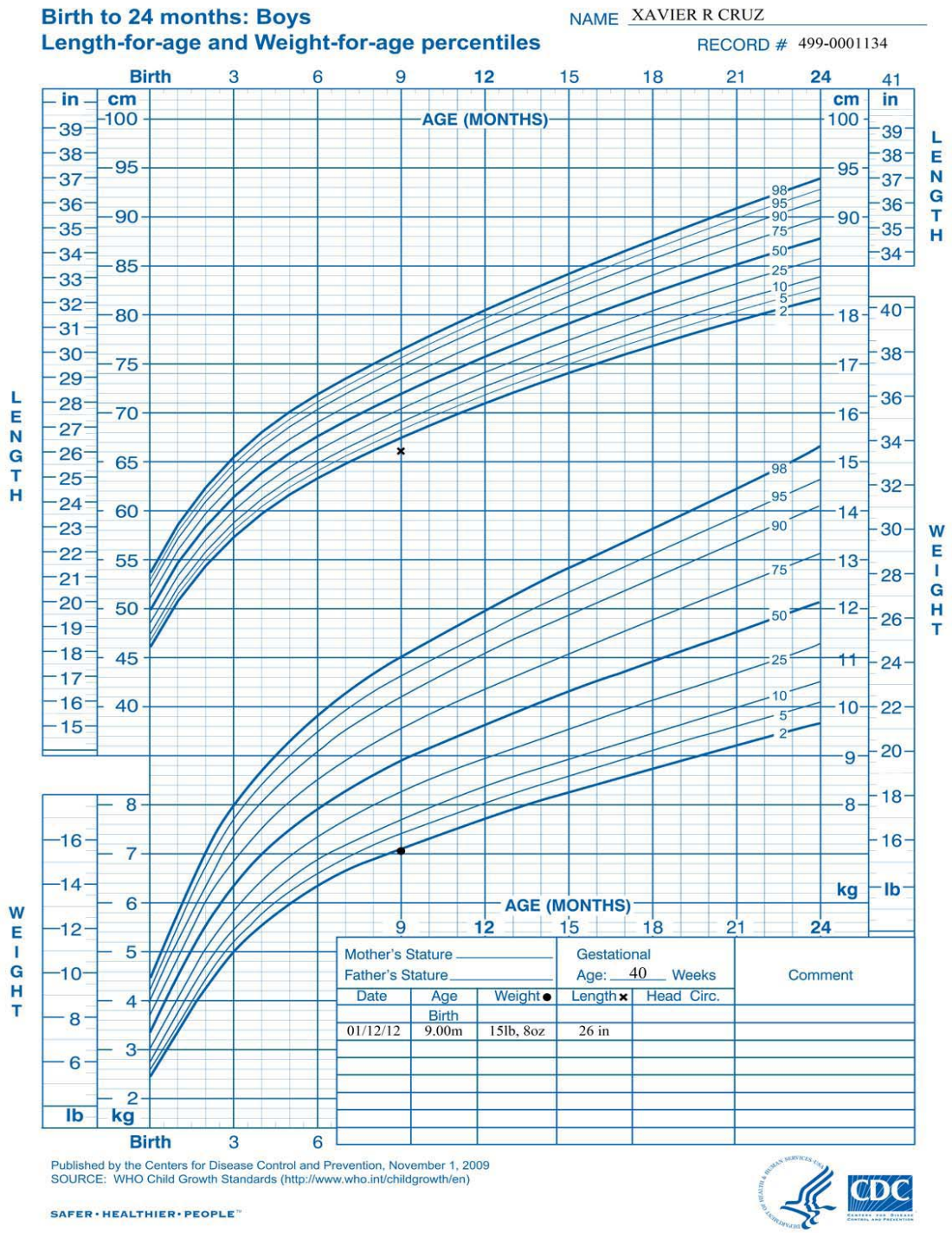


Figure 265.4a: Plotting of Length for Determination of Short for Age (infant)

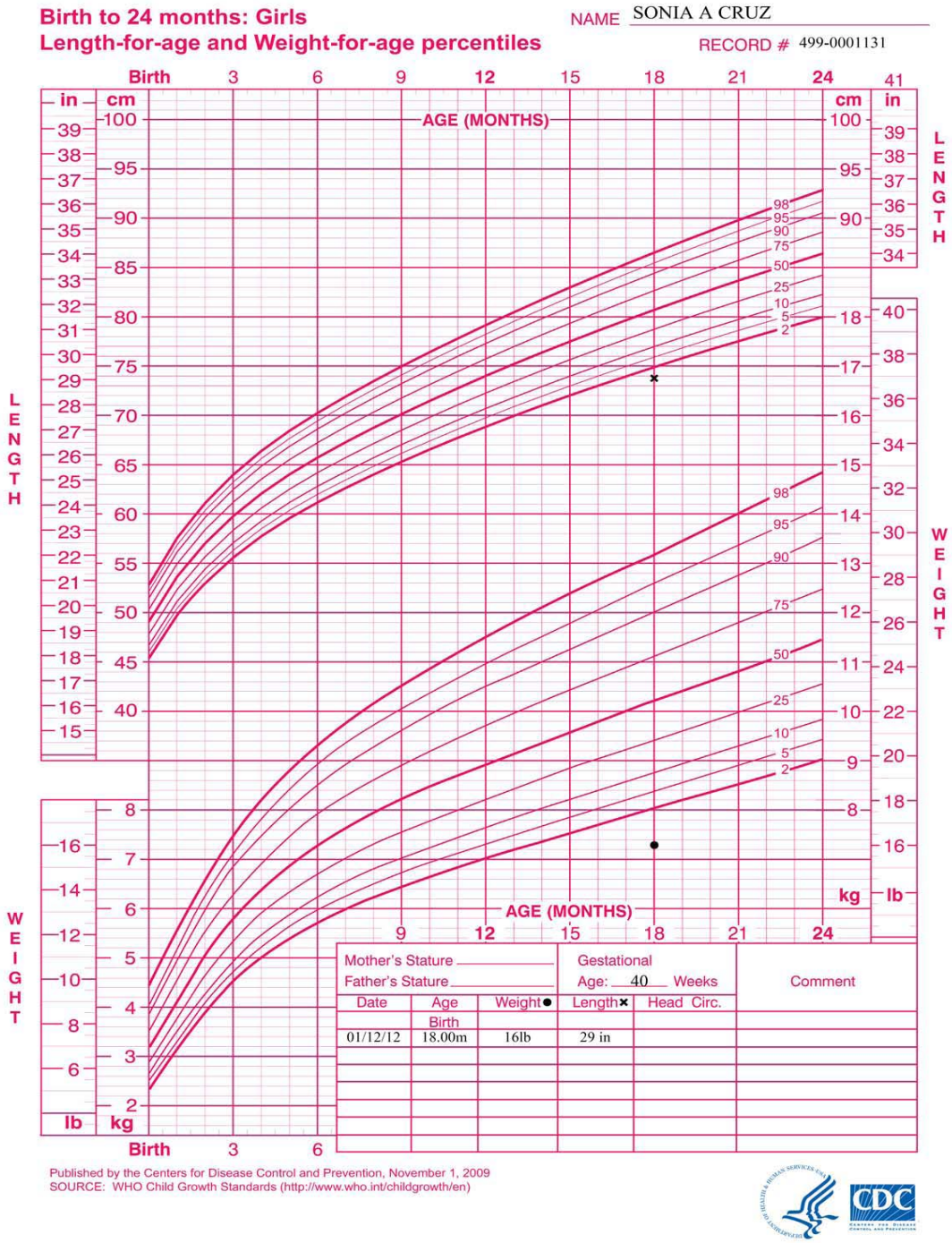


Figure 265.4b: Plotting of Length for Determination of Short for Age (child 1 - <2 yrs. old)

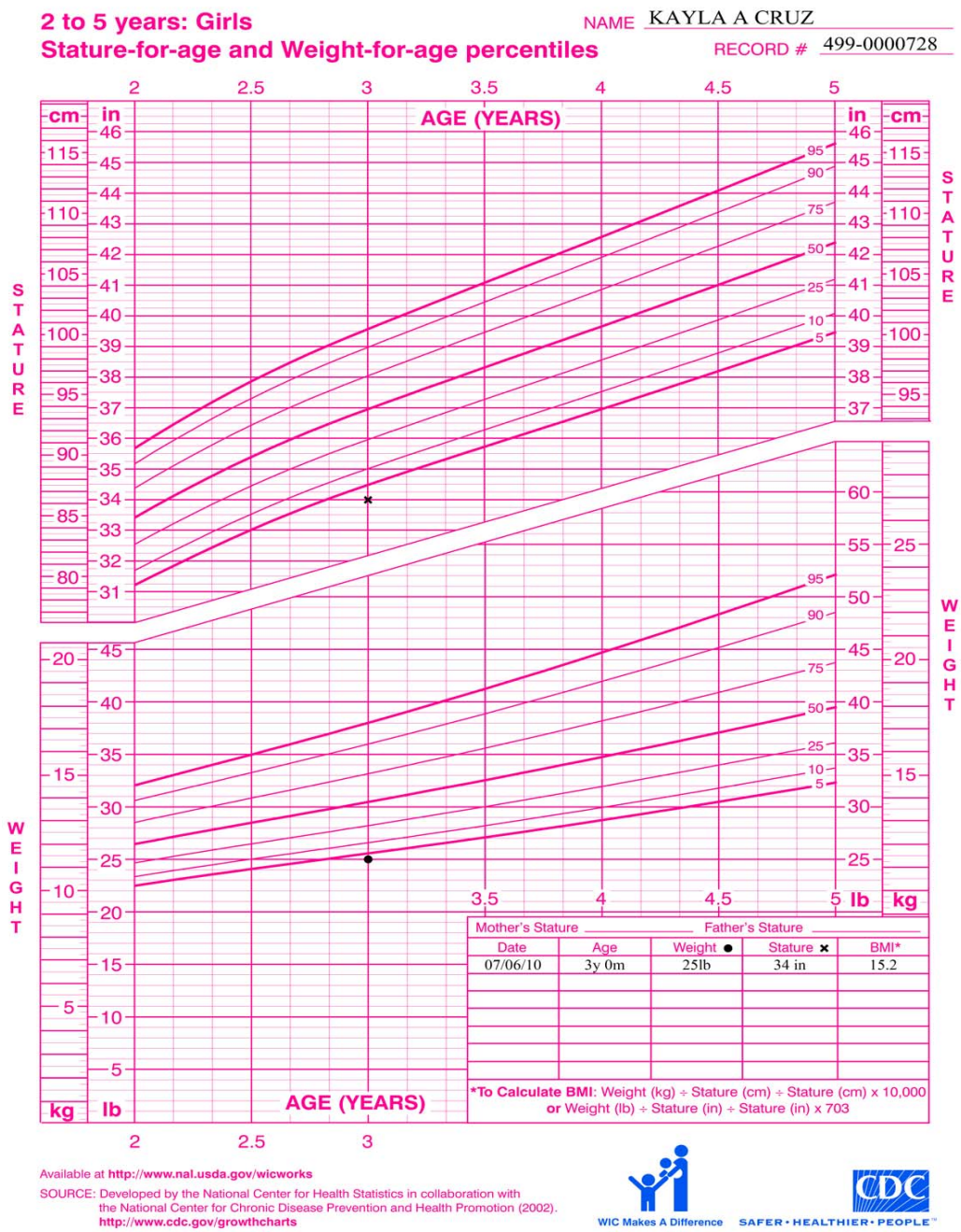


Figure 265.4c: Plotting of Height for Determination of Short for Age (child 2-5 yrs. old)

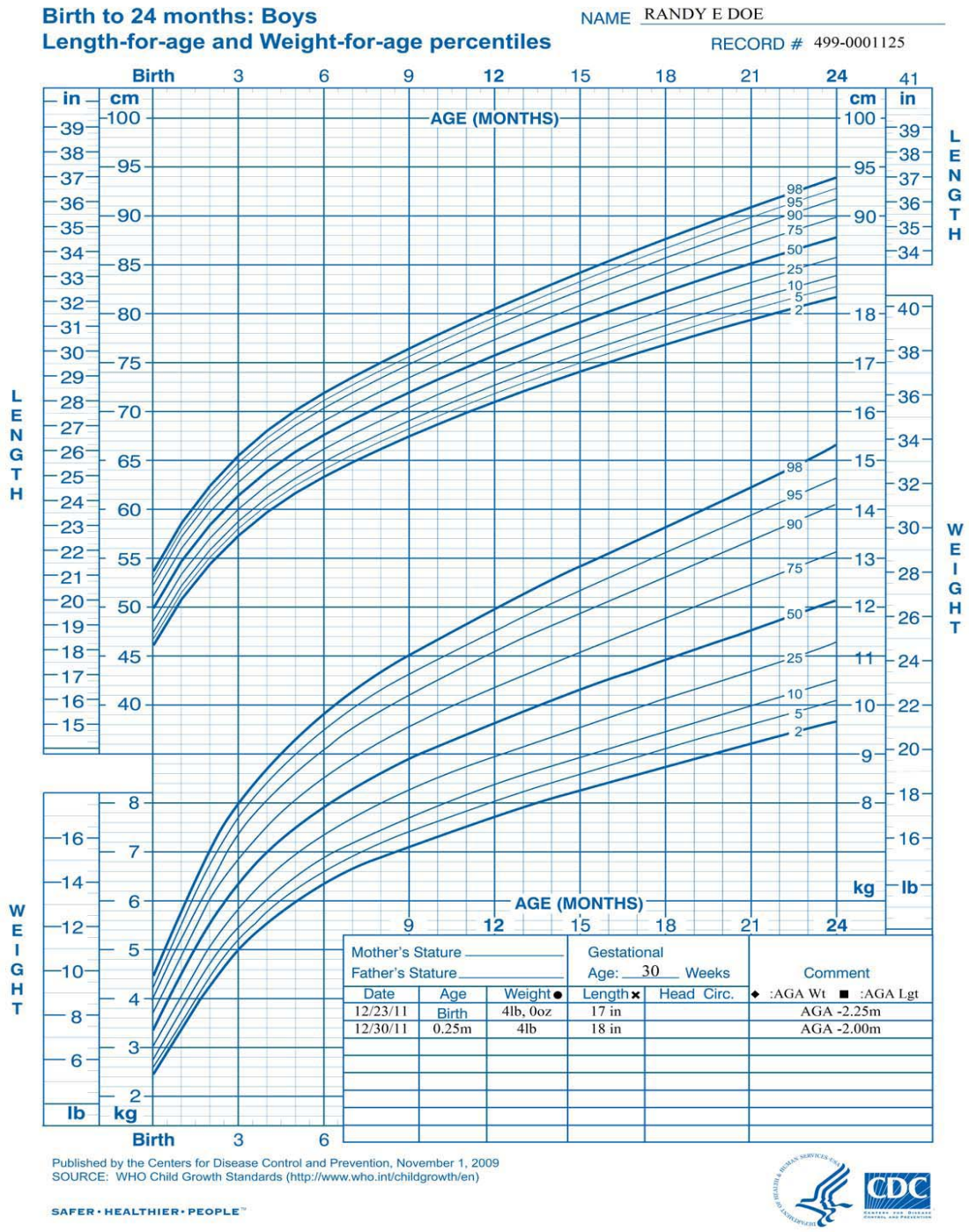


Figure 265.4d Randy's Growth Chart

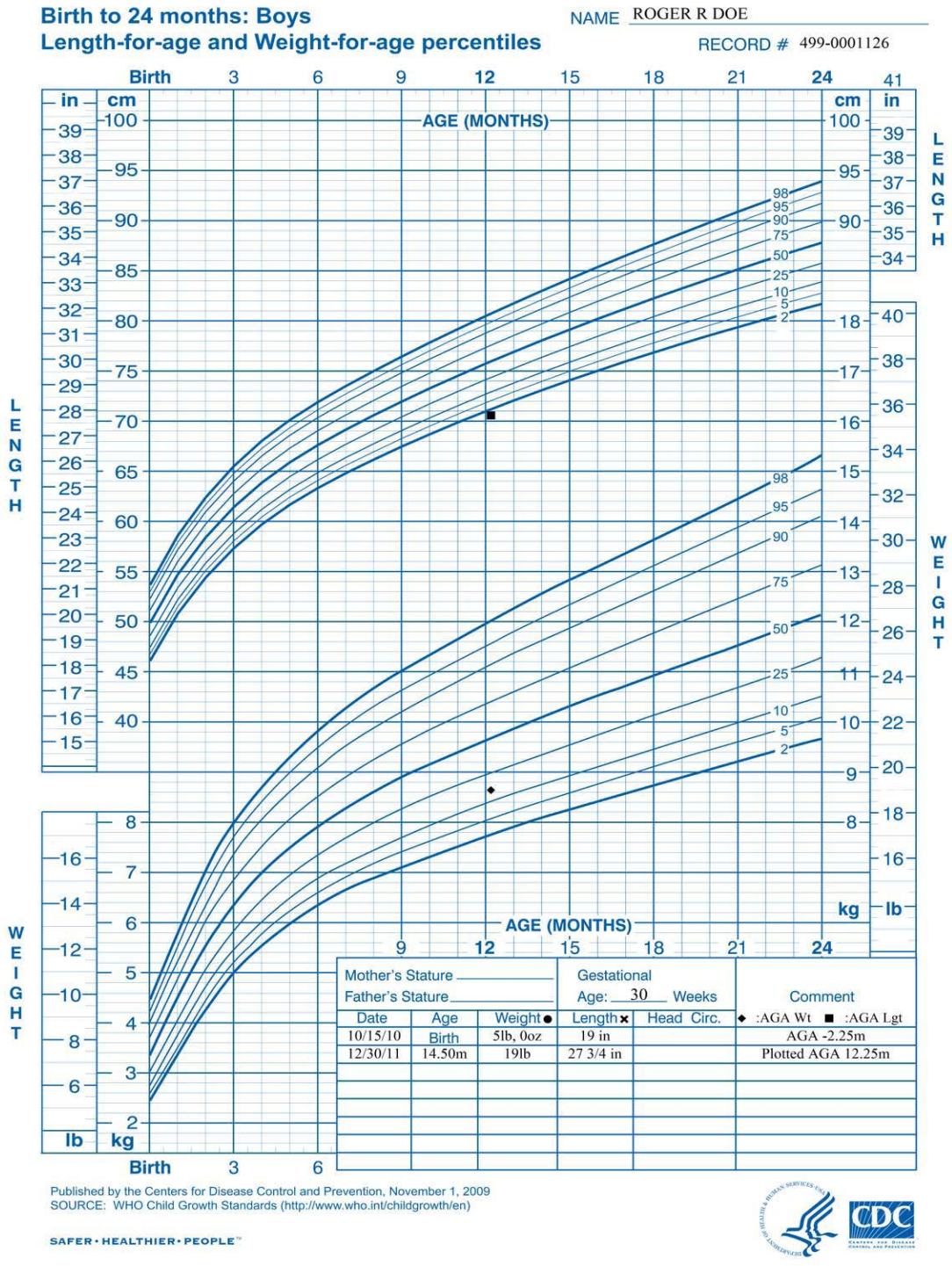


Figure 265.4e Roger's Growth Chart Demonstrating Short for Age

265.5 Use of Special Growth Charts for Premature Infants

A number of growth charts have been developed for monitoring growth of infants born of varying gestational age and for those weighing less than 2.5 kilograms (5.5 pounds). These special charts are used in the hospital setting. In actual clinical practice, the CDC Growth Charts plotted with corrected age are used to follow the growth of preterm infants. See the following link: http://depts.washington.edu/growing/Assess/Grgrids.htm

Recommendations for how long to correct vary from 1-3 years of age. The WIC Certification System uses AGA plotted values (up to 24 months) on the CDC growth charts and health professionals assess this growth chart when certifying premature infants.

A low birth weight infant will usually plot below normal limits. Although below the 10th or 5th percentiles, growth should maintain a steady curve. It is not until the second or third year that these children will catch up to their born-of-average-weight peers.

265.6 Additional Information Concerning Automated Growth Charts

The following information may be useful to health professionals.

- The system plots more accurately (¼ months versus ½ months) than the age listed on the WIC Certification System screen. (The growth chart programming is separate from the WIC Certification System screen.)
- Once staff has entered how many weeks premature, the data does not need to be reentered at next visit unless the information has changed. (The box appears white until staff tab by it.)
- The system calculates AGA up to 24 months to ensure that very premature babies are followed for adequate growth.
- If participant values cannot be plotted, the word “plotted” will not appear in front of the AGA information on the growth chart. An asterisk (*) will appear next to the value.

- If a value plots inside of the legend, the dot will change color to either red (boys) or blue (girls).

- The system will attempt to plot any information that is placed in the birth weight and length fields. If the data is unknown, leave these fields blank.

- The system plots infants and children (<2 years old) on the CDC Birth to 24 Months growth charts assuming recumbent length is measured. The system plots children 2-5 years old on the CDC BMI growth charts assuming standing height is measured. Growth chart evaluation, risk code determination, and nutrition assessment must be made using the appropriate growth chart based on whether a length or height measurement was made. Health professionals should document on the Nutrition Care Plan if an older child (2-5 years old) was measured recumbent. In such rare situations, anthropometric risk codes cannot be assigned.

- To reduce wait time, staff can minimize the growth chart page and work on another tab while the WIC Certification System is plotting anthropometric data.

- The growth chart default zoom setting is for 150% and shows the topmost part of each growth chart. Staff may use the scroll bar to move the view down the page or change the zoom settings.

266. Weight Evaluations for Women

Body Mass Index (BMI) is used to evaluate weight status for prenatal, postpartum and breastfeeding women. BMI Table for Determining Weight Classification for Women, Table 266, is to be used for women of all ages. The table identifies weight at < 18.5 as underweight, 18.5-24.9 as normal weight, 25.0-29.9 as overweight and ≥ 30.0 as obese. For prenatal women, the WIC Certification System calculates the BMI from entered anthropometric data, determines weight classification, and plots the prenatal weight gain. WIC staff must print and maintain in the chart a current copy of the Prenatal Weight Gain Chart.

266.1 Using the BMI Table for Determining Weight Classification for Women

A woman's prepregnancy and postpartum BMI is determined using the BMI Table for Determining Weight Classification for Women, Table 266. Determination requires completion of the following steps:

- Weigh the woman without her shoes and heavy clothing according to the procedures in the section headed "Techniques for Determining Weight."
- Measure the woman's height according to the procedures in the section headed "Techniques for Height and Length Measurement."
- Find the woman's actual height along the left side of the table. For height measurements of ½ inch or greater, use the next whole inch. For height measurements of less than ½ inch, use the lower inch.
- Find the woman's weight or the range within which her weight falls in. For weights greater than or equal to ½ pound, use the next whole pound. For weights less than ½ pound, use the lower pound weight.
- The column heading above this weight or weight range identifies the woman's weight status.

BMI Table for Determining Weight Classification for Women (1)

Height (Inches)	Underweight BMI <18.5	Normal Weight BMI 18.5-24.9	Overweight BMI 25.0-29.9	Obese BMI ≥30.0
48”	<60 lbs	60-82 lbs	83-98 lbs	> 98 lbs
49”	<63 lbs	63-85 lbs	86-102 lbs	>102 lbs
50”	<65 lbs	65-89 lbs	90-106 lbs	>106 lbs
51”	<68 lbs	68-92 lbs	93-111 lbs	>111 lbs
52”	<71 lbs	71-96 lbs	97-115 lbs	>115 lbs
53”	<74 lbs	74-100 lbs	101-119 lbs	>119 lbs
54”	<76 lbs	76-103 lbs	104-124 lbs	>124 lbs
55”	<79 lbs	79-107 lbs	108-129 lbs	>129 lbs
56”	<82 lbs	82-111 lbs	112-133 lbs	>133 lbs
57”	<85 lbs	85-115 lbs	116-138 lbs	>138 lbs
58”	<89 lbs	89-118 lbs	119-142 lbs	>142 lbs
59”	<92 lbs	92-123 lbs	124-147 lbs	>147 lbs
60”	<95 lbs	95-127 lbs	128-152 lbs	>152 lbs
61”	<98 lbs	98-131 lbs	132-157 lbs	>157 lbs
62”	<101 lbs	101-135 lbs	136-163 lbs	>163 lbs
63”	<105 lbs	105-140 lbs	141-168 lbs	>168 lbs
64”	<108 lbs	108-144 lbs	145-173 lbs	>173 lbs
65”	<111 lbs	111-149 lbs	150-179 lbs	>179 lbs
66”	<115 lbs	115-154 lbs	155-185 lbs	>185 lbs
67”	<118 lbs	118-158 lbs	159-190 lbs	>190 lbs
68”	<122 lbs	122-163 lbs	164-196 lbs	>196 lbs
69”	<125 lbs	125-168 lbs	169-202 lbs	>202 lbs
70”	<129 lbs	129-173 lbs	174-208 lbs	>208 lbs
71”	<133 lbs	133-178 lbs	179-214 lbs	>214 lbs
72”	<137 lbs	137-183 lbs	184-220 lbs	>220 lbs
73”	<139 lbs	139-189 lbs	190-227 lbs	>227 lbs
74”	<143 lbs	143-194 lbs	195-233 lbs	>233 lbs
75”	<147 lbs	147-199 lbs	200-239 lbs	>239 lbs
76”	<151 lbs	151-205 lbs	206-246 lbs	>246 lbs
77”	<155 lbs	155-210 lbs	211-252 lbs	>252 lbs
78”	<159 lbs	159-216 lbs	217-259 lbs	>259 lbs
79”	<163 lbs	163-221 lbs	222-265 lbs	>265 lbs
80”	<168 lbs	168-227 lbs	228-272 lbs	>272 lbs
81”	<172 lbs	172-232 lbs	233-279 lbs	>279 lbs
82”	<176 lbs	176-238 lbs	239-286 lbs	>286 lbs
83”	<180 lbs	180-244 lbs	245-293 lbs	>293 lbs
84”	<185 lbs	185-250 lbs	251-300 lbs	>300 lbs

(1) Adapted from the Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults. National Heart, Lung and Blood Institute (NHLBI), National Institutes of Health (NIH). NIH Publication No. 98-4083.

TABLE 266

266.2 Prenatal Weight Gain Chart

The purpose of the Prenatal Weight Gain Chart is to compare a woman's actual weight gain during pregnancy to the desirable pattern of weight gain during pregnancy. The record may be shared with the participant and used as an effective counseling tool. The health professional assesses each pregnant woman's weight gain pattern and provides appropriate counseling, monitoring and referral.

A Prenatal Weight Gain Chart must be printed at initial certification and filed in the participant's chart. If the woman receives an additional weight check during her certification period, staff is to enter the information into the system as a "K" appointment, hand record on the previous weight gain chart or print out the most current update to the weight gain chart, file the updated version and discard any outdated versions. Remember that anthropometric data must be "saved" before the system will be able to plot data. The system only plots for pregnant women and the Prenatal Weight Gain Chart is not "saved" for each pregnancy.

1) Selection of the Appropriate Weight Gain Chart

Selection of the appropriate weight gain chart is based on the woman's prepregnancy weight. Four different weight gain charts are available for use: the Prenatal Weight Gain Chart for underweight, normal weight, overweight, or obese women. The Prenatal Weight Gain Chart only shows the acceptable weight gain range for the woman's prepregnancy weight. See Figure 266.2A Example of determining appropriate weight gain chart.

2) Plotting Weight Gain on the Computer

The WIC Certification System will plot the weight gain achieved through use of the height, weight, pre-pregnancy weight, date of visit, and EDC date entered as part of the certification process. The WIC Certification System uses plotting symbols (underweight = ▲, normal weight = ●, overweight = **x**, and obese = ■) to emphasize the weight classification of the woman. The top of the Prenatal Weight Gain Chart provides the target weight gain range and the woman's weight classification. If an asterisk appears next to the weight, the weight loss or gain could not be plotted on the Prenatal Weight Gain Chart.

EXAMPLE 1:

Mary Beth is five feet tall (60 inches) and weighed 94 pounds prior to conception; therefore, according to the BMI Table for Determining Weight Classification for Women (Table 266), she was underweight. Since it is a singleton pregnancy, plot her prenatal weight gain on the Prenatal Weight Gain Chart - underweight (Figure 266.2A).

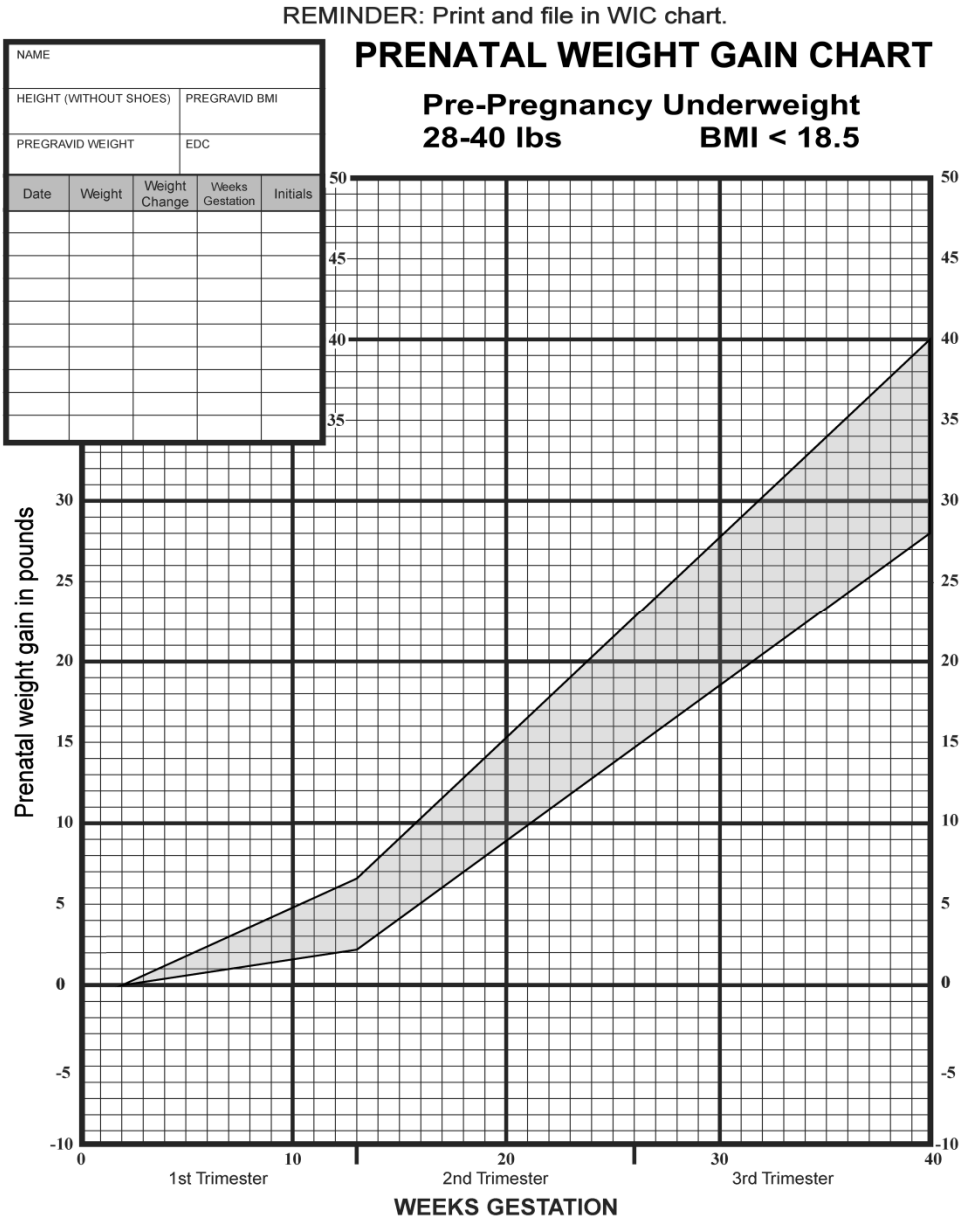


Figure 266.2A Example of determining appropriate weight gain chart.

- Repeat any weight measurement immediately if the grid shows a sharp increase or decrease in weight to rule out measuring error.

3) Plotting Weight Gain on Paper Prenatal Weight Gain Charts

Paper Prenatal Weight Gain Charts should only be used at clinics with no access to the WIC Certification System or in emergency situations when the WIC Certification System is not functioning. Blank Prenatal Weight Gain Charts are located in Appendix 200 and a few copies of each chart must be available in the clinic for emergency purposes.

Record the following information on the front of the form:

- The woman's name, height, pre-pregnancy weight, pre-pregnancy BMI (Pre-pregnancy weight is what the woman tells you she weighed before she became pregnant. This reported weight may or may not be accurate.)

- The EDD or EDC (Estimated Date of Delivery/Confinement). If the woman has not been given an EDD by her health care provider, ask whether she remembers the date that her last menstrual period started. Calculate delivery date by using a gestation wheel. Line up on the gestation wheel the date "last menses began" with the date she tells you. Read the EDD at the arrow.

- Weeks gestation at each visit. Using a gestation wheel, line up the EDD/EDC arrow with the woman's EDD/EDC. Locate today's date on the outer edge of the card, then find the weeks of pregnancy on the center part of the wheel.

- The woman's weight change. Subtract her pre-pregnancy weight in pounds from her present weight in pounds to determine weight change. Enter today's date, the woman's present weight and her weight change in the spaces provided and plot it on the chart. To plot the woman's weight gain or loss:

Find the weeks of pregnancy at the bottom of the grid. Using a plotting aid (ruler, right angle, Accuplot) line up the vertical (top to bottom) line with the woman's current week of pregnancy.

- Find the change in pound weight to date on the sides of the grid. Move the plotting aids up or down until the horizontal (left to right) line is lined up with the woman's change in pound to date. Always plot weight change from prepregnancy weight. Do not plot change from last visit.

- Mark the intersection with a dot.

- Repeat any weight measurement immediately if the grid shows a sharp increase or decrease in weight to rule out measuring error.

Figures 266.2B and 266.2C provide examples illustrating use of the chart to plot prenatal weight gain.

EXAMPLE 2:

Mary Beth, at a height of five feet (60 inches) and prepregnancy weight of 94 pounds is underweight. Her EDD is 12/25/10. Her weight, at her last visit on 6/26/10 was 97 pounds. Today (7/24/10) her weight is 99 pounds. According to the correctly recorded information below, Marybeth should be counseled on gaining weight at a rate of about 1 pound per week. Her most recent weight gain is slightly below the recommended range of weight gain for underweight women.

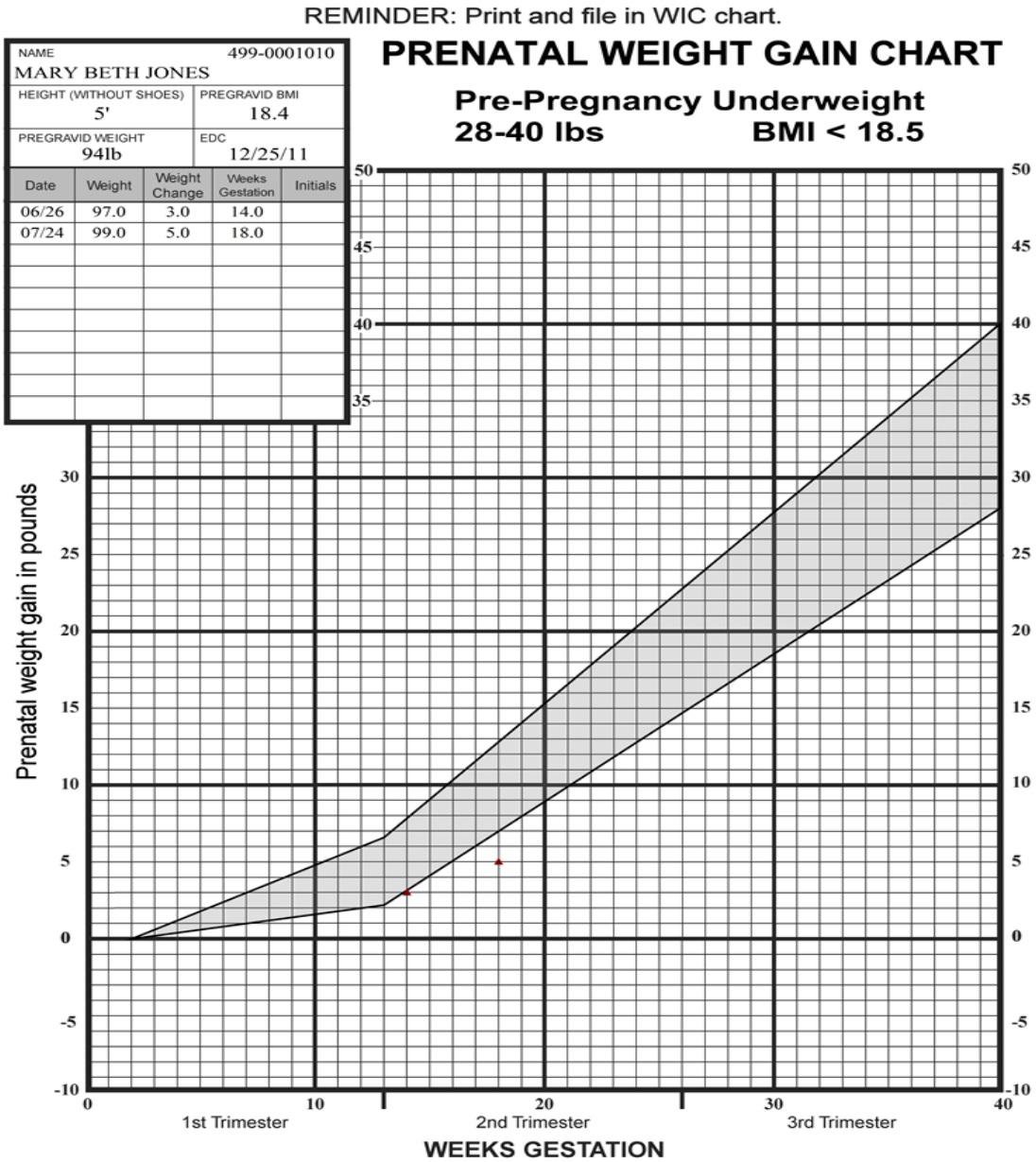


Figure 266.2B - Example of recording a woman's weight gain progress when her EDD and prepregnancy weight is known.

EXAMPLE 3

Roberta, at a height of 65 inches, current weight of 176 pounds and a prepregnancy weight of 160 pounds, is overweight. Since she has only a positive pregnancy test verified by a registered nurse from a crisis pregnancy center, her EDD is unknown. However, she reports the first day of her last menstrual period was 2/23/10. Therefore, her EDD according to the gestational wheel is 11/30/10. Today's date is 8/9/10 and she is 23 weeks gestation. According to the correctly plotted Prenatal Weight Gain Chart below, Roberta is above the recommended weight gain range for overweight women.

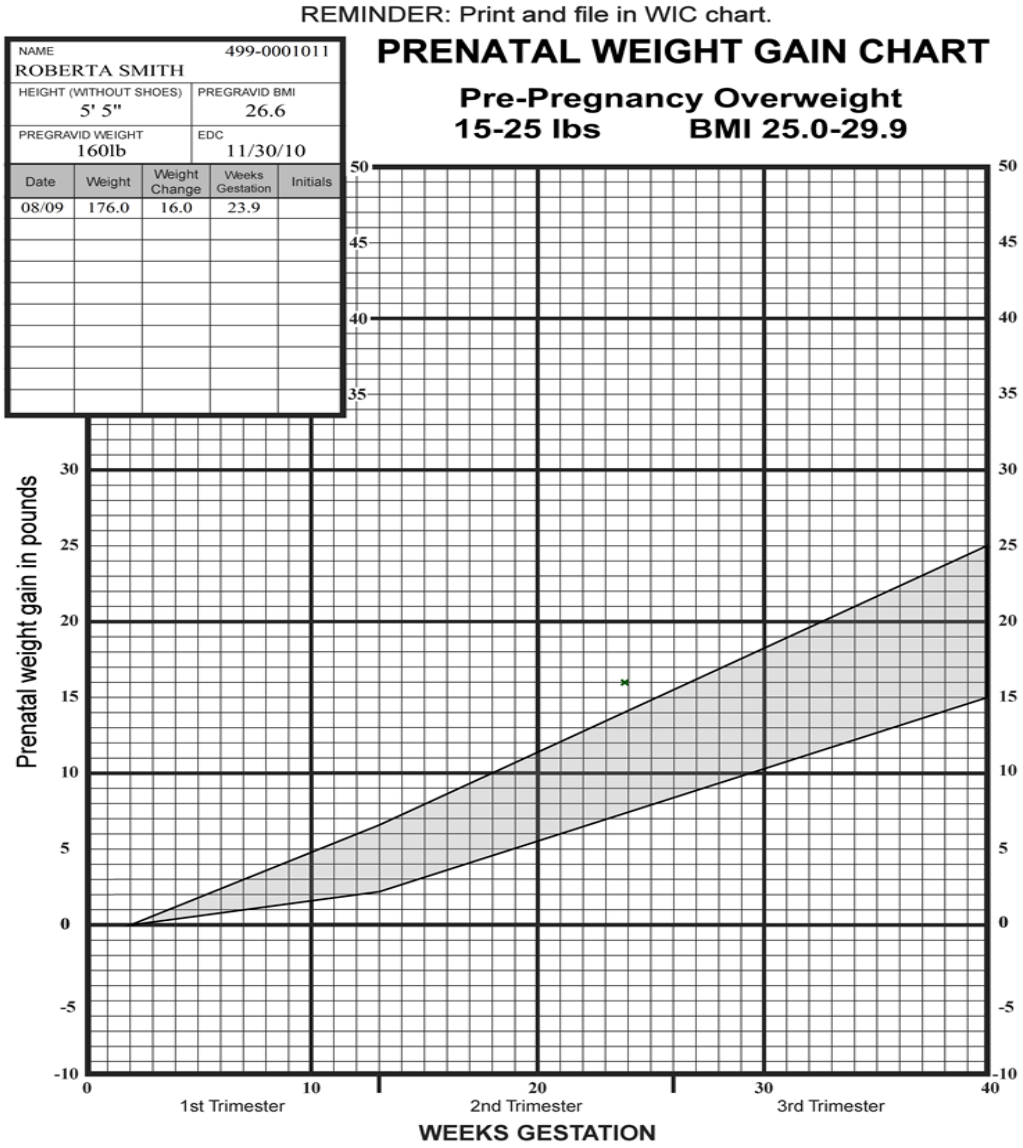


Figure 266.2C - Example of recording a woman's weight gain progress when her EDD is unknown.

4) Evaluation of Weight Gain

Evaluate the weight gain by determining whether the plotted points fall within the lines for acceptable range of weight gain. Health professionals should refer to the key on the top of the chart for assistance in review and assessment of the woman's weight classification and gain. The pattern of weight gain is more important than the total amount of weight gained during any trimester. Weight should show a steady increase. Any weight loss after the first trimester or rapid increase in weight signals a situation that needs closer evaluation regardless of the woman's weight status.

In general, the Institute of Medicine recommends the following weight gain patterns:

- For underweight and normal weight women: average 1 pound per week for each week of the second and third trimester.
- For overweight women: average .6 pound per week for each week of the second and third trimester.
- For obese women: average .5 pound per week for each week of the second and third trimester.

The 2009 IOM report provided provisional guidelines for twin gestations:

- Normal weight women: 37-54 pounds
- Overweight woman: 31-50 pounds
- Obese women: 25-42 pounds
- There is insufficient information to provide a provisional total weight gain for underweight women.
- A consistent 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.

The 2009 IOM report provided provisional guidelines for triplet gestations:

- Overall weight gain should be around 50 pounds with a steady rate of weight gain of approximately 1.5 pounds per week throughout the pregnancy.

267. Hematological Tests

A hematological test must be performed on WIC applicants as part of the minimum required health data. Staff must use the Hemocue Analyzer with infants and children less than 2 years old.

- Exceptions include religious or medical reasons and the WIC chart must contain either a statement of the applicant's refusal to have blood drawn for religious reasons or documentation from a physician. (Staff should enter "99" for the blood values in the WIC System.)

- If the medical condition is considered life long, such as hemophilia, a new statement from the physician is not necessary for subsequent certifications.

- An applicant refusing the hematocrit or hemoglobin test without citing a religious or medical reason will be denied WIC services.

- Exceptions and refusals should be minimal, once staff explains the non-invasive procedure.

- Blood values from physicians or other laboratories can be accepted, in lieu of WIC performing the hematological test, as long as the test was performed within 60 days of the certification appointment. Written documentation from a doctor or laboratory is preferred. Results obtained by phone from a doctor's office or laboratory are recorded on the Health History form or Nutrition Care Plan. Record the result, date the test was done, signature of staff receiving the results and date the verbal information was received.

Procedures for obtaining samples, performing hemoglobin tests, and maintaining and servicing equipment are outlined in Sections 267.1 through 267.2. Since all Ohio WIC clinics use the Masimo Pronto and HemoCue 201+ Analyzers, the procedures listed below reference using both of these analyzers. Additional details and trouble shooting for the analyzers can be found in the *Operating Manuals*.

Staff responsible for performing blood work must:

- have received formal training (registered nurse, licensed practical nurse, laboratory technician, or other trained paraprofessional)
- have been trained by one of the aforementioned or the State WIC office, or

- have been trained by a person who has received training from the State WIC office, and

- receive annual competency training and, at a minimum, documented semi-annual monitoring.

Tests are completed through use of a finger for the Masimo Pronto or finger or toe (infants) for the HemoCue 201+ Analyzers. Use the same procedures when using the toe as the following sections depict for use of a finger.

267.1 Procedures for Using Hematological Equipment

A. Masimo Pronto Analyzer

The Masimo Pronto hemoglobin system consists of a reusable finger sensor and a noninvasive pulse CO-Oximeter. The CO-Oximeter emits multiple light wavelengths through the finger sensor and provides a spot checking hemoglobin (SpHb). The reading is the result of light attenuation characteristics and proprietary algorithms.

1) Assembling the equipment: Masimo Pronto Analyzer, cable, sensor, and alcohol pads.

2) Preparing the finger: Massaging the finger and warming a cold finger increases blood flow. References to "you" or "your" refer to the staff person performing the following procedure:

a) With your thumb and index finger, grasp the individual's finger of either hand about 3 inches below the tip of the finger (see Figure 267.1A).

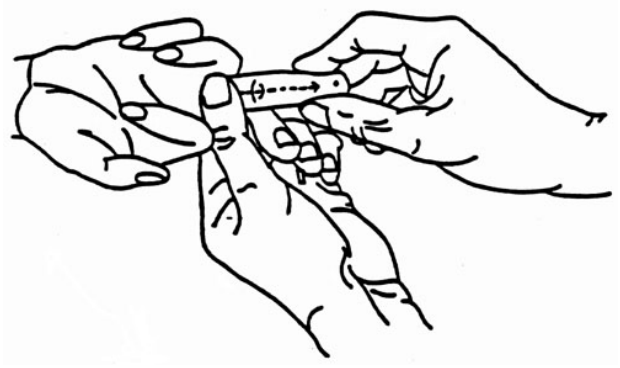


Figure 267.1A Massaging the finger

b) With your other hand, hold the sides of the individual's finger as illustrated.

c) Move your hand toward the top of the individual's finger applying a gentle massaging motion on the fleshy portion of the finger.

d) Repeat the massaging process 5 or 6 times.

e) With the alcohol pad, cleanse the finger, if it is excessively dirty.

f) Thoroughly dry the finger by either air drying or drying with a piece of gauze.

3) Taking second tests: Only one test is needed at each certification appointment. Staff may elect to retest a participant, if a very low or high hemoglobin value is obtained. If two samples are taken, place the higher of the two values in the WIC System on the visit tab. (acceptable variance of ±1.2) Since different body fluids/tissues are measured, do not compare Masimo Pronto and Hemocue 201+ results. Staff may note Masimo Pronto higher results especially late in pregnancy or postpartum due to the hormonal changes.

4) Positioning the participant:

a) Seat the adult or child where the heart to elbow to hand placement is level. A child can stand if the hand is on a flat surface.

b) Keep the arm in a relaxed position. The arm should not be reaching up, hanging down, or stiff.

c) Keep the sensor cord as straight as possible, running it up the back of the hand and lower arm.

d) Allow 6-8 inches of sensor cord to run up towards the heart.

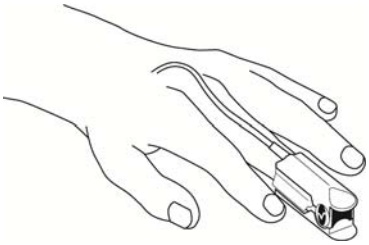


Figure 267.1B Placement of Sensor Cord

5) Processing and reading the specimen:

a) Use the correct size finger sensor. The pediatric sensor can be used for children and most women. The adult sensor is used when the woman's finger is too large for the pediatric sensor.

b) Place the finger sensor on the participant's finger of the nondominant hand, if easily available.
Adults: ring finger
Children: middle finger
Small Children: (2-3 years old) thumb

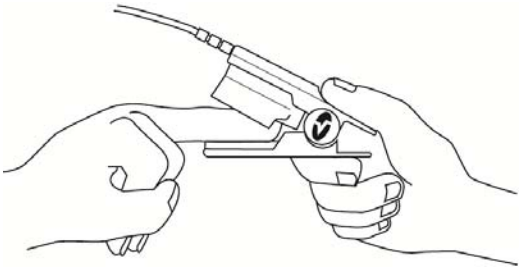


Figure 267.1C Placement of Sensor

Any finger with a good perfusion index (PI) can be used that produces a reading.

c) Ensure the finger is inserted as far as it can be placed.

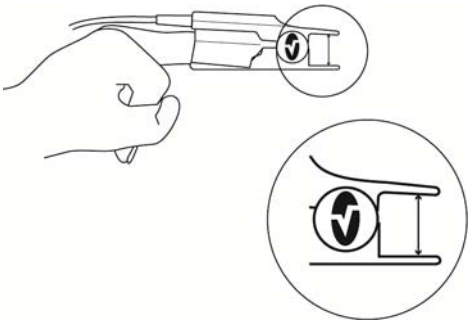


Figure 267.1D

d) Check Perfusion Index (PI) on the analyzer.
If PI less than 1.0:
-Move sensor to another finger.
-Check placement of hand and arm.
-Check for cold fingers.

e) Keep the hand still and avoid excessive movement until a reading is displayed.

f) Press the test (SpHb) button after hearing the audible tone. In approximately 60 seconds, the hemoglobin value is displayed in the window.

g) Record the measurement.

h) Clean the sensor with an alcohol pad after each test.

i) Staff may test multiple family members without the analyzer "counting down," if the tests are taken within 5 minutes.

6) Results that may not be processed include:

- participants with finger or fingernail deformities
- participants wearing metallic or dark fingernail polish,
- participants with or wearing very long nails, or
- participants with excessive movement or very low perfusion (cold fingers).

For these situations or for any time the Masimo Pronto does not produce a result (no "beep," shows "low SIQ"), staff must use the HemoCue 201+ Analyzer. See procedures below.

7) Safety Precautions
A sanitary work area must be maintained and safety precautions followed.

- The work surface can be cleaned at the end of the day. If a clean paper towel is used as a cover for the work surface, replace it after each use.

- Hand washing - The clinic should have hand washing facilities available close to the area in which the blood test is done. Hands must be washed immediately before and immediately after each family group has been tested with antiseptic soap and water. If hand washing facilities are not available, the hands must be swabbed with alcohol or other antiseptic hand sanitizer immediately before and immediately after each blood test. Hand washing is preferred.

- Medical gloves – Medical gloves are considered "best practice." If used, they can be changed between each family group that is tested. Do not use gloved hands to touch participant files, pens, etc.

B. HemoCue 201+ Analyzer

The Hemocue® blood hemoglobin system consists of disposable microcuvettes with reagent in dry form and a photometer. The microcuvette is used as a reaction vessel and measuring cuvette. Reading of the blood sample takes place in the photometer which follows the reaction and presents the result only when the reaction has stopped.

1) Assembling the equipment: The following pieces of equipment are needed.
   - HemoCue 201+ Analyzer,
   - microcuvette,
   - biohazardous container,
   - alcohol pads,
   - sterile gauze or cotton, (fine to use gauze from opened containers)
   - band aids,
   - sterile, disposable finger-stick device (with retractable blade), and disposable medical gloves

2) Preparing the finger: Massaging the finger and warming a cold finger increases blood flow. References to "you" or "your" refer to the staff person performing the following procedure:

   a) With your thumb and index finger, grasp the individual's finger of either hand about 3 inches below the tip of the finger (see Figure 267.1A).

   b) With your other hand, hold the sides of the individual's finger as illustrated.

   c) Move your hand toward the top of the individual's finger applying a gentle massaging motion on the fleshy portion of the finger.

   d) Repeat the massaging process 5 or 6 times.

   e) With the alcohol pad, cleanse the ball or pad of the finger.

   f) Thoroughly dry the finger by either air drying or drying with a piece of sterile gauze.

3) Taking second tests: Only one test is needed at each certification appointment. Staff may elect to retest a participant, if a very low or high hemoglobin value is obtained. If two samples are taken, place the higher of the two values in the WIC System on the visit tab. Since different body fluids/tissues are measured, do not compare Masimo Pronto and Hemocue 201+ results.

4) Withdrawing the blood:

   a) Perform a finger or toe stick as described in *Obtaining Blood Samples* Appendix 200.

   b) Wipe away the first two or three drops of blood and then introduce the microcuvette's tip into the middle of the third or fourth drop of blood.

   c) Fill the microcuvette completely in a continuous process. No more blood should be added after the first filling.

   d) Dry off any surplus blood on the tip of the microcuvette with a quick movement against a lint-free paper towel or tissue.

e) Check the microcuvette for air bubbles in the sample.

f) If an air bubble is present, discard and select another microcuvette. (Small air bubbles around the edge do not influence the results.)

g) If a second sample is to be taken from the same fingerstick, it is important that it is done immediately. Wipe away the remains of the last sample, and use the next drop.

5) Processing and reading the specimen:

a) Place the microcuvette in the holder and insert it in the photometer. The microcuvette must be analyzed within ten minutes after being filled.

b) After 15-45 seconds, the hemoglobin value is displayed in the window.

c) Record the measurement.

d) Discard the microcuvette in appropriate biohazard container.

6) Safety Precautions
A sanitary work area must be maintained and safety precautions followed.

- The work surface must be cleaned after every use with alcohol or a 10% bleach solution. If a clean paper towel is used as a cover for the work surface, replace it after each use. The work surface can then be cleaned at the end of the day.

- Hand washing - The clinic should have hand washing facilities available close to the area in which the blood work is done. Hands must be washed immediately before and immediately after each blood test with antiseptic soap and water. If hand washing facilities are not available, the hands must be swabbed with alcohol or other antiseptic hand sanitizer immediately before and immediately after each blood test. Hand washing is preferred.

- Medical gloves – Medical gloves are required and must be changed between each blood test performed. To prevent cross contamination, a medical glove or paper towel should protect the hand that disposes of the used Hemocue microcuvette. Do not use gloved hands to touch participant files, pens, etc.

- Hazardous waste disposal - The clinic must have a separate container for the disposal of hazardous waste: Finger-stick devices and microcuvettes must be placed into sharps containers. Blood stained cotton or gauze and band-aids are disposed of in hazardous waste containers. These items should not be put in a waste basket which is used for other purposes. The hazardous waste disposal container must be a closed container with a small opening to prevent the waste from falling out of the container, if the container is knocked over. The hazardous waste disposal container should be disposed of as required by the grantee agency's hazardous waste policy.

- Hepatitis B vaccine - WIC employees at risk for occupational exposure to Hepatitis B must be provided an opportunity to receive the Hepatitis B vaccine through the WIC grantee agency. WIC employees who have been exposed to Hepatitis B must be provided proper evaluation and follow-up.

267.2 Maintenance and Servicing of Hematological Equipment

Refer to the manufacturer's directions for the proper maintenance and servicing of the analyzers. General guidance is listed below. If these measures do not correct any problem you may have, please contact the company sales representative for additional assistance.

A. Masimo Pronto

- Wipe off the machine portion weekly or more often, as needed. Maintain a cleaning log.

- Wipe finger sensors with an alcohol pad after each family is tested and store in a clean container such as a resealable plastic tote.

- Store the Masimo Pronto in an area that is not extremely hot or cold. The Masimo Pronto must be acclimated to the environment where it is used to perform at its optimal level. If the analyzer will be transported to a clinic, try to avoid temperature swings and set the analyzer up as soon as staff arrives at the clinic. Do not leave the analyzer in a car for long periods of time.

- Change batteries when two green lights remain on the battery indicator field. If the batteries are not changed, the analyzer may stop in the middle of a test.

- Dispose of used sensors according to local policy for disposal of electronic materials.

- Report any issues with the machines or sensors directly to Masimo.

B. HemoCue 201+ Analyzer

- Clean daily, if used. Maintain a cleaning log.

- Clean the microcuvette holder daily:

    - Use alcohol or mild detergent and water.

    - Rinse with plain water and towel dry. Holder must be completely dry before being replaced.

- Clean the optic eye *only* when the machine indicates to do so.

    - Dampen a cotton swab with plain water. Squeeze off excess water.

    - Estimate the location of the optic eye marking on the top of the machine.

    - Mark that distance off on the swab and insert the top so that the cotton end is about where the optic eye is located.

    - Slant the swab up slightly and gently clean the area.

    - Slant the swab down slightly and gently clean the area.

    - Remove the swab and discard.

- Repeat with a clean cotton swab, if necessary.

268 - 270 **RESERVED**

271. Initially Ineligible Applicants

An ineligible applicant is an individual who has failed to meet one or more of the eligibility criteria (categorical, residential, income, or medical/nutritional risk). The terminology, initially ineligible, applies to applicants who are applying for the first time and those applicants who have been terminated from the program and currently are not receiving WIC benefits. The following steps must be completed to process the initially ineligible applicant.

271.1 Nutrition Education

Initially ineligible applicants must be offered an opportunity to receive nutrition education specific to the category of that individual or specific to the participant's questions or desires. For example, a pregnant woman could receive generalized counseling on nutrition during pregnancy and breastfeeding information or only information on high iron foods because that was her only request.

271.2 Notification Requirements

1. The Notice: The WIC Program Cannot Serve You (HEA 4462) is used for those applicants who fail to meet eligibility criteria and who are not currently receiving WIC services. This is a two-part form with an original top copy and one additional copy. Upon completion, the top copy is maintained in the WIC chart and the bottom copy given to the applicant. The applicant should be asked to read the letter. The contents of the letter shall be verbally explained to ensure understanding.

2. Information on this letter shall be completed as follows.

- Complete the full name of the person. (One notice for each applicant.)
- Enter the certification appointment date on the second line of the letter.
- Mark the box next to the reason for denying service and any additional information as needed. (Usually, it will be one of the first 2 boxes.)
- The signature lines and date are completed by the participant or guardian (if present) and a member of the WIC staff. Enter today's date (the date of completion).

271.3 Initially Ineligible Applicants Rights

The following rights must be verbalized to the applicant or parent/guardian upon notification of ineligibility:

- Standards for eligibility and participation in the WIC Program are the same for everyone regardless of race, color, sex, age, national origin or disability.
- Any decision made by the local agency regarding WIC eligibility may be appealed.
- The applicant may reapply at any time they feel there has been a change in eligibility status.

271.4 File Maintenance

Each initially ineligible participant will have a chart with the following contents:

- A completed Ohio WIC Program Application form and
- The top copy of the signed notification letter (The WIC Program Cannot Serve You).
- Initially ineligible files must be kept separate from active and termination files.

272. Eligible Applicants

An eligible applicant is an individual who has met all of the eligibility criteria as described previously in this chapter. The certification process is completed by following the information in subsections 272.1 to 272.10.

272.1 Processing Eligible Applicants When the Local WIC Project is at Maximum Caseload

When an applicant is eligible, but the local WIC project is at maximum caseload, the applicant must be placed on a waiting list according to the policies and procedures defined in the Waiting List section. Notification requirements for applicants being placed on the waiting list follow.

(1) Notice: The WIC Program Cannot Serve You, form HEA 4462 – The State-developed form is to be used and issued to new applicants being placed on a waiting list and to current participants being terminated and placed on a waiting list. This is a two-part form which includes a top original copy and one additional copy. Upon completion, maintain the top copy in the WIC chart and give the bottom copy to the applicant/participant.

(2) Instructions for Completion of the Notice: The WIC Program Cannot Serve You Letter – Information on the letter is completed as follows.

- Complete the name of the person being placed on the waiting list.
- Enter the date on which WIC services will end for current participant. This date shall be at least 15 days prior to the food end date.
- Checkmark the *Your name is being placed on a waiting list because service slots are full at this time* line.
- Complete the signature lines with signatures of the parent, guardian, or representative and a member of the WIC staff. Enter today's date.

- Review the applicant's right to a Fair Hearing and encourage the applicant to contact the clinic with any address changes. Tell the applicant that contact will be made by the WIC clinic when the waiting list resolves.

272.2 Processing Eligible Applicants When the Local WIC Project is Not at Maximum Caseload

The following subsections outline the steps to be completed in processing an eligible applicant when the local WIC project is not at maximum caseload. The subsections outline certification periods, nutrition education, prescribing supplemental foods, notification requirements, time frames for notification of certification, participant rights and responsibilities, and issuing the identification card and master record.

272.3 Certification Periods

Certification periods are based on the date eligibility is determined.

(1) Certification Periods for Women – The following information outlines the certification periods for women.

- Pregnant women are enrolled any time during the current pregnancy. The certification period for pregnant women is determined by the estimated delivery date. Certification continues through the duration of pregnancy and for up to six weeks postpartum; however, food may be received for up to eight weeks postpartum. A recertification appointment must be scheduled within six weeks postpartum so as to prevent interruption in the receipt of WIC foods if the woman is determined eligible as a breastfeeding or nonbreastfeeding postpartum woman.

- Breastfeeding women are enrolled any time before their breastfeeding infant becomes one year of age. The certification period for breastfeeding women is determined by the date eligibility is determined. A breastfeeding woman is categorically eligible until the end of the month in which she notifies the clinic that she is no longer breastfeeding or the end of the month in which her infant becomes one year of age, whichever comes first. A certification period lasts approximately six months.

- Nonbreastfeeding postpartum women are enrolled any time before the end of the sixth month after the termination of their pregnancy. The pregnancy termination date for women experiencing a miscarriage or abortion is the end of the month in which the miscarriage or abortion occurs. The certification period extends six months from this date. Nonbreastfeeding postpartum women become categorically ineligible at six months after the termination of pregnancy.

(2) Certification Periods for Infants – Infants are enrolled any time before one year of age. The certification date for infants is based on the date eligibility is determined. Applicants/participants shall be certified as infants if the certification/recertification date is prior to their first birthday. Certification intervals shall last approximately six months.

(3) Certification Periods for Children – Children are enrolled any time before five years of age. The certification date for children is based on the date eligibility is determined. Applicants/participants shall be certified as children if the certification/recertification date falls on or after their first birthday. Certification intervals shall last approximately six months. The child is categorically ineligible at the end of the month in which the child turns five years of age.

(4) Time Variation in the Length of Certification Periods – Recertification appointments should be scheduled during the participant's food end month or within thirty days before the food end date for participants to receive maximum food benefits. Certification periods cannot be increased. WIC staff may shorten a participant's certification period when a certification appointment is made to accommodate two or more family members who had previously been scheduled for separate appointments. When exercising this option of time variation, WIC staff must ask the participant or guardian for permission. WIC staff should consider category, length of eligibility, and the likelihood of risk eligibility in deciding which participant should have the certification period shortened.

272.4 Nutrition Education

Eligible applicants must be provided with nutrition education at the time of eligibility determination. Nutrition education must be based upon assessed information, including participant concerns and interests, which will bring about desirable behavior changes that will improve or maintain nutritional status and health.

The local WIC project shall also schedule the individual for a secondary or high-risk nutrition education appointment within the certification period.

272.5 Prescribing Supplemental Foods

The certifying health professional shall prescribe an individual food package for each eligible participant. The food package must be individualized based on the applicant's age, categorical status, nutrition needs or goals, household conditions, and food preferences/intolerances.

Time frames for food issuance may differ as follows.

- Projects must issue food benefits to the participant at the same time as eligibility notification. An exception can be made, if requested by the participant/guardian, as in the case of the participant/guardian needing to obtain required documentation for a change in formula. Other exceptions including home visits and paper clinic sites are addressed in Section 330 of Chapter 300.

- For participants receiving PKU or metabolic formulas, formula may be issued from ODH Bureau of Children with Medical Handicaps prior to WIC certification. WIC reimbursement will begin at the date of certification. Additional food benefits for non-PKU or non-metabolic formula shall be issued as above. Instructions for issuing metabolic formulas are found in Chapter 300.

The local WIC project shall also provide the participant with an Authorized Foods List, approved vendors list, and an explanation of the food issuance system detailed in Chapter 300.

272.6 Explanation of the WIC Program

Staff must provide an explanation of the WIC program at every certification and recertification appointment. One of the following three methods must be used.

A. Read bullets 1 through 6 below as written or discuss each one in very similar verbiage.

- The purpose of the WIC Program is to provide nutritional support, i.e., education and strategies for a healthy diet, supplemental foods, referrals and breastfeeding promotion and support, during critical times of growth and development, to improve and achieve positive health outcomes.
- The nutrition assessment process is necessary to identify nutrition needs (e.g., medical conditions, dietary practices) and interests so that WIC can provide benefits that are responsive to the participant's wants and needs.
- The relationship between the WIC staff and the participant is a partnership – with open dialogue and two-way communication – working to achieve positive health outcomes.
- WIC food benefits are prescribed for the individual, to promote and support the nutritional well-being of the participant and to help meet the recommended intake of important nutrients or foods.
- The food provided by the Program is supplemental, i.e., it is not intended to provide all of the participant's daily food requirements.
- Each participant must reapply at the end of the certification period and be reassessed for Program eligibility.

B. Show the Welcome to WIC DVD. Best practice is to play the video for the participant in a room where there are no distractions.

C. Read the entire Welcome to WIC Letter (WTW) (HEA4435) verbatim.

Staff must read or discuss the following bullet in very similar verbiage when there is an active waiting list in addition to any of the above methods.

- The nature of the WIC priority system and the priority designation for the individual; if the local agency is not serving all priorities.

272.7 Notification Requirements – Welcome to WIC Letter (WTW) (HEA4435)

Instructions for Completion of the WTW:

- Complete the participant's full name.

- Write one nutrition risk reason. Do not abbreviate. Use the terminology listed for each risk code (Sections 245-249) or listed in the Summary of Medical Codes for Nutrition Risk Criteria (Section 250) in Chapter 200.

- Complete the nutrition goal with one, mutually agreed-upon goal. Only the participant, guardian, or health professional can complete this section.

- Enter anthropometric and hemoglobin data (recommended, not required).

- Complete the space for the next nutrition education and certification appointments if the appointments are determined at the time of the certification appointment. If the appointment information is listed on the WNC Cardbook, it does not need to be rewritten on the WTW.

- Complete the food end date, and check the appropriate categorical termination reason if a categorical termination occurs before the next certification visit. In this case, the WTW also serves as prior notice of termination. No other termination letter or notice is required.
  -Clinic flow suggestion: if this section does not apply to a participant, mark through the section and tell the participant it does not apply.

- Explain the *Information Sharing in the WIC Program* section and provide the *Information Sharing in the WIC Program* pamphlet. Complete other sections as needed.

- Read or review the Participant Rights and Responsibilities sections and signature statement.

- Have the participant or guardian sign the WTW. In cases where the participant cannot write, an "X" is acceptable on the signature line. A WIC staff member must sign the WTW letter as a witness if the participant or guardian signs with an "X."

- Sign the WTW and complete the WIC Effective Date. The WIC effective date is the date that *all* of the certification information (income, medical data, etc.) has been provided, assessed, and eligibility has been determined. Generally, it is the same day of the visit and the participant or guardian is provided food benefits. Any WIC staff member can sign the WTW.

- The *Signature of WIC Personnel* line and *WIC Effective Date* are **not** completed, if all certification information is not available at the first clinic visit date. (The participant is in pending status.) The *WIC Effective Date* and the *Signature of WIC Personnel* line are completed at the time the participant or guardian brings the required information. The copy of the WTW is provided to the participant on that date. **The participant or guardian signature is always obtained at the first clinic visit date.**

The State-developed form is issued to each participant at initial and recertification appointments as notification of eligibility. This is a two part form which includes the top original copy and an additional copy. A separate letter is fully completed for each participant within a family.

- Maintain the top original copy in the WIC chart and issue a copy to the participant or guardian at each certification visit following determination of identity, categorical, residential, economic, physical presence, and nutritional eligibility.

272.8 Participant Rights and Responsibilities

At initial and subsequent certifications, the following participant rights and responsibilities on the WTW must be verbally explained to the applicant/participant or guardian. During recertification appointments, WIC staff may summarize the rights and responsibilities.

A. Participant Rights:

- 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.
- You may appeal any decision made by the local agency regarding your eligibility for the program.
- The local agency will make breastfeeding and nutrition education services available to you or your parent or guardian.

B. Participant Responsibilities:

I understand that failure to abide by my responsibilities may result in disqualification. I and my alternates must:

- Not sell, trade, or give away WIC food or formula, breast pumps, or WIC Nutrition Cards (WNC). This includes using online outlets such as Craigslist or Ebay to illegally sell or trade WIC benefits.
- Not accept from the vendor cash, credit, unauthorized foods, or other items of value for WIC Nutrition Cards.
- Not physically abuse, threaten physical abuse, or verbally abuse anyone at the WIC clinic or store.

- Notify the clinic if I have difficulty buying WIC foods at the store or if I am treated unfairly by store staff.

- Not make false or misleading statements or misrepresent, hide, or withhold facts to obtain benefits.

- Not receive WIC benefits from more than one WIC program at a time.

- Use the WIC foods for the participant only. Send WIC Nutrition Card or food benefits with participants if they leave the household.

- 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.

- Notify the clinic of a change in income, address, telephone number, family size, and pregnancy due date.

- Use WIC Nutrition Cards during the valid dates.

- Keep WIC Nutrition Card in a safe place. Lost and stolen current month benefits cannot be replaced.

- Return loaned breast pumps when asked.

- Bring back excess, unopened formula and baby foods to the WIC clinic.

272.9 Issuing the Participant Master Record (WIC PR109)

The Participant Master Record (PMR) serves as the verification of certification for transfer of Ohio WIC participants. The PMR must be issued to all migrants and any member of a migrant family. Each member of the migrant family must receive a PMR at each certification appointment. The PMR must also be issued to any participants that are likely to transfer during the current certification period.

The procedure to issue a PMR is contained in the WIC System User Manual. To validate the PMR, the following information must be added: printed name and signature of WIC staff and name and address of the local WIC clinic.

273 Participants Applying for Recertification

All participants, who are currently active, can reapply for services. The recertification appointment must be scheduled during the food end month to avoid interruption in services. When a participant misses a recertification appointment and notifies the clinic, the appointment should be rescheduled.

273.1 Recertification and Education Appointment Notices

Participants are notified of upcoming appointments via the mail or by telephone.

(1) Mail

a. WIC Appointment Notice Card (HEA 4495)
The WIC System will print *WIC Appointment Notice* cards (Appendix 200) for staff. The cards are preprinted in both English and Spanish. The recertification appointment notice is issued not less than 15 days prior to the expiration of the current certification period. Best practice: Issue the *WIC Appointment Notice* not less than 15 days prior to the scheduled appointment and the expiration of the current certification period.

The following information will print on the front of the cards:

- Return address*
- Clinic telephone number
- Participant names*
- Participant's address
- Day, date, and time of the scheduled appointment (if printing a card for more than one participant, the system will print the earliest appointment time)
- Reference to the back of the card to see what to bring to the appointment
- Termination notice
- Personalized message (optional)*

- *Note: Staff may choose to have the return address listed as the mailing address or the physical address of the clinic; to print one card per participant or one card per group; and to include a personalized message that will print on the front of all of the cards.

- *Note: A "K" appointment is defined as a meeting with the health professional to review weight, height, blood work, etc. An "E/F" appointment is defined as group, module, etc. with food issuance.

Copies of the preprinted cards and *Appointment Reminder Card Instructions* are found in Appendix 200. Individual appointment cards cannot be reprinted to accommodate for a change of address or date once the original card has been printed and mailed. If the card has not been mailed, edit the card. Otherwise, use a new card to update the information.

Staff using the WIC *Appointment Notice* must use the *Appointment Record Report*. This report is the record of issuing appointment reminder cards and serves as notice of termination documentation. The report will list participants individually, whether the cards were printed by participant or group. The label from this report prints:

- Participant name
- Participant ID number
- Date of birth
- Appointment date
- Date the *Appointment Reminder Card* was printed

Staff must place the label in a readily accessible area of the chart, never placing one label over another. Staff either places all printed labels in the charts as soon as the report is run or only places labels in the charts of participants who have been terminated per the *Termination Report*.

b. Locally developed appointment reminders for education appointments

Staff may use locally developed reminders for education/benefit pick-up appointments. A sample must be kept on file for review during management evaluations.

(2) Telephone

a. Participants may be contacted by telephone as an appointment notice. Telephone appointment notice calls must be documented in the WIC chart, or on telephone logs or schedules. If telephone logs or schedules are used to document telephone contacts, the logs must be kept in clearly labeled folders and retained three years from the date of the submission of the Annual Reconciliation Report for the fiscal year to which the item pertains. Failure to keep a recertification appointment following a telephone appointment notice requires that a termination letter be issued.

b. The Automated Reminder System (ARS) can be used for appointment notice calls. The ARS Reports must be kept in clearly labeled files and retained three years from the date of the submission of the Annual Reconciliation Report for the fiscal year to which the item pertains. Failure to keep a recertification appointment following an ARS telephone appointment notice requires that a termination letter be issued.

273.2 Determining Eligibility During Recertification

All eligibility criteria including identity, category, residence, income, physical presence, and medical/nutritional risk requirements must be met for the participant to be recertified. A new application form must be completed. Methods for making these determinations do not differ from those at initial certification, with the exception of special identification and categorical recertification documentation allowances for infants and children noted in the Identification Requirement and Categorical Requirement sections.

a. If any of the eligibility criteria are not met, the participant must be terminated. The clinic must terminate the participant and issue a termination letter.

b. A *Welcome to WIC (WTW) Letter* must be completed for participants who are eligible for recertification. Methods for the completion of the *WTW Letter* do not differ from those at initial certification, with the exception that participants may receive a shortened review of the rights and responsibilities. (If the participant acknowledges the rights and responsibilities and requests the information not be repeated, staff can omit this discussion.) Best practice is to review all of the rights and responsibilities. The effective date of continued participation is the date that all of the required information was provided and assessed and continued eligibility is determined. The participant signs the letter and is given a copy.

If the local WIC project is at maximum caseload, participants due for recertification do not take precedence over new applicants.

273.3 Nutrition Education and Food Package Assignment During Recertification

Nutrition education and food package assignment methods do not differ from those at certification. See Section 272, Eligible Applicants, for details. Likewise, the participant must be scheduled for a secondary or high-risk nutrition education appointment within the new certification period.

274. Changes in Categorical Status

The following list summarizes changes in participant categorical status and policies for implementing those changes:

- A participant initially certified as an infant retains infant status until the first recertification following the infant's first birthday. However, a child's food package must be assigned for the month in which the infant turns 13 months of age. The health professional must assign the child's food package during the certification appointment prior to the first birthday.

- A participant certified as a pregnant woman retains pregnancy status until her six-week postpartum appointment. At that time, if eligible, she must be recertified as a postpartum or breastfeeding woman. During this postpartum recertification visit, requirements are completed as described in the Participants Applying for Recertification section (Chapter 200). For those pregnant women with an early or late delivery date, the expected date of delivery (EDD) should be updated. This allows the system to recalculate the certification date. For a woman with a very early delivery, a void and reissue of the woman's benefits may be required.

- A woman who discontinues breastfeeding during the initial six-month postpartum certification period may extend her eligibility for the remainder of that six-month period, if her current nutritional risk eligibility is documented as applicable to her nonbreastfeeding (N) status. The postpartum woman's category must be changed from breastfeeding (B) to nonbreastfeeding (N). This procedure ensures that Ohio WIC breastfeeding statistics reflect actual breastfeeding rates.

  Since both breastfeeding and nonbreastfeeding women are postpartum, certification for either category of postpartum women is for up to a six-month period. If one or more of the medical/nutritional risk codes used for the breastfeeding woman is appropriate to the postpartum nonbreastfeeding category, another nutrition assessment is not required. However, if the only risk codes the breastfeeding postpartum woman has are breastfeeding-related (i.e., risk codes 70, 74) a nutritional risk appropriate to her nonbreastfeeding status must be determined for her continued eligibility.

Therefore, when a woman stops breastfeeding within her first six-months postpartum the procedure is as follows:

- Clinic staff sets up an appointment for the woman and advises her that she must bring in all remaining coupons or WNC. (A change in category cannot be completed without the coupons/WNC to be voided and reissued.

- A risk code must be based on the woman's risk or the health professional must assign an appropriate new code or codes. The new code must be based on a newly completed Health History form or new anthropometric measurement or blood iron value. If this assessment produces no risk codes, code 31 "Needs Diet Guidance" should be assigned.

- The health professional must assign a postpartum food package for the participant. The coupons or WNC issued to the woman when she was breastfeeding must be in-hand. A void and reissue for future months should be accomplished by entering the new food package into the computer system.

- If the woman is found to be eligible, her certification continues until six months after the termination of her pregnancy.

A woman who discontinues breastfeeding during her second six-month postpartum certification period must be terminated. The termination is effective at the end of her current 30-day food month, provided there is sufficient time to satisfy the minimum 15-day notification of termination. If the notification of termination period extends into the beginning of her next food month, the termination is effective at the end of that food month.

Example: Helen delivers on January 15 and is certified as a breastfeeding woman on January 19 with a termination date of July 31. Helen is still breastfeeding on July 2 and is recertified as a breastfeeding woman with a new termination date of January 31 of the next year. Helen is issued benefits for August 1 through October 31. On August 25, Helen contacts the clinic and says she has stopped breastfeeding. Helen should be terminated effective September 30. This is because the 15-day notification of termination period extends into her next 30-day food month (September 1 to September 30). Helen should return her last month's (October) coupons to the clinic or bring her WNC for October benefits to be debited. Had Helen notified the clinic on August 15, termination would have been effective on August 31 because the 15-day notification requirement would have been satisfied.

275. **Terminations**

Terminated participants are ineligible to receive program benefits (WNCs, FMNP coupons or breast pumps*). The following sections define situations for which a participant may and may not be terminated from the WIC program and the notification requirements that must be implemented.

*In rare instances, a breast pump may be provided to a woman not on the WIC program, as long as her infant is active on the WIC program.

Individuals who have previously participated in the WIC program may reapply for WIC services. It is preferred to reuse the inactive chart with the same participant number.

275.1 Situations When a Participant Must Be Terminated

- Pending information for a recertification appointment has not been received within 30 days for income or 60 days for anthropometric data.** (The WIC System terminates the participate regardless of the type of missing data in 60 days.)
- Any time the clinic staff is aware that the family income is in excess of WIC Income guidelines.*
- A woman's six month postpartum period has ended and she is not breastfeeding.* (B changed to N after 6 months)**
- A breastfeeding woman is ineligible because her child has turned one year old.**
- A child turns five years old.**
- The participant moves out of the local project's geographic service area.**
- The participant has failed to pick up benefits for two consecutive months.**
- The participant fails to come in for a scheduled recertification appointment. **
- The participant or guardian informs the clinic that she does not wish to continue receiving WIC benefits.*

- At recertification, the participant is being placed on the waiting list.*
- The local WIC project has determined that the participant is abusing the WIC program.***
- Dual participation is resolved.*
- A participant's death is reported.*

*Participants who are determined ineligible to continue on the WIC program must be terminated manually by the local WIC project. The termination may occur during a recertification appointment or any time during the certification period that ineligibility is determined.

Generally, only future benefits are voided. For example, the parents of a child call and staff determines they are over income. The parents report having some benefits left in the current month and for future months. Allow the current month benefits to be used. For future month benefits, manually terminate the participant and lock the WNC on the first day of the following month. Ask for the WNC to be returned and inform the participant that the benefits will not be available in the future months.

**The WIC System will automatically terminate these participants.
*** State WIC staff will terminate these participants.

275.2 Situations When a Participant May Not Be Terminated

- The participant fails to keep non-WIC clinic appointments such as child health, immunization, and prenatal appointments.
- The participant fails to keep the **first** midcertification appointment (nutrition education or high-risk encounter).
- The participant fails to notify the WIC clinic of a change in address (unless the new address is out of the local WIC project's geographic service area).

- The participant fails to comply with the WIC health professional's recommendations or show improvement in nutritional status.

- Pending information for a certification appointment has not been received within 30 days for income or 60 days for anthropometric data. (The WIC System purges the participant regardless of the type of missing data in six months. Since the participant has never been eligible, the WIC System can only purge, not terminate the participant.)

275.3 Notification Requirements

There are three ways to provide notification of termination to participants:

1. The Notice: The WIC Program Cannot Serve You (HEA 4462)
   This notice is issued in the following circumstances:
   - Participants and/or applicants are determined ineligible for residential, economic, or categorical reasons.
   - Participants or applicants are waitlisted or do not complete the certification process (bring all required information).
   - Participants failing to keep a recertification appointment following either a staff telephone or Appointment Reminder System (ARS) appointment notice.
   - Active participants must receive this notice for program abuse.
   - Staff using the Termination Report may also use this notice to notify participants who miss appointments.

2. The Welcome to WIC Letter (WTW) (HEA 4435)
   When the **Service Ending Notice** is completed, the WTW letter serves as termination notice for:
   - children turning 5 years old,
   - women who are six months postpartum and not breastfeeding, and
   - breastfeeding women whose infants are turning one year old.

   When the exact date is written on the letter, the WTW letter serves as termination notice for missed midcertification appointments. See Section 272.7. For walk-in nutrition education appointments, use either May 1-31, 2015 or 5/1-31/15.

3. WIC Appointment Notice Card (HEA 4495)
   The WIC Appointment Notice Card serves as notice of termination for missed recertification and midcertification appointments, as long as the Appointment Record Report is run and the associated label is placed in the participant's chart. See Section 273.

275.4 Instructions for Completion of the Notice: The WIC Program Cannot Serve You Letter

This is a two part form with an original top copy and one additional copy. Upon completion, the top copy is maintained in the WIC chart and the bottom copy given to the participant. When terminating for categorical reasons, the letter is issued not less than 15 days prior to the food end date. When terminating for program abuse, the letter is issued not less than 15 days prior to the established date of termination.

Information on this letter shall be completed as follows.

- Complete the full name of the person being terminated. (One notice for each participant.)

- Enter the date on which WIC services will end. If completing the letter at recertification or when categorically ineligible, this is the food end date. If terminating for program abuse, the date entered is the established termination date with at least 15 days prior notice.

- Mark the box next to the reason for termination and any additional information as needed.

- The signature lines are completed by the participant or guardian (if present) and a member of the WIC staff. Enter today's date.

- If termination letters are mailed, staff must write "mailed" in the participant signature box.

275.5 Termination/Ineligible Files

- Initially ineligible files must be separate from active and termination files.
- Terminated files may be kept with actives files as long as there is an effective way to purge and audit.
- All clinics within a project must use the same filing method.

275.6 Termination/Purge Reports

Termination and Purge Reports, at a minimum, must be run monthly by each clinic. Larger clinics should run these reports weekly so as not to slow the WIC Certification System.

276. Transfers

The following subsections describe procedures for transferring a WIC participant to another local WIC project, state, or the Department of Defense (DoD) program and for processing a transfer from another local WIC project, state, or the DoD program. When a participant requests to transfer services to any other WIC clinic, providing participant information does not require any further signature or approval from the participant.

276.1 Transfer Definitions

1. Active Transfers
   Participants who move from the local WIC project in which they are an active participant are entitled to transfer their WIC certification to another local WIC project, state, or the DoD WIC Overseas Program. The transfer process *continues* WIC benefits until the current date of certification ends.

2. Inactive Transfers
   Projects must regularly ask applicants if they have received services from any Ohio WIC clinic. If the participant has received services and is not in active status, staff must request a transfer process through the WIC System. The health history information and the participant identification number must follow a participant who moves from one Ohio clinic to another Ohio clinic. Unlike an active transfer, participation is not guaranteed and the participant must reapply for WIC services.

   - Staff may not process terminated participants as "new" participants until research is done and an old identification number cannot be found. Research includes using the Statewide Search function. See *WIC Information on Transferring Groups and Participants Using the Statewide Search* Appendix 200.

276.2 Transferring a Participant to Another Local WIC Project

If the participant requests a transfer to another Ohio WIC clinic, the following procedures must be completed:

- Give the participant the name, address, and telephone number of the local WIC project to which the participant is moving. Inform the participant to contact the new local WIC project for an appointment.

- Complete the letter *Notice: The WIC Program Cannot Serve You*. Keep a copy in each participant's WIC chart. **Do not terminate the participant in the WIC System or void any benefits.** The WIC System will automatically terminate in-state transfer participants when the participant records reach the new clinic.

    - If an Ohio WIC clinic is notified of a participant's transfer to another local agency ***after*** it has taken place, a *Notice: The WIC Program Cannot Serve You* letter does not need to be completed. Documentation of missed certification and food issuance appointments serve as termination notice.

276.3 Transferring a Participant to Another State

If the participant requests a transfer to another state, the following procedures must be completed:

- Print a Participant Master Record (PMR) for each WIC participant who is transferring. Validate the PMR with printed name of staff, staff signature and clinic address.

- Give the participant the state's contact information. Inform the participant to contact the state/new local WIC project for an appointment and that the Participant Master Record is required to complete the transfer process.

- The local staff can access the USDA WIC website at http://www.fns.usda.gov/wic/Contacts/ContactsMenu.htm for any state's contact information.

- Complete the letter *Notice: The WIC Program Cannot Serve You*. Keep a copy in each participant's WIC chart. Ask for **WIC Nutrition Cards (WNCs) if there are no current month's benefits.**

- Void future benefits. Place a #1 severity message on the participant's comments tab indicating that the participant was transferred. **Do not terminate the participant in the WIC System.**

- Void **future** benefits using the *Issue* choice on the top menu bar void/reissue function.

- After selecting the months to void, click the A*ssign New Food Items* button and then click the *Remove All Items* button. Click "OK" and select "in hand" for void reason. Click the *Void & Reissue* button.

- If an Ohio WIC clinic is notified of a participant's transfer to another state ***after*** it has taken place, a *Notice: The WIC Program Cannot Serve You* letter does not need to be completed. Place a #1 severity message on the participant's comments tab indicating that the participant was transferred. Documentation of missed certification and food issuance appointments serve as termination notice.

276.4 Transferring a Participant to the DoD Program

The DoD Program is a program like WIC for United States (US) active military personnel and support staff members who are stationed overseas and their dependents. Information about the DoD program can be accessed on the TRICARE web site at: http://www.tricare.osd.mil/wic.

Eligibility in the DoD program is limited to the following:

- Members of the armed forces on duty at certain stations outside the U.S. and their dependents;

- Civilians who are employees of a military department (i.e., Army, Navy, or Air Force) who are US nationals and live outside the U.S. and their dependents; and

- Employees of DoD contractors who are U.S. nationals and live outside the US and their dependents.

As defined by DoD, a dependent includes a spouse. U.S. nationals are individuals who are US citizens, or individuals who are not U.S. citizens but owe permanent allegiance to the U.S. as determined in accordance with the Immigration and Nationality Act. With the exception of using the Alaskan income guidelines, all other eligibility requirements for the DoD program are the same as the USDA WIC program's requirements.

Therefore, WIC program participants who are transferred overseas and meet eligibility for the DoD program are eligible for that program until the end of their certification period.

Follow procedures stated in Transferring a Participant to Another State and this additional step:

Instruct the participant:

- There is no guarantee that the DoD program will be operational at the overseas site where they will be transferred.
- By law, only certain individuals are eligible for the DoD program.
- Issuance of a Participant Master Record does not guarantee continued eligibility and participation in the DoD program.

276.5 Processing a Transfer From Another Ohio WIC Project

The procedures a local WIC project must complete when certifying a group who is transferring from another Ohio project are as follows:
If the group is active:

- If a participant reports having received services at an Ohio WIC clinic, check the Statewide Search Function. In-state transfers must always retain their original participant numbers and must be entered in the WIC system as a transfer.
- Request an in-state transfer using the Statewide Search function. The computer process usually takes two business days.
- The participant must complete a *WIC Program Application* form (HEA 4460).

  Income does not need to be verified for an active transfer. FNS has determined that relocation is not a sufficient reason for a reassessment of income. Therefore, the income eligibility of an active participant continues through the end of the certification period. The in-state WIC system transfer process will automatically populate the demographic tab with income and original income verification code *after* the transfer is received from the other Ohio clinic.

- After the in-state transfer request has been completed, the clinic must call the participant to schedule an appointment to issue food benefits (as needed) and a store list. At the clinic appointment, staff completes the certification procedures per the Certification System 5.X User Procedure Manual.

    - Instruct the participant to continue using current WNC at local approved vendors.

- Lost WNCs returned to local projects:

    - If able to determine WNC belongs to an active participant, contact participant to pick up the card at the clinic. **Do not mail WNCs to participants.** WNCs can be mailed to another WIC project.

    - If WNC belongs to an inactive participant or unable to determine ownership, return the card quarterly to the State WIC office.

276.6 Processing a WNC Participant Transferring Out of a Family Group

A participant may transfer into a newly created group or into an existing group. Follow certification procedures to determine eligibility of the participant in the new household. In either case, current month benefits will not be available to the receiving group.

A. Transfer to a Newly Created Group
    1. Complete the current procedures* to transfer a participant from one group to another.
    2. The WNC, with future months' benefits, for the new group can be picked up from the issuing clinic six calendar days following the transfer date.

B. Transfer to an Existing Group
    1. Complete the current procedures* to transfer a participant from one group to another.
    2. The WNC for an existing group can be updated after the six calendar day waiting period.

3. The WNC for the current group will be locked on the first day of the month following the month of transfer and future months benefits will not be available.
    - The head of the current group must bring the WNC into the issuing clinic so that remaining current month benefits can be removed and future months' benefits updated.

*Use the Statewide Search function. See *WIC Information on Transferring Groups and Participants Using the Statewide Search* Appendix 200.

C. 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.

276.7 Processing a Transfer From an Out-of-State Project

The procedures a local WIC project must complete when certifying a participant who is transferring from an out-of-state project are as follows:

- Ask the participant for a Verification of Certification (VOC) document. If any information is missing, call the local WIC project that completed the VOC document. If the participant does not present a VOC document, the participant must be treated as a new applicant and entered into the WIC system as such.

- Request an out-of-state transfer using the Certification System 5.X User Procedure Manual for the participant with a VOC document.

- The participant must complete a *WIC Program Application* form (HEA 4460).

  Income does not need to be verified for an active transfer, use the monthly amount stated by the participant on the application. FNS has determined that relocation is not a sufficient reason for a reassessment of income. Therefore, the income eligibility of the participant with a valid VOC card continues through the end of the certification period. The out-of-state WIC system transfer process will automatically populate the demographic tab with the income and income verification code, 20 - VOC transfer.

- In the visit tab, staff must use visit type "M-out of state transfer." In the risk tab, enter certification and termination dates from the VOC Card.

- When staff enters certification begin and end dates, the WIC System validates the certification periods as follows:

  - Infant – up to one calendar year from birthdate (e.g., 1/10/14-1/10/15)

  - Child – up to twelve calendar months from the certification date

  - Pregnant – up to eleven calendar months from the certification date (nine months plus six weeks)

  - Breastfeeding – up to twelve calendar months from the certification date

  - Postpartum – up to six calendar months from the certification date

- If the dates staff has entered do not fit into these "valid" periods, a message box will appear and the WIC system will automatically convert the termination dates entered to the appropriate end of the month. Transferring prenatal and postpartum participants will receive food instruments for the entire month of their certification end date.

  - For infants and children, foods will be issued until the end of the month *prior* to the infant's first birthday or child's next birthday. If the infant's birthday is October 15th, food will be issued through September 30th. October foods are contingent upon keeping the next appointment.

  - For breastfeeding women, foods will be issued until the end of the month prior to the termination date. To obtain foods for the last month, staff will need to call Help Desk.

Transferring participants must be given the risk code 80 - Transfer or 81 - Infant Transfer.

Issue a WNC with food benefits, a store list, and an Authorized Foods List or Quick Response code (QR) to the out-of-state participant.

A. Participants with coupons containing food items

- Select a food package that contains the remaining foods. Remember, the WIC System will prorate the selected food package. For future months, select a full package.

- Mark "void" on any out-of-state coupons presented by the transferring participants and mail the voided coupons back to the original clinic.

B. Participants with EBT cards

- Call the original clinic and select a food package that contains the remaining foods. Remember, the WIC System will prorate the selected food package. For future months, select a full package.

- Mail the EBT card back to the original clinic.

C. Participants without coupons, EBT cards, or unable to reach originating clinic:

- Use the transfer food package which includes 4 gallons of milk, 36 ounces cereal, 2- 64 ounces juice, 16 ounces whole grains, 1 dozen eggs, 1 peanut butter or 64 ounces canned beans for the current month per participant. For future months, select a full package.

D. Participants with formula benefits:

- Issue the formula which will automatically be prorated by the WIC System. (Regardless of what is left on coupons or EBT card for the current month.)

276.8 Transfers from Out-of-State Projects with One Year Certifications

In some cases, an infant (I), child (C), or breastfeeding (B) woman transferring from another state may have been certified for a period extending up to one year.

- These participants remain eligible for services through that certification period.

- One of the transfer risk codes must be used and clinic staff must use the certification dates from the VOC card.

- Six months following the date of transfer, the I, C, or B woman must be seen in the WIC clinic as a follow-up ("K") appointment.* (The purpose of this visit is to update anthropometric and hematological values and provide nutrition counseling and breastfeeding support.)

- If the infant is six months of age or older, a follow-up appointment is not needed for the infant or breastfeeding woman.

- If the child is six months or more into the certification period, a follow-up appointment is not needed.

- The participants cannot be terminated at the follow-up appointment.

*Schedule for Midpoint Follow-up Appointments for I, C and B

Age at or months into Transfer Appointment	Midpoint of 1 yr. certification	Food Issuance Times	Certification Period
0-1 month	5-6 months	3m, **6m**, 9m	12 months
1 month	5-6 months	3m, **6m**, 9m	11 months
2 months	7-8 months	5m, **8m**, 11m	10 months
3 months	8-9 months	6m, **9m**	9 months
4 months	8-9 months	**7m**, 10m	8 months
5 months	8-9 months	**8m**, 11 m	7 months

Bold = midpoint follow-up appointment

276.9 Processing a Transfer From the DoD Program

Follow the procedures stated in Processing a Transfer From an Out-of-State Project and the additional steps below. A sample DoD WIC Overseas Program Participant Profile Report/Verification of Certification (VOC) Card is located in Appendix 200.

At a minimum, it should contain the participant's name, date of certification and expiration of certification date. If the participant does not present the DoD VOC card or the required information is incomplete, the project has the option of contacting the DoD program through email at http://www.tricare.osd.mil/wic, then select "local WIC Overseas office."

If the participant is due for a recertification or the information cannot be obtained, the Ohio project must treat the participant as a new applicant.

- Use the first and last letters of the country's name where the DoD program was located in the "out of state" transfer box on the WIC System.

- Mark "void" on any DoD program food instruments presented by the transferring participants and mail the voided food instruments to Choctaw Management/Services Enterprise.

- Choctaw Contracting Services
  2161 NW Military Highway, Suite 308
  San Antonio TX 78213
  Phone: 1-877-267-3728 (toll-free)
  Fax: 210-341-3336
  Email: mpapplewhite@cmse.net

276.10 Participants Who Transfer Out-of-State and Return During the Ohio Certification Period

The following transfer situations may occur when an Ohio participant transfers to an out-of-state entity and returns in a short time period.

- If the participant was certified in the out-of-state entity, honor that state's certification period and process the participant as a transfer per policy and the WIC Certification System User Manual instructions.

- If the participant was not certified in the out-of-state entity (or that state honored the Ohio certification period) and is in an active certification period in the Ohio WIC System, continue current certification period.

276.11 Returned Ohio WNCs from DoD or Other States

Returned WNCs are received at individual clinics or at the State WIC office.

- If the State WIC office receives returned WNCs, Help Desk staff will call the clinic and report that the participant is no longer active in Ohio. Clinic staff places #1 severity message on comments tab.

- If the local clinic receives returned WNCs, send card quarterly to State WIC and place #1 severity message on comments tab.

276.12 Processing Transfers When Using a Waiting List

A transferring participant may contact the local WIC project when a waiting list is being used.

If a slot is not available when the transferring participant contacts the local WIC project, place the participant on the waiting list. Process the transferring participant before any other participant, including Priority I participants, when a slot becomes available.

277. Summary of Steps in Processing a WIC Applicant

The Checklist for a WIC Certification found in Appendix 200 outlines a suggested procedure for processing an applicant through the WIC clinic. Each local WIC project may need to modify the procedures based on staffing and physical arrangement of the clinic. All points listed must be covered with each applicant/participant.

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280. Waiting Lists

When the maximum caseload is being served, the local project must maintain a waiting list. A waiting list is a list of potential participants who have been determined eligible to receive WIC benefits but who cannot be placed on the program due to case load ceilings. Eligibility is determined through a process called precertification described in subsection 280.1.

The names of applicants telephoning to inquire about WIC benefits cannot be placed on the waiting list. Their names may be placed on a telephone log if the clinic cannot schedule a certification appointment at the time of the call. These names on the telephone log are not considered part of the waiting list and are not to be included on the monthly program activity report. WIC charts for participants being placed on the waiting list must be maintained in a separate waiting list file.

280.1 Precertification

Precertification is defined as the process of certifying an applicant for the program but holding the paperwork in the clinic until a caseload slot is open. This process includes giving nutrition education. A slot becomes available in three ways: current participants are terminated, current participants are not recertified, **.**or case load ceilings are increased by the State WIC office. The local project must manually terminate participants who qualify for recertification but who cannot be recertified because participants are on the waiting list who are in a higher priority. The local project must not wait for the computer to generate a termination form on the participant. The slot is not open until these terminated participants are not receiving food for the month in question. For example, a child turned .5 years old in December. He receives December food so the slot is not open until January.

Steps in precertification include:

- Complete the Ohio WIC Program Application.
- Verify identification, residence, income, and pregnancy, if applicable.
- Obtain required minimum health data.

- Complete the Certification form except for fields 6, 9, 32 and 33.
- Give nutrition education and document.
- Determine eligibility.
- Obtain the participant's signature on the Welcome to WIC letter, and the Notice: Your Name Is Being Placed On Waiting List.
- If the participant is eligible, file Certification Form, Welcome to WIC letter and supporting documentation in the participant's chart and place in the waiting list file.
- Place the appropriate information on the waiting list.
- Give the participant a copy of the Notice: Your Name Is Being Placed On a Waiting List.

280.2 Setting Up a Waiting List

Waiting lists must be kept by priority. Participants are to be placed on a waiting list according to the priority for which they qualify when precertified.

A waiting list must include the following information:

- name of applicant,
- date of placement on waiting list,
- address or telephone number of participant,
- participant category, i.e., pregnant, breastfeeding, postpartum, infant or child,
- birthdate,
- medical condition code, and
- priority status.

Separate waiting lists must be kept for each priority that the local project is likely to serve. However, in no case shall an applicant who requests placement on the waiting list be denied inclusion. Using the example, if a recertification applicant qualified as a Priority V participant, and requests to be put on the waiting list, a Priority V waiting list must be started.

Participants transferring from another WIC project in midcertification must be placed on a midcertification transfer waiting list.

280.3 Filling a Participant Slot

Specific procedures must be followed when filling open participant slots. These procedures include processing of midcertification transfers and precertified applicants and are outlined in the following subsections.

280.4 Midcertification Transfers

Midcertification transfers have priority over all other waiting list participants. If the local project is serving any priority, midcertification transfers must be placed on the program the date on which they visit your clinic. If all priorities are on a waiting list and a slot is not available when a participant transfers from another WIC project, the participant's name must be placed on a midcertification transfer waiting list. Once the local project has participant slots to fill, midcertification transfers must be removed from the waiting list first. As long as there are names on the midcertification transfer list, do not certify from any other waiting list or recertify existing participants. Certify midcertification transfers according to the date on which they visited your clinic.

280.5 Filling Slots According to Nutritional Risk Priority System

Once all midcertification transfers have been removed from the waiting list, slots must be filled by priority. The local agency must apply the nutritional risk priority system to ensure that the highest priority persons become program participants first when caseload slots become available. For example, all Priority I applicants on the waiting list must be contacted before service is given to Priority II-VI participants, all Priority II applicants must be contacted before service is given to Priority III-VI, and so on.

280.6 Filling Slots By Date and Subpriority

If all applicants within a particular priority cannot be served, fill the slot by either date of placement on the waiting list or a subpriority list as follows.

- If date of placement on the waiting list is to be used, certify the participant in the highest priority with the oldest date first. For example, an applicant placed on the waiting list on 10/7/85 should be certified before an applicant placed on the waiting list on 10/8/85.

- If a subpriority list is to be used to certify participants within a priority, a written subpriority policy must first be submitted to the State WIC Health Planning Unit for approval. A subpriority list is an ordering of medical codes for each priority arranged in order of their importance in the local project. The local project must include all medical codes in the subpriority list.The exception to this requirement is the use of medical code 63, possibility of regression. The use of medical code 63 is not permitted in any priority placed on a waiting list.

  The local agency must be consistent within a priority in the manner in which participants are certified. If the subpriority list is used, it must be used for everyone eligible in the priority for which it is being used. It is acceptable to fill slots by subpriority for some priorities and date for other priorities. For example, the local WIC project may choose to serve by a subpriority list for Priority I, but by date for Priorities II-VI. If this is the case, a written policy must be kept on file.

280.7 Filling Slots With Participants Due for Recertification Versus Waiting List Participants

Participants due for recertification do not have priority for service over persons on the waiting list. If there are applicants on the waiting list that have been precertified and are found to be a higher priority than the person due for recertification, the local project must certify the applicant on the waiting list. If there are applicants on the waiting list that have been precertified and are the same priority as a participant due for recertification, the local project must certify the applicant on the waiting list if the local project is certifying by date. If the local WIC project is certifying by a subpriority list, the local WIC project must decide which applicant within this same priority to serve based on the subpriority list.

280.8 Procedure for Filling Available Slots in Coupon Projects

Once the local project has a participant slot to fill, it proceeds in the following manner.

- Determine who will fill the slot: a midcertification transfer participant, a recertification or a waiting list person.
- If the slot will be filled by recertifying a current participant, proceed with a routine recertification.
- If the local WIC project will serve a person from the waiting list, complete the letter The WIC Program Can Now Serve You. Send this letter to the potential participant.
- When the participant comes to the clinic for this appointment, explain the coupon system, give secondary nutrition education and document it in the chart. The most efficient way to see these people may be in group sessions.
- Fill in fields 32 and 33 with income and family size, and complete today's date in field 6 and the food end date in field 9 on the Certification Form. The food end date is calculated from today's date or the birthdate. Add manual issue numbers and valid date. The Certification Form is then ready to be processed.
- Complete the dates on the Welcome to WIC letter. The certification date and the date the foods will start should appear in the sentence "You are eligible to participate in WIC effective _____." " You will begin to receive WIC foods by _____."
- If the local project receives no response by the day after the scheduled appointment, remove the name from the waiting list and move the chart to an inactive waiting list file.

280.9 Procedures for Filling Available Slots in Dairy Projects

Once the local project has a participant slot to fill, proceed in the following manner.

- Determine who will fill the slot: a midcertification transfer participant, a recertification or a waiting list person.
- If the slot will be filled by recertifying a current participant, proceed with a routine recertification.
- If the local project will serve a person from the waiting list, complete the letter The WIC Program Can Now Serve You. Send this letter to the potential participant.

- If the slot will be filled within 30 days from when the participant was precertified the local project may choose to send the Welcome to WIC letter rather than this notification letter.
- When the participant comes to the clinic for this appointment, explain the dairy delivery system, give the secondary nutrition education and document it in the chart. The most efficient way to see these people may be in group sessions.
- Fill in fields 32 and 33 with income and family size, and complete today's date in field 6 and the food end date in field 9 on the Certification Form. The food end date is calculated from today's date or the birthdate. The Certification Form is then ready to be processed.
- Complete the dates on the Welcome to WIC letter. The certification date should appear in the sentence "You are eligible to participate in WIC effective _____." Refer to the dairy calendar for the date the foods will start. Distribute the Welcome to WIC letter.
- If the local project receives no response by the day after the scheduled appointment, remove the name from the waiting list and move the file to an inactive waiting list file.

280.10 Notification Requirements for Waiting List Participants

Notification requirements for participants being placed on and removed from the waiting list are outlined in the section headed Eligible Applicants.

280.11 Purging the Waiting Lists

The local project must purge waiting lists of ineligible applicants. The requirements for purging the waiting lists are:

- Remove categorically ineligible participants from the waiting list once a month. This includes children who have turned five years old, women who are at the end of their postpartum period and breastfeeding women who have ceased breastfeeding.
- Midcertification transfers whose current certification period has expired should be purged from that list and be contacted for precertification.

280.12 Reporting Waiting List Statistics

Report the total number of participants on each waiting list by priority on your Monthly Program Activity Report. Only those who have been precertified should be reported. Potential participants on a telephone or appointment log are not to be reported.

If there is no one on the waiting list, enter -0-. The waiting list must be purged prior to reporting these figures.

281. Migrant Farmworkers

Migrant farmworkers are defined as individuals whose principal employment is in agriculture on a seasonal basis, who have been so employed within the last 24 months, and who establish, for the purposes of such employment, a temporary abode. They are considered expedited service participants and must be notified of their eligibility or ineligibility within 10 days of the initial date of request for services. Staff follow the same certification processes as other participants with the exception of the information provided in the following sections.

281.1 Residence and Service Area

Migrant farmworkers must reside within Ohio. Length of residency is not used as an eligibility requirement. Residency self-declaration as documented on the WIC Program Application is acceptable as per Section 206.

281.2 Income Verification

The income of a migrant farmworker's economic unit must be determined at least once every 12 months.

- Check the date of the most recent income verification on the Verification of Certification (VOC) card. If this date is 12 months old or less, income need not be reverified. If this date is greater than 12 months old or does not appear, income must be verified at the time of the clinic visit.

- Do not reverify income, if the migrant has an **expired** Verification of Certification (VOC) card as long as the income has been verified within the past 12 months.

- Use *annual* income versus *current* income, if this information is readily available. Use the *Ohio WIC No Proof* form, as needed.

281.3 Other Requirements

Staff must issue a Participant Master Record for each member of the migrant family at every certification appointment to facilitate certification in other states. Be sure that the most recent income verification date is completed.

In the WIC System, “migrant” is selected for residency status on the demographic tab and code 95 Migrant/Homeless is assigned.

282. Foreign Students and Other Aliens

Foreign students or other aliens are individuals who are currently citizens of another country, but who are residing temporarily in the United States. This section provides specific information about foreign students and eligibility for WIC.

282.1 Foreign Students and Other Aliens' Eligibility for WIC

United States citizenship is not a condition of WIC eligibility. Foreign students and other aliens may apply for and receive WIC benefits, if eligible.

282.2 Immigration and Naturalization Service (INS) Status

The determination and confirmation of immigration status with the Immigration and Naturalization service (INS) is not required as part of the certification process.

A person entering the country as a foreign student is allowed entry solely to pursue a full course of study. The study must occur at an established institution of learning or other recognized place of study in the United States designated by the student and approved by the Attorney General after consultation with the Office of Education. The alien spouse and unmarried minor children of any such student, if accompanying or following to join the student, are classified by INS as foreign students.

Any children born to foreign students during their stay in the United States are subject to the same INS rules as their parents.

282.3 Income of Foreign Students and Aliens

In order to obtain a visa, aliens, including foreign students, are expected to have sufficient funds to cover all living expenses and must assert they will not become a public charge. Foreign students must file financial information with INS to obtain a visa. The foreign students should have copies of this information. The local WIC project must review this information plus any current information according to the income eligibility criteria described in this chapter.

282.4 INS Concern with Public Assistance

Local projects must be aware that the Immigration and Nationality Act states that "Any alien in the United States...shall, upon order of the Attorney General, be deported who...in the opinion of the Attorney General, has within five years after entry become a public charge from causes not affirmatively shown to have risen after entry." WIC is a noncash benefit program; therefore, an alien or foreign student may receive WIC services and not be considered a public charge.

In the event that INS representatives contact the local project for information about a foreign student or alien, the local project must notify the State WIC office.

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

Coordination of WIC and other health care services is necessary for administrative efficiency, convenient service provision for applicants and participants, and for WIC to serve as an adjunct to good health care during critical times of growth and development. Whenever possible, the certification procedures completed by the local WIC project must be combined with the certification or intake procedures for other health programs or services administered by the state and local agencies. The combining of these services may include verification procedures, certification interviews, income calculations, and sharing of medical data.

283.1 Health Care Referral and Access for Participants

The local WIC project must ensure that ongoing, routine pediatric, obstetric, and postpartum care (such as infant, child, prenatal, postpartum, and lactation examinations) are available to WIC participants. The local project must make the appropriate health services available to participants and inform the participants of available health services. If the local project cannot make appropriate health services available, the local project must enter into written agreements with private providers and other agencies to refer participants for ongoing, routine health services. (See the Private Physician/Hospital/Clinic Medical Services Memorandum of Agreement in Appendix 200 and the WIC Grant Application Package.)

In some rare instances, the local project may have problems securing the written agreement for referrals to private providers. Should this occur, the WIC staff must contact the Nutrition and Administration Services Unit at the State office. (The healthcare services do not have to be provided by an entity located in Ohio or in the same county as the local project.)

Some local WIC project's grantee agencies may no longer provide *direct* health services, such as prenatal or well child clinics, but provide designated staff that link referred WIC participants to existing practitioners or clinics. In this scenario, a Private Physician/Hospital/Clinic Medical Services Memorandum of Agreement is not required. However, WIC directors must describe in detail this referral plan in the WIC Grant Application package.

283.2 Referrals for Health Care and Other Services

During the course of the certification interview, the local WIC project may find that the applicant/participant has other health care or human services needs in addition to the need for WIC. The local WIC project must inform the applicant/participant of the availability of other health care and human services programs in the community or locality.

The local WIC project must set up a referral system with other health and human service agencies in the community. The local WIC project must have access to basic information about such programs in order to make an informed decision on the need for referring the applicant/participant. Such information includes the program name, name of the program director, location, and telephone number for the program, scope of program services, target population, and any applicable fees.

In addition, the local WIC project should maintain a supply of pamphlets about other available health and human services programs to give to WIC applicants/participants as needed. Pamphlets can usually be obtained free of charge from the service agency. The address and phone number of the local County Department of Job and Family Services (CDJFS) must be posted in an area that is easily visible to all participants.

At a minimum, information must be maintained on and referrals made to the following programs or health care services:

- Ohio Works First (OWF) - also known as Temporary Assistance for Needy Families (TANF) program
- Food Assistance - also known as Food Stamps or Supplemental Nutrition Assistance Program (SNAP)
- Healthy Start Medicaid
- Medicaid (Title XIX)
- Ohio Healthcheck (Early and Periodic Screening, Diagnosis, and Treatment Program-EPSDT)
- Cooperative Extension’s Expanded Food and Nutrition Education Program (EFNEP)

- Family Planning
- Immunization
- Child and Family Health Services-CFHS (prenatal and well child care)
- Alcohol and Drug Abuse Counseling and Treatment
- Mental Health Services (referrals of depression, etc.)
- Child Abuse Counseling
- Children with Medical Handicaps (CMH)
- Ohio Infant Mortality Reduction Initiative (OIMRI)
- Community/Migrant/Indian/Federal Health Centers
- Ohio Childhood and Lead Poisoning Prevention Program (CLPP)
- Breastfeeding Support Groups
- Help Me Grow (HMG) – Early Intervention (EI) Services

Suggested referral services are:

- AIDS Testing
- Homeless Shelter
- Food Pantries
- Child Support Enforcement Agencies
- Regional Perinatal Dietitian

The referral process can also be used to provide **specific** information to local physicians and health care providers regarding high-risk participants (See Section 403). Proper use of the referral process allows WIC health professionals to communicate new or follow-up information within the local healthcare community to help provide seamless care to WIC participants.

283.3 Referral Procedure

Several processes exist to refer participants or participant information to other health care and social service providers.

- Interprogram and interagency agreements (PPM section 122.4) along with the *Information Sharing in the WIC Program* brochure (PPM section 122.5 and Appendix 100) allow the sharing of participant eligibility and outreach information with programs described in the brochure.

- The *Welcome to WIC (WTW) Letter* allows sharing of information with Head Start/Early Head Start, medical providers for breast pumps, and other entities that are written in the "other" area and check marked by the participant or guardian.

- For other **specific** sharing of data, the *WIC Interagency Referral and Follow-up Form* is designed for referral to or from the WIC program. The *WIC Interagency Referral and Follow-up Form* is used to document specific referral information (i.e., health care data) about the applicant/participant. The form is completed by WIC project staff when information about the participant is to be released to another health care provider or human services agency. At a minimum, the form must be used for referrals to Child and Family Health Services (CFHS), Children with Medical Handicaps (CMH), or Help Me Grow (HMG) programs.

- The *WIC Interagency Referral and Follow-up Form* can also be used by a referring agency to provide information about a WIC applicant/participant to the local WIC project.

- Written approval must be obtained from the State WIC Office NAS Unit prior to use of a locally developed form. The approval letter must be kept on file for review during management evaluations.

- Note: Providing participant information to another WIC clinic does not require signature or approval from the participant. (See Section 276.)

The *WIC Interagency Referral and Follow-up Form* is a two part form completed as follows:

- Complete the applicable parts of the form noting in particular, the reason for the referral.

- Have the applicant/participant sign the form.

- Fax* the form or send the bottom copy of the form to the agency to which the applicant/participant is being referred. If the form is faxed, document on the form the date of faxing or attach the "successful" fax message.

- Maintain the top copy, if mailed, in the applicant/participant's file.

- Should an applicant/participant decline to share the information with another entity, this should be noted either on the comment section of the WIC System or in the participant's file.

Should a local WIC project receive a *WIC Interagency Referral and Follow-up Form,* follow the procedure outlined below:

- If asked to contact the person being referred, do so within five working days of receipt of the form. If the person referred was instructed to make the contact and has not done so in two weeks, then the receiving WIC project must make a reasonable effort to contact the person either by mail or phone.

- Complete the bottom portion of the form, indicating what action has been taken (e.g., instructed on iron rich foods).

- Return one copy of the form to the agency or physician who made the referral. (If the form is faxed,* document on the form the date of faxing or attach the successful "send" message.)

- Keep a copy of the form in the applicant's/participant's file.

It is recommended that individuals or agencies receiving the *WIC Interagency Referral and Follow-up Form* from the local WIC project staff also follow the procedures listed above. The local project is encouraged to share the form with referring agencies when setting up the referral network, welcoming new physicians into the community, or during outreach encounters with health care and human services entities.

*When faxing confidential information, confirm fax numbers and call the recipient to be sure the information was received by the proper recipient. The fax face sheet must have a statement stating the following:

> "This facsimile is intended for the sole use of the intended recipient and may contain privileged, sensitive, or protected health information. If you are not the intended recipient, be advised that any use, disclosure, copying, distribution, or action taken in reliance on the contents of this communication is prohibited. If you are receiving this facsimile in error, please notify the sender via telephone or return facsimile immediately." or a similar statement that ensures that confidentiality is being maintained.

283.4 Referral on *Application for Health Coverage & Help Paying Costs* Form

1. If an applicant needs referred for Medicaid, the local WIC clinic can:
   - Provide the *Application for Health Coverage & Help Paying Costs* form by:
     - ✓ Downloading and printing it from the following website: http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM07216.pdf

     - ✓ Providing a form from a supply obtained from your local CDJFS **(order by form number ODM 07216). Note: This form is not stocked in the WIC warehouse; it can be obtained through resources noted above.**

- ✓ Providing the applicant with the website for applying online at: http://medicaid.ohio.gov/forohioans/GetCoverage.aspx

2. If the applicant completes the *Application for Health Coverage & Help Paying Costs* form while waiting in the WIC clinic and gives it back to WIC staff, it must be forwarded that day to the CDJFS office. A longer forwarding time may be necessary with consideration given to part-time, evening, and weekend clinics. Inform the applicant to contact the agencies receiving referrals if they have not been contacted within ten days of the referral date.

284. Certification Without Charge

WIC applicants/participants shall be provided with services related specifically to WIC eligibility determination and nutrition counseling at no charge. These services include hematocrits, hemoglobins, height and weight measurements, and health professional time.

In those local agencies where WIC is a part of the total health care system, a fee may be charged to WIC applicants/participants for access to other services. Agencies may charge for access to WIC services as part of their total health care system, provided that free WIC screening and certifications are equally accessible. This means that a WIC applicant/participant may be charged a fee only when other services provided by the agency are received in addition to WIC. If WIC is the only service the applicant/participant requests from the agency, it must be provided at no cost.

PPL NO. 1

285. Participant File Maintenance

Applicant or participant files must be kept on all individuals who apply for WIC services. This section also addresses referrals not responded to and screenings performed over the phone.

285.1 Record Retention

Records must be maintained for three years from the date of the submission of the Final Expense Report from the date the participant becomes inactive. All records, except medical case records of individual participants (unless they are the only source of certification data), must be available during normal business hours for representatives of USDA, the State WIC office, and the Department of the Comptroller General of the United States to inspect, audit, and copy. Any reports resulting from such examinations must not divulge names of individuals. If any type of litigation, audit, or other action involving the records has been started before the end of the three year period, the records must be kept until all issues are resolved, or until the end of the regular three year period, whichever is later.

Ineligible files and waiting lists must be kept separately. Terminated files may be kept with active files as long as there is an effective way to purge and audit. All clinics within a project must use the same filing method. Applicant/participant files may be destroyed after the record retention time period. Every effort must be made to ensure confidentiality of the applicant/participant files when these records are destroyed.

285.2 Contents of Completed WIC Charts

Table 285 lists required contents of WIC charts (electronic and paper). If the information is not kept in a WIC chart, documentation of the records must be included in the individual's medical record and be available for review.

285.3 Combined Program Applications and Referrals with No Response

If the applicant does not respond to the contact attempt or follow through with a scheduled appointment, the local WIC project must keep the referred application form in an "Inactive CPA Referral File" for a period of one calendar year.

285.4 Phone Requests Screened

- For participants currently on the program, update the chart and computer screen and schedule an appointment, if eligible, or enter a comment, if noneligible. A *WIC Cannot Serve You* Letter may need to be sent if over income or self-withdrawal and the project completes a manual termination. See section 275 regarding termination procedures. Projects may elect to let the WIC System auto terminate self-withdrawal or over income participants as long as a critical message has been made so that no future benefits are issued. See section 275.

- For individuals who call for information about the WIC program to determine qualification but who do not schedule or come for an appointment, no documentation is required.

Table 285

Type of WIC Chart and Retention Period	Description	Contents (includes electronic & paper chart)
Active Files 3 years from the date of the submission of the Final Expense Report	Eligible and receiving WIC services	-an Ohio WIC Program Applicationform -prenatal weight grid -Health History form -Nutrition Care Plan -*Welcome to WIC* letter top copy -prescription information, as needed -completed WIC System tabs including growth chart for infants & children -scheduling information
Ineligible Files 3 years from the date of the submission of the Final Expense Report	Not currently receiving services and was not receiving services at time of application	-an Ohio WIC Program Application form -Notice: *WIC Cannot Serve You Letter* top copy
Terminated Files 3 years from the date of the submission of the Final Expense Report	Not currently receiving services but was receiving services at time of application	-an WIC Program Application form -prenatal weight grid -Health History form -Nutrition Care Plan -*Welcome to WIC* letter top copy (for categorical terminations or missing midcert. appointment) -Appointment Notice Sticker (for missing recert. appointment) -*WIC Program Cannot Serve You* letter top copy (for other term. reasons) -prescription information, as needed -completed WIC System tabs
CPA and referrals not responded for a year	Participant did not apply (CPA received from another agency)	-Referral CPA All can be maintained in one file labeled: Inactive CPA Referral File.
Phone screenings	May or may not be receiving services	-For participants, update existing records. -For inquiring individuals, no paperwork is required.
Waiting List	Eligible, no open slots available	Same as active file with addition of: -Notice: *WIC Cannot Serve You* letter top

Files		copy *If the participant becomes active, the chart will also contain a top copy of the *WIC Program Can Now Serve You* letter

CHAPTER 300

300. Introduction to Chapter 300 - Food Issuance

In addition to serving as an adjunct to health care, the WIC program provides supplemental foods to participants. This complements the food dollars being spent by the participant and provides nutrients most often lacking in diets of low-income individuals. WIC benefits are supplemental and should not be relied upon as an emergency measure when other resources have been exhausted.

WIC provides prescribed amounts of the following foods:

Children and Women	**Infants**
Milk, low lactose/lactose free, or soy Milk	Formula
Cereal	Infant cereal
Whole grain foods	Infant fruits and vegetables
Peanut butter	Infant meats
Beans/peas	
Eggs	
Juice	
Cheese	
Tofu	
Canned fish	
Fruits and vegetables	
Special formulas (if applicable)	

Ohio WIC supplemental foods are made available to participants through the retail vendor system. Participants receive a WIC Nutrition Card (WNC) which is used at an authorized WIC vendor. The WNC computer chip retains the type and amount of food the participant is allowed to purchase. If prescribed by the health professional, child and adult participants will receive cash value benefits (CVB) on the WNC. The CVB allows participants to purchase authorized fruits and vegetables. The redemption of this portion of the WNC is based on the dollar value assigned and not on the amount of fruits and vegetables purchased by the participant.

This chapter provides information for prescribing and issuing WIC supplemental foods. Title 7, CFR Part 246.10 of the Federal Regulations serves as the regulatory basis for the information in this chapter.

301. Authorized Foods

Foods chosen for the WIC program supply the nutrients most often lacking in the diets of the population served by the WIC program as determined from results of *The Ten State Nutrition Survey and the Health and Nutrition Examination Survey*. Collaboration with the Institute of Medicine (IOM) emphasized the need for the supplemental foods provided by WIC to be consistent with the Dietary Guidelines for Americans and current infant feeding practice guidelines of the American Academy of Pediatrics. As a result, authorized WIC foods are high in protein, iron, calcium, vitamin A, vitamin C, folate and fiber and low in saturated fat and cholesterol.

301.1 Federal Guidelines

Title 7, CFR Part 246.10 sets the standards by which foods can be authorized for WIC. The standards include:

- minimum nutrient content,
- maximum monthly food prescription amounts, and
- ability to tailor the types and amounts of foods as deemed necessary by the health professional.

301.2 Product Review and Authorization

Each State WIC program selects specific types and brands of foods for inclusion on the Authorized Foods List, considering cost and availability of foods. Changes to the Ohio WIC Authorized Foods List are generally effective October 1.

Food Products: Food product manufacturers' requests for product review and authorization are completed biennially beginning February of even-numbered years.

Formulas: Formula manufacturers' requests for product review and authorization are completed annually beginning February of each year.

301.3 Ohio Authorized Food Criteria

The following are the general criteria used to approve a food for use in the

Ohio WIC program. The food must:

- meet the minimum nutrient content specifications (Title 7, CFR Part 246.10);
- be compatible with current dietary recommendations for maternal, infant, and child health;
- meet Ohio WIC authorized foods criteria;
- be commonly used by WIC participants;
- have a retail cost that is competitive with similar WIC approved foods; and
- be available from WIC vendors throughout the state.

The minimum requirements for supplemental foods established by federal regulations can be found in Title 7, CFR Part 246.10, [12] *Minimum Requirements and Specifications for Supplemental Foods, Table 4* and can be accessed with the following links:

http://www.fns.usda.gov/sites/default/files/wic/WICRegulations-7CFR246.pdf

http://www.fns.usda.gov/sites/default/files/03-04-14_WIC-Food-Packages-Final-Rule.pdf

See the Ohio WIC Authorized Foods List for specific products available to Ohio WIC participants.

301.4 Ohio WIC Authorized Foods List

The Ohio WIC Authorized Foods List identifies allowable food items for purchase. The list is prepared by the State WIC office and specifies particular food items within the general categories of milk, cheese, eggs, canned fish, peanut butter, beans or peas, juice, cereal, whole grains, and a cash value benefit (CVB) for fruits and vegetables. Supplemental foods for infants include infant cereal and baby foods. The types and brands of formula provided through the WIC program are not listed on the Authorized Foods List; however, the formula type and brand will be specific on the WIC Nutrition Card (WNC) and printout received in the clinic based on the food package prescribed by the WIC health professional.

Participants may only redeem the types and quantities of the foods listed

on their WNC printout, and no food substitutions are authorized.

Changes or updates to the Ohio WIC Authorized Foods List are released at least 60 days prior to the effective date. When changes or updates are made to the list, local WIC projects are responsible for the following activities:

- All local WIC project staff must be informed.

- All participants must receive a copy of the revised list prior to the effective date, with all changes or updates clearly explained. The revised list is often most conveniently distributed during benefit pickup and at certification or recertification visits.

- State WIC informs all contracted vendors of the changes or updates in writing with a copy of the list. A copy of the letter sent to the local project containing this notification must be kept on file at the local WIC project.

302. Prescription of Supplemental Foods

The Ohio WIC Authorized Foods List is the tool from which the supplemental food packages are developed. WIC foods are prescribed by the certifying health professional based on the participant's category and individual needs.

302.1 Personnel Responsible for Food Package Prescriptions

Only Ohio WIC Certifying Health Professionals are authorized to prescribe supplemental foods and change food packages. WIC Health Professional Hiring Guidelines can be found in Appendix 100.

302.2 Other Personnel Who May Issue Changed Food Packages in Unusual Situations

In rare instances, when there is no certifying health professional available in a clinic and a participant presents a prescription for formula, clerical staff should contact the project's Nutrition and Administrative Services (NAS) Consultant at the State WIC office to obtain approval to provide a food package. The clerical staff must document the phone call for approval. Upon return to the clinic, the health professional should be notified and review all relevant information.

302.3 Purposes of Food Package Prescriptions

The food package is an individualized combination of foods prescribed by the health professional for the participant. The health professional must consider the following:

- the quantity and form of foods based on nutritional needs and goals;
- participant preferences;
- household conditions (e.g., lack of refrigeration); and
- food intolerances or restrictions (e.g., provide low lactose/lactose free milk in place of regular milk).

302.4 Guidelines for Food Package Prescriptions

When prescribing a food package, the following guidelines should be considered:

- Medical or nutritional needs such as:
  - weight status;
  - food allergies;
  - lactose malabsorption and intolerance;
  - dental caries;
  - developmental, sensory, or motor disabilities;
  - medical conditions (e.g., diabetes, hypercholesterolemia); and/or
  - inborn errors of metabolism.

- Dietary habit information, such as:
  - ethnicity, cultural background or religious beliefs;
  - meal patterns (meals routinely away from home or meal schedule) which influence the types of foods typically consumed in the home;
  - lifestyle, activity level, and home environment (e.g., very little cooking done in the home); and/or
  - physical capabilities of the person responsible for food purchasing, meal planning and preparation.

303. Food Package Prescription for Women

The purpose of this section is to provide information concerning nutritional considerations for the categories of women potentially eligible for WIC benefits. Also included in this section are guidelines for prescribing food packages, examples of how to use these guidelines, and a table of monthly food package quantities presented in terms of standard servings.

303.1 Nutritional Considerations of the Pregnant or Breastfeeding Adolescent

As a result of the rapid growth occurring at puberty, several points must be considered before prescribing a food package.

1. The increased nutritional needs of the adolescent period depend on the number of years after menarche and parity. According to an Institute of Medicine report, "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."

2. Changing food habits due to psychosocial influences can also compromise nutritional intake. The following factors should be assessed.

   - peer group pressure
   - need for independence
   - emotional stress
   - interest in body shape and size
   - eating away from home

3. Food intakes tend to be low for this group when compared to values for older women. According to the Institute of Medicine 1996, “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.”

4. Each pregnant adolescent's kilocalorie needs and weight gain should be evaluated in terms of her preconception body weight and activity level.

Very lean girls will need a higher than average weight gain. Obese girls will need the normal weight gain during pregnancy. Dieting is not to be undertaken at this time since research has shown that weight loss may lower fetal birth weight.

303.2 Nutritional Considerations of the Pregnant or Breastfeeding Adult Woman

- The adult woman's kilocalorie needs should be evaluated based on preconception body weight and activity level. If kilocalorie intake is low and protein intake is adequate, encourage nonprotein foods.

- Breastfeeding women do not require increased calories to produce adequate amounts of breastmilk. However, breastfeeding women do need adequate caloric and nutrient intake to protect their own health status.

- Women who are pregnant and breastfeeding at the same time (tandem nursing) need to consume sufficient calories to gain weight at the appropriate rate for their pregnancy. They should be encouraged to eat healthful, wholesome foods when hungry and drink to quench thirst.

303.3 Nutritional Considerations of the Postpartum Woman

For the postpartum woman, the food package provides many of the nutrients which are often in short supply following a pregnancy. Replenishing these nutrient stores helps ensure a healthier mom and a healthy start for future pregnancies.

- The need for protein and kilocalories is reduced in the postpartum period. This decreased need is reflected in a smaller food package for the postpartum woman when compared with the pregnant or breastfeeding woman. The need for good sources of high quality protein continues.

- The adolescent postpartum woman's nutritional needs may be greater than those of the adult postpartum woman based on her growth needs. As in pregnancy, vitamin A, calcium, and iron are often low in adolescent postpartum women.

303.4 Nutritional Considerations of the Pregnant, Breastfeeding or Postpartum Woman Requiring Special Formula

The basic nutritional needs of these participants are similar to the needs of pregnant, breastfeeding or postpartum women not requiring formula. However, the manner in which these needs are met may be very different. Prescribing healthcare providers are physicians, nurse practitioners and physician's assistants and are the only persons authorized to prescribe special formulas. They are also required to indicate which WIC foods are appropriate for those women receiving special formula. The WIC health professional must obtain the appropriate information using the Ohio WIC Prescribed Formula and Food Request form as explained in Section 310 titled "Formulas." This information is critical in individualizing the participant's food package. Such information will also assist the health professional in counseling the participant in a manner which reinforces the physician's or nurse practitioner's care plan for this individual.

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

The supplemental foods provided by the WIC program can supply the pregnant, lactating or postpartum woman with a substantial percentage of needed energy, protein, vitamin A, vitamin C, calcium, iron, fiber and folate.

Pregnant and/or Breastfeeding: Singletons

- Pregnant, singleton women are eligible for the pregnant women food package. Those pregnant women indicating that they are planning to breastfeed must receive the exclusively breastfeeding food package in the last month of their certification period while pregnant as an incentive to breastfeed.

- An exclusively breastfeeding woman whose infant receives no formula from the WIC program is eligible for the exclusively breastfeeding food package until the baby turns one year old. When the infant begins eating solid foods, the mother can continue to receive the exclusively breastfeeding food package.

- A breastfeeding woman who is not exclusively breastfeeding is defined as substantially, partially, or minimally breastfeeding (See Section 304.1). A substantially or partially breastfeeding woman is eligible to receive a substantially/partially breastfeeding food package as long as she is

substantially/partially breastfeeding until the baby turns one year old. A substantially or partially breastfeeding woman of an infant under six months of age who decreases or ceases breastfeeding is eligible to receive the postpartum food package until she reaches six months postpartum.

- A minimally breastfeeding woman is eligible to receive a postpartum food package until the baby turns six months old. After the baby is six months old, the mother is still eligible for WIC services, but is no longer eligible for supplemental foods. In order to count the mother in the WIC Certification System, the breastfeeding food item selection is entered in the system and will remain until she has either ceased minimally breastfeeding and the status is changed or the breastfed baby has turned one year old.

- A breastfeeding woman receiving supplemental foods, who is pregnant again, should be recertified as a pregnant participant, but will be prescribed a breastfeeding food package as appropriate. The breastfeeding while pregnant participant can only receive a breastfeeding food package if the breastfed infant is 12 months of age or younger and not receiving formula from WIC.

Pregnant and/or Breastfeeding: Multiples

- Women pregnant with multiples are eligible for the pregnant with multiples food package. If they indicate that they are planning to breastfeed, they must receive the exclusively breastfeeding multiples food package in the last month of their certification period while pregnant as an incentive to breastfeed.

- Women exclusively breastfeeding multiples are eligible for the exclusively breastfeeding multiples food package. Women are only eligible for this food package if they are exclusively breastfeeding **all** infants from the same pregnancy.

- Woman who are substantially or partially breastfeeding multiples are eligible for the substantially or partially breastfeeding multiples food package. Women are only eligible for this food package if they are substantially or partially breastfeeding infants from the same pregnancy. See section 304, tables 304.2 and 304.3 for determining breastfeeding categories.

- Women who are minimally breastfeeding multiple infants from the same pregnancy are eligible for the postpartum food package until the infants turn six months old. See section 304 for determining breastfeeding categories.

- A woman breastfeeding multiples receiving supplemental foods, who is pregnant again, should be recertified as a pregnant participant, but will be prescribed a breastfeeding food package as appropriate. The breastfeeding while pregnant participant can only receive a breastfeeding food package if the breastfed infants are 12 months of age or younger and not receiving formula from WIC.

Postpartum

- A postpartum woman is eligible to receive a postpartum food package until the baby turns six months old.

When prescribing a food package, the health professional should carefully assess the participant's nutritional needs and should tailor the food package prescription accordingly. The following points should also be considered.

- Omit peanut butter for participants whose nutritional status (including dietary intake) indicates a need to reduce fat consumption and when key nutrients are available from other sources.

- Encourage water rather than juice to satisfy thirst. Juice provides extra calories which may not be needed by the normal or overweight woman. The exception would be the breastfeeding woman whose fluid intake may be compromised by decreasing the juice received.

- Limit the amount of the food prescribed if the participant indicates a dislike for a particular WIC food. A participant refusing several items in the food package cannot be refused services.

- Plan the food prescription to provide adequate amounts of the key nutrients since the Dietary Reference Intakes (DRI) for pregnant and breastfeeding women are higher for most nutrients than for postpartum women.

- In order to authorize low lactose or lactose free milk, there must be documentation on the woman's health history that she has either reported

being diagnosed with lactose intolerance by a physician or she has reported symptoms of lactose intolerance (nausea, diarrhea, abdominal bloating, or cramps) when dairy products are consumed. Low lactose or lactose free milk is substituted for milk on a ratio of one to one in half-gallon increments.

- Reduced fat (2%) milk for women may be authorized as part of a careful nutrition assessment by the health professional. Women are only eligible for this substitution if a medical need is present; it is not based on personal preference. Examples of medical need include, but are not limited to: slow weight gain, maternal weight loss, underweight or other conditions that affect nutritional status. Risk codes for pregnant women include: 10, 13, 91, and 93. Risk codes for breastfeeding and postpartum women include: 14, 91, and 93.

- Whole milk may be authorized if there is a valid prescription for both whole milk and a special formula, see Section 312 Guidelines for Issuance of Special Formulas.

- Soy milk and/or tofu may be authorized by the health professional as a substitution for milk if there is documentation on the health history that she has been diagnosed by a physician with a qualifying medical condition such as milk allergy, severe lactose maldigestion, or she follows a vegetarian/vegan diet. It is at the discretion of the health professional to decide if more than 4 lbs. of tofu are to be substituted for milk.

Tables 303.1-303.4 have been developed to assist the health professional by listing the number of servings provided each month by a given amount of food.

GUIDELINES FOR PRESCRIBING FOOD PACKAGES FOR PREGNANT AND SUBSTANTIALLY AND PARTIALLY BREASTFEEDING WOMEN

Food item	Amount	Serving Size	Serving/Month
Milk	5.5 gallons	1 cup	88
	4 gallons	1 cup	64
	2 gallons	1 cup	32
Juice	144 ounces	½ cup	36
	128 ounces	½ cup	32
	96 ounces	½ cup	24
	64 ounces	½ cup	16
Cereal	36 ounces	1 ounce	36
Eggs	1 dozen	1 egg	12
Peanut butter	16 to 18 ounce container	2 tablespoons	7-9
Beans*	1 pound dry	½ cup (cooked)	12
Whole grains	1 pound	1 slice or ½ cup	16 slices/varies
Fruits and vegetables	$10	1 medium piece of fruit, 1 cup raw vegetables or ½ cooked vegetables	Varies

*64 oz. of canned beans may be substituted for 1 lb. of dry beans

Table 303.1

GUIDELINES FOR PRESCRIBING FOOD PACKAGES FOR POSTPARTUM WOMEN

Food item	Amount	Serving Size	Serving/Month
Milk	4 gallons	1 cup	64
	3 gallons	1 cup	48
	2 gallons	1 cup	32
Juice	96 ounces	½ cup	24
	64 ounces	½ cup	16
	1-11.5/12 oz concentrate	½ cup	12
Cereal	36 ounces	1 ounce	36
Eggs	1 dozen	1 egg	12
Peanut butter	16 to 18 ounce container	2 tablespoons	7-9
Beans*	1 pound dry	½ cup (cooked)	12
Fruits and vegetables	$10	1 medium piece of fruit, 1 cup raw vegetables or ½ cooked vegetables	Varies

*****beans may be substituted for peanut butter

Table 303.2

GUIDELINES FOR PRESCRIBING FOOD PACKAGES FOR EXCLUSIVELY BREASTFEEDING WOMEN/WOMEN SUBSTANTIALLY OR PARTIALLY BREASTFEEDING MULTIPLES/WOMEN PREGNANT WITH MULTIPLES

Food item	Amount	Serving Size	Serving/Month
Milk	6 gallons	1 cup	96
	4 gallons	1 cup	64
	2 gallons	1 cup	32
Cheese	1 pound	2 ounces	8
Juice	144 ounces	½ cup	36
	128 ounces	½ cup	32
	96 ounces	½ cup	24
	64 ounces	½ cup	16
Cereal	36 ounces	1 ounce	36
Eggs	2 dozen	1 egg	24
Fish	30 ounces	3 ounces	10
Peanut butter	16 to 18 ounce container	2 tablespoons	7-9
Beans*	1 pound dry	½ cup (cooked)	12
Whole grains	1 pound	1 slice or ½ cup	16 slices/varies
Fruits and vegetables	$10	1 medium piece of fruit, 1 cup raw vegetables or ½ cooked vegetables	Varies

*64 oz. of canned beans may be substituted for 1 lb. of dry beans

Table 303.3

GUIDELINES FOR PRESCRIBING FOOD PACKAGES FOR EXCLUSIVELY BREASTFEEDING WOMEN BREASTFEEDING MULTIPLES

(The following items are averaged over two months' time: cheese, juice, peanut butter and whole grains)

Food item	Amount	Serving Size	Serving/Month
Milk	9 gallons	1 cup	144
	5 gallons	1 cup	80
Cheese	3 pounds	2 ounces	12
Juice	432 ounces	½ cup	54
Cereal	54 ounces	1 ounce	54
Eggs	3 dozen	1 egg	36
Fish	45 ounces	3 ounces	15
Peanut butter	3 16 to 18 ounce containers	2 tablespoons	21-27**
Beans*	3 pounds dry	½ cup (cooked)	12**
Whole grains	3 pounds	1 slice or ½ cup	24 slices/varies
Fruits and vegetables	$15	1 medium piece of fruit, 1 cup raw vegetables or ½ cooked vegetables	varies

* 64 oz. of canned beans may be substituted for 1 lb. of dry beans
** any combination of peanut butter and beans are averaged over two months

Table 303.4

Examples for using Tables 303.1-303.4 follow:

EXAMPLE 1:

A pregnant woman indicates that she only drinks one cup of milk per day. Further questioning reveals that the most she could possibly drink would be two cups per day. Refer to the line on Table 303.1 which provides servings/month of milk. If a food package containing four gallons of milk is given, the participant will have enough milk for 32 days (64 servings/month ÷ two servings/day). Since she might be willing to cook with the extra milk, four gallons would be an appropriate amount. Food packages containing five and a half gallons of milk would be too large for this participant.

EXAMPLE 2:

A postpartum woman is determined to be overweight according to the BMI Table for Determining Weight Classifications for Women in Chapter 200 in the section titled "Weight Evaluations for Women." Further questioning reveals that she drinks juice about 3 or 4 times a week and cooks with beans often. Refer to the line on Table 303.2 which provides servings/month of juice. If the food package containing one 64 ounce bottle of juice is given, the participant will have enough juice for 4 servings per week (16 servings/month ÷ 4 servings/week). Since the participant cooks with beans often and prefers canned beans, 64 ounces of canned beans can be included in the food package in place of 18 ounces of peanut butter.

304. Food Package Prescription for Infants

Optimum infant nutrition is a key factor in influencing the ultimate physical and mental growth and development of the child. Sufficient calories and nutrients must be provided to meet the developmental needs of the growing infant. The diet must be selected, prepared and offered in such a way that a foundation is laid for the development of sound eating habits throughout life. Breastfeeding is the optimal way to lay this foundation. If a mom is unable to or chooses not to offer breastmilk, formula is the next choice.

304.1 Breastfeeding Definitions and the Mother/Infant Dyad

The food packages breastfeeding women and breastfed infants are eligible for are directly related to the breastfeeding frequency of the mother/infant dyad. To ensure breastfeeding success, breastfed infants in the first month of life should not receive supplemental formula. Health professionals should address concerns and provide support and appropriate follow-up for all breastfeeding dyads so that supplemental formula is only prescribed if necessary. Early supplementation can cause lactation failure. Breastfed infants that are assessed as requiring supplementation within the first month of life are only eligible to receive one can of powder formula. This one can of formula is not to be routinely given to all breastfed babies. The goal is to provide support during the first month so that the mother/infant dyad can return to exclusive breastfeeding. The following are breastfeeding definitions for the first 30 days of life and beyond, and the food packages mother/infant dyads are eligible to receive.

Exclusively (E) Breastfeeding

		Food Package Eligibility	
Age of the baby	**Definition**	**Infant**	**Mother**
0-30 days old (birth month)	No formula	Exclusively breastfeeding	Exclusively breastfeeding
1-5 months	No formula	Exclusively breastfeeding	Exclusively breastfeeding
6-11* months	No formula; Baby cereal and baby foods	Exclusively breastfeeding; baby cereal and baby foods	Exclusively breastfeeding

Table 304.1

*Month 11 is equivalent to the month in which the infant turns one year old.

Substantially (S) Breastfeeding

		Food Package Eligibility	
Age of the baby	**Definition**	**Infant**	**Mother**
0-30 days old (birth month)	averages < 3.5 oz formula/day	1 can powder formula	Substantial breastfeeding
1-5 months	averages ≤8oz formula/day	Partial formula or less	Substantial breastfeeding
6-11* months	averages ≤8oz formula/day	Partial formula or less; baby cereal and baby foods	Substantial breastfeeding

Table 304.2

*Month 11 is equivalent to the month in which the infant turns one year old.

Partially (P) Breastfeeding

		Food Package Eligibility	
Age of the baby	**Definition**	**Infant**	**Mother**
0-30 days old (birth month)	averages 3.5oz formula/day	1 can powder formula	Partial breastfeeding
1-5 months	averages 9-16 oz formula/day	Partial formula or less	Partial breastfeeding
6-11* months	averages 9-16 oz formula/day	Partial formula or less; baby cereal and baby foods	Partial breastfeeding

Table 304.3

*Month 11 is equivalent to the month in which the infant turns one year old.

Minimally (M) Breastfeeding

		Food Package Eligibility	
Age of the baby	**Definition**	**Infant**	**Mother***
0-30 days old (birth month)	averages >3.5 oz formula/day	Full formula	Postpartum
1-5 months	averages >16 oz formula/day	Full formula or less	Postpartum
6-11** months	averages >16 oz formula/day	Full formula or less; baby cereal and baby foods	Postpartum

Table 304.4

*Minimally breastfeeding women are only eligible for supplemental foods until the baby is six months old. After the baby is six months old, the mother is still eligible for WIC services, but is no longer eligible for supplemental foods.
**Month 11 is equivalent to the month in which the infant turns one year old.

Mother/Infant Dyad: Multiples

If a mother of multiples is exclusively breastfeeding at least one infant from the same pregnancy, she is considered a substantially breastfeeding woman of multiples.

A breastfeeding mother of multiples may choose to provide formula to all infants from the same pregnancy. To determine her breastfeeding status, the total amount of formula provided to all infants should be divided by the total number of infants. The calculated average amount of formula should then be compared to the above tables.

EXAMPLE:
A mother breastfeeds both of her four month old infants. Infant A receives 8 ounces of formula per day and Infant B receives 12 ounces of formula per day. Determine the average amount of formula for each infant: 8 oz. (of formula) + 12 oz. (of formula) = 20 oz. total formula for both infants. 20 oz. ÷ 2 (# of infants) = 10 ounces of formula per day per infant. Table 304.3 shows a mother of an infant age 1-5 months who receives 9-16 ounces of formula per day is eligible for a partially breastfeeding multiples food package.

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

Exclusively breastfed infants: These infants will have no benefits issued to the WNC. The mother will be issued three months of benefits for the exclusively breastfeeding woman's food package.

- Local staff should provide breastfeeding support and encouragement to protect exclusive breastfeeding.

Substantially or partially breastfed infants: These infants may be issued one can of powder formula if appropriate based on local clinic policy, health professional judgment, and breastfeeding staff recommendation. It is important to note that no additional formula can be issued in the birth month once the one can has been redeemed. No benefits will be prescribed for the subsequent two months until breastfeeding status is reviewed. The mother will be issued three months of benefits for the partially breastfeeding woman's food package.

- The ultimate goal for the mother/infant dyad is to return to exclusive breastfeeding. Local staff should provide breastfeeding support and encouragement to promote exclusive breastfeeding.

Minimally breastfed infants: The nonbreastfeeding formula package is available to minimally breastfeeding infants as appropriate. It is possible for an infant who is substantially/partially breastfed to be issued the nonbreastfeeding formula package in the first month of life because the other option of one can of powder formula may not be enough. In subsequent months, health professionals have the ability to choose from all formula tailoring options, so that over the duration of several months, only the amount of supplemental formula that is needed is provided. Health professionals must not prescribe breastfed infants formula amounts that result in the infant receiving an excessive amount of formula. Infants may be issued three months of benefits. The mother will be issued three months of benefits for the postpartum woman's food package.

- Although the infant received a nonbreastfeeding formula package in the birth month, appropriate breastfeeding follow-up and support should be offered to the mother/infant dyad with the goal of minimizing the amount of supplemental formula the infant is receiving. It is possible for the mother/infant dyad to return to either exclusively, substantially, or partially breastfeeding.

304.3 General Guidelines for Prescribing and Issuing Food Packages for the Breastfeeding Mother/Infant Dyad

- Voiding and Reissuing Food Packages for the Breastfeeding Mother/Infant Dyad: Because the food packages available for the mother/infant dyad are directly related to the breastfeeding status and frequency of the dyad, any time there is a change in breastfeeding frequency, there will be a change in the food package that should be provided. Therefore, the breastfeeding status and/or breastfeeding frequency fields **must** be updated in the WIC system prior to voiding and reissuing benefits. This is the only way to ensure that the mom and infant receive the most appropriate food package.

  - Exclusively breastfed infant: if after appropriate follow-up it is determined that supplemental formula is needed, formula can be added to the WNC. Formula should not be prescribed for a breastfed baby solely based on the mother's concern that she is not making enough breastmilk.

  - Substantially or partially breastfed infant: if after appropriate follow-up it is determined that the infant's food package needs to be adjusted, it is appropriate to do the following:

    - Birth Month – Add current and/or adjust future benefits. The amount of formula is prorated according to the week that the participant comes to the clinic to request the change.

    - Month 1 through Month 11 - Tailor the amounts of formula prescribed to meet the needs of the infant and then add current month and/or adjust future benefits. The amount of formula is prorated according to the week that the participant comes to the clinic to request the change.

  - Minimally breastfed infant: if after appropriate follow-up it is determined that the infant's food package needs to be adjusted, it is appropriate to do the following:

    - Tailor the amounts of formula prescribed to meet the needs of the infant. After assessing the intake of breastmilk and formula, it is possible that a tailored formula package can be offered instead of the nonbreastfeeding (full) formula package. Health professionals have the ability to choose from several tailored formula options when prescribing the food package.

304.4 Infant Formulas

- Food package selections for non-breastfed infants 0-5 months of age are limited to infant formula. Iron-fortified, milk-based formula is the Ohio WIC program's standard choice of formula. Refer to Section 312 for specific considerations and required documentation for providing a formula other than an iron-fortified, milk-based formula.

- At-risk infant formula packages: In rare instances an infant between 6-12 months who is on a prescribed formula may not be able to tolerate infant cereal and baby foods and may be able to receive a larger amount of infant formula. Infants eligible for food packages with larger amounts of formula must meet the following:

    - must be 6-12 months of age;
    - have one of the following risk codes for the certification period which the prescribed formula will be issued: 50, 51, 53, 56, 57, 91 or 93; and
    - the Ohio WIC Prescribed Formula and Food Request form must be completed and the "Required Supplemental Food Information" section (Part C) of the form must indicate that all infant foods are contraindicated.

  If the infant meets all of the criteria listed above, the health professional may prescribe the at-risk infant formula package. There may be instances where an infant is assessed by the health professional as having a valid medical need to delay the introduction of solids, meets the age and risk criteria, but is not on a prescribed formula. If this occurs, the health professional must document the reason for assigning the at-risk formula package on the nutrition care plan and should contact the participant's healthcare provider regarding the assessment.

304.5 Nutritional Considerations for the Addition of Cereal and Baby Foods

The addition of cereal and baby food at six months of age is not to be construed as a rigid schedule for the introduction of supplemental foods for individual infants. Some infants may receive cereal at four months of age as determined appropriate by their health care provider, but the WIC program is unable to provide cereal before six months of age. Baby food fruits and vegetables can be provided to all infants at six to twelve months of age. Baby food meats can be provided only to the exclusively breastfed infant starting at six months of age. Amounts of baby

food fruits, vegetables, and meats must be tailored by the health professional to the infant's needs.

The following points should be considered before determining the amounts of cereal and baby food to provide:

- Consider the infant's developmental signs as well as the infant's rate of growth, level of activity, and whether or not semisolid food has been introduced, if this information is available. Use these indicators to determine when to add cereal and baby food to the food package rather than automatically prescribing them at a certain age. (See Appendix 200, Justification Risk Code 38.) Document in the infant's chart any condition which might delay or prevent the introduction of supplemental foods.

Tables 304.5 and 304.6 have been developed to assist the health professional by listing the serving size, or number of jars per week and month of infant cereal and baby foods. Serving size will vary depending on the age of the infant.

GUIDELINES FOR PRESCRIBING FOOD PACKAGES FOR INFANTS

Food Item	Amount	Serving Size	Servings/Month
Infant Cereal	8 ounces	2 tablespoons	30
	16 ounces	2 tablespoons	60
	24 ounces	2 tablespoons	90

Table 304.5

Food Item	Amount	Jars/Week	Jars/Month
Infant Fruits	64 ounces	4	16
and Vegetables	128 ounces	8	32
	192 ounces*	12	48
	256 ounces*	16	64
Infant Meats	40 ounces*	4	16
	60 ounces*	6	24
	77.5 ounces*	7	31

An (*) indicates amounts are only available to the exclusively breastfed infant.

Table 304.6

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

In the month that an infant turns 13 months of age, a child's food package must be issued unless a physician's prescription is provided by the parent/caregiver stating that formula should be continued beyond 12 months of age. Conversion of the infant to the child food package may occur no earlier than the month in which the infant turns one year of age. When converting the food package from an infant to a child food package, parents should be reminded that whole milk will be provided until the child is two years old. See Section 305 for other milk options.

305. Food Package Prescriptions for Children

A number of food package options are available to assist the health professional in prescribing a food package which meets the individual child's needs and preferences. Children between the ages of one and five years are in a period of changing nutritional needs as body size, rates of growth, and physical activity change.

This section includes guidelines for prescribing food packages, examples of how to use these guidelines, and Table 305.1 which lists the number of servings provided each month by a given amount of food.

305.1 Nutritional Considerations of Children Requiring Special Formula

For child participants who must stay on infant formula or a prescribed pediatric formula, a prescription is required. Prescribing healthcare providers are physicians, nurse practitioners and physician's assistants and are the only persons authorized to prescribe infant formulas or special formulas for children over one year of age. They are also required to indicate which WIC foods are appropriate for those children receiving infant formula or a prescribed pediatric formula. Child participants receiving a prescribed formula are eligible to receive additional milk substitutions. See Section 312 for specific information about special child food package milk substitutions.

The WIC health professional must obtain the appropriate information using the Ohio WIC Prescribed Formula and Food Request form as explained in Section 312. This information is critical in individualizing the participant's food package. Such information will also assist the health professional in counseling the participant in a manner which reinforces the prescribing healthcare provider's care plan for this individual.

305.2 Guidelines for Prescribing Food Packages for Children

When prescribing a food package, the health professional should carefully assess the participant's nutritional needs and should tailor the food package prescription accordingly. The following points should also be considered:

- Refer to the prescription guidelines defined in section 304.6 titled "Conversion of an Infant Food Package to a Child Food Package."

- Amounts of peanut butter and eggs may be reduced or eliminated for participants whose nutritional status (including dietary intake) indicates a need

to reduce fat, cholesterol, and/or sodium consumption and when key nutrients are available from other sources.

- In order to authorize low lactose/lactose free milk, there must be documentation on the health history that the parent/caregiver has either reported that the child has been diagnosed with lactose intolerance by a physician, or the parent/caregiver has reported that the child experiences symptoms of lactose intolerance (nausea, diarrhea, abdominal bloating, or cramps) when dairy products are consumed. Low lactose or lactose free milk is substituted for milk on a ratio of one to one in half-gallon increments.

- Too much milk or juice may decrease the young child's appetite for foods which require more chewing such as poultry, red meat, and vegetables. Iron deficiency may result if this situation exists for an extended period of time.

- Remind the parent/guardian that water, rather than juice, may be used to satisfy thirst. Juice provides extra calories which may not be needed by the normal or overweight child. Children should not routinely drink more than four to six ounces of juice per day.

- Limit the amount of, or do not authorize, a particular WIC food if the parent/guardian indicates a child's dislike for that food.

- Small children can easily choke on food. Foods that are small, round, tough or smooth are most likely to cause choking. Peanut butter can cause choking if it is spread thickly or spoon fed; therefore, it should not be routinely included in the food package when the infant turns one year of age. When peanut butter is included in the food package for children less than three years of age, health professionals must inform the parent/guardian that it is a choking hazard and educate on safe feeding practices.

- For participants who have one or more meals per day provided by a child care center or other institutional feeding program on a regular basis, tailor quantities of milk, eggs, juice, peanut butter or legumes, whole grains, and cereal accordingly.

- Whole milk can only be provided to children ages 12 to 23 months. Reduced fat (2%) milks may be issued to 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. The need for reduced fat (2%) milk for children ≥ 24

months of age will be determined as part of the careful nutrition assessment by the health professional. Children are only eligible for this substitution if medically warranted and not based off of personal preference. Examples include, but are not limited to: failure to thrive, slow weight gain, underweight or other conditions that affect nutritional status. Risk codes for children 2-5 years include: 53, 55, 56, 91, and 93. Whole milk can only be provided to children 24 months and older with a valid prescription for both whole milk and a special formula. See Chapter 300 section 312 Guidelines for Issuance of Special Formulas.

- Soy milk and/or tofu may be authorized by the health professional as a substitution for milk with a qualifying medical condition such as milk allergy, severe lactose maldigestion, and vegetarian/vegan diets. See Chapter 300 section 312 Guidelines for Issuance of Special Formulas.

Tables 305.1A and 305.1B have been developed to assist the health professional by listing the number of servings provided each month by a given food and serving size.

GUIDELINES FOR PRESCRIBING FOOD PACKAGES
CHILDREN 1-3 YEARS OLD

Food item	**Amount**	**Serving Size**	**Servings/Month**
Milk	4 gallons	½ cup	128
	3 gallons	½ cup	96
	2 gallons	½ cup	64
Juice	128 ounces	⅓ cup	43
	96 ounces	⅓ cup	32
	64 ounces	⅓ cup	21
	48 ounces	⅓ cup	16
Cereal	36 ounces	¼ cup	Varies
Eggs	1 dozen	1	12
Peanut butter	16 ounce container	1 tablespoon	14-18
Beans*	1 pound dry	½ cup cooked	12
Whole grains	2 pounds	½ slice or ¼ cup	64/varies
Fruits and vegetables	$8	¼-⅓ cup cooked or ⅔-½ cup raw	Varies

Table 305.1A ***beans may be substituted for peanut butter; 64 oz. of canned beans may be substituted for 1 lb. of dry beans

GUIDELINES FOR PRESCRIBING FOOD PACKAGES
CHILDREN 4 – 5 YEARS OLD

Food item	Amount	Serving Size	Servings/Month
Milk	4 gallons	½ cup	128
	3 gallons	½ cup	96
	2 gallons	½ cup	64
Juice	128 ounces	½ cup	32
	96 ounces	½ cup	24
	64 ounces	½ cup	16
	48 ounces	½ cup	12
Cereal	36 ounces	½ cup	Varies
Eggs	1 dozen	1 egg	12
Peanut butter	16-18 ounce container	1 tablespoon	14-18
Beans*	1 pound dry	½ cup cooked	12
Whole grains	2 pounds	1 slice or ½ cup	32 slices/varies
Fruits and vegetables	$8	½ cup cooked or 1 cup raw	Varies

Table 305.1B ***beans may be substituted for peanut butter; 64 oz. of canned beans may be substituted for 1 lb. of dry beans

An example using Table 305.1A follows:

EXAMPLE:

A two-year-old child is determined to be underweight when he plots below the 5th percentile on a Body Mass Index (BMI)-for-age growth chart. The parent/guardian indicates that the child usually consumes two servings of skim milk, one serving of cheese, and one serving of juice each day. The child refuses eggs, but is not allergic to them.

An appropriate food package for this child would be one which included four gallons of milk, 36 ounces of cereal, two 64 ounce containers of juice, one dozen eggs, and 18 ounces of peanut butter. The parent or guardian should be encouraged to make cream soups and puddings. Although the child refuses eggs fixed alone, cooking with eggs should be encouraged. One percent milk should

be encouraged over skim milk. Two percent milk may be authorized if the health professional deems it appropriate, unless the child refuses or has a medical condition which contraindicates this product. The health professional must document reasons for authorizing 2% milk. The parent or guardian may be encouraged to offer cereal for small snacks during the day. The juice provided is about what the child normally drinks.

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310. Formulas

The Ohio Department of Health, Bureau of Nutrition Services, subscribes to the infant feeding recommendations made by the American Academy of Pediatrics, Committee on Nutrition. Breastfeeding is the feeding method of choice for most infants. Infants who are not exclusively breastfed should receive iron-fortified formula until one year of age.

Table 310A briefly describes each of the WIC-approved formulas available to participants in Ohio, outlines indications for use, and specifies the supporting documentation required, if any.

Caregivers are often concerned about the amount of formula that an infant should take. Table 310B provides general guidelines for formula intake for infants 0-12 months of age; health professionals and caregivers should understand that intakes varying from these guidelines may be normal. In determining appropriate formula intake, the WIC health professional should evaluate the infant's growth, especially weight for length, as well as formula preparation methods, the infant's developmental readiness, and intake other than formula. The caregiver should be reminded that WIC is a supplemental nutrition program and may not provide all of the formula required to meet the infant's needs.

The amount of formula an infant receives is dependant upon:

- The breastfeeding status of the mother/infant dyad
    - If an infant is substantially (S) or partially (P) breastfed, the infant can receive up to the maximum amount of formula for a substantially/partially breastfed infant.
    - If an infant is minimally (M) breastfed, the infant can receive up to the maximum amount of formula for a nonbreastfed infant.
    - Refer to sections 304.1-304.3 for additional information.

- The age of the infant
  - Formula amounts in food packages are variable from month to month as the amount of formula is based upon the age of the infant. The Formula Guide in Appendix 300 outlines the amount of formula per month infants are eligible to receive and the tailoring options available for nonbreastfed and breastfed infants.

310.1 Nonauthorized Formula Documentation

The Ohio WIC program cannot provide formulas that are not WIC-eligible, does not authorize all formulas that are WIC-eligible, nor provides authorized formula over the federal maximum amounts. In these circumstances, the WIC Formula Availability Letter in Appendix 300 provides documentation for participants and applicants to submit to their Medicaid or Medicaid Managed Care Plan for coverage.

The WIC Formula Availability Letter is used to provide the participant or parent/guardian with the following:

- documentation indicating what formula and how much formula the participant receives from WIC per month,
- documentation that the formula prescribed is not WIC authorized, or
- documentation indicating that the participant has inquired about applying or has applied for WIC and is not eligible.

This letter **must** be completed when an applicant/participant needs:

- more formula than WIC provides;
- multiple formulas;
- a non-WIC-authorized formula, and chooses to participate in WIC; or
- a non-WIC-authorized formula, and chooses not to participate in WIC.

A copy of the letter must be retained in the participant's chart. An applicant that contacts the WIC clinic via phone to inquire about the availability of a formula should also receive this letter if the formula inquired about is not available from WIC. For clinic purposes, it is recommended that projects retain copies of letters completed for non-WIC participants.

Staff is to give or mail the completed letter to the participant who then submits it for processing. WIC staff is only required to provide the WIC Formula Availability Letter, but many participants may be unsure of how to proceed once the WIC Formula Availability Letter is complete. Staff should encourage them to contact their Medicaid managed care member line for assistance.

If staff chooses to fax a copy of the WIC Formula Availability Letter to the pharmacist or homecare company in order to better assist the participant, consent must first be obtained. Local WIC staff needs to fill in the consent for sharing information part of the Welcome to WIC (WTW) letter and have the participant sign the WTW letter. If the WIC Formula Availability Letter is needed after the certification or recertification appointment, local WIC staff must update the most recent WTW letter with the appropriate entity and the participant must initial the consent for sharing information part of the WTW letter.

AUTHORIZED WIC FORMULAS

TYPE OF FORMULA Name of Formula	**BASIC DESCRIPTION** (Reconstituted amounts are for one can).	**INDICATIONS FOR USE**	**DOCUMENTATION REQUIRED**
Milk-Based, Iron-Fortified Infant Formula • Similac Advance (Abbott)	Milk-based, iron-fortified formula. Provides 20 calories and .36 mg iron per fluid ounce. Available in powder, liquid concentrate, and Ready-to-feed (RTF). Reconstituted powder 12.4 oz: 90 fl oz Reconstituted concentrate: 26 fl oz	For routine feeding as a supplement to breastfeeding or when breastfeeding is discontinued before age one.	None for powder or liquid concentrate RTF requires documentation of necessity on Health History Form. **Follow state policy for use of RTF.**
Soy-Based, Iron-Fortified Infant Formula • Similac Soy Isomil (Abbott)	Soy-based, iron-fortified formula. Provides 20 calories and .36 mg iron per fluid ounce. Available in powder, liquid concentrate, and RTF. Reconstituted powder 12.4 oz: 90 fl oz Reconstituted concentrate: 26 fl oz	For management of galactosemia, lactose intolerance, and temporary lactose intolerance following illness. May also be used for routine feeding. Generally not recommended for premature infants due to the risk of osteopenia.	None for powder or liquid concentrate RTF requires documentation of necessity on Health History Form. **Follow state policy for use of RTF.**
Milk-Based, Iron-Fortified, Low-Lactose, and Rice Thickened Infant Formula • Similac for Spit-Up (Abbott)	Milk-based, iron-fortified formula with added rice starch. Vitamins and minerals are balanced to prevent displacement from added rice starch. Provides 19 calories and .36 mg iron per fluid ounce. Available in powder and RTF. Reconstituted powder: 90 fl oz	For management of symptoms of gastroesophageal reflux disease (GERD) or other feeding disorders not associated with overfeeding or incorrect positioning.	Authorization from a prescribing healthcare provider. Documentation of medical need and appropriateness. **Follow state policy for use of formulas with added rice starch.** RTF requires documentation of necessity on Health History Form. **Follow state policy for use of RTF.**
Milk-Based, Low-Lactose Infant Formula • Similac Sensitive (Abbott)	Milk-based, low-lactose, iron-fortified infant formula. Provides 19 calories and .36 mg iron per fluid ounce. Available in powder and RTF. Reconstituted powder: 90 fl oz	Available for infants with documented lactose intolerance. Not intended for the treatment of galactosemia. Note: The added prebiotic *galacto-oligosaccaride* (GOS) is milk based and adds a small amount of lactose.	Authorization from a prescribing healthcare provider. Documentation of medical need and appropriateness. **Follow state policy for use of low-lactose/lactose-free milk-based formula.** RTF requires documentation of necessity on Health History Form. **Follow state policy for use of RTF.**
Milk-Based, Modified Vitamin and Mineral Content Infant Formula • Similac PM 60/40 (Abbott)	Milk-based, low-iron formula. Provides 20 calories and .14 mg iron per fluid ounce. Provides reduced levels of several vitamins, minerals, and electrolytes. Provides 60% of protein as casein, 40% protein as whey. Available in powder. Reconstituted powder: 102 fl oz	Indicated for infants predisposed to hypocalcemia or whose renal, digestive, or cardiovascular functions would benefit from lowered mineral levels.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.

AUTHORIZED WIC FORMULAS

TYPE OF FORMULA Name of Formula	**BASIC DESCRIPTION** (Reconstituted amounts are for one can).	**INDICATIONS FOR USE**	**DOCUMENTATION REQUIRED**
Premature Infant Formula • Similac Expert Care NeoSure (Abbott)	Milk-based, iron-fortified premature formula. Provides 22 calories and ~.40 mg iron per fluid ounce. Available in powder and RTF. Reconstituted powder 13.1 oz: 87 fl oz	Standard formula for preterm infants. Available to preterm or low birth weight infants up to twelve months adjusted age.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first. RTF should generally be reserved for immunocompromised premature infants, or premature infants under six-months of adjusted age.
Premature Infant Formula • Enfamil EnfaCare (Mead Johnson)	Milk-based, iron-fortified premature formula. Provides 22 calories and ~.40 mg iron per fluid ounce. Available in powder and RTF. Reconstituted powder: 82 fl oz	Standard formula for preterm infants. Available to preterm or low birth weight infants up to twelve months adjusted age.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first. RTF should generally be reserved for immunocompromised premature infants, or premature infants under six-months of adjusted age.
Hypoallergenic Infant Formula • Enfamil Nutramigen with Enflora LGG (Mead Johnson)	Extensively hydrolyzed, lactose-free formula. Contains 0% of fat as MCT. Provides 20 calories and .36 mg iron per fluid ounce. Available in powder. Reconstituted powder: 87 fl oz	Indicated for infants with cow milk or soy protein sensitivity or severe food allergies.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Infant Formula • Enfamil Nutramigen (Mead Johnson)	Extensively hydrolyzed, lactose-free formula. Contains 0% of fat as MCT. Provides 20 calories and .36 mg iron per fluid ounce. Available in liquid concentrate and RTF. Reconstituted concentrate: 26 fl oz	Indicated for infants with cow milk or soy protein sensitivity or severe food allergies.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first. **Follow state policy for use of RTF for this product.**
Hypoallergenic Infant Formula with MCT • Similac Expert Care Alimentum (Abbott)	Extensively hydrolyzed, lactose-free formula. Contains 33% of fat as MCT. Provides 20 calories and .36 mg iron per fluid ounce. Available in powder and RTF. Reconstituted powder: 115 fl oz	Indicated for infants with cow milk or soy protein sensitivity, severe food allergies and fat malabsorption. Note: powdered Alimentum contains corn; RTF is corn-free.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first. **Follow state policy for use of RTF for this product.**
Hypoallergenic Infant Formula with MCT • Enfamil Pregestimil (Mead Johnson)	Extensively hydrolyzed, lactose-free formula. Contains 50% of fat as MCT. Provides 20 calories and .36 mg iron per fluid ounce. Available in powder. Reconstituted powder: 112 fl oz	Indicated for infants with cow milk or soy protein sensitivity, severe food allergies and fat malabsorption.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.

AUTHORIZED WIC FORMULAS

TYPE OF FORMULA Name of Formula	BASIC DESCRIPTION (Reconstituted amounts are for one can).	INDICATIONS FOR USE	DOCUMENTATION REQUIRED
Hypoallergenic Elemental Infant Formula • PurAmino DHA/ARA (Mead Johnson)	100% amino-acid based formula. Contains 33% of fat as MCT. Provides 20 calories and .36 mg iron per fluid ounce. Available in powder. Reconstituted powder: 98 fl oz	Indicated for infants with cow milk or soy protein sensitivity, gastrointestinal impairment, sensitivity to extensively hydrolyzed proteins and severe food allergies.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Elemental Infant Formula with MCT • EleCare for Infants (Abbott)	100% amino-acid based formula. Contains 33% of fat as MCT. Provides 20 calories and .36 mg iron per fluid ounce when prepared as infant formula. Available in powder. Reconstituted powder: 95 fl oz	Indicated for infants with cow milk or soy protein sensitivity, gastrointestinal impairment, sensitivity to extensively hydrolyzed proteins, severe food allergies and fat malabsorption.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Elemental Infant Formula with MCT • Neocate Infant with DHA & ARA (Nutricia North America)	100% amino-acid based formula. Provides 20 calories, 0.16 mg iron per fluid ounce, and 33% MCT oil. Available in powder. Reconstituted powder: 84 fl oz	Indicated for infants with cow milk or soy protein sensitivity, gastrointestinal impairment, sensitivity to extensively hydrolyzed proteins and severe food allergies.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Elemental Caloric Medical Food • Neocate Nutra (Nutricia North America)	100% amino-acid based medical food. Provides 175 calories, 3 grams protein, 7 grams fat, 2.2 mg iron per serving (37grams of powder.) Preparation will vary as prescribed by physician or dietitian.	Indicated for infants and children with cow milk or soy protein sensitivity, gastrointestinal impairment, sensitivity to extensively hydrolyzed proteins and severe food allergies. Note: Not nutritionally complete. Not for use with tube feeding.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Blenderized Foods Pediatric Formula • Compleat Pediatric (Nestle)	Nutritionally complete, milk-based, lactose and gluten-free formula. Protein is from casein, chicken, and pea puree. Provides 30 calories and .39 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with intolerance to standard pediatric formulas requiring tube feeding. Not for oral supplementation. Note: contains cranberry juice cocktail, chicken, peas, green beans, and peaches.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Blenderized Foods Reduced Calorie Pediatric Formula • Compleat Pediatric Reduced Calorie (Nestle)	Nutritionally complete, milk-based, lactose and gluten-free formula. Protein is from casein, chicken, and pea protein powder. Provides 18 calories and .38 mg iron per fluid ounce. Contains 3.4g/L of insoluble fiber. Available in RTF.	Indicated for children over 1 year of age requiring tube feedings with decreased energy needs. Not for oral supplementation. Note: contains cranberry juice, chicken, peas, green beans, peaches, carrots, and tomatoes.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.

AUTHORIZED WIC FORMULAS

TYPE OF FORMULA Name of Formula	**BASIC DESCRIPTION** (Reconstituted amounts are for one can).	**INDICATIONS FOR USE**	**DOCUMENTATION REQUIRED**
Milk-Based Pediatric Formula • Boost Kid Essentials 1.0 Cal (retail) (Nestle)	Nutritionally complete, milk-based, lactose and gluten-free formula. Protein is from whey and casein. Provides 30 calories and .41 mg iron per fluid ounce. Available in RTF. Retail packaging is 8.25 oz.	Indicated for children over 1 year of age requiring tube feeding, full diet, or oral supplementation. Limited approval for infants with serious medical conditions. Contact NAS consultant for approval.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Pediatric Formula • PediaSure • PediaSure Enteral • PediaSure with Fiber • PediaSure Enteral with Fiber (Abbott)	Nutritionally complete, milk-based, lactose and gluten-free formula with or without fiber. Protein is predominately casein. Provides 30 calories and .40 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with a medical condition requiring tube feeding, full diet, or oral supplementation. Limited approval for infants with serious medical conditions. Contact NAS consultant for approval.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Pediatric Formula • Nutren Junior • Nutren Junior with Fiber (Nestle)	Nutritionally complete, milk-based, lactose and gluten-free formula with or without fiber. Protein is 50% whey, 50% casein. Provides 30 calories and .40 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age requiring tube feeding, full diet, or oral supplementation. Limited approval for infants with serious medical conditions. Contact NAS consultant for approval.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based High Calorie Pediatric Formula • Boost Kid Essentials 1.5 Cal • Boost Kid Essentials 1.5 Cal with fiber (Nestle)	Nutritionally complete, milk-based, lactose and gluten-free formula with or without fiber. Protein is from whey and casein. Provides 45 calories and .41 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with higher calorie needs requiring tube feeding, full diet, or oral supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based High Calorie Pediatric Formula • PediaSure 1.5 Cal • PediaSure 1.5 Cal with Fiber (Abbott)	Nutritionally complete, milk-based, lactose and gluten-free formula with or without fiber. Contains added DHA Omega-3. Protein is from milk protein concentrate. Provides 44 calories and .34 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with higher calorie needs requiring tube feeding, full diet, or oral supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Soy-Based Pediatric Formula • Bright Beginnings Soy Pediatric Drink (PBM Products)	Nutritionally complete, soy-based, lactose and gluten-free formula. Provides 30 calories and .40 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age for full diet or oral supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.

AUTHORIZED WIC FORMULAS

TYPE OF FORMULA Name of Formula	BASIC DESCRIPTION (Reconstituted amounts are for one can).	INDICATIONS FOR USE	DOCUMENTATION REQUIRED
Peptide-Based Pediatric Formula with MCT • Peptamen Junior • Peptamen Junior with Fiber • Peptamen Junior with Prebio[1] (Nestle)	Nutritionally complete, lactose-free, 100% whey protein, peptide-based formula. Contains 60% of fat as MCT. Available with or without fiber or with Prebio[1]. Provides 30 calories and .40 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with gastrointestinal impairment and/or malabsorption requiring tube feeding, full diet, or oral supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Peptide-Based Pediatric Formula with MCT • PediaSure Peptide (Abbott)	Nutritionally complete, lactose-free, kosher, Protein is 70% whey, 30% casein, peptide-based formula. Contains 50% of fat as MCT. Provides 30 calories and .41 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with gastrointestinal impairment and/or malabsorption requiring tube feeding, full diet, or oral supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Peptide-Based High Calorie Pediatric Formula with MCT • PediaSure Peptide 1.5 Cal (Abbott) • Peptamen Junior 1.5 Cal (Nestle)	Nutritionally complete, lactose-free, peptide-based formula. Protein source is predominately whey and fat source is at least 50% MCT. Provides 45 calories and approximately 0.61 mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with higher calorie needs due to gastrointestinal impairment and/or malabsorption requiring tube feeding, full diet, or oral supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Pediatric Formula with MCT • EleCare Junior (Abbott)	100% amino-acid based, nutritionally complete formula. Contains 33% of fat as MCT. Provides 30 calories and .40 mg iron per fluid ounce when prepared as a pediatric formula. Available in powder. Reconstituted powder: 64 fl oz	Indicated for children over 1 year of age with gastrointestinal impairment, severe food allergies, and malabsorption who are sensitive to extensively hydrolyzed formulas.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Pediatric Formula with MCT • Neocate (E028) Splash (Nutricia North America)	100% amino-acid based, nutritionally complete formula. Contains 35% of fat as MCT. Provides 30 calories and .40mg iron per fluid ounce. Available in RTF.	Indicated for children over 1 year of age with gastrointestinal impairment, severe food allergies, gastroesophageal reflux and malabsorption who are sensitive to extensively hydrolyzed formulas.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Hypoallergenic Pediatric Formula with MCT • Neocate Junior • Neocate Junior with Prebiotics (Nutricia North America)	100% amino-acid based, nutritionally complete formula. Contains 35% of fat as MCT. Provides 30 calories and .40mg iron per fluid ounce. Available in powder. Reconstituted powder: 65 fl oz	Indicated for children over 1 year of age with gastrointestinal impairment, severe food allergies, and malabsorption who are sensitive to extensively hydrolyzed formulas. Note: Calories from protein (14%), carbohydrate (44%), and fat (42%) differ when compared to Neocate One+	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.

AUTHORIZED WIC FORMULAS

TYPE OF FORMULA Name of Formula	**BASIC DESCRIPTION** (Reconstituted amounts are for one can).	**INDICATIONS FOR USE**	**DOCUMENTATION REQUIRED**
Caloric Additive • Super Soluble Duocal (Nutricia North America)	Energy enhancer that is completely soluble in water, liquids, and moist foods without altering taste. Provides 42 calories per tablespoon of powder. Preparation will vary as prescribed by physician or dietitian. Available in powder. Reconstituted powder: 175 fl oz	Indicated for children and women with disorders of protein and amino acid metabolism, protein restricted diets, electrolyte restricted diets, or high energy diets (i.e. failure to thrive).	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Clear Liquid Pediatric and Adult Formula • Boost Breeze (Nestle)	Clear liquid, fruit-flavored, low fat, lactose and gluten-free formula. Protein is 100% whey (milk). Provides 31 calories and .33 mg iron per fluid ounce. Available in RTF.	Indicated for children and women with a need for clear liquid diet or fat malabsorption requiring oral supplementation. Note: Not nutritionally complete. Not for use with tube feeding	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Pediatric and Adult Formula • Carnation Breakfast Essentials (Nestle)	Milk-based, lactose and gluten-free formula. Provides 30 calories and .56 mg iron per fluid ounce. Available in RTF.	Indicated for children or women with a medical condition or disease resulting in higher calorie needs. NOT to be used for tube feeding.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Adult Formula • Boost (Nestle)	Nutritionally complete, milk-based, lactose and gluten-free formula. Provides 30 calories and .56 mg iron per fluid ounce. Available in RTF.	Indicated for women requiring increased calories. Used for tube feeding, full diet or diet supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.
Milk-Based Adult Formula • Ensure (Abbott)	Nutritionally complete, milk-based, lactose and gluten-free formula. Provides 30 calories and .56 mg iron per fluid ounce. Available in RTF.	Indicated for women requiring increased calories. Used for tube feeding, full diet or diet supplementation.	Authorization from a prescribing healthcare provider. Update every six months or at the end of the authorization duration, whichever comes first.

INFANT FORMULA INTAKE GUIDELINES

Age in Months	Amount and Frequency of Formula Feeding
0-1	6-8 feedings every 24 hours; 2-4 fluid ounces each feeding; 18-24 fluid ounces every 24 hours
1-3	5-6 feedings every 24 hours; 4-5 fluid ounces each feeding; 24-28 fluid ounces every 24 hours
3-5	5 feedings every 24 hours; 5-6 fluid ounces each feeding; 24-30 fluid ounces every 24 hours
5-7	4-5 feedings every 24 hours; 6-8 fluid ounces each feeding; 24-32 fluid ounces every 24 hours
8-9	3-5 feedings every 24 hours; 6-8 fluid ounces each feeding; 24-32 fluid ounces every 24 hours
10-12	3-4 feedings every 24 hours; 6-8 fluid ounces each feeding; 24 ounces every 24 hours

Table 310 B

311. Iron-Fortified Formulas

Infants who are not exclusively breastfed should receive iron-fortified infant formula until one year of age. Nonspecialized iron-fortified infant formulas available from the WIC program provide 20 calories and .30 to .37 milligrams of iron per fluid ounce at standard dilution.

Iron-deficiency anemia is common in infancy, especially among socioeconomic groups targeted by the WIC program. The risk of iron deficiency is greatest when iron stores built up before birth have been depleted, after about two months in preterm infants and after about four months in term infants. The consequences of iron deficiency, even without anemia, can include decreased muscle function; impaired growth; impaired temperature regulation; enhanced absorption of heavy metals, especially lead; changes in gastrointestinal function resulting in malabsorption; altered immunity, with increased susceptibility to infection and parasitic disease; and behavioral problems, including attention deficit disorders in infants and children.

Supplemental iron can correct iron-deficiency anemia, but other consequences of inadequate iron intake during infancy and childhood are believed to be irreversible. The WIC program, by encouraging mothers to breastfeed their infants and providing iron-fortified infant formula, is recognized as a major contributor to the declining prevalence of anemia among infants and preschool children.

No documented evidence supports claims that addition of iron to infant formula causes an increased incidence of feeding problems, gastrointestinal disturbances, or behavioral difficulties. These problems are usually related to factors such as overfeeding, incorrect formula dilution, early introduction of solid foods, improper refrigeration or poor sanitation. Every attempt should be made to identify and resolve these types of problems before an infant's formula is changed. When formula intolerance occurs in an infant under one month of age, or who stopped breastfeeding less than one month ago, promote breastfeeding by helping the mother initiate lactation or relactation.

311.1 Contract Formulas

The state of Ohio bids and contracts with one formula manufacturer to provide that manufacturer’s

- standard iron-fortified, milk-based formula;
- iron-fortified, soy-based formula;
- iron-fortified, milk-based, low-lactose/lactose-free formula; and
- iron-fortified, milk-based, low-lactose/lactose-free, added rice starch formula.

Any formula other than the four standard contract formulas is considered a special formula. Ohio WIC's current manufacturer contract for iron-fortified, milk-based, low-lactose/lactose-free and iron-fortified, milk-based, low-lactose/lactose-free, added rice starch formulas are both19 calorie per ounce formulas. Therefore, while they remain contract formulas, they must be treated like special formulas which need to be prescribed for specific nutrient content or treatment of a medical condition. Local project health professional staff should establish and maintain contact with area physicians, at a minimum, on a yearly basis, to educate on WIC policies related to authorized formulas.

311.2 Forms in Which Iron-Fortified Formulas are Available

Concentrate, powder, and ready-to-feed (RTF) formulas are available from the WIC program. Not all of the WIC-approved formulas are provided in all three forms, either because a formula is not manufactured in a particular form or because of considerations of availability and cost containment.

A. Concentrate formula is the form most commonly provided. Availability, ease of preparation, and acceptability support use of concentrate formula. Concentrate formula is easily mixed, 1:1 with water. Concentrate formula may also be preferred for premature infants and infants with underlying medical conditions as it is a commercially sterile product and powder infant formula is not.

B. Powder formula must be mixed exactly according to the manufacturer's instructions. The caregiver should be instructed not to pack powder formula in the scoop and not to round or heap the scoop. Situations for which powder formula may be preferred include:

- The infant who is breastfed and is receiving supplemental formula since an opened can of powder formula can be safely stored for a longer period of time than an opened can of concentrate formula. For specific guidelines on issuing breastfed infants formula, see Section 304, Food Package Prescriptions for Infants.

- Powder formula should generally be prescribed if refrigeration is lacking.

- If an infant is frequently away from home, particularly during the summer, powder formula may be preferred from a food safety perspective.

- Powder formulas are heat-treated during processing, but they are not commercially sterile products. Outbreaks of *Enterobacter sakazakii* infections in neonatal intensive care units have been linked to use of powder infant formulas. Based on this information, caution should be exercised when prescribing powder formula to premature, low birth weight, or otherwise immunocompromised infants.

C. RTF formula is prediluted formula providing the same caloric and nutrient composition as concentrate and powder formulas at standard dilution. State WIC will consider issuing RTF formula in some emergency situations. Health professionals should contact their NAS consultant for more information.

RTF formula is issued and documented only as follows:

- The water supply used in formula preparation has been determined to be unsafe by the local or State health department following water testing. There is generally a fee for water testing. RTF formula is not authorized merely because the water does not look, smell, or taste good, or because other household members drink bottled water. Objective documentation of an unsafe water supply, such as a water test report, letter, or blanket order from the health department, must be filed in the participant's chart and referenced on the Health History or Nutrition Care Plan form.

- The health professional questions the caregiver's ability to prepare concentrate or powder formula properly. The health professional should document this assessment on the Health History or Nutrition Care Plan form.

- Similac Expert Care Alimentum RTF or Enfamil EnfaCare RTF may be prescribed in the case of an infant or child that requires this formula and has a family history of corn allergy, a suspected or diagnosed corn allergy, or has demonstrated intolerance to Similac Alimentum Advance powder or Enfamil EnfaCare powder. This is because these powdered formulas contain corn while RTF is corn free. **Note:** Enfamil EnfaCare is a premature infant formula and should only be provided to infants who were born prematurely.

- RTF formula may be prescribed for premature, low birth weight, or otherwise immunocompromised infants when the formula only comes

in RTF or powder forms. This is because outbreaks of *Enterobacter Sakazakii* infections in neonatal intensive care units have been linked to use of powder infant formula. RTF formulas should be used as they are commercially sterile products.

- RTF formula may be issued at the health professional's discretion if the participant has a medically relevant health condition which necessitates the use of RTF formula because the infant is immunocompromised and/or the RTF formula better accommodates the infant's condition (e.g., continuous tube feeds). RTF formula should not be issued for basic tolerance issues or participant preference.

311.3 Types of Iron-Fortified Formulas Available

Four types of standard formulas are available from the WIC program: milk-based; soy-based; milk-based, low-lactose/lactose-free; and milk-based, low-lactose/lactose-free with added rice starch.

A. Milk-based formulas are commonly issued because they are readily available and well tolerated by most infants.

- Only available for issuance up until the infant reaches one year of age chronologically.

- Available for issuance up until the infant reaches eighteen months adjusted for gestational age (AGA) for an AGA infant.

- In the case of a non-AGA child over 12 months of age who has a medical condition requiring the use of this formula, the health professional should obtain a valid prescription and contact a NAS Consultant at the State WIC office to request approval for a system override. Refer to Section 305.1 about children requiring special formulas.

B. Soy-based formulas contain soy protein and are lactose-free. Soy formula is generally used by participants consuming vegetarian diets and by individuals demonstrating lactose intolerance or certain metabolic conditions.

1. This formula is only available for issuance up until the infant reaches one year of age chronologically.

2. In the case of an adjusted for gestational age (AGA) infant, it is available for issuance up until the infant reaches eighteen months AGA.

3. In the case of a non-AGA child over 12 months of age who has a medical condition requiring the use of this formula, the health professional must obtain a valid prescription and contact a NAS Consultant at the State WIC office to request approval for a system override. Refer to Section 305.1 about children requiring special formulas.

4. Situations for which a soy-based formula may be appropriate include:

   - management of galactosemia; Powder soy-based formula is recommended for the management of galactosemia as it contains approximately 14 mg of galactose per liter when it is reconstituted while liquid concentrate or ready-to-feed soy-based infant formulas contain approximately 85 mg of galactose per liter. The variation in galactose content can be attributed to a stabilizer, carageenan;

   - management of lactose intolerance;

   - adherence to a vegetarian diet requiring avoidance of animal protein formulas; and

   - short term management (two to three weeks) of secondary or temporary lactose intolerance that may follow a gastrointestinal illness.

   Soy-based formula is not recommended as an appropriate formula in the following situations:

   - management of cows' milk protein allergies. Hydrolyzed protein formulas are generally more appropriate for managing cows' milk protein allergies; and

   - routine or long-term feeding of low birth weight infants. Some research has identified delayed bone mineralization and maturation in low birth weight infants receiving soy-based formula. If long-term feeding is necessary, an additional source of calcium and phosphorus may be indicated.

C. Milk-based, low-lactose/lactose-free formulas are milk-based formulas containing milk protein but not the milk sugar, lactose. These formulas are

intended for infants for whom lactose sensitivity or lactase deficiency is a concern and a milk-based formula is preferred. Many special formulas are low-lactose/lactose-free as described in Table 310A.

1. From birth to 12 months of age, milk-based, low-lactose/lactose-free formulas may be issued and documented as follows:

   - The infant must have trialed the standard contract milk-based formula or received a valid and documented medical exemption from hospital or physician before issuing milk-based, low-lactose/lactose-free formula; and

   - Documentation must be present on the Health History form that the parent/caregiver has reported that the infant/child has been diagnosed with lactose intolerance by a physician; or the parent/caregiver reports that the infant/child experiences symptoms of lactose intolerance (diarrhea, fussiness, excessive gas, abdominal bloating) when age appropriate amounts of formula are consumed; and

   - A prescription must be completed by a prescribing healthcare provider using the Ohio WIC Prescribed Formula and Food Request form (Appendix 300), or an alternate prescription containing all required information.

2. Documentation of the medical reasons for issuance of milk-based, low-lactose/lactose free formulas **must** be present in the participant's chart. It is recommended that health professionals educate parents on the importance of reintroducing lactose into the child's diet. Lactose intolerance is over-diagnosed in infancy and is often temporary as a result of an acute diarrheal disease. Since breast milk contains lactose, a lactose-containing formula is preferred for formula-fed infants.

3. Milk-based, low-lactose/lactose-free formula is not recommended as an appropriate formula for the management of galactosemia or cows' milk protein allergies. Hydrolyzed protein formulas are indicated for management of cows' milk protein-induced enteropathy or enterocolitis.

4. In the case of an adjusted for gestational age (AGA) infant, it is available for issuance up until the infant reaches eighteen months AGA.

5. In the case of a non-AGA child over 12 months of age who has a medical condition requiring the use of this formula, the health professional must obtain a valid prescription and contact a NAS Consultant at the State WIC office to request approval for a system override. Refer to Section 305.1 about children requiring special formulas.

D. Milk-based, low-lactose/lactose-free formulas with added rice starch are designed to reduce symptoms of gastroesophageal reflux disease (GERD) while maintaining a nutrient profile similar to standard infant formula. The product formulation corrects for the macronutrient, vitamin and mineral displacement that can occur when manually adding rice cereal to standard infant formula.

1. From birth to 12 months of age, a health professional may issue this formula **after** assessing for the following:

   - overfeeding as the cause for spit-up (see Table 310B); and
   - feeding position as the cause for spit-up.

   Health professionals **must** assess for overfeeding and incorrect feeding position to prevent milk-based low-lactose added rice starch formulas from being misused for normal infant spit-up, and it **must** be documented in the participant's chart. In these instances, instruction should be given on appropriate volumes for age and/or correct feeding positions. In addition, the infant must have trialed the standard contract milk-based formula or received a valid and documented medical exemption from hospital or physician before beginning the milk-based, low-lactose/lactose-free formula with added rice starch.

2. Recent studies have indicated that putting a child in an infant seat inclined at 60 degrees exacerbates reflux. Studies have revealed that prone placement, putting the infant on the stomach, is actually the best option for positioning and treating GERD. The prone position allows for the infant's back and abdomen to stretch more which leads to less pressure and reflux. Allowing the infant to have "tummy time" after eating may help reflux. However, it is not recommended for an infant to sleep in the prone position as it increases risk for sudden infant death.

3. Documentation of the medical reasons for issuance of milk-based, low-lactose/lactose-free, added rice starch formulas **must** be present in the

participant's chart. Milk-based, low-lactose/lactose-free with added rice starch formulas may be issued and documented as follows:

- Documentation on the health history that the parent/caregiver has reported that the infant has been diagnosed with GERD by a physician; or

- The parent/caregiver reports that the infant experiences symptoms of GERD or other associated feeding disorders including, but not limited to: severe, chronic projectile vomiting (not associated with overfeeding); weight loss, poor growth, low calorie intake, or failure to thrive; food refusal (due to discomfort caused by GERD or vomiting); certain cases of cleft lip/palate; any gastrointestinal surgery, strictures, or short bowel syndrome; chronic aspiration; tube feeding; or

- The participant is on a prescribed medication for reflux; and

- A prescription must be completed by a prescribing healthcare provider using the Ohio WIC Prescribed Formula and Food form (Appendix 300), or an alternate prescription containing all required information.

4. At the end of six months, it is recommended that the contract milk-based formula be trialed by the participant unless not medically warranted. A retrial is important because GERD often improves or resolves as the child gets older. It would be inappropriate to leave the child on a specialized formula that does not meet current needs. Health professionals should educate parents of the importance of choosing appropriate formulas, proper intake and feeding position, and starting the child on appropriate solid foods.

5. This formula is only available for issuance up until the infant reaches one year of age chronologically.

6. In the case of an adjusted for gestational age (AGA) infant, it is available for issuance up until the infant reaches eighteen months AGA.

7. In the case of a non-AGA child over 12 months of age who has a medical condition requiring the use of this formula, the health professional must obtain a valid prescription and contact a NAS Consultant at the State WIC office to request approval for a system override. Refer to Section 305.1 about children requiring special formulas.

312. Special Formulas

A special formula is authorized or prescribed for its specific nutrient content or for treatment of a medical condition. Special formulas may have a modified protein, amino acid or nitrogen composition, altered fat source, altered carbohydrate source, and/or decreased residue. Special formulas are specific for treatment of conditions such as prematurity, inborn errors of metabolism, other genetic disorders, malabsorption problems, or severe protein sensitivity. Some special formulas may be used as the sole source of nutrition. Some are suitable for tube feeding. Special formulas are issued, with authorization from a prescribing healthcare provider, for women, infants and children requiring special diets. Prescribing healthcare providers are physicians, nurse practitioners, and physician's assistants and are the only persons authorized to prescribe special formulas. Table 310A briefly describes each of the special formulas, except those for inborn errors of metabolism, available to participants and outlines indications for use.

312.1 Guidelines for Issuance of Special Formulas

All special formula prescriptions must be completed by a prescribing healthcare provider using the *Ohio WIC Prescribed Formula and Food Request Form* (Appendix 300), or an alternate prescription containing all required information. Prescriptions are required for the following circumstances:

- special formula for infants;
- any formula for a child over 12 months of age;
- any formula for a woman participant;
- authorization to substitute cheese for a child or woman participant who is prescribed a special formula; and/or
- authorization to substitute whole milk or whole low lactose or lactose free milk for a child over two years of age and a woman participant who is prescribed a special formula.

312.2 Prescriptions

- Prescribing healthcare providers must indicate on the form if there are any contraindications to supplemental foods or can opt to give the WIC health professional the authority to prescribe appropriate foods.
- Only physicians, physician's assistants, or nurse practitioners can prescribe whole milk and cheese substitutions as appropriate.
- The date on an initial authorization form for WIC formula must not be more than 60 days prior to the date the authorization form is provided to the clinic.

- The prescription form must be maintained in the participant's WIC chart or its location in a corresponding medical chart must be clearly referenced in the WIC chart.
- The prescription form must be completed at least every six months, or, if the authorization is for less than six months, at the end of the authorization period.

1. The following information must be included on the authorization form:
   - participant's name, DOB, caregiver's name, and weeks born early (if applicable);
   - written medical diagnosis or reason for formula;
   - amount of formula provided per day;
   - intended length of use of the formula;
   - name of formula;
   - restrictions or contraindications for supplemental foods (if applicable);
   - whole milk/cheese substitutions (if applicable);
   - signature, credentials, and contact information of the prescribing healthcare provider; and
   - date prescription was written.

2. If an authorization form is incomplete, the health professional should make reasonable effort to obtain missing information while the participant is at the WIC clinic.

   - Participants should not be routinely turned away for incomplete prescriptions.
   - If a prescription is incomplete and the physician's office cannot be reached for the additional information while the participant is in the WIC clinic, one month of formula may be issued while the additional required documentation is being obtained. The one month issuance can occur as long as the formula prescribed is not contraindicated for the participant's condition.
   - Once the missing information is obtained, the information along with the date and name of the person with whom the health professional spoke, must be documented on the participant's authorization form.

3. If the original authorization is received via telephone, the call must be taken by a health professional who must immediately document the verbal order in the participant's chart. This method may only be used when absolutely necessary in order to prevent undue hardship to the participant or to prevent a delay in providing formula that would place the participant at increased nutritional risk. If formula authorization is obtained via telephone, the reason must be documented in the participant's chart and a completed authorization form must be obtained within two weeks of the telephone authorization.

312.3 Available Special Formulas

Special formulas available to infants, children and women with medical conditions requiring special diets are outlined on Table 310A. This table describes special formulas, details indications for use, and explains documentation required. Information on PKU and metabolic formulas offered by Ohio WIC and/or the Ohio Metabolic Formula Program can be obtained by contacting the State WIC office.

The Ohio WIC Prescribed Formula and Food form is **not** to be used to prescribe special metabolic (including PKU) formulas. See Section 318 for instructions on prescribed metabolic formulas.

312.4 Standard Premature Infant Formulas

Similac Expert Care NeoSure and Enfamil EnfaCare are milk-based formulas designed to meet the needs of premature infants after discharge from the hospital and through 12 months adjusted age. Premature infant formulas can be issued beyond one year of chronological age in the case of an adjusted for gestational age (AGA) infant. If there is a circumstance of a non-AGA child who is chronologically over one year of age who has a medical condition requiring these formulas, the health professional should contact a NAS Consultant at the State WIC office to request approval for issuance.

- At standard dilution, these formulas provide 22 calories per fluid ounce as well as increased levels of protein, vitamins, calcium, phosphorus, and other minerals.
- To achieve proper dilution, follow manufacturer's directions. Health professionals should be aware of any special instructions, which may differ from standard mixing instructions for powdered formula, and ensure that the caregiver understands how to prepare these formulas.
- Powdered versions of Similac Expert Care NeoSure and Enfamil EnfaCare are mixable to 20, 22, 24, 27, and 30 calories per fluid ounce.

312.5 Pediatric Beverages for Infants and Children

Pediatric beverages are nutritionally complete, balanced formulas designed for children over one year of age who may be undernourished due to illness or inability to eat. They may be fed orally or via tube.

A. With authorization from a prescribing healthcare provider, pediatric beverages may be provided for infants with a diagnosis of bronchiopulmonary dysplasia (BPD) who are at least four months of age. If an authorization is received requesting a pediatric beverage for an infant with a diagnosis other than BPD, the health professional should contact the participant's physician and/or neonatal dietitian and discuss the appropriateness of its use for that infant. If the physician or dietitian can provide scientific evidence that it is an appropriate formula, the health professional should contact a NAS Consultant at the State WIC office to request approval for a system override so that a pediatric beverage food package can be issued.

B. With authorization from a prescribing healthcare provider, pediatric beverages can only be provided for children with medical conditions and cannot be provided solely for the purpose of enhancing nutrient intake or managing body weight. Pediatric beverages cannot be issued solely for the following:

- a child refuses to take a multivitamin,
- a child is a picky eater,
- a child is underweight but is not diagnosed as having failure to thrive and the diet can be managed using regular foods,
- a child is assessed to be at-risk-for or is overweight, or
- a child is assessed to be at an average Body Mass Index.

If the medical diagnosis is only for one of the above mentioned issues, health professionals have the ability to either request additional information from the physician prior to issuing the pediatric beverage or to deny prescription requests if there is not a medical condition justifying its use.

312.6 Food Packages with Special Formulas

A. Special infant formula food packages for at-risk infants

- Infants between 6 to 12 months of age who are prescribed a special

formula and not able to tolerate cereals and baby foods as indicated on the *Ohio WIC Prescribed Formula and Food Request Form* may be eligible to receive a larger amount of formula. Refer to section 304.4 for additional information.

B. Special food packages for child participants

- Children who are chronologically over 12 months of age, but who have an adjusted gestational age (AGA) that is between 6 months and 18 months are eligible for a child food package, the special child food packages or the infant formula food packages. Children, who are chronologically over 12 months (no AGA) and are in need of a special formula that is not available in the WIC certification system at the local level, may be eligible to receive the formula by a "Request for System Override." Staff should contact a NAS Consultant for approval in these instances. Refer to the Formula Guide in Appendix 300.

- In addition to receiving special formula and supplemental foods as prescribed, child participants may be eligible for milk substitutions.

    - Whole milk or whole low lactose or lactose free substitution: whole milk or whole low lactose or lactose free milk can be issued for children 24 months of age or older in place of reduced fat or low fat milk if prescribed by a physician. Children are only eligible for this substitution if diagnosed with a qualifying medical condition. Examples include but are not limited to: failure to thrive, slow weight gain, underweight or other conditions that affect nutritional status. If whole milk or whole low lactose or lactose free milk is prescribed by a physician without a qualifying medical condition, whole milk or whole low lactose or lactose free milk cannot be provided.

    - Reduced fat (2%) milk for children 24 months of age or older may be authorized as part of a careful nutrition assessment by the health professional. Children are only eligible for this substitution if a medical need is present; it is not based on personal preference. Examples of medical need include, but are not limited to: failure to thrive, slow weight gain, underweight or other conditions that affect nutritional status.

- Dry milk substitution: In instances where a participant is receiving a special food package and requests dry milk instead of fluid milk, see the Prescribed Formula Package Milk Option for Children and Women in Appendix 300 for appropriate substitutions.

- Cheese substitution: cheese can be issued for children 12 months of age or older in addition to lower quantities of milk if prescribed by a physician. Children are only eligible for this substitution if diagnosed with a qualifying medical condition. Examples include but are not limited to: lactose intolerance, failure to thrive, slow weight gain, underweight or other conditions that affect nutritional status. If cheese is prescribed by a physician without a qualifying medical condition, cheese cannot be provided. Children who receive cheese will have a reduction in the amount of milk provided. The following outlines the cheese allowance for child participants:

Category	**Cheese (per month)**	**Milk (per month)**
Children	2 pounds	2 ½ gallons

Table 312.1

C. Special food packages for women participants
- In addition to receiving special formula and supplemental foods as prescribed, women participants may be eligible for milk substitutions.

- Whole milk or whole low lactose or lactose free milk substitution: whole milk or whole low lactose or lactose free milk can be issued in place of reduced fat or low fat milk if prescribed by a physician. Women are only eligible for this substitution if diagnosed with a qualifying medical condition. Examples include but are not limited to: slow weight gain, low weight before or after pregnancy, or other conditions that affect nutritional status. If whole milk or whole low lactose or lactose free milk is prescribed by a physician without a qualifying medical condition, whole milk or whole low lactose or lactose free milk cannot be provided.

- Reduced fat (2%) milk for women may be authorized as part of a careful nutrition assessment by the health professional. Women are only eligible for this substitution if a medical need is present; it is not based on personal preference. Examples of medical need include, but are not limited to: slow weight gain, underweight or other conditions that affect nutritional status.

- Dry milk substitution: In instances where a participant is receiving a special food package and requests dry milk instead of fluid milk, see the Prescribed Formula Package Milk Option for Children and Women in Appendix 300 for appropriate substitutions.

- Cheese substitution: cheese can be issued in addition to lower quantities of milk if prescribed by a physician. Women are only eligible for this substitution if diagnosed with a qualifying medical condition. Examples include but are not limited to: lactose intolerance, slow weight gain, low weight before or after pregnancy, or other conditions that affect nutritional status. If cheese is prescribed by a physician without a qualifying medical condition, cheese cannot be provided. Women who receive cheese will have a reduction in the amount of milk provided. If the participant is prescribed cheese they cannot receive tofu as an additional milk substitution. The following outlines the cheese allowance per category for woman participants:

Category	Cheese (per month)	Milk (per month)
Pregnant Substantially/Partially breastfeeding	2 pounds	4 gallons
Postpartum/Minimally breastfeeding	2 pounds	2 ½ gallons
Exclusively breastfeeding* Substantially/Partially breastfeeding multiples* Pregnant with multiples*	2 pounds	4 ½ gallons
Exclusively breastfeeding multiples*	2 pounds	7 ½ gallons

Table 312.2

*This table only reflects cheese/milk substitution amounts. Therefore, these quantities of cheese are in addition to the cheese options found in the Food Package Guide in Appendix 300.

312.7 Food Packages with Soy Milk and Tofu

A. Children

- Soy milk and/or tofu may be authorized as a substitution for milk if there is documentation on the Health History form that she has been diagnosed by a physician with a qualifying medical condition such as milk allergy, severe lactose maldigestion, or she follows a vegetarian/vegan diet. It is at the discretion of the health professional to decide if more than 4 lbs. of tofu are to be substituted for milk. Participant preference without an associated medical condition is not a valid reason for prescribing these foods. Children do not need to be on a special formula to receive soy milk or tofu.

  The *Ohio WIC Prescribed Formula and Food Request Form* section C related to milk substitutions must be completed. If a participant presents an alternate prescription containing the required information, the prescription is considered valid.

- Soy milk is substituted for milk on a ratio of one to one in half-gallon increments. Tofu is substituted 32 ounces (2 pounds) per one half-gallon of milk. A child participant receiving tofu will have a reduction in the amount of milk provided. If the participant is authorized tofu she cannot receive cheese as an additional milk substitution. The following outlines the tofu allowance for child participants:

Food Package	**Tofu (per month)**	**Milk* (per month)**
Maximum (4 gallons)	32 oz	3 ½ gallons
	64 oz	3 gallons
	96 oz	2 ½ gallons
	128 oz	2 gallons
	160 oz	1 ½gallons
	192 oz	1 gallon
	224 oz	½ gallon
	256 oz	none
Tailored (3 gallons)	32 oz	2 ½ gallons
	64 oz	2 gallons
	96 oz	1 ½ gallons
	128 oz	1 gallon
	160 oz	½ gallon
	192 oz	none
Tailored (2 gallons)	32 oz	1 ½ gallons
	64 oz	1 gallon
	96 oz	½ gallon
	128 oz	none

Table 312.3

*Low lactose or lactose free milk may be substituted in place of milk.
**Soy milk may be substituted in place of milk.

B. Women

- Soy milk substitution: soy milk may be substituted for reduced fat, low-fat, or skim milk if there is documentation on the health history that there has been a diagnosis by a prescribing healthcare provider of a qualifying medical condition such as milk allergy, severe lactose maldigestion, or the participant follows a vegetarian/vegan diet. Participant preference without an associated medical condition is not a valid reason for prescribing this food. A prescription is not required for women to receive soy milk. Soy milk is substituted for milk on a ratio of one to one in half-gallon increments.

- Tofu substitution:
  - Thirty-two to sixty-four ounces (2 to 4 lbs) of tofu may be substituted for whole* milk with authorization from a prescribing healthcare provider. Thirty-two to sixty-four ounces (2 to 4 lbs) of tofu may be substituted for reduced fat, low-fat, or skim milk without a prescription as long as there is documentation on the health history that there has been a diagnosis by a prescribing healthcare provider of a qualifying medical condition such as milk allergy, severe lactose maldigestion, or the participant follows a vegetarian/vegan diet. If the participant does not have a qualifying medical condition, tofu cannot be provided. Participant preference without an associated medical condition is not a valid reason for authorizing this food.

  - Ninety-six (6 lbs) or more ounces of tofu may be substituted for whole* milk with authorization from a prescribing healthcare provider. Ninety-six (6 lbs) or more ounces of tofu may be substituted for reduced fat, low-fat, or skim milk without a prescription as long as there is documentation on the health history that there has been a diagnosis by a prescribing healthcare provider of a qualifying medical condition such as milk allergy, severe lactose maldigestion, or the participant follows a vegetarian/vegan diet. Participant preference without an associated medical condition is not a valid reason for prescribing these foods. Women do not need to be on a special formula to receive soy milk or tofu. The *Ohio WIC Prescribed Formula and Food Request Form* part C related to milk substitutions must be completed.

A valid medical diagnosis must be provided. If a participant presents an alternate prescription containing the required information, the prescription is considered valid.

- Women who receive tofu will have a reduction in the amount of milk provided. Tofu is substituted 32 ounces (2 lbs) per one half-gallon of milk. If the participant is authorized tofu, she cannot receive cheese as an additional milk substitution. The following outlines the tofu allowance per category for woman participants:

  * If whole milk is provided in combination with tofu, prescription requirements for issuance of whole milk must be followed.

Category	**Milk Packages (gallons)**			**Tofu (per month)**
	5 ½	**4**	**2**	
Pregnant & Substantially/Partially breastfeeding	5	3 ½	1 ½	32 oz*
	4 ½	3	1	64 oz*
	4	2 ½	½	96 oz
	3 ½	2	none	128 oz
	3	1 ½		160 oz
	2 ½	1		192 oz
	2	½		224 oz
	1 ½	none		256 oz
	1			288 oz
	½			320 oz
	none			352 oz
	4	**3**	**2**	
Postpartum/Minimally breastfeeding	3 ½	2 ½	1 ½	32 oz*
	3	2	1	64 oz*
	2 ½	1 ½	½	96 oz
	2	1	none	128 oz
	1 ½	½		160 oz
	1	none		192 oz
	½			224 oz
	none			256 oz
	6	**4**	**2**	
Exclusively breastfeeding, Substantially/Partially breastfeeding multiples, & Pregnant with multiples	5 ½	3 ½	1 ½	32 oz*
	5	3	1	64 oz*
	4 ½	2 ½	½	96 oz
	4	2	none	128 oz
	3 ½	1 ½		160 oz
	3	1		192 oz
	2 ½	½		224 oz
	2	none		256 oz
	1 ½			288 oz
	1			320 oz
	½			352 oz
	none			384 oz

Table 312.4

*****Tofu at these amounts does not require a prescription.

**Low lactose or lactose free milk or soy milk may be substituted in place of milk.

Category	**Milk Packages (gallons)**		**Tofu (per month)**
	9	**5**	
Exclusively breastfeeding multiples	8 ½	4 ½	32 oz*
	8	4	64 oz*
	7 ½	3 ½	96 oz
	7	3	128 oz
	6 ½	2 ½	160 oz
	6	2	192 oz
	5 ½	1 ½	224 oz
	5	1	256 oz
	4 ½	½	288 oz
	4	none	320 oz
	3 ½		352 oz
	3		384 oz
	2 ½		416 oz
	2		448 oz
	1 ½		480 oz
	1		512 oz
	½		544 oz
	none		576 oz

Table 312.5

*****Tofu at these amounts does not require a prescription.
Low lactose or lactose free milk or soy milk may be substituted in place of milk.**

313-317 RESERVED

318. Prescription of Special Formulas for Inborn Errors of Metabolism

The Ohio WIC program provides reimbursement for certain metabolic formulas (including PKU formulas) to the Ohio Department of Health Metabolic Formula Program (ODH/MFP) for women, infants and children who have been diagnosed by a physician as having an inborn error of metabolism. The Ohio WIC program does not provide metabolic formula benefits for redemption at authorized WIC pharmacies. The Ohio MFP coordinator will make every attempt to notify the WIC clinic of a new participant with a metabolic disorder prior to his or her first WIC visit. If a participant has a metabolic disorder and is *not* associated with the Ohio MFP, WIC staff should complete a *WIC Formula Availability Letter* so that the participant will be able to obtain formula from Medicaid.

Individuals who receive metabolic formula through the MFP and who may meet eligibility requirements for the WIC program are encouraged to enroll in WIC. The role of the local WIC project staff is to ensure that all certification procedures to enroll the participant are completed and that benefits are processed for payment. WIC health professionals are also part of the treatment team through monitoring diet compliance and reinforcing nutrition education provided by metabolic dietitians. Local WIC health professionals may issue metabolic formula food packages if the participant is receiving formula from ODH/MFP. The WIC program may provide metabolic formula alone or in combination with Similac Advance or Similac Soy Isomil powder formula (for infants and some children as appropriate), and supplemental foods from the Ohio WIC Authorized Foods List. Only the metabolic dietitian and physician can prescribe any additional, appropriate WIC authorized foods.

318.1 Issuance of Benefits for Metabolic Formula

The steps to issue benefits for applicants with an inborn error of metabolism who were referred to WIC by the metabolic service provider or other health professional are as follows:

1) WIC applicants with an inborn error of metabolism who are referred to WIC are issued benefits through the following steps:

   - A referral form and completed *Authorization to Distribute Metabolic Formula* form must be sent to the WIC office in the county in which the applicant lives.

- Process inborn error of metabolism referrals according to the Chapter 200 Section titled “Referral Procedure.” Screen the applicant's income by telephone to avoid an unnecessary visit to the clinic in the case that the applicant is not income eligible.

- Complete the *Welcome to WIC Letter* (WTW) Information Sharing in the WIC Program section titled, “Other,” for the metabolic service provider at the participant’s certification appointment.

- If needed, contact the referring metabolic dietitian to discuss the transfer of information needed for certification and food package prescription.

2) WIC applicants with an inborn error of metabolism who do not have a referral to WIC are issued benefits through the following steps:

   - An applicant with an inborn error of metabolism who is referred to WIC by a health professional not associated with a metabolic center may be certified as a WIC participant, but no benefits may be issued until the applicant is seen by a metabolic service provider. Referral to a metabolic provider should occur as follows:

     - Identify the metabolic center closest to the applicant's residence. See section 318.3 to obtain a current list of metabolic service providers. If this list is not available, contact ODH/MFP for the name and address of the metabolic service provider closest to the applicant's residence.

     - If the applicant has transferred from out of state and has not established a metabolic service provider in Ohio, contact ODH/MFP.

   - Complete the *Welcome to WIC Letter* (WTW) Information Sharing in the WIC Program section titled, “Other,” for the metabolic service provider at the participant’s certification appointment.

   - Contact the metabolic dietitian to discuss transfer of information needed for certification and food package prescription, if the *Authorization to Distribute Metabolic Formula* (ADF) form is missing or incomplete, as defined in Section 318.6. See Section 318.3 to obtain a current list of metabolic service providers.

- Complete an *WIC Interagency Referral and Follow-up Form* (HEA 4427) for the metabolic service provider and the local public health nurse.

318.2 Sending a *WIC Interagency Referral and Follow-up Form* to Metabolic Service Team Providers

Sending the *WIC Interagency Referral and Follow-up Form* allows the health professional to share and obtain information with the metabolic dietitian and with the public health nurse if subsequent follow-up or coordination is needed. Refer to the Chapter 200 section titled "Referral Procedure." In order to facilitate coordination of services prior to certification, obtain a *WIC Interagency Referral and Follow-up Form* (HEA 4427) with the following information:

- participant's name
- available anthropometric data and blood work results and date collected
- nutrition objectives which have been set
- nutrition education provided and date
- any other pertinent information

318.3 Ohio Metabolic Service Team Providers

There is a list of Metabolic Service Teams in Appendix 300. In addition, an updated list of metabolic centers in Ohio can be obtained via the internet or by contacting the Children with Medical Handicaps program. To acquire an updated list from the internet:

1. Go to the ODH web page at www.odh.ohio.gov.
2. Click on "M" in the "A-Z Index."
3. Click "Metabolic Formula."
4. Click on "Clinic Locations."
5. Click on "Ohio Metabolic Centers."

318.4 Nutrition Education for Participants with an Inborn Error of Metabolism

Participants with an inborn error of metabolism must be offered basic and midcertification opportunities for nutrition education. The metabolic dietitian provides dietary counseling pertaining to the applicant's metabolic condition.

Additional counseling by the WIC health professional, including referrals and handouts provided, is limited to the use of the metabolic nutrition education modules or topics not related to the dietary management of the metabolic disease, such as food budgeting/purchasing, meal planning, dental health, label reading, or other topics agreed upon with the metabolic dietitian. The WIC health professional may reinforce information provided by metabolic dietitians. Written documentation of counseling provided by the metabolic dietitian at follow-up appointments may also be used to meet the participant's midcertification nutrition education contact. This documentation should be completed as outlined in the Chapter 400, section 403 titled, "Ohio WIC High-Risk Policy and Protocols."

Breastfeeding promotion requires additional consideration for participants with an inborn error of metabolism. Breastfeeding an infant with a metabolic disorder requires special procedures and careful monitoring. If a mother wants to breastfeed an infant who has a metabolic disorder, refer her to the metabolic service provider for instruction. If the metabolic service provider feels that breastfeeding the infant would be appropriate, provide breastfeeding counseling and send a copy of the counseling provided to the metabolic dietitian.

318.5 Documentation of Medical Data and Nutrition Education

When the applicant is seen in the local WIC project for certification, the WIC health professional processes the applicant according to standard procedures as outlined in Chapter 400, Section 403 "Ohio WIC High-Risk Policy and Protocols."

In addition to following standard policy, the following must also be documented in the participant's chart:

- completed *WIC Interagency Referral and Follow-up Form* (HEA 4427) with applicant's signature and any instructions provided by the metabolic dietitian. See Section 318.2 for additional information on completing the referral form;

- completed *Authorization to Distribute Metabolic Formula* (ADF) form; and

- copy of the applicant's progress notes sent by the metabolic dietitian, if they contain significant information.

318.6 Use of the *Authorization to Distribute Metabolic Formula* Form

A completed *Authorization to Distribute Metabolic Formula* form (located in Appendix 300) signed by both the metabolic center dietitian and physician must be obtained prior to formula issuance. The metabolic center dietitian lists the amount of the prescribed formula and the amounts of WIC foods to be provided. This completed form serves as the physician's prescription for issuance of the selected metabolic formula. A new prescription is required every six months per Section 312.

318.7 Food Package Authorization

Food packages provide metabolic formulas, including PKU formula, and may include the following:

- Children and women participants: milk, cheese, juice, adult cereal, infant cereal, eggs, beans, peanut butter, whole grains, fruits and vegetables and canned fish. The metabolic dietitian will provide the participant with a list of adult cereals that are appropriate.

- Infant participants receiving metabolic formulas may also receive the following: Similac Advance or Similac Soy Isomil (powder), infant cereal, and baby foods. For infants and children requiring a metabolic/PKU formula and who are also prescribed Similac Advance or Similac Soy Isomil, an appropriate food package is a combination of metabolic/PKU formula and powder Similac Advance or Similac Soy Isomil.

- Participants receiving only PKU/metabolic formulas must be assigned the appropriate food package.

Based on the *Authorization to Distribute Metabolic Formula* form, the WIC health professional assigns the appropriate food package.

318.8 Procedures for Issuing Benefits for Metabolic Formula

Participants with an inborn error of metabolism who participate in the ODH/MFP receive benefits for metabolic formula (including PKU formula), supplemental foods, and Similac Advance or Similac Soy Isomil, if prescribed. Because metabolic formula is distributed through the ODH/MFP, the following procedures must be completed to process benefits for metabolic formula (including PKU formula):

- Issue benefits for Similac Advance, Similac Soy Isomil, and supplemental food, if any, to the participant on the WNC.

- File the original Authorization to Distribute Metabolic Formula Form in the participant's chart.

319. Management of Suspected Formula Intolerance

Formula intolerance may result from sensitivity or allergy to formula ingredients. Exclusive breastfeeding for the first six months of life and continued breastfeeding along with complementary foods for the first year and beyond is recommended for all infants, and is especially important for infants at risk of developing allergies.

Symptoms attributed to formula intolerance may be associated with a variety of other factors. The health professional should review the factors and suggestions in Table 319 when evaluating complaints of formula intolerance.

The WIC program may not always be able to provide the formula requested by a physician or health care provider for management of suspected formula intolerance.

Mothers of infants who are found to be allergic or sensitive to any type of formulas should be informed that sometimes relactation is possible and, if desired, WIC will provide the resources to assist with this.

319.1 Elimination/Challenge Testing

An elimination/challenge test may be conducted to evaluate formula intolerance and to determine the need for a formula other than the contract milk-based or soy-based formula. Elimination/challenge testing must be managed by a physician or a health care provider. To conduct an elimination/challenge test:

1. Eliminate from the diet all foods other than the formula suspected of causing a problem for a limited period of time.
2. If symptoms are relieved, foods are reintroduced one at a time to see whether symptoms recur.
3. If symptoms are not relieved, the formula is changed and the response to the new formula evaluated. (Hypoallergenic formula may be used when food allergy is suspected).
4. If symptoms persist, factors other than foods or formula may be investigated.
5. If symptoms are relieved when a different formula is used, the suspected formula may be reintroduced (challenged).
6. If symptoms recur, the cause of the problem is likely to be the suspected formula.

SUGGESTIONS FOR MANAGING SUSPECTED FORMULA INTOLERANCE

Factors contributing to onset of problems	Suggestions for management of problems
Infant experiencing formula intolerance is less than one month old or stopped breastfeeding less than one month ago.	Offer to help the mother initiate lactation or relactate.
Early introduction of solids and juices or infant is overfed.	Obtain diet assessment. Counsel on appropriate intake for age.
Formula is diluted or stored incorrectly.	Ask how formula is prepared, how prepared formula is stored and what happens to partially used bottles of formula. Opened cans of formula other than powdered formula should be refrigerated and used within 48 hours. Formula remaining in a bottle after a feeding should be discarded.
Infant is not burped during feeding or is handled roughly during/after feeding.	Recommend burping 1-2 times during feedings and handling baby gently during and after feeding. More vigorous burping may be needed to expel gas before it passes beyond the stomach.
Home environment is stressful.	Carefully ask how things are going at home. Refer for support or counseling as needed.
Water supply is unsafe.	Water from a private well can be tested for bacterial safety. Refer concerns about nitrates, lead and other substances to the physician or local health department.
Infant is sensitive to formula ingredients or is sensitive to one brand of formula.	Suggest trying iron-fortified powdered formula or changing to another brand of iron-fortified formula and reassess after several days of use.

Table 319

SUGGESTIONS FOR MANAGING SUSPECTED FORMULA INTOLERANCE

Factors contributing to onset of problems	Suggestions for management of problems
Caregiver reports vomiting, diarrhea, constipation or other abnormal conditions.	Investigate the behaviors reported. Since caregivers may misinterpret conditions such as diarrhea, constipation and vomiting, the health professional must determine the accuracy of the caregiver's report. Review normal behaviors such as spitting up, normal stools, and normal changes in stools when diet changes are made. Refer to physician or health care provider as needed.
Infant has recently been ill.	Onset of gastrointestinal symptoms may be secondary to the illness.
Infant is receiving medications or supplemental vitamins/minerals.	Obtain health history. Medications and vitamin/mineral supplements may cause a change in stool color and firmness. If on medication, counsel caregiver to observe changes in stools when medication is discontinued. If supplements are used, suggest discontinuing for a few days to determine if problem resolves.
Infant has symptoms of colic.	Use casein hydrolysate formula if other formula changes, including a trial on soy formula, are unsuccessful. Issue the Calming Your Fussy Baby pamphlet for tips.
Infant remains intolerant of or allergic to certain formulas.	Refer to physician or health care provider for feeding recommendations.

Table 319

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322. Food Package Guide

Health professionals use the Food Package Guide and Formula Package Guides located in Appendix 300, together with the Ohio WIC Authorized Foods List, to prescribe supplemental foods for participants. These guides indicate the monthly amounts of the WIC foods that can be prescribed for each participant category and the tailoring options available for each food. The Ohio WIC Authorized Foods List identifies the specific food items in each category that may be purchased with the WNC.

322.1 Selecting Food Packages for Women and Children

The Food Package Guide lists the foods available for each participant category. Those foods listed for each category are the only types of foods that can be prescribed. The quantities listed below each food are the tailoring options available for the food package selection. Not all foods listed for each category need to be included in the assigned food package.

Health professionals select the foods for the food package using the food and formula drop down menu located in the "Select Food Packages" section of the risk tab in the system. Only the food items and the tailoring options the participant is eligible to receive will appear in the food and formula drop down menu.

322.2 Selecting Food Packages for Participants Receiving Formula

For infants receiving formula and for women and children participants receiving a prescribed formula, the food and formula drop down menu will only list the formulas the participant is eligible for and the foods that may be added to the food package. For those participants receiving prescribed formula, the appropriate foods need to be selected as authorized on the Ohio WIC Prescribed Formula and Food Request form. See Section 312 for additional information on special formulas. See the Formula Package Guide in Appendix 300 for the quantities of formula per month participants may be eligible to receive. Also reference the Prescribed Formula Package Milk Options for Children and Women guide for the milk substitution options participants may be eligible to receive.

323. Food Package Changes

Food package changes may be required in the following instances:

- infant requires a formula change,
- child requires a formula change,
- woman requires a formula change,
- child requires a formula to milk change,
- woman requires a formula to milk change,
- child requires a milk to formula change,
- woman requires a milk to formula change,
- participant preferences or needs change,
- infant begins receiving cereal and baby foods, and/or
- infant turns one year of age.

323.1 Midmonth Food Package Changes

Any participant who needs current and future months' food packages changed to a package that includes formula is eligible for a midmonth food package change. To make midmonth food package changes, the participant must bring in the WNC before the project can reissue a new food package. The participant will receive the number of cans remaining or the prorated amount, whichever is less.

323.2 Making a Midmonth Formula Change

When making a midmonth formula change for a participant, the project must use the Midmonth Formula Change function in the WIC System for the benefits that remain in the current month of issuance. Formula to formula and food to formula changes for participants are the only midmonth food package changes that may be made using this function. There is no limit to the number of midmonth formula changes that can be completed within a valid period.

The following must occur for a midmonth formula change:

- The WNC must contain some formula benefits to allow the midmonth formula change to occur.
- Documentation of the midmonth formula change and change in the future months' formula must be in the participant's chart. This documentation must include the date, what the food package was changed to, and the health professional's signature.
- Caregivers should return any unneeded formula to the clinic. See section 324 for receiving returned formula.

Midmonth Changes for Infants

1. Formula Amount Increases: If an infant receiving a substantially/ partially breastfeeding food package or tailored quantities of a minimally breastfeeding/full formula food package requires additional formula but has redeemed all of the current month's benefits, call the Nutrition and Administrative Services (NAS) Consultant. Approval will not be provided for contract formulas.

2. Formula Changes: If a formula change is needed at the same time as a formula amount increase, follow midmonth formula change procedures. Caregivers should return any unneeded formula to the clinic. See section 324 for receiving returned formula.

3. If the participant has spent all of the benefits and brings the remaining cans to the clinic, the infant may be eligible for a formula exchange.
   - Health professionals must contact a NAS consultant.
   - Health professionals must document relevant information in the WIC chart and formula log per Section 324.

323.3 Other Food Package Changes

To make food package changes other than midmonth food package changes, the WNC must be present and staff must use the void and reissue function in the Certification System. Documentation of future months' food package changes must be entered in the participant's chart. This documentation must include the date, what the food package was changed to, and the health professional's signature.

Food to formula changes:

1. Single food items cannot be debited or credited on the Void/Reissue screen.

2. Formula can be added and the WIC System will prorate for the current month.

3. Void and reissue future months' food packages.

324. Process of Receiving Returned or Donated Formula

Instances where formula may be brought to a clinic include:

- A participant returns a formula that they are no longer using.
- A participant returns extra formula that they cannot use.
- Formula is donated from a person who is not on WIC.

Clinics must accept returns and are allowed to accept donations. Returns and donations are to be taken to local food banks or other agencies that offer food items to the public including BCMH, FQHC, physician's offices, hospitals, and others. All expired formula must be discarded.

Clinics that accept returned formula and, in turn, donate the formula to food banks or other agencies must create and maintain a log to document:

- who returned formula,
- number of formula cans received,
- formula type,
- date received,
- where formula is donated, and
- date formula is donated.

State Staff will monitor the log during Management Evaluations.

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330. Ohio WIC Nutrition Card

The Ohio WIC Nutrition Card (WNC) is the plastic, electronic benefits transfer card used by active participants or alternates to purchase supplemental food and fruits and vegetables (cash value benefits {CVBs}) at authorized retail vendors.

330.1 WNC

1. WNC Issuance

The WNC is shown in Figure 330.1. A parent/guardian receives a card for use by up to four participants at a time. If the family consists of five active participants, the parent/guardian will receive two cards: one card with four participants' benefits plus one card with one participant's benefits.

Figure 330.1 WIC Nutrition Card (WNC)

State staff ensures an adequate supply of blank WNCs for local projects. The State office determines stock levels of WNCs for each clinic and ships as needed.

- Each box of WNCs contains 300 cards.
- Cards are received for each clinic.

- Each card has a Primary Account Number (PAN).
- PANs are electronically transmitted into each clinic's WIC System.
- The amount of food contained on each card is determined by the food package prescribed to each participant on a card.
- Transactions can be completed any time during the current month.
- On the last day of a month, exact time of WNC insertion and Personal Identification Number (PIN) verification determines which month's benefits are debited.

2. Foster Parents

Foster parents must receive one card for each foster child because foster children have the potential to frequently move in and out of groups.

- Exception: If the foster children are designated to not be separated, the project may issue one card.

3. Multiple Card Issuance

When a parent/guardian is issued more than one card, clinic staff will initial one of the cards with permanent marker in a manner so that the parent/guardian will know which participants' benefits are on each of the cards.

330.2 Issuing and Loading Benefits to the WNC

Cards are issued to active participants after certification has been completed, and updated when a participant returns for a midcertification nutrition education/food issuance appointment or recertification. WIC participants must personally come to the clinic to receive and update the card.

The WIC system allows the clinic to generate up to three full months of food benefits at any one time within a certification period. The clinic retains the option to issue either one, two, or three months of food benefits to a participant. WNCs can be replaced three times per year. If an additional card needs to be replaced, the participant must be issued benefits monthly.

Although using food benefits as an incentive to have participants return to the clinic can be useful in some situations, participants cannot be denied food benefits if they refuse to attend nutrition education sessions, update immunizations, etc.

1. Food benefits are issued the day of certification except in the following instances:

   a. The applicant is in pending status: This indicates that certification procedures were not completed due to required information being unavailable. Required information must be received by the clinic within 30 days for income and 60 days for anthropometric data.

   b. In specific circumstances where the certification information is provided by a home visiting nurse, mailed information, or telephone conversations with a participant; for example, a pregnant applicant on strict bed rest who has provided the clinic staff with sufficient documentation to certify her without being present in the clinic. In this situation, the WNC is provided when the applicant or her authorized representative can come to the clinic to pick up the card.

   c. When the WIC System is down; e.g., power outage: WNCs for the certified participants cannot be provided until the WIC System is back up and the participant can return to the clinic.

2. Loading Benefits to the WNC

   a. Verifying Primary Account Numbers (PANs)

      Each WNC contains a PAN which is linked to a group.

      - Insert the WNC in the card reader; the PAN will automatically display in the WIC System.

      - Verify during new card setup, updates to the card, and card replacement that the participant's PAN matches the computer screen.

   b. Generating Benefits

      "Food Issuance" on the WIC System allows clinic staff to issue benefits. Specific procedures to issue WNCs/benefits are stated in Section 11.0 of the WIC System User's Manual. Below is key terminology needed to understand benefit issuance.

- Base Date

  The Base Date displays the date through which a participant has foods issued.

- FI Pickup Date

  The FI Pickup Date shows when the participant is scheduled to pick up benefits during a recertification or midcertification appointment. This date can be changed and does not affect the participant's Base Date. A participant can be scheduled a month prior to the FI Pickup Date for benefit issuance. When this field is left blank, it will default to 8:00 am on the same day as the Base Date.

3. Issuing Food Benefits for a Group of Participants

   All active participants on the WNC are grouped by a head of household. This is usually an adult in the group who may or may not be a WIC participant. To issue benefits:

   - On the Main screen, click on the first participant eligible to receive benefits in the group.
   - Click on Issue Foods tab.
   - After the benefits are issued, the system will automatically move to the next participant.
   - This process will continue until benefits have been issued for all eligible participants in the group.

4. Issuing Food Benefits During Mid and Recertification Appointments

   A change in formula, address, or breastfeeding status may alter the participant's assigned food package. If so, the Certifying Health Professional (CHP) must prescribe a new food package.

5. Withholding Benefits Due to Issuance Errors

   Project staff may not withhold current or future months' benefits to correct any errors made when issuing WNCs. For example, if the

clinic staff accidentally voids and reissues benefits and gives all of the benefits to the wrong participant (incorrect PAN), and the participant does not return to correct the WNC, future benefits cannot be withheld to "make up" for the error. Benefits can only be held or suspended in specific participant abuse situations.

6. Prorated Food Benefits

Prorated benefits are benefits which do not equal the maximum allowable amount of the prescribed food package. The WIC System automatically prorates a food package based on the date the participant picks up benefits after the base date, when a mid-month formula change is made, and for new participants who are certified after the first week of the month. Benefits will be available for the calendar month in which they are issued.

7. Participants not Receiving Food Benefits

Although the participant receives no items, assign the appropriate food packages for the following participants so they will be counted in the total caseload:

- Exclusively breastfeeding infants who are not receiving baby cereal or baby food; and

- Breastfeeding women who choose to recertify, whose breastfeeding frequency is minimal, and whose infant is seven months of age or older.

8. Personal Identification Numbers (PIN)

The PIN is a four digit number selected by the participant that protects access to the benefits on the card and, therefore, must be kept confidential. The PIN must be entered each time the participant uses the card. Staff must not record PINs. If a participant enters a PIN incorrectly seven times, the card will automatically lock. The participant will not be able to access benefits until the card is unlocked at the issuing clinic site. Only group head can authorize a PIN change with identification, preferably picture ID.

9. WNC Confirmation

Any time a card is replaced or benefits are credited or debited, clinic staff must confirm that the participant can access the benefits before leaving the

clinic. To confirm:

- Instruct the participant to insert the card.
- Instruct participant to enter the PIN.

10. Incorrect Card Issuance

Clinic staff must be careful to update the correct card and give the correct card to the correct participant/guardian. If a WNC is inappropriately issued:

- Call the participant that received the incorrect card immediately.
- List the card as “lost” per section 330.6, if contact not made by the end of the business day.
- Continue to call the participant.
- Ask participant to bring incorrect card to clinic.
- Provide the correct benefit on a new card to the correct participant.

330.3 Scheduling

Benefit pickup is typically coordinated with the second nutrition education offering to the certified participant and is called "midcertification nutrition education." Although every effort should be made to encourage attendance at midcertification nutrition education offerings, participants refusing or unable to attend cannot be denied benefits.

Procedures to schedule participants for midcertification nutrition education appointments are discussed in the section titled “Scheduling Appointments” in the Certification System User Procedure Manual. Benefits can be issued for participants within a month prior to their Base Date.

Prior notification of midcertification appointments must be given. The local project can use any of the following options to provide the participant with notification:

- mail the State-developed appointment reminder card, *WIC Appointment Notice*, located in Appendix 200, or a State-approved local agency developed form;

- telephone participants;

- use the Appointment Reminder System (ARS) to telephone participants; or

- use the Welcome to WIC (WTW) letter.

330.4 Benefit Pickup

WIC participants, guardians, or alternates must personally come to the clinic to receive benefits.

Any time a participant, guardian, or alternate comes into the clinic to pick up benefits, the following steps must be completed:

1. Ask for identification; picture identification is preferable but not necessary. Participants or alternates will be told to bring the WNC with them to every appointment.

2. Ask for the names of all participants for whom the participant, parent, or alternate is picking up benefits. To reduce the number of appointments participants or parents need to attend, group midcertification education appointments for all members in a family unit, even if all the benefits cannot be generated on the same day.

3. Ask for any address changes to update the WIC System. An address change may cause the food package to change in the following situations:

   - water supply is deemed unsafe
   - lack of refrigeration
   - homelessness

4. Clinic staff should also identify any necessary formula or food preference changes and refer the information to the health professional.

5. Direct the participant or alternate to the midcertification nutrition education activity, if the appointment is for midcertification. The participant must be offered the opportunity to speak with a health professional at each midcertification visit.

6. Have the participant, guardian, or alternate insert the card and enter the PIN. This step confirms that benefits can be accessed.
   Load the next set of food benefits to the WNC.

7. Encourage guardians of newborns to purchase small amounts of formula at a time until formula tolerance is determined.

8. Explain how to use the WNC, as needed. All new participants must receive a complete explanation per section 331, Instructions for WIC Nutrition Card.

9. Remind participants of the next scheduled WIC appointment.

10. Tell the participant that WNCs are not to be defaced. Lost, stolen or damaged cards must be reported immediately.

11. During benefit issuance, the participant must receive or be asked if she has the following documents: a WNC, benefits printout, a current Ohio WIC Authorized Foods List, and an authorized vendor list in the county.

Late Benefit Pickup

Participants picking up benefits more than seven days after the Base Date will receive a prorated food package. The longer the participant waits to pick up the benefits in the first month's valid range, the fewer foods the participant will receive since the WIC System automatically prorates the food package. If the participant does not pick up the benefits during the first valid period, the WIC System will automatically skip that food package. This will not affect the future months' benefits, if these benefits are picked up on time. For the month skipped, the participant is not counted in the clinic's caseload.

330.5 Food Package Changes

Food benefits can be adjusted for the current and future months for one or more participants on the WNC. Adjustments include: formula to formula and food to formula. The WNC must be present to perform these functions. Food package changes for unusual situations require a call to the Nutrition and Administrative Services (NAS) Consultant and assistance by Help Desk. Refer to section 323.

330.6 WNC and Benefit Replacement

WNCs and future months' benefits can be replaced. Current month's benefits can only be replaced under limited circumstances.

1. WNC Replacement

   - WNCs can be replaced up to three times per year. If an additional card needs to be replaced, the participant must be issued benefits monthly for the remainder of that year.

   - There is no participant cost to replace a WNC.

2. Benefit Replacement

   Current month's benefits can only be replaced when the participant has a damaged WNC or for medically fragile participants. In the latter case, Nutrition and Administrative Services Consultant must be contacted prior to replacement.

   - There is a six-day waiting period for benefits to be replaced. The WIC System will indicate the date of benefit replacement, which is dependent upon the clinic doing daily data transfers.

   - Current month's benefits cannot be replaced on the last six calendar days of the month.

   - WIC cannot replace food purchased with WNCs that are subsequently damaged or destroyed in a natural disaster.

   a. Lost/Stolen WNC

      WNCs that are reported as **lost or stolen** by the participant will be replaced; however, benefits will not be replaced in the current month. Future benefits will be loaded to a new WNC after the six day waiting period.

      - For "lost" cards, guardians or participants will be asked to search for the card. Clinic staff will flag the card as lost when the report is received. Remind the participant if the card is found to immediately come to the clinic so the card can be "unlisted." Clinic staff will reassign the WNC to the group and it can be used immediately. If unable to locate the card, the card will be replaced with future months' benefits. Should the original card be found after the waiting period, current month's benefits may be restored. Call the WIC Help Desk for assistance.

b. Damaged WNC

WNCs that are visibly damaged by being exposed to the elements, torn, or laundered, or do not function in the store or clinic card reader will be replaced and the current month's benefits will also be replaced. The participant must present the WNC or remnants of the WNC to the clinic for replacement of *current* month's benefits to occur after the six day waiting period.

3. Replacement Reason Codes

The following reasons are used in the system when replacing WNCs and/ reissuing benefits. Selecting one of the choices below places the PAN on the Hot Card List (HCL).

1. Lost: Use this code when participants report that a card is lost or there is documentation of a fire, flood, or natural disaster in the participant's file.

2. Stolen: Use this code when the participant reports that the card has been stolen or any blank cards stolen from the project.

3. Failed to function: Use this code when the participant reports that the card will not work and the card does not appear to have been damaged.

4. Damaged: Use this code when the participant brings in a WNC that is visibly damaged or blank cards that have been damaged at the clinic.

4. Following Replacement

After replacing WNC and applicable benefits:

a. Review with the participant responsibility and care of WNCs, as appropriate, and advise that the participant will be investigated if benefits are redeemed at a later date.

b. Enter a critical message to record lost, stolen, damaged WNCs.

c. Returned/Defective/Damaged WNCs: collect and store returned and defective WNCs in a safe centralized area for the project. Send quarterly to State WIC at: Ohio Department of Health, WIC Program, 246 N. High St., 6th floor, Columbus, OH 43215.

330.7 WNC Storage Security

Whenever WNCs are not in use, they must be kept in a locked, secured area. Locked, secured areas include locked drawers, file cabinets, closets, or safes. Do not leave cards unattended on desktops during breaks, lunch, or at the end of the day.

331. Instructions for WIC Nutrition Card (WNC) Use

At the initial certification visit, and as necessary at recertification and midcertification visits, each participant, parent/guardian, or alternate shopper must be given verbal instructions for WNC use. Clear, thorough instructions are important to ensure that WNCs are used properly for the intended purpose.

331.1 Alternates

The participant or parent/guardian may choose individuals to serve as alternate shoppers to pick up and/or redeem benefits. Local staff may elect to document the alternate's name in the application margin or on the comment screen. An alternate shopper must meet the following criteria:

- be someone the participant or parent/guardian can trust with the Personal Identification Number (PIN). Staff should recommend someone 16 years of age or older;
- understands the benefit pickup and redemption procedures (the participant/guardian is responsible for teaching the alternate shopper); and
- cannot be a staff member of the local WIC project unless directly related to the participant.

Benefits can be provided to anyone who presents with the WNC, a valid ID, and knows the PIN.

331.2 Guidelines for Using WNCs

At the initial certification visit, and as necessary at recertification and midcertification visits, the following instructions are to be given to the participant, parent/guardian, or alternate shopper.

1. WNCs may be used only at authorized WIC vendors in Ohio.
2. Benefits are redeemable only for foods listed on the current Ohio WIC Authorized Foods List.
3. Only the participant, parent/guardian or alternate shopper may use the WNCs.
4. WNCs or benefits may not be sold or traded for cash or any other item.

5. Benefits can be redeemed at any time during the valid period up to 11:59 pm on the last day of the month; however, participants should be encouraged to purchase weekly. This ensures participants are receiving nutritional foods throughout the month, and helps prevent food spoilage.

6. WNCs must not be defaced, punctured or altered in any manner. WNCs should be cared for in a manner that prevents damage to the card.

7. Only the authorized types and amounts of WIC food items listed on the card may be purchased.

8. Substitution of an unauthorized food item for an authorized WIC food item is not allowed.

9. Check for authorized WIC food items on sale.

10. Manufacturers' coupons and store discount cards may be used on authorized WIC food items.

11. Two for one sales on authorized WIC food items allow the purchase of a double amount of that authorized WIC food item.

12. Change or credit cannot be given for items or amounts not purchased.

13. When redeeming the cash value benefit (CVB), change cannot be given if the participant does not use the total value. If the purchase exceeds the value, the last fruit or vegetable item will be removed from the purchase. Participants should be encouraged to place the fruit or vegetable items in the order of preference.

14. Benefits not redeemed during the month are not carried forward to the next month.

331.3 Steps for Redeeming Benefits

There are steps that shoppers must follow when redeeming benefits. When followed, these steps help expedite the redemption process. They are as follows:

1. Tell the cashier a WNC will be used to purchase WIC food items and present any manufacturers' coupons to the cashier.

2. Separate the WIC food items from all other foods.

3. Insert the WNC into the Point of Sale (POS) machine and follow the machine prompts. The participant/alternate must enter the PIN; cashiers are not to enter the PIN. Do not take the WNC out of the POS until the entire transaction is completed.

4. Verify that prices charged for WIC food items are correct. Check for correct sale prices and proper crediting of manufacturers' coupons.

5. Completing the transaction with your WNC indicates receipt of WIC food items equaling the total cost on the cash register.

6. Remove the WNC card.

7. Take the WNC receipts as a record of sale and remaining benefits.

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333. WIC Vendor Complaint Procedures

Complaints may be filed against WIC participants and vendors. Reasons for complaints may vary depending on the situation. Complaints may include, but are not limited to:

- adverse treatment of a vendor's employees or the WIC participant;
- persistent attempts by the participant to purchase unauthorized food items;
- refusal of the store employee to allow participants to take advantage of "buy one-get one free" or other special offers; and
- attempted purchase of unauthorized food items by the participant.

The State and local WIC office takes complaints very seriously. A complaint form must be completed when complaints are received. The complaint form is located in Appendix 300 and must be copied by the project.

File the complaint in the file for that vendor or participant and send a copy of the complaint form to:

Attention: Vendor Operations Section
The Ohio Department of Health
Bureau of Nutrition Services
246 N. High Street, 6th Floor
P.O. Box 118
Columbus, Ohio 43215-0118

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CHAPTER 400

400. Introduction to Chapter 400 - Nutrition Education in the Ohio WIC Program

The nutrition education component of the Ohio WIC program is intended to address participants' specific nutritional risk conditions and to encourage positive nutrition and health habits during program participation and after it has ended. Each participant has at least two opportunities for nutrition education services during the certification period. The general organization of the Nutrition Education Chapter is as follows.

- Section 401 provides policy and procedure for the scope of nutrition education services required to be provided at the certification and midcertification appointments.
- Sections 402 through 404 provide guidelines for counseling all participant categories, including required breastfeeding services, and programs for women.
- Section 405 details guidelines for providing manual, single-user, portable, electric breast pumps and hospital-grade, electric breast pumps to WIC participants.
- Section 406 details guidelines for the Breastfeeding Peer Helper Program.
- Sections 407 through 410 provide guidelines for providing nutrition education to individuals and groups and selecting education materials.
- Section 411 defines the State WIC Nutrition Education Plan.
- Section 412 provides direction for administration of the Participant Survey.
- Section 414 provides guidelines related to the training and responsibilities of WIC health professionals. Refer to Chapter 100, Section 114 for information regarding training opportunities offered by State WIC.
- The Appendix to Chapter 400 contains a variety of self-assessment tools, sample lesson plans, a bibliography of references for information found in the Chapter and other pertinent information.

401. Requirements for Providing Nutrition Education

Nutrition education means individual and group sessions and the provision of materials that are designed to improve health status and achieve positive change in dietary and physical activity habits, and that emphasize the relationship between nutrition, physical

activity, and health, all keeping with the personal and cultural preferences of the individual.

Nutrition education is a part of the counseling provided to each participant at initial and all subsequent certifications. Screening and assessment are necessary prerequisites to appropriate nutrition education and counseling. Screening and assessment include:

- height, weight, and blood iron level measurements and their evaluation;
- evaluation of dietary intake;
- a review of current and past medical/health problems relevant to the participant's WIC visit, and
- attention to the participant's nutrition/health concerns and interests.

Based on this information, the health professional, cognizant of participant concerns and interests, counsels the participant about desirable behavior changes that will improve or maintain nutritional status and health. The health professional also determines how midcertification education will be provided to the participant. Nutrition education should be a part of every midcertification visit. The midcertification education experience should, when possible, reinforce the certification/recertification counseling.

The type and frequency of additional opportunities for nutrition education depend on the participant's nutritional status. For those assessed to be high-risk, appointments are usually scheduled for individualized follow-up. Midcertification nutrition education for lower risk participants may be delivered individually or in a group setting.

Caring and knowledgeable health professionals are the cornerstones of quality nutrition education services. Projects must ensure that opportunities and resources are available to staff members to continue skill development throughout their employment. Health professionals must periodically evaluate their own skills and the project's delivery of nutrition services to facilitate favorable participant outcomes – healthy moms, infants and children.

401.1 Nutrition Education at Certification/Recertification

1. The WIC nutrition education session includes provision of appropriate counseling and referral to each eligible participant. These sessions may include any of the following topics, or a topic of priority for the participant that has nutrition implications:

a.) Discussion of anthropometric and hematological data and, if needed, methods to improve status;

b.) Review of past nutrition-related issues and praise for meeting the previous nutrition goal;

c.) Discussion of dietary intake including methods to improve nutritional status or praise for healthful dietary habits, and

d.) Discussion of WIC food benefits that are particular to the participant's medical/nutritional status with suggestions for how these foods can be incorporated into a healthy eating plan.

2. The counseling session must include:

a.) Establishing, in concert with the participant/caregiver, a goal that is reflective of the participant's needs and interests;

b.) Explanation, in terms that the participant can understand, of at least one of the risk factors that make the participant eligible for WIC services;

c.) Referral, when appropriate, to other health, social, and education agencies for non-WIC services, or to other health care providers for more in-depth nutrition evaluation and counseling;

d.) Documentation of this counseling session, and

e.) Determination of how the midcertification nutrition education contact will be achieved (type, topic, etc.).

f.) Tobacco, alcohol and other drug counseling requirements, as follows:

Local WIC projects must, at a minimum, ensure that all pregnant, postpartum and breastfeeding participants and all caregivers of infant and child participants receive information about tobacco, alcohol, and other drugs at initial certification. Information addressing these harmful substances must be available for participants and caregivers to take home and review. This information can be in the form of brochures or handouts and made available in the general display in the WIC clinic or agency. If a participant has been terminated and then reapplies for WIC

benefits, this is considered an initial certification and the participant or caregiver must be provided substance abuse material.

Substance abuse awareness information must be provided in one or more of the following ways:

1. Place a general display of alcohol, tobacco, and drug information in the clinic or agency. To ensure that new participants are aware of the display, the participants or caregivers must be referred to the general display by a local staff member.

2. Offer substance abuse brochures or pamphlets to participants and caregivers during initial certifications.

3. Discuss substance abuse issues and offer a pamphlet/brochure during initial certifications.

4. Discuss substance abuse issues, offer pamphlet/referral telephone numbers and provide coloring books or stickers to children.

Counseling tips are found in Appendix 400, *Sample Substance Abuse Counseling Tips.*

401.2 Nutrition Education at Midcertification

Projects must provide each participant with an opportunity to receive additional nutrition education sometime during the certification period. This can be at high-risk sessions for individuals; at general sessions conducted for groups or individuals; through use of State-developed nutrition education modules; through use of computer or internet nutrition education modules; or by coordinating nutrition education with other programs. Projects must offer a variety of nutrition education options. Participants, however, cannot be denied supplemental foods for failure to attend or participate in midcertification nutrition education activities.

All midcertification nutrition education provided in the WIC clinic must include an offer of interaction between a WIC health professional and the participant or caregiver. If a module or bulletin board is used, upon its completion, the participant or caregiver must be asked if she would like to speak with a health professional.

(1) The following are guidelines for scheduling midcertification nutrition education sessions.

(a) Each project must develop and keep on file a schedule of nutrition education sessions offered. These sessions can be scheduled for three or six month time periods. Sessions should be scheduled to accommodate approximately one-sixth of caseload each month for midcertification nutrition education.

(b) The schedule must include sessions offered for each category of participant at regular intervals to ensure that participants can be scheduled for a session specific to their category and within the time frames of food issuance requirements.

(c) The sessions must be offered at varied times and days to accommodate ease in scheduling participants for topics of interest to them or important for their medical/nutritional problems (risk codes).

(d) It is recommended that at least one session every six months be provided directly to child participants.

(2) The following list of staff responsibilities must be followed by WIC projects.

(a) Health professionals must conduct all high-risk counseling; licensed dietitians have the requisite training to provide this in-depth counseling and should be assigned these responsibilities whenever possible (see Appendix to this chapter for suggested supervision guidelines for dietetic technicians).

(b) All WIC health professionals may conduct sessions related to specific medical/ nutritional risk codes, i.e., low blood iron, overweight child, or calcium intake. Sessions related to specific medical/nutritional risk codes, conducted by WIC health professionals other than LDs and/or RNs, must be developed and/or approved by a licensed dietitian.

(c) According to the dietitian licensure law, only licensed dietitians (LDs) or RNs, may conduct classes that meet the following definition:
"a planned program based on learning objectives with expected outcomes designed to modify nutrition-related behaviors" Ohio Administrative Code 4759-01."

(d) General sessions may be conducted by health professional staff or guest speakers, or support staff. If the session is to be taught by staff other than an LD or RN, the session outline must either be developed or approved by a licensed dietitian. Following are examples of general classes:

- cooking demonstrations
- vegetable gardening
- thrifty shopping
- safe food handling

If the session is conducted by staff other than a health professional, questions, whose answers are not contained within the lesson plan script, are to be referred to a health professional.

(3) The following are necessary components of a lesson plan.

(a) Each group session must have a written lesson plan on file which contains learning objectives, identified target audience, teaching methods, applicable teaching materials including handouts and films/tapes and some form of participant evaluation. A Sample Lesson Plan is located in the Appendix to Chapter 400.

(b) The group session topics must be varied; types of presentation methods must be appropriate and include at least two different techniques, e.g., video and discussion for some sessions, cooking demonstration for others.

(c) All group sessions must have a nutrition component which must be part of the written lesson plan in order to be considered a midcertification contact. Following are examples of acceptable and unacceptable topics:

- Acceptable:
  - breastfeeding
  - foods for healthy teeth
  - making foods for baby
  - immunization

- Unacceptable, without a nutrition component:
  - bathing the baby
  - car seat safety
  - line dancing

(d) The materials/methods for group sessions (handouts and audiovisuals) must be appropriate to the needs of the participants.

(4) Classrooms should be as conducive to teaching/learning as possible. Space, sound, light, temperature and seating should be appropriate for the size and characteristics of the participants attending the session.

(5) The following points must be considered when scheduling participants.

(a) Each project must develop criteria for scheduling participants for group, individual and high-risk sessions.

(b) Each project must develop criteria for scheduling participants whose medical conditions preclude their attendance at secondary nutrition education classes, e.g., prenatal ordered on complete bed rest.

(c) Take into consideration the participant's needs, interests and availability when assigning midcertification nutrition education sessions. If a class is not available that fits the participant's needs, a brief individual counseling session should be offered.

For example, a prenatal participant must not be scheduled for a "feeding the toddler" group class for the sole purpose of ease of scheduling nutrition education and food issuance according to the clinic's master schedule. In this case the clinic should schedule another, more appropriate class or schedule the participant for a brief individual session.

(6) The following points should be considered when determining attendance.

(a) Each project must maintain accurate attendance records.

(b) Projects must develop policies describing their follow-up and rescheduling of no-shows for all types of midcertification sessions.

(c) Projects must develop policies regarding lateness/missed group sessions and when an alternate is acceptable for attending midcertification sessions. For example, an alternate is not acceptable for prenatals, nor in situations where an alternate picks up food instruments for multiple groups, etc. Options include issuing food benefits month by month until the participant receives nutrition education.

(d) Special considerations for scheduling nutrition education sessions:

- For pregnant women less than two months from their estimated delivery date, no additional nutrition education is necessary if:
  - breastfeeding information has been provided during the certification appointment and
  - the woman does not meet the criteria for high-risk follow-up.
- For a group of two or more participants, scheduling a separate session for each participant is not required if:
  - no one in the group meets the criteria for high-risk follow-up, and
  - a general session can be scheduled that will benefit all group members. For example, a postpartum woman and her baby could both be scheduled for a session "good nutrition for mom and new baby."

    However, a prenatal woman and her three year old child could not both be scheduled for "breastfeeding." The project has the option to schedule the child for food issuance only in this situation.

- When one or more members are high-risk, schedule the high-risk participants for an individual appointment and schedule the rest of the group for a nutrition class that will benefit all members, or include counseling in the high-risk session applicable to the other family members. Projects should attempt to schedule both appointments on the same day, as close together as possible.

- Children and infants are not required to attend sessions that address their needs unless sessions are designed specifically for child participants. The participant will receive credit for session attendance if the caregiver attends a session that will benefit the infant/child.

- Projects may credit a participant with attending a midcertification nutrition education session if the participant is receiving individualized nutritional counseling by a health professional in another agency, e.g., a participant with PKU who is counseled by a metabolic dietitian, if the project staff can verify the date and nature of the additional nutritional counseling.

- Projects may also credit a participant with attending a midcertification nutrition education session offered by EFNEP or other agency if a method for verifying attendance has been developed.

(7) Projects must periodically review the effectiveness of its secondary nutrition education offerings and make adjustments to improve these services by methods such as:

- monitoring no show rates,
- analyzing participant evaluations,
- soliciting comments from participant surveys, and
- pre and post tests.

401.3 Coordinating Nutrition Education with Other Programs

In order to facilitate caseload growth and maintenance within the WIC program, as well as to coordinate services with other programs to better serve the participant, the State WIC office is allowing nutrition education received from other agencies to count as the midcertification nutrition education component for the WIC program.

Allowing nutrition education received from other agencies to fulfill the midcertification nutrition education component for the Ohio WIC program will reduce the amount of time participants spend in the WIC clinic. This option is not available for high-risk participants. Midcertification nutrition education options for high-risk participants are addressed in Section 403 of this chapter.

At the WIC health professional's discretion, a participant who is not high-risk may receive individual nutrition counseling/education from a non-WIC source which could be used as a substitute for WIC midcertification nutrition education. For example, a postpartum woman is attending smoking cessation classes. If documentation of her attendance is provided, this can be substituted for midcertification nutrition education provided at the WIC clinic. Education provided by non-WIC sources must be WIC-appropriate. Use of such non-WIC nutrition education sources must be documented.

Following are the steps required for coordinating group midcertification nutrition education with other agencies/programs:

(1) The local WIC health professional makes initial contact with the other program/agency to explain the coordination project and to ask for cooperation.

(2) The local WIC health professional schedules a site visit. During the visit, the WIC health professional meets with the agency coordinator to discuss the authorization process and what is required.

(3) The WIC health professional reviews the nutrition related lesson plan and attends the activity. (The lesson plan must contain the required information listed in the Sample Lesson Plan Format. A sample is in the Appendix to chapter 400.) If the WIC health professional believes that the activities are an appropriate substitute for a WIC midcertification nutrition education class, authorization is made. The Non-WIC Midcertification Nutrition Education Authorization form is completed. This form and the lesson plan are kept on file in the WIC clinic along with the other WIC midcertification

nutrition class outlines. This authorization form is found in the Appendix to this chapter.

- Reauthorization must be completed if the nutrition activity content changes Significantly, or if the WIC health professional believes that it is necessary.

If this method of midcertification nutrition education is agreed upon by the WIC health professional and the participant or participant's caregiver at certification/ recertification, the following will happen:

(1) The WIC health professional gives the Non-WIC Midcertification Nutrition Education Certificate of Attendance form to the participant or participant's caregiver. The form is completed by the non-WIC local agency personnel who provide the nutrition education. A sample of this form can be found in the Appendix to this chapter.

(2) The form is brought back to the WIC clinic by the participant or participant's caregiver at a time determined by the WIC clinic staff and the participant. Foods are issued for the participant and an appointment scheduled for the recertification visit.

(3) The Non-WIC Midcertification Nutrition Education Certificate of Attendance form is kept in the participant's chart as documentation of attendance.

- The Non-WIC Midcertification Nutrition Education Certificate of Attendance form must be completed for every midcertification nutrition education appointment it is intended to replace. (See the Appendix to Chapter 400 for a copy of the form.)

- A locally developed form is acceptable as long as it has prior State WIC approval. This letter of approval must be kept on file in the WIC project.

- Projects should follow locally established procedures for rescheduling participants who miss their midcertification nutrition education/food issuance appointments.

Agencies that provide nutrition education that may be an acceptable substitute for a WIC midcertification nutrition education may include, but are not limited to, the following:

* Head Start
* Cooperative Extension
* Graduation, Reality, and Dual-Role Skills Program (GRADS)
* Learning, Earning, and Parenting Program (LEAP)
* Extended Food and Nutrition Education Program (EFNEP)
* Grocery Stores
* Hospital/community dietitians
* La Leche League
* Local Lamaze classes
* Home Visiting Nurses

401.4 Midcertification Nutrition Education Provided Via the Telephone

Providing nutrition education via the telephone is an optional method of delivering midcertification nutrition education.

Each health professional is responsible for determining if a participant is eligible to receive telephone nutrition education. Each participant's eligibility for telephone nutrition education should be determined on an individual basis. Telephone nutrition education should not be used routinely, therefore, listed below are criteria for the types of participants eligible and not eligible to receive telephone nutrition education as their midcertification contact.

Participants eligible to receive nutrition education via the telephone:

- Low-risk participants who have missed two scheduled midcertification nutrition education appointments, or
- Low-risk participants with a priority 4, 5 or 6 risk code, or
- Low-risk participants who work during clinic hours or have other scheduled appointment conflicts or family obligations, or
- Low-risk or high-risk participants who have missed a scheduled follow-up appointment for reasons such as: illness, imminent childbirth, transportation difficulties, or inclement weather.

Participants not eligible to receive nutrition education via the telephone:

- High-risk participants who do not fall into the above category,
- Participants determined to meet the high-risk criteria established by the State and local **High-Risk Policy and Subsequent Protocols** (must be followed according to those protocols), and

. Breastfeeding mom and infant when the health professional is concerned about the breastfeeding relationship.

Telephone nutrition education counseling should be specifically related to the participant's risk code and reinforce the goals set at the previous certification/recertification visit. If, during the course of the counseling session, it is determined that the participant needs to be seen in the clinic for a more in-depth counseling session, the health professional should schedule the participant for an appointment and document the findings in the participant's WIC chart.

Documentation of the telephone nutrition education contact must appear on the Nutrition Care Plan form and include the date the contact was made and the content of the education provided.

If the participant or participant's caregiver is not able to pick up the food instruments at the clinic, follow the mailing of food instruments policy defined in Chapter 300 of the WIC Policy and Procedure Manual.

Follow-up counseling to the telephone nutrition education contact must occur at the next recertification visit.

402. Nutrition Policy and Practice Guidelines

The nutrition policy and practice guidelines are included to assist staff in education and counseling of participants. Sections 402.1-402.2 provide information on specific topics. Further information on specific medical/nutritional risks is addressed separately under High-Risk Plan (Section 403). The practice guidelines discussed in section 402.3 are intended to trigger thoughts of the counselor and to help guide the development of the nutrition care plan.

402.1 Ohio Department of Health Specific Policies

The Ohio Department of Health (ODH) is committed to promoting optimal health and safety for all Ohio infants and to reducing infant mortality. ODH recognizes its leadership role in establishing standards for policies and practices that promote healthy behaviors among its employees, programs, subgrantees, and other state agencies for what ODH believes to be in the best interest of Ohio's citizens. The purpose of policy is to establish a consistent message across all department programs and activities. All WIC programs and employees must adhere to ODH policies.

A. ODH Policy on Infant Feeding

ODH, in alignment with the American Academy of Pediatrics, recommends exclusive breastfeeding for six months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for one year or longer as mutually desired by mother and infant. ODH recognizes that there are rare individual and/or family circumstances in which breastfeeding must be limited or is contraindicated. (See Appendix 400 for the complete policy document titled *Ohio Department of Health Policy on Infant Feeding*.)

B. ODH Policy on Infant Safe Sleep

In all activities and publications, ODH programs and subgrantees shall adhere to the infant safe sleep standards as endorsed by the American Academy of Pediatrics (AAP) in their Task Force on Sudden Infant Death Syndrome's report, *SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment*, released in October 2011. (See Appendix 400 for the complete policy document titled *Ohio Department of Health Policy on Infant Safe Sleep*.)

402.2 WIC Specific Nutrition Policies

State WIC has developed some specific nutrition care plan policies and best practice counseling guidelines for targeted medical and nutritional topics. The materials located in Appendix 400 should be used to train new health professionals and those health professionals who may have a limited nutrition background or less experience in these areas.

A. Alcohol Screening and Brief Intervention (ASBI) for Prenatals

The usual procedures for review and documentation on the *Health History* form and *Nutrition Care Plan* (NCP) apply. Follow the *Alcohol Screening and Brief Intervention (ASBI)Procedures* located in Appendix 400 at the first prenatal certification appointment. The *Screening Tool* and *ASBI Scoring Tool* are located in Appendix 400. Scoring and additional activities are outlined as follows.

Positive (red) answers to questions 2, 3, or 4 of the *ASBI Screening Tool* indicate current drinking while pregnant and the health professional must:

- offer specific brief intervention using the *WIC Project Care Health and Behavior Workbook*,
- mark as high-risk on the *Nutrition Care Plan*,
- schedule a follow-up appointment within 4-6 weeks, and
- use the *ASBI Follow-up Visit Question* located in Appendix 400 at that follow-up appointment.

Positive (red) answers to questions 1 or 5 indicate risky behavior that put a participant at an increased risk to drink alcohol while pregnant and the health professional must:

- offer specific brief intervention using the *WIC Project Care Health and Behavior Workbook*, and
- schedule an individual midcertification appointment, and
- use the *ASBI Follow-up Visit Question* located in Appendix 400 at that follow-up appointment.

B. Assessment and Documentation of Tube Feedings and Supplement Use with Risk Codes 56, 91, and 93 Policy

Recognizing the scope of practice for WIC health professionals and the opportunity for providing quality continuity of care for a very high-risk population, policy on the assessment and documentation of tube feedings and supplement use was established.

Health professionals certifying participants with risk code 56, 91, and/or 93 and who are prescribed a formula must assess the tube feeding or supplement. The usual procedures
for review and documentation on the *Health History* form and *Nutrition Care Plan* (NCP) apply. In addition, the health professional **must** document under *Assessment* on the NCP:

- amount of feeding or supplement consumed per day (average);
- tolerance or complications of the feeding;
- concerns, if any, regarding the caregiver's ability to provide the feeding or compliance issues; and
- contact with the physician, if necessary, to change amount or type of feeding.

The same documentation is required whether the information is received at certification, recertification, midcertification, or walk-in appointments. See *Assessment and Documentation of Tube Feedings and Supplement Use with Risk Codes 56, 91, and 93* in Appendix 400.

C. Assessment of Overfeeding of Formula - Best Practices
The document, *Assessment of Overfeeding of Formula,* provides best practice procedures and can be located in Appendix 400.

D. Gestational Diabetes - Best Practices
The document, *Gestational Diabetes (GDM) Assessment & Counseling Tips for Health Professionals*, provides best practice procedures and can be located in Appendix 400.

E. Pica Assessment and Counseling - Best Practices
The document, *Pica Assessment & Counseling Tips for Health Professionals,* provides best practice procedures and can be located in Appendix 400.

402.3 Nutrition Practice Guidelines

Nutrition practice guidelines for each participant category are located in Appendix 400. The guidelines are provided to assist health professionals with counseling and trigger thoughts of topics to discuss with nonparticipatory participants. Covering the entire list in one session is **not** required nor warranted. Choose the items which are most applicable for each participant or situation, prioritize them, set up a care plan, and provide appropriate follow-up care. Remember, the selection of the topic is always participant driven.

403. Ohio WIC High-Risk Policy and Procedures

Certain participants require more frequent nutrition counseling, monitoring, and referrals due to their fragile medical or nutritional condition. These participants are termed "high-risk" and must receive specific, individual nutrition care in addition to general WIC services or staff must verify that these services are already being provided. The intensive nutrition care should supplement, not replace, other community care, minimize duplication of services, and not provide a hardship for the participant. The following sections describe the Ohio WIC High-Risk Policy and Procedures.

403.1 High-Risk Policy

A. Documentation Standards

The Ohio WIC program developed **minimum** high-risk policy and procedures that all local projects must use. The following documentation is required for **all** high risk participants.

- Document concerns by using stars, asterisks, highlighting areas, or writing clarifying information on the Health History form.
- Circle, check, or document high-risk (HR) in the space indicated on the Nutrition Care Plan (NCP).
- Document counseling topics, as needed, for continuity of care on the NCP.
- Mark the referral box, as needed, on the NCP and mark the referral on the WIC System.
- Document if the participant refuses referral on the NCP.
- Document high-risk appointments not kept. Record attempts made to reschedule and/or provide telephone counseling and referral on the NCP**.**

B. Exceptions to Ohio WIC High-Risk Policy

- Local projects may make changes (more restrictive) or additions to the Ohio WIC High-Risk Plan. Local needs assessments and epidemiological studies can help identify specific high-risk groups not covered by the State minimum policy.

- A local project must note in the request for proposal (RFP) the changes or additions to the Ohio High-Risk Policy and write additions using the following format:

- a description of the criteria,
- information to be covered during a visit,
- how often the participant needs to be seen, and
- when referral is required and to whom the referral will be made.

- Participants with high-risk characteristics who are being seen on a regular basis by other health care providers **where nutritional counseling is provided**; e.g., participants with PKU who receive nutritional counseling from a metabolic dietitian. When participants are under the care of a non-WIC health professional, counseling provided by the non-WIC health professional that is documented as stated below may be used in place of the individual midcertification nutrition education requirement. The health professional can decide to provide benefits once documentation is obtained or schedule the participant for a general nutrition education session for benefit pickup. These participants are still designated as high-risk on the NCP.

  Document counseling provided by non-WIC health professionals in one of the following methods:
  - The WIC chart must contain signed documentation from the non-WIC health professional.
  - The WIC health professional must have access to the participant's medical chart and document follow-up on the NCP.
  - The WIC health professional may speak with the non-WIC health professional and document the contents of the follow-up contact on the NCP.
  - The WIC health professional must document the rationale for the exception.

- Participants without high-risk characteristics who are assessed by the health professional as needing extra follow-up. These participants may be followed using high-risk procedures.

403.2 Procedures for Assigning High-Risk Status

Participants that have been assessed and assigned certain risk codes are considered high-risk. The specific risk codes, combination of risk codes, or designated parts of a risk code are provided in sections 403.3 and 403.4. Once the criteria is met, the participant **must** be designated as high risk on the NCP. Depending on the HP's assessment and exceptions to the Ohio High-Risk Policy, the participant may need to be seen individually and a formal referral written. If the participant's health status is good and community follow-up is being provided, the HP may schedule the participant for general nutrition education after documenting the situation. The participant is still designated as high risk, but intensive individualized counseling is not performed by WIC staff.

403.3 Single Risk Codes or Portions of Single Risk Codes Indicating High-Risk Status

A. Low Hematocrit or Hemoglobin (P, B, N, I, C)
-Hematocrit less than or equal to 30.0%, or
-Hemoglobin less than or equal to 10.0 grams per 100 milliliters (P, I, C)

-Hematocrit less than or equal to 33.0%, or
-Hemoglobin less than or equal to 11.0 grams per 100 milliliters (B, N)

(a) Risk Code 20

(b) Follow-up

- Follow up every three months after certification until blood values are greater than high-risk cut-off value.
- If the health professional receives physician documentation/diagnosis of other diseases that produce low hematocrit/hemoglobin values, then follow up every three months is not required.
- If the value is abnormally low, send the participant to the primary caregiver or urgent care immediately.

(c) Major points to be covered initially and, as needed, at follow-up

- Assess current hematocrit/ hemoglobin.
- Assess diet and counsel on correcting dietary inadequacies that relate to iron intake and absorption.

- Encourage the use of non-heme iron-rich foods consumed with Vitamin C-rich foods.
- Interview for possible sources of lead ingestion.
- Encourage participant to take physician prescribed vitamins and/or iron supplements.
- Discuss the relationship between low blood iron and participant's health status.
- Counsel on maintaining an adequate milk supply (B).

(d) Referral

- Refer to the primary health provider using the WIC Interagency Referral and Follow-up Form HEA 4427.
- If participant is receiving treatment for low H/H, the health professional may document no referral sent for this reason or send a referral and indicate to the physician what WIC's hemoglobin values are. If a participant does not have a physician, document that a referral could not be sent.
- At follow-up, if hematocrit or hemoglobin has not improved beyond high-risk parameters, refer again.
- Refer for lead testing, if indicated.

B. Women less than or equal to 15 years of age
-at the time of conception (P)
-at conception for most recent pregnancy (B, N)

(a) Risk Code 40

(b) Follow-up

- If living conditions are a concern or several major nutritional needs are identified, within six weeks of certification, if not, at midcertification appointment. (P, B, N)
- Every three months until participant is recertified if health professional determines the teenager needs continued monitoring and counseling (P, B, N)
- Encourage mother to have infant weighed weekly either at the WIC office or pediatrician's office to assess adequate milk intake, until weight gain is within normal limits. (B)

- Continue follow-up at midcertification and recertification appointments.

(c) Major points to be covered initially and, as needed, at follow-up

- Assess weight status and dietary intake.
- Evaluate participant's living conditions.
- Counsel on correcting dietary inadequacies within living condition constraints.
- Counsel on initiating and maintaining an adequate milk supply. (B)

(d) Referral

- Refer to appropriate service agencies , as needed.
- Refer to breastfeeding support program for teen mothers, if available.
- At two - three weeks of age, if infant weight has not exceeded birth weight, **refer immediately** to infant's primary health provider using the WIC Interagency Referral and Follow-up Form HEA 4427.

C. Pregnant women with gestational diabetes (P)

(a) Risk Code 44

(b) Follow-up

- At three months or sooner depending on health status and dietary intake

(c) Major points to be covered:

- Assess appropriate weight status.
- Assess diet and counsel on correcting any inadequacies or excesses relating to dietary intake.
- Ensure that specialized products are used for appropriate medical conditions and are prepared correctly.
- Reinforce any identified nutritional objectives from WIC or non-WIC health professionals.

(d) Referral

- Nutrition services, as needed or requested
- Other care providers, as needed or requested

D. Alcohol/illegal drug use/misuse of prescription drugs (P, B, N)
-Consumes **any** alcohol during current pregnancy (P)
-Routine current use of ≥ 2 drinks per day. A serving is: 1 can of beer (12 fluid ounces), 5 oz. wine, or 1 ½ fluid ounces liquor **or** binge drinking (drinks 5 or more drinks on the same occasion on at least one day in the past 30 days or heavy drinking (drinks 5 or more drinks on the same occasion on five or more days in the previous 30 days. (B, N)

-Use of illegal drugs; i.e., marijuana, cocaine, crack, PCP, LSD, heroin (P, B, N)
(Breastfeeding is contraindicated for a woman using illegal drugs.)

-Misuse of prescription drugs (P, B, N)

(a) Risk Code 47 or 48

(b) Follow-up

- Follow up within six weeks of certification.
- If weight gain achieves normal limits for the weight status of the participant, follow up every three months with weight check until participant is recertified postpartum. (P)
- If weight gain does not achieve normal limits for the weight status of the participant, follow up monthly until weight gain is within normal limits or participant delivers. (P)
- Encourage mother to have infant weighed weekly either at the WIC office or pediatrician's office to assess adequate milk intake. (B)
- If mother's weight is within normal limits for the weight status of the participant, follow up at midcertification and recertification appointments with weight check. (B, N)
- If weight is below 18.5 BMI, follow up monthly until weight is within normal limits. (B, N)

(c) Major points to be covered (Refer to the Appendix 400 for professional references about substance abuse.)

- Ask about current alcohol/illegal drug use.
- Encourage participation in referral programs if participant has not yet done so or if use remains at a high-risk level.
- Assess and counsel on appropriate weight status and dietary intake. Address any dietary inadequacies.
- At subsequent follow-ups, review progress toward resolving dietary deficiencies.
- Instruct to pump breastmilk and dump it on occasions of high-risk alcohol intake. (B)
- Recommend breastfeeding cease if illegal drug use, especially cocaine use, occurs. (B)

(d) Referral

- Refer to physician and/or alcohol and drug abuse program available in your area using the WIC Interagency Referral and Follow-up Form HEA 4427.
- At two - three weeks of age, if infant weight has not exceeded birth weight, **refer immediately** to primary health provider using the WIC Interagency Referral and Follow-up Form HEA 4427. (B)

E. High weight for height (C)
≥ 2 - 5 years of age and at the ≥ 95th percentile BMI on the CDC age/sex specific growth charts.

(a) Risk Code 54

(b) Follow-up

- At midcertification and recertification appointments

(c) Major points to be covered

- Discuss relationship of dietary intake to weight, including healthy snack and food choices.
- Discuss relationship of physical activity level to weight.
- Discuss family mealtime activities; i.e., caregivers are responsible for providing healthy food choices and child is responsible for how much to eat.
- Reassure parents that healthy children come in all shapes and sizes.

(d) Referral

- Refer to primary physician using the WIC Interagency Referral and Follow-up Form HEA 4427.
- Refer to private practice dietitian for weight management plan, as needed or requested.

F. Slow growth (I, C)
Infants or children with failure to thrive (FTT), or an inadequate rate of weight gain

(a) Risk Code 56

(b) Follow-up

- At midcertification and recertification appointments

(c) Major points to be covered

- Assess current growth and growth trends.
- Assess diet, including breast milk intake, and counsel on correcting any inadequacies relating to dietary intake or preparation of foods.
- Ensure that specialized formulas/products are used for appropriate medical conditions and are prepared correctly.
- Reinforce any identified nutritional objectives from WIC or non-WIC health professionals.

(d) Referral

- Refer to nutrition services or other care providers as needed.
- Refer breastfed infants to an IBCLC or CLC.

G. Breastfeeding issues (B, I)
-A breastfeeding woman with complications or potential complications of breastfeeding, including: (B)

- severe breast engorgement
- recurrent plugged ducts
- mastitis
- flat or inverted nipples
- cracked, bleeding or severely sore nipples
- age equal to or greater than 40 years
- failure of milk to come in by four days postpartum
- tandem nursing (breastfeeding two siblings who are not twins)

-A breastfeeding infant with any of the following complications of breastfeeding, including: (I)

- jaundice
- weak or ineffective suck
- difficulty latching onto mother's breast
- inadequate stooling (for age, as determined by physician or other health care professional) and/or fewer than six wet diapers per day.

(a) Risk Code 74

(b) Follow-up of breastfeeding dyad

- Encourage mother to have infant weighed weekly to assess adequate milk intake. Weights can be taken at the WIC office, pediatrician's office, or by a visiting home nurse.

- Assess mother weekly until milk supply is established and breastfeeding issues are resolved. This can be done over the phone if infant weight gain is adequate.

- At midcertification and recertification appointments: Midcertification appointment growth checks can be discontinued when growth and dietary intake are appropriate.

(c) Major points to be covered initially and, if necessary, at follow-up:

- Assess for breastfeeding issues.
- Teach comfort techniques for engorgement, sore nipples, plugged ducts and mastitis.
- Teach how to evert flat or inverted nipples if infant has a problem latching on.
- Assess adequacy of and teach how to increase milk supply.
- Discuss mother's nutritional needs if she is nursing multiple infants/children.
- Assess infant weight gain (should be at least four ounces per week).
- Assess current growth and growth trends.
- Assess number of times infant nurses per 24 hours (should be at least 8-12 times in 24 hours).
- Assess number of dirty and wet diapers. (Infant should have one dirty diaper per day of life up to four days old. Generally after four days, infants should have six wet diapers per day.)
- Assess whether infant is effectively removing milk from the breast. (Adequate number of wet and dirty diapers can indicate effective sucking.)
- Counsel on supplemental feedings as appropriate to ensure continued lactation and absence of nipple confusion.

(d) Referral

- At initial certification, refer breastfeeding women with breastfeeding issues to the WIC breastfeeding coordinator or other trained WIC staff.

- At follow-up, if breastfeeding issue is not resolved, refer to La Leche League, an International Board Certified Lactation Consultant (IBCLC), other trained lactation expert and/or her physician or pediatrician.

- At two - three weeks of age, if infant weight has not exceeded birth weight, **refer immediately** to primary health provider using the WIC Interagency Referral and Follow-up Form HEA 4427.

H. Medical conditions that affect nutrient intake/inborn errors of metabolism (P, B, N, I, C)

Participant with inborn error of metabolism or medical conditions that affects nutrient intake or utilization.

(a) Risk Code 91 or 93

(b) Follow-up

- Follow up at three months or sooner depending on health status and dietary intake.
- Encourage mother to have infant weighed weekly either at the WIC office or pediatrician's office to assess adequate milk intake, until weight gain is within normal limits. (B, I)

(c) Major points to be covered:

- Assess appropriate weight status. (P, B, N)
- Assess infant weight gain (should be at least four ounces per week). (I)
- Assess current growth and growth trends. (I) (C)
- Assess diet and counsel on correcting any inadequacies or excesses relating to dietary intake or preparation of infant foods.
- Ensure that specialized products are used for appropriate medical conditions and are prepared correctly.
- Reinforce any identified nutritional objectives from WIC or non-WIC health professionals.

(d) Referral

- Medical or nutrition services, as needed or requested
- At two - three weeks of age, if infant weight has not exceeded birth weight, **refer immediately** to primary health provider using the WIC Interagency Referral and Follow-up form HEA 4427.
- Other care providers as needed or requested

403.4 Combinations of Risk Codes Indicating High-Risk Status

A. Slow weight gain and low weight before pregnancy (P)
Not obtaining a recommended weight gain [at least one pound (underweight), < .8 pound (normal weight), < .5 pound (overweight), and < .4 pound (obese) per week] during the second and third trimesters **or** low weight gain at any point in pregnancy such that the weight plot is below the appropriate weight gain range **and** prepregnancy Body Mass Index (BMI) less than 18.5

(a) Risk Codes 10 and 13

(b) Follow-up

- Follow up at four to six week intervals until weight gain is within normal limits or participant is recertified postpartum.
- If weight gain achieves normal limits for the weight status of the participant, follow up every three months with a weight check until participant is recertified postpartum.
- If weight gain does not achieve normal limits for the weight status of the participant, follow up monthly until weight gain is within normal limits or participant is recertified postpartum.

(c) Major Points to be covered

- Discuss relationship between maternal weight gain and infant birth weight.
- Assess weight gain and dietary intake.
- Counsel on correcting any inadequacies found, with emphasis on high caloric foods.

(d) Referral

- At initial visit, refer to primary health care provider using the WIC Interagency Referral and Follow-up form HEA 4427.
- At follow-up visit, refer to health care provider again at health professional's discretion.

B. Low weight before pregnancy and cigarette use (P)
Enter pregnancy at less than 18.5 Body Mass Index (BMI) **and** smoke at least twenty cigarettes (1 pack) per day

(a) Risk Codes 13 and 46

(b) Follow-up

- Follow up at four to six week intervals until weight gain is within normal limits or participant is recertified postpartum.
- If weight gain achieves normal limits for the weight status of the participant, follow up every three months with weight check until participant is recertified postpartum.
- If weight gain does not achieve normal limits for the weight status of the participant, follow up monthly until weight gain is within normal limits or participant is recertified postpartum.

(c) Major points to be covered initially and, as needed, at follow-up:

- Discuss relationship between maternal weight gain, cigarette smoking and infant birth weight.
- Assess weight gain and dietary intake.
- Counsel on correcting any inadequacies found, with emphasis on adequate caloric intake.
- Encourage smoking cessation and counsel on how to reduce cigarette use.

(d) Referral

- At initial visit, refer to smoking cessation program, if available or needed.
- At follow-up, refer to health care provider using the WIC Interagency Referral and Follow-up form HEA 4427 if weight gain is less than at least 1 pound per week.

C. Low weight and cigarette use (B)
Prepregnancy or current postpartum weight (< 6 months postpartum) or current postpartum weight is less than 18.5 Body Mass Index (BMI) **and** smokes at least twenty cigarettes (1 pack) per day

(a) Risk Codes 14 and 46

(b) Follow-up of breastfeeding dyad

- Follow up at midcertification and recertification appointments with a weight check.
- Encourage mother to have infant weighed weekly either at the WIC office or pediatrician's office to assess adequate milk intake.

(c) Major points to be covered initially and, as needed, at follow-up:

- Discuss relationship between cigarette smoking and decreased milk production.
- Assess weight and dietary intake of mother and infant and counsel on correcting any inadequacies found. Emphasize high calorie and Vitamin C rich foods.
- Encourage cessation or reduction of cigarette use.
- Counsel on smoking after nursing the baby rather than before and remind not to smoke around the baby.

(d) Referral

- At initial visit, refer to smoking cessation program, if available as needed.

- At follow-up, if infant weight gain is less than four ounces per week, **refer immediately** to infant's primary health provider using the WIC Interagency Referral and Follow-up form HEA 4427.
- Refer to IBCLC as needed.

D. Born early in combination with low birth weight (I)
Infants who are born early (37 weeks gestation) **and** low birth weight (5 lbs 8 ozs or 2500 gms)

(a) Risk Codes 50 and 51

(b) Follow-up

- Follow up at midcertification and recertification appointments.
- Midcertification growth checks can be discontinued, when growth and dietary intake are appropriate.

(c) Major points to be covered

- Assess current growth and growth trends.
- Assess diet and counsel on correcting any inadequacies relating to dietary intake or preparation of infant food, with emphasis on adequate caloric intake.

(d) Referral

- Refer to physician any negative or erratic growth pattern as needed.
- Refer to IBCLC as appropriate.

404. Breastfeeding Promotion and Support

The choice of an infant feeding method is an important component of preconceptual and prenatal counseling and education. WIC staff is required to provide accurate infant feeding information in a culturally competent manner and support the mother in her choice.

404.1 Ohio Department of Health Policy on Infant Feeding

The Ohio Department of Health, in alignment with the American Academy of Pediatrics, recommends exclusive breastfeeding for six months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for one year or longer as mutually desired by mother and infant. The Ohio Department of Health recognizes that there are rare individual and/or family circumstances in which breastfeeding must be limited or is contraindicated.

A. The *Ohio Department of Health Policy on Infant Feeding* must be adopted by all local WIC agencies and communicated to all staff.

    1. The *Ohio Department of Health Policy on Infant Feeding* (see Appendix 400) must be prominently displayed in each clinic.

    2. All current, new, or contract employees, volunteers, interns, and outreach personnel must be familiar with the statement.

B. All staff must be trained in appropriate skills necessary to implement the policy.

404.2 Clinic Environment

WIC clinic environments must promote and support breastfeeding.

A. Breastfeeding supportive messages must be present in all applicable activities, publications, and displays.

    1. Display posters that promote breastfeeding.

2. Eliminate the visibility of formula and bottle feeding equipment not in current use as an educational tool.

3. Evaluate all visual aids, including posters, and nutrition education materials in order to support ODH Infant Feeding Policy Statement.

B. Mothers should be encouraged to breastfeed their infants in the clinic. Every effort must be made to provide a private place for women to nurse if requested.

C. WIC staff must tell pregnant and breastfeeding participants about the enhanced food package for women who exclusively breastfeed, and exclusively breastfeeding infants over six months. Refer to Section 304.1 for all definitions of the breastfeeding dyad.

D. Infant formula must not be emphasized as a WIC food benefit.

E. Local projects must maintain an up-to-date list of local breastfeeding educational and supportive resources.

404.3 Staffing Requirements and Responsibilities

WIC's primary goal is to provide optimal nutrition for our participants, and breastfeeding is the foundation of good nutrition. All WIC staff has an important role in promoting breastfeeding as the norm in the community. For this reason, all WIC staff must be supportive of the breastfeeding dyad.

A. Breastfeeding Coordinator

1. Each local project must designate a breastfeeding coordinator. The breastfeeding coordinator must sustain and evaluate the project's breastfeeding program and maintain knowledge and training in lactation management (refer to Appendix 100 *Sample Local WIC Breastfeeding Coordinator Job Description* for breastfeeding coordinator responsibilities). Proof of participation in continuing education must be recorded and maintained by the project director or designee.

2. When reassigning or filling a vacant breastfeeding coordinator position, if the candidate is not an International Board Certified Lactation Consultant (IBCLC), candidate qualifications must be discussed with the Nutrition and Administrative Services Consultant (NAS) or the State WIC Breastfeeding Coordinator prior to hiring.

3. Project directors must send to the NAS Consultant a *Certifying Health Professional/Breastfeeding Coordinator Resume*, found in Appendix 100, for the assigned breastfeeding coordinator. This is usually accomplished with the grant application; however, if a breastfeeding coordinator vacancy is filled during the fiscal year, a resume must be sent separately with the eQAR.

4. See PPM Section 113 for additional job-specific duties, training, and meeting requirements.

B. International Board Certified Lactation Consultant (IBCLC)

Local WIC projects are required to contract with, employ, or have some other agreement with a readily available IBCLC to provide referral service for breastfeeding problems beyond the scope of WIC staff.

C. Breastfeeding Peer Helper Supervisor

1. Each local project must designate a peer helper supervisor. Refer to Section 406.8 for peer helper supervisor responsibilities.

2. This role can be filled by the breastfeeding coordinator or other local WIC staff with breastfeeding and supervisory experience as appropriate. However, a current peer helper cannot also be designated as the peer helper supervisor.

D. Breastfeeding Peer Helper

1. Each local project must have a Breastfeeding Peer Helper Program, employing *at least* one peer helper. Refer to PPM Sections 113 and 406 for peer helper responsibilities, training requirements, and hiring considerations.

2. Project directors must send to the NAS Consultant a *Breastfeeding Peer Helper Resume,* found in Appendix 100, for the assigned peer helper. This is usually accomplished with the grant application; however, if a peer helper vacancy is filled during the fiscal year, a resume must be sent separately with the eQAR.

E. Health Professional

The WIC health professional must promote breastfeeding among Ohio's mother-infant dyads. This includes, educating and supporting the mother in achieving her breastfeeding goals, staying up to date on research related to breastfeeding, making breastfeeding referrals, and emphasizing breastfeeding food packages. Refer to the following documents in Appendix 400: *Instructions for using the WIC Health Professional Guide to Support Normal Breastfeeding in the Birth Month, WIC Health Professional Guide to Support Normal Breastfeeding in the Birth Month, and Newborn Weight Loss Table.*

F. Support Staff

WIC support staff's role in breastfeeding includes demonstrating a positive attitude toward breastfeeding, encouraging mothers in their efforts, making breastfeeding referrals, and maintaining basic breastfeeding education.

404.4 Counseling Practices

WIC staff must use participant-centered counseling when talking with women and their families about infant feeding. Refer to section 406.4 part B for specific information regarding requirements for length and frequency of contacts.

A. Prenatal Counseling Practices

All pregnant women must be given instruction on how to initiate and maintain breastfeeding.

1. Infant feeding discussions must be initiated in a way that will not force the mother to choose an infant feeding method before her concerns are addressed. ("What are your thoughts about how you plan to feed your baby?") It is important to ask open-ended questions to discern potential barriers to breastfeeding before the mother determines her infant feeding choice. Indicate in the "BF expectation" field in the WIC System that the participant is undecided until the participant has

received enough information to make an informed choice.

2. Assess knowledge base and extent of breastfeeding experience. ("What have you heard about breastfeeding?")

    a. All women must have their needs and concerns about breastfeeding addressed and be provided educational materials as needed.

    b. Refer women to an infant feeding class or a follow-up individual counseling session as appropriate.

    c. If a mother indicates she will choose not to breastfeed, her decision must be respected. Efforts should still be made to educate about breastfeeding as appropriate.

3. The benefits of breastfeeding must be discussed using individually targeted materials. In addition, the health consequences of feeding infant formula should also be discussed.

4. Additional mandatory education necessary for all pregnant women includes: basic information about skin to skin and instruction on hand expression. See appendix 400 for *Why do I need to learn hand expression?* and *Breastfeeding Hand Expression* handouts.

5. Other points of discussion could include:
    a. the importance of colostrum: encourage all mothers to provide their colostrum to their newborn infant;

    b. how to get a good latch;

    c. newborn belly size and the adequacy of colostrum and milk supply to satisfy needs as the infant grows;

    d. initiation of breastfeeding in the hospital;

    e. how to establish and maintain milk supply; and

    f. infant hunger signs.

6. Encourage education of significant other, support person, and family.

7. Discuss the importance of exclusive breastfeeding. Review the exclusive breastfeeding woman's food package. For women who do not intend to exclusively breastfeed, encourage them to breastfeed as much as possible.

8. Offer breastfeeding support resources.

B. Postnatal Counseling Practices

Continued support and encouragement are vital to help a mother achieve her breastfeeding goals. Although every woman may have different issues, there are some educational points that all postnatal women must receive.

1. All women must be taught the difference between normal breast fullness and engorgement. Engorgement is an emergency situation and all staff must be trained to offer appropriate comforting methods or referral. There must be a written engorgement plan in place that indicates each staff person's role in the event that breastfeeding staff is not available.

2. Education regarding bottle feeding techniques that imitate breastfeeding must be given to all mothers who plan to offer a bottle. The following information about bottle feeding like breastfeeding should be covered:

    a. holding the infant when feeding from a bottle;

    b. positioning tummy to tummy;

    c. feeding according to hunger and satiety cues;

    d. pacing feedings; and

    e. changing feeding position from side to side.

3. Information about hand expression must be offered to all postpartum women.

4. Reasons for introducing formula or weaning must be fully explored and the discussion documented.

5. Upon the issuance of any infant food package containing formula, a postpartum mother must be educated on the proper and safe preparation and storage of formula.

6. Other points of discussion could include:

    a. the importance of providing breastmilk for the first six months without the use of supplemental formula, water, or solids;

    b. the potential need for Vitamin D supplementation;

    c. infant feeding cues: for newborns, emphasize nursing on demand or at least 8-12 times per 24 hours;

    d. positioning and latch-on techniques, including laid back breastfeeding: observe mother nursing if possible;

    e. how to determine if the infant is receiving enough breastmilk: remind her that she may bring her baby to WIC anytime to get weighed; and

    f. growth spurts and the need to increase nursing frequency.

7. Anticipatory guidance may also be needed concerning:

    a. returning to work or school;

    b. use of breast pumps;

    c. safe preparation, handling, and storage of expressed breastmilk and/or formula; and

    d. the impact of supplemental formula and pacifiers on breastmilk supply.

8. Provide appropriate materials and refer to community resources on breastfeeding management and support.

404.5 Keeping and Evaluating Data

A manual or electronic system to keep records on the rate of breastfeeding

initiation and duration should be developed and evaluated by the project breastfeeding coordinator. WIC clinics can generate reports detailing breastfeeding information or develop manual reporting mechanisms as needed.

404.6 Coordination and Outreach

Coordination of efforts with other health care and social institutions is essential for the successful promotion and support of breastfeeding. WIC projects must:

A. coordinate promotion and support efforts with local health care systems, educational institutions, and other local entities that impact the lives of the WIC participants;

B. reference WIC's support of breastfeeding in all outreach materials;

C. include a breastfeeding advocate on WIC Advisory Councils where applicable;

D. network with local certified nurse midwives, nurse practitioners, physicians, pharmacists, and other applicable community health partners; and

E. provide annual updates to local hospitals and health care providers about WIC breastfeeding program activities. This information should also be shared with the wider community.

405. Ohio WIC Breast Pump Policy

The State WIC office purchases manual breast pumps, single and multi-user, portable electric breast pumps and hospital-grade electric breast pumps for issuance by local WIC projects. All manufacturers producing pumps purchased by the Ohio WIC program carry liability insurance as required by law. Use of the pumps as described in the following policy is in accordance with the Food and Drug Administration (FDA) designated use for each type of pump.

Breast pumps should not be used as incentives to breastfeed. The following policies and guidelines must be followed when providing breast pumps to WIC participants. **However, local projects may make additions to these policies depending on local needs and situations. Additional local breast pump policies must be preapproved by the State WIC office.**

After initial training, all staff who issues pumps must receive an annual update on how to assemble and clean the pumps. An experienced peer helper or the breastfeeding coordinator can provide this update.

Staff issuing pumps must be confident that participants receiving pumps, regardless of the source, know how to assemble, use and clean the pump. Staff is not required to teach this information to participants who already know how to assemble, use and clean the pump.

405.1 Insurance Pump Provision

The Affordable Care Act, the health insurance reform legislation passed into law in 2010, requires that both public and private health insurers pay the full cost of breast pumps for nursing mothers. This benefit can be accessed by breastfeeding women independent of WIC, but must be the primary method for WIC breastfeeding women to receive a pump. WIC staff may assist breastfeeding women in any of the following ways:

- education on pump benefit coverage requirements,
- referral to Ohio Medicaid for eligibility determination and/or enrollment (obtain permission to refer to Ohio Medicaid via the Welcome to WIC letter),

- referral to a Durable Medical Equipment (DME) provider,
- education on pump assembly and usage, and/or
- follow-up to ensure continued success with the pump.

A. Private Insurance Pump Provision

Breast pumps and supplies are a private insurance benefit. Participants with private insurance should obtain a breast pump through this benefit as a primary method for receiving a pump.

B. Medicaid Managed Care (MMC) Pump Provision

Breast pumps and supplies are an Ohio Medicaid benefit, provided to mothers or infants receiving Medicaid. Participants on Ohio Medicaid should obtain a breast pump through this benefit as a primary method for receiving a pump.

Pumps are covered by Ohio Medicaid under the following conditions:

1. The requested breast pump is prescribed by an eligible prescriber actively involved in the mother's or infant's care that addresses the medical need for a pump.

2. The pump is deemed medically necessary by the ordering prescriber when one or more of the following conditions exist:

    a. the infant is unable to initiate breastfeeding due to a medical condition such as prematurity, oral defect;
    b. mother/infant separation;
    c. mother is required to take a medication or undergo a diagnostic test that is contraindicated with breastfeeding;
    d. inadequate milk supply;
    e. engorgement; or
    f. breast infection.

3. Prior authorization is not needed for the purchase of a breast pump. Ohio Medicaid reimburses up to $202.50 for a single-user electric pump.

4. Hospital grade rental pumps do not require an initial prior authorization. The rental period is ninety consecutive days. The rental period may be extended beyond the initial ninety days with prior authorization. Total rental period for a pump will not exceed 180 consecutive days including the initial rental period. Rental pumps are covered by Ohio Medicaid at $75 per month.

5. If the WIC health professional or lactation consultant determines that a hospital-grade pump is required and the private insurance or MMC provider will only authorize a single-user or manual pump, then the WIC office can loan the mother a WIC owned hospital-grade pump.

6. If the private insurance or MMC provider will not reimburse for an electric breast pump for any reason, then WIC can provide a pump as outlined in Section 405.2.

7. If the participant receives a pump through the private insurance or MMC provider, WIC staff may provide education on assembly and use of the pump. Document if pump instruction was offered or given.

8. Breast pumps are considered durable medical equipment (DME) for private insurance or MMC billing purposes. Durable medical equipment is provided through a DME provider. WIC projects should maintain an updated list of local and mail order DME providers that service participants in their geographic area.

405.2 WIC Pump Provision

Pumps can only be issued to mothers or their infants who are certified for the WIC program in Ohio as breastfeeding or being breastfed and after determination that private insurance or Ohio Medicaid is not an option.

A WIC Breastfeeding Coordinator or other trained, designated staff must decide the need for a breast pump and issue the pump.

A. Manual Pumps

Manual pumps purchased by the State WIC office are **given** to participants, not **loaned**.

Manual pumps can be issued to participants who are separated from their baby for any length of time or whenever deemed necessary by the local WIC breastfeeding coordinator or other designated staff.

Mothers who will be separated for fewer than four consecutive hours should be taught hand expression and provided a manual pump.

B. Electric Pumps

Single and multiple-user portable electric pumps and hospital grade electric pumps may be provided to mothers to initiate and/or maintain a milk supply. Refer to Appendix 400 for the *Breastfeeding Decision Tree for Provision of a Breast Pump* to determine whether to loan or give an electric pump to a participant.

Mothers should have access to electrical power where they will be pumping. If a mother lacks access to electricity, a battery pack or pedal pump can be provided.

Participants receiving any electric pump through WIC must sign a *Release Form for Distribution of Breast Pump Ohio WIC Program* and complete an *Ohio WIC Loaned/Single-user Electric Breast Pump Survey*. Give a copy to the participant and file the original either in the participant's chart, infant's chart or a central file. These forms can be found in Appendix 400.

1. Loaning Multiple-user Portable Electric Pumps

Only pumps approved by the Food and Drug Administration (FDA) as multiple-user pumps may be loaned to participants. The FDA has accepted the manufacturer’s description of the following portable

electric pumps as multi-user and may be reissued to other mothers with a new attachment kit:

a. Nurture III portable electric breast pump; and
b. Hygeia EnJoye portable electric breast pump.

Multi-user portable electric pumps should be loaned to mothers who are returning to work or school for more than four consecutive hours on any given day. The mother's milk supply should be well established and baby exclusively breastfeeding and receiving no formula from WIC.

2. Issuing Single-user Portable Electric Pumps

Single-user portable electric breast pumps are **given not loaned** and may only be given to babies who are not receiving formula from the WIC program.

With few exceptions, mothers must be certified as exclusively breastfeeding, committed to providing breastmilk to their infant, and must have a well-established milk supply to receive a single-user electric breast pump.

Single-user electric breast pumps can be given to participants planning to return to work or school full or part-time, with anticipated separation from baby of four consecutive hours or more in a given day.

3. Loaning Hospital Grade Electric Pumps

All hospital grade pumps are classified as multiple-user pumps and can only be loaned, not given to WIC participants. Provide a new attachment kit with each loaned pump.

Hospital grade pumps are most effective at initiating and maintaining lactation for mothers whose infants are too young or weak or have other disorders that do not allow them to nurse at the breast and/or while breastfeeding problems are resolved.

405.3 Instructions for Pump Care, Maintenance, and Use

All manufacturers of pumps purchased by the Ohio WIC program assume liability, if the product is used as instructed.

Participants receiving electric breast pumps through WIC must receive written and verbal instruction on its proper use and cleaning from a trained, staff person and **demonstrate** understanding of those instructions before receiving the pump.

For participants receiving a pump through the private insurance or MMC provider, WIC staff may provide education on assembly and use of the pump. Document if pump instruction was offered or given.

Provide *Breastfeeding Hints for Mothers Returning to Work* or *Hints for Breastfeeding Mothers Returning to School* found in Appendix 400 to assist mothers with pumping tips.

405.4 Participant Follow-Up

Mothers issued an electric breast pump through WIC must receive follow-up to ensure continued success with the pump. Contact with mother's reporting a problem must be documented in the Notes portion of the *Release Form for Distribution of Breast Pump Ohio WIC Program*. For participants receiving a pump through the private insurance or MMC provider, WIC staff may provide follow-up to ensure continued success with the pump. For WIC-issued pumps:

A. A follow-up phone call must be made within two weeks of pump issuance by WIC staff to assist mothers with any problems or concerns with the pump (72 hours is recommended).

B. If the mother does not call the WIC program at one month, a phone call must be made within six weeks of pump issuance by WIC staff to provide ongoing support and assistance.

C. If a mother reports no pump issues, additional contacts are not required. Record the date of the contact in the space provided on the *Release Form for Distribution of Breast Pump Ohio WIC Program.*

D. Follow-up required for high-risk breastfeeding dyads is outlined in the high-risk policy in Chapter 400 of the WIC Policy and Procedure Manual.

405.5 WIC Pump Retrieval

Local projects must make an effort to retrieve a WIC loaned pump that is not returned when requested. Remind participants that the Welcome to WIC (WTW) Letter states that failure to return a loaned breast pump when asked may result in disqualification from the program.

To retrieve the pump the following steps should be taken in the order listed:

A. Contact all parties by phone number listed on the *Release Form for Distribution of Breast Pump Ohio WIC Program*, requesting that the pump be returned to the local project by a specific date.

B. If the participant says that the pump was stolen, request that the participant bring a copy of the stolen property police report to the WIC clinic.

C. Mail a certified letter to the participant requesting return of the pump. See *Breast Pump Retrieval Letter Sample* and the *Breast Pump Retrieval Letter Follow-Up Sample* in Appendix 400.

D. Document all call attempts and letters sent.

E. Give WIC benefits on a monthly basis until the pump is returned.

If all attempts to retrieve the pump have failed, record the pump as missing in the *Defective/Missing/Disposed of Pumps* column in the first table and the details of the missing pump in the *Defective/Missing/Disposed of Pumps* table of the electronic *Ohio WIC Program State Supplied Pump and Kit Issuance Form* found in Appendix 100.

Local staff should send all documentation to the State WIC office for appropriate follow up. The State WIC office will determine if a participant must refund the amount of the pump and/or be disqualified from the program as allowed in the signed WTW letter.

WIC participants who have been loaned a hospital grade electric breast pump should return the pump when requesting increased formula unless actively working with a lactation consultant to return to exclusive breastfeeding. Projects may not refuse to provide formula, but may issue WIC benefits monthly until the pump is returned or reported lost or stolen.

405.6 WIC Pump Service and Maintenance for Loaned Pumps

Upon return, the pumps must be visually inspected for cleanliness and checked for return of all parts, except attachment kit and, for certain models, the carrying bag.

Pumps must be cleaned with a soft cloth moistened (not dripping) with warm water and a disinfectant before loaning the pump to the next participant. Follow manufacturer cleaning recommendations for additional guidance.

405.7 WIC Pump Warranty

Manufacturers' standard warranties apply to all pumps and will not begin until a pump is issued to a participant.

A. One year warranty:
    1. Medela Personal Double Pump
    2. Ameda Purely Yours
    3. Medela reconditioned Symphony

B. Two year warranty: Bailey Medical Nurture III

C. Three year warranty:
    1. Hygeia EnJoye
    2. Medela reconditioned Lactina Select

405.8 Handling Defective WIC Pumps

A. Defective Manual Pumps

1. Manual pumps that are found to be broken on delivery or at first use must be reported to the State WIC office.

2. Complete the *Defective/Missing/Disposed of Pumps* section found in the electronic *Ohio WIC Program State Supplied Pump and Kit Issuance Form* quarterly report.

3. Notify the pump manufacturer for a replacement and issue the WIC participant another manual pump.

B. Defective Electric Pumps

1. If the pump does not work properly, or if a mother experiences a problem with the pump before the warranty has expired, WIC staff must return the pump to the manufacturer.

2. The local project should issue a new pump only after the participant has returned the defective pump to the WIC office or shows proof that the defective pump was returned by the participant to the manufacturer.

3. Complete the *Defective/Missing/Disposed of Pumps* section found in the electronic *Ohio WIC Program State Supplied Pump and Kit Issuance Form* quarterly report. Staff is advised to retain pump packaging materials for ease in returns.

4. Pumps provided through an MMC plan found to be defective should be returned to the durable medical equipment (DME) company where it was issued.

405.9 Managing Physical Inventory of WIC Pumps

Projects should manage the purchase, storage, distribution and recovery of breast pumps like any other type of agency procurement in order to prevent theft or unauthorized use or distribution.

Upon receipt, all electric, manual and attachment kits must be counted when received to ensure that the order is complete and the numbers recorded on the electronic *Ohio WIC Program State Supplied Pump and Kit Issuance Form* quarterly report are correct. Report all order discrepancies to State WIC immediately.

All pumps (electric and manual) and attachment kits must be stored in a secure area or cabinet.

All new pumps and attachment kits must be stored in unopened packaging, received from the manufacturer.

Issuance of all pumps must be recorded on the electronic *Ohio WIC Program State Supplied Pump and Kit Issuance Form* quarterly reporting form as part of the Quarterly Activity Report (eQAR). Local WIC projects can give extra single-user electric pumps to other local WIC projects. After the local projects determine the final location of the pump, record potential pump transfers on the electronic *Ohio WIC Program State Supplied Pump and Kit Issuance Form.*

405.10 Evaluation of the WIC Pump Program

The *Ohio WIC Loaned/Single-user Electric Breast Pump Survey* must be used to evaluate participant program satisfaction and appropriate pump use. Follow the steps below when administering the survey:

A. Print and initiate the survey by completely filling in the top “For WIC Staff Use Only” box whenever a participant is issued a pump from WIC. Local WIC staff is encouraged but not required to complete a survey with participants who received a pump from another source.

B. Place the initiated form in either the infant's or mother's chart or a central file.

C. WIC staff and the mother must complete all questions on the survey when she returns a loaner pump or, for mothers receiving a single-user pump, when she requests more formula, or after using the pump for six months, whichever comes first.

D. For State WIC analysis, enter data for each individual survey at least quarterly into the provided survey format. Retain surveys for one year per section 109.8.

405.11 WIC Staff Use of WIC Owned Pumps

WIC staff will have access to a hospital-grade, electric breast pump while at work only.

Participants have first use priority of a hospital-grade, electric breast pump placed in the WIC office.

A breastfeeding WIC staff member must purchase her own attachment kit unless she is also an active WIC participant.

405.12 Keeping Expressed Breastmilk Safe / Pump Education Materials

All breastfeeding women need accurate information about collecting, storing and warming expressed breastmilk to maintain the quality and safety of the milk for later feeding.

The *Pumping and Storing Breastmilk* handout found in Appendix 400 or other suitable document can be copied and given to participants to aid with pumping and storing breastmilk.

406. Ohio WIC Breastfeeding Peer Helper Program

The choice to breastfeed requires education, commitment, support, and skilled help. Ohio WIC supports local breastfeeding peer helper programs by providing technical assistance, sample forms, and the following policy.

406.1 Definition of a Paraprofessional Breastfeeding Peer Helper

The USDA training program, *Loving Support © Through Peer Counseling Training*, defines a paraprofessional breastfeeding peer helper as: those without extended professional training in health, nutrition, or the clinical management of breastfeeding who are selected from the group to be served and are trained and given ongoing supervision to provide a basic service or function. Paraprofessionals provide specific tasks with a defined scope of practice. They assist professionals, but are not licensed or credentialed as healthcare, nutrition, or lactation consultant professionals.

Ohio Revised Code (ORC) 4757.02 prohibits any person from using a job description incorporating the word "counselor" unless currently authorized by licensure to act in the capacity indicated by the title. To comply legally with the state's professional standards committees, **the term "counselor" cannot be used for peers in Ohio WIC**.

406.2 Guidelines for Hiring a Breastfeeding Peer Helper

A successful breastfeeding peer helper program begins with careful selection of peers. Local projects will actively recruit peer helpers keeping in mind the definition of a paraprofessional breastfeeding peer helper found in section 406.1.

A. Refer to section 113.5 for Paraprofessional Breastfeeding Peer Helper minimum qualifications for hiring.

B. Other characteristics to consider include:

1. enthusiasm for breastfeeding,
2. communication skills,
3. timeliness,

4. responsibility,
5. previous work experience,
6. bilingual/cultural awareness,
7. flexibility, and
8. creativity.

C. Open-ended questions allow conversation and encourage the interviewee to describe her experiences. Appendix 400 contains a *Breastfeeding Peer Helper Sample Interview Form* and *Breastfeeding Peer Helper Sample Interview Questions* that can be used to elicit subjective and objective information from potential peer helpers.

D. It may be helpful to request potential peers to provide recommendations from their previous employer, La Leche League leader, friends or family she might have helped with breastfeeding, and other contacts in the community.

406.3 Breastfeeding Peer Helper Training

Breastfeeding peer helpers must receive initial training using the *Loving Support © Through Peer Counseling Training* provided by the United States Department of Agriculture.

A. Using the *Loving Support © Through Peer Counseling Training* modules, local projects can train their peers as a project or regionally with other projects. Local training teams must include at least one trainer who is familiar with *Loving Support © Through Peer Counseling Training*.

B. Initial training of breastfeeding peer helpers must include training requirements listed in section 113.5, as well as:

1. basic breastfeeding information included in scope of practice,
2. Ohio WIC Policy and Procedure as applicable,
3. WIC confidentiality expectations (see *Sample Confidentiality Statement* in *Using Loving Support to Manage Peer Counseling Programs* in Appendix 400**),**
4. peer helper job expectations (see *Breastfeeding Peer Helper Sample Position Description* in Appendix 400*),* and
5. when a referral is needed (see *Breastfeeding Peer Helper Yield List* in Appendix 400).

C. Peers should be given opportunities to meet with other peers. This is especially important for projects with only one peer helper since it is helpful for peers to receive feedback and support from other peers.

D. Ongoing training is required to equip peers with the tools they need to be successful and confident. Ohio WIC breastfeeding peer helpers must participate in at least six hours of continuing education activities by reading appropriate articles, participating in conference calls, and attending seminars, workshops, in-services, or conferences. Proof of participation in continuing education must be recorded and maintained by the project director or designee.

E. Acceptable continuing education topics include:

1. communication,
2. breastfeeding support,
3. job performance,
4. cultural sensitivity,
5. general health and safety issues, and
6. computer skills.

406.4 Breastfeeding Peer Helper Caseload and Contacts

The following guidance is to assist peer helpers in working with participants.

A. Caseload

All WIC projects are individualized and require varying amounts of peer helper time depending on caseload, clinic flow, and experience. The following ranges are offered as a guide to local projects with the expectation that adequate peer hours will be offered to run a successful Peer Helper Program. If projects are able to support more than the hours proposed, they are highly encouraged to do so. If projects are below the minimum hours suggested, discuss the reasons with your NAS consultant.

Projects with a caseload of:

1-1,000 = 10 - 20 hours per week of peer helper time
1,001-2,000 = 20 - 30 hours per week of peer helper time
2,001- 4,000 = 30 - 45 hours per week of peer helper time

4,001- 8,000 = 45 - 60 hours per week of peer helper time
8,001 – 25,000 = 100 - 150 hours per week of peer helper time
Over 25,001 = 150 - 300 hours per week of peer helper time

B. Contacts

The breastfeeding peer helper will be expected to attempt to establish a relationship with pregnant, breastfeeding, and postpartum WIC participants. See below for guidance on length of time and frequency of contacts. Each project should consider a specific timeline that fits individual clinic needs.

1. Length of time

   Contacts with mothers will take variable amounts of time depending on her particular needs. As a general rule allow:

   a. four to six phone calls per hour (ten to fifteen minutes per call),
   b. fifteen to thirty minutes per hospital visit,
   c. fifteen to thirty minutes per clinic visit, and
   d. thirty to sixty minutes for classes or support group meetings.

2. Frequency

   a. In order to establish rapport, all pregnant women must be contacted by a WIC peer helper at least twice during her pregnancy. Local projects are encouraged to contact a WIC participant as appropriate beyond the two contact minimum.

      Prenatal contacts include:
      1) office visits,
      2) classes or support groups,
      3) phone calls,
      4) agency approved texting or social media, and
      5) mailings.

b. All pregnant women who plan to breastfeed or are undecided should receive an initial postpartum contact within three days of delivery; however, they must be contacted within seven business days of delivery.

1) Definition of initial postpartum contact: a contact occurs when the participant and breastfeeding or health professional staff communicate regarding breastfeeding status, support, and possible questions.

2) Examples of an appropriate initial contact:

a) Peer helper or breastfeeding staff calls participant near delivery date and makes initial contact in appropriate time frame.
b) Participant calls breastfeeding staff to report delivery of baby.
c) Participant calls clinic and would like to make an appointment:
   i. If breastfeeding or health professional staff is available, transfer participant to speak with them for initial breastfeeding contact.
   ii. If breastfeeding and health professional staff are unavailable, the participant must be called back in order to make initial contact.
d) Peer helper calls the participant and leaves a message.

For reporting purposes, a telephone message counts as the initial contact. However, further calls must be made shortly after initial contact in order for peer helper to support the participant.

3) If a participant unexpectedly delivers early and the initial contact occurs after seven days, the peer should count the initial contact based on when the delivery occurred.

For reporting purposes, these instances can be noted separately so that the initial contact data is not distorted.

c. In the first few weeks after delivery, mothers need substantial support in order to gain confidence in breastfeeding. Peer helpers should follow up with breastfeeding mothers as often as necessary immediately following delivery. Each mother will have different needs and peers should take a participant-centered approach when helping them.

d. Once a mother is confident that she is making enough milk and there are no other concerns, frequency of contacts may decrease accordingly. It is important for the WIC peer helper to continue communication with moms to ensure prolonged success with breastfeeding. Peers should follow breastfeeding women for twelve months postpartum or until weaning occurs.

406.5 Breastfeeding Peer Helper Scope of Practice

Peer helpers must operate within their scope of practice. Each peer helper may have different education levels and skill sets. The following are general guidelines for peer helper scope of practice in the Ohio WIC program.

A. Provide breastfeeding education and advocacy:

1. educate parents on the aspects of normal breastfeeding;
2. describe benefits of breastfeeding and risks of formula feeding;
3. provide anticipatory guidance to reduce the occurrence of problems;
4. provide information and additional breastfeeding resources;
5. educate regarding effects of supplemental and complementary feeding on lactation;

6. address cultural attitudes and practices, including various myths and misconceptions about breastfeeding;
7. provide emotional support to mother and significant other;
8. assist in teaching breastfeeding classes and coordinating breastfeeding support groups; and
9. act as an advocate for breastfeeding in the community, workplace, and health care system.

B. Demonstrate techniques and communication skills:

1. demonstrate various positioning techniques for mother and baby, and
2. select and explain assistance techniques in order to:

    a. increase infant breastmilk intake,
    b. increase maternal milk supply,
    c. hand express breastmilk,
    d. safely and effectively collect and store breastmilk,
    e. nurse effectively at night,
    f. breastfeed in public, and
    g. wean safely.

3. discuss the following items and demonstrate correct use:

    a. breast pads and nursing bras,
    b. nursing pillows and foot stools,
    c. slings and soft baby carriers,
    d. artificial nipples and pacifiers,
    e. nipple creams and oils,
    f. nipple shields and breast shells, and
    g. breast pumps.

C. Conduct successful breastfeeding appointment:

1. obtain consent from mother when necessary,
2. gather mother and infant history,
3. observe and document relevant information,
4. offer assistance or education regarding expressed needs,
5. assist in developing a breastfeeding plan and setting goals, and
6. provide appropriate follow-up.

D. Provide long term breastfeeding support:

1. assist in implementing plans for the continuation of breastfeeding including:

a. returning to work or school,
b. temporary mother-baby separation,
c. cluster feedings,
d. growth spurts, and
e. "nursing strike" or breast refusal.

2. help with minor breastfeeding difficulties such as:

a. moderate breast engorgement,
b. plugged ducts,
c. delayed or inconsistent milk ejection reflex, and
d. variations in milk supply.

E. Participate in additional activities:

1. assist other breastfeeding peer helpers,
2. provide and participate in training sessions for WIC or agency staff,
3. attend or present at WIC staff meetings, and
4. promote breastfeeding in the local community.

F. Refer to peer supervisor when appropriate:

1. Ohio WIC peer helpers must not provide specific medical or nutritional advice outside of their scope of practice.
2. Refer to the *Breastfeeding Peer Helper Yield List* found in Appendix 400 for a suggested list of issues outside of the peer helper scope of practice.
3. Peer helpers will continue to provide support when a lactation expert or other health professional is addressing the issue unless directed otherwise.

406.6 Breastfeeding Peer Helper Practice Locations

WIC Breastfeeding peer helpers should work primarily in the WIC clinic setting meeting women face to face. Peers must follow the employment practices

dictated by their WIC grantee agency regarding work schedules, travel vouchers, and other personnel issues, including liability.

A. If the local grantee agency guidelines permit, WIC breastfeeding peer helpers can provide services in a variety of other settings such as:

    1. hospitals;
    2. physicians' offices;
    3. various locations around the community;
    4. participant's workplace;
    5. home visits (see Appendix 400 for *Breastfeeding Home Visiting Guidelines,* and *Breastfeeding Peer Helper Home Visiting Standards*).

B. Projects that have ongoing arrangements with locations should enter into a Memorandum of Understanding with the partnering entity.

C. Providing services outside of normal clinic hours is an ideal part of a successful peer helper program. If the local grantee agency guidelines permit, these services could include:

    1. a breastfeeding helpline,
    2. evening or weekend support group meetings,
    3. evening or weekend visits to the hospital, and
    4. attending prenatal or postnatal clinics at physicians' offices or hospitals.

D. Peer helpers providing services outside of normal working hours must be instructed on how to refer mothers and babies having problems. All referrals must be documented and reported to the peer supervisor the next business day.

406.7 Breastfeeding Peer Helper Career Path

Participation in the Breastfeeding Peer Helper Program offers many advantages to the peer. Some advantages include additional job experience, continuing education, enhanced communication skills, and improved self-confidence. This in turn could lead to a sense of empowerment to further pursue her passion for breastfeeding.

A. Continuing education and additional credentialing

1. WIC encourages continuing education. However, the WIC program will not guarantee:

    a. to pay for all continuing education and credentialing;
    b. to provide all continuing education credits needed to keep a certification; or
    c. to increase pay, responsibilities, or job title/classification.

2. If an increase in pay, responsibilities, or job title/classification is requested by the peer, this must be discussed with local WIC supervisory staff. Ultimately providing additional job opportunities or pay is at the discretion of the grantee agency.

B. Local projects may develop a career path for peers within the WIC program. For example, if the local agency permits, a job description can be created for a "Senior Peer" position which would have increased responsibility and possibly increased pay. See *Sample Job Description – WIC Senior Breastfeeding Peer Counselor* in Appendix 400.

C. Some peer helpers may have the opportunity to become certified as a Certified Lactation Counselor (CLC), Certified Lactation Specialist (CLS), or International Board Certified Lactation Consultant (IBCLC). WIC supports this achievement; however, additional pay, responsibilities, or job title/classification cannot be guaranteed through the WIC program. It is important to remember the definition of a paraprofessional peer helper, located in section 406.1, when obtaining additional credentials. Local projects are not required to financially support peers in attaining credentials.

If a peer helper receives financial assistance from the local WIC project to attain credentials, she must fulfill the following requirements:

1. work for WIC one year prior to attaining the credential, and
2. commit to working at least one additional year in the Ohio WIC program.

406.8 Breastfeeding Peer Helper Supervision and Support

A. The following must occur in order to provide appropriate supervision and support for peer helpers:

1. Support from the WIC grantee agency, by allowing peers flexibility in work duties, hours, and locations. The WIC grantee agency is encouraged to institute a policy for allowing peers to bring their babies to work.

2. Preferably, an IBCLC should be the breastfeeding peer helper supervisor. If this is not applicable, another staff person with additional breastfeeding training is acceptable.

3. Breastfeeding peer helper supervisors should obtain continuing education in various topics, including breastfeeding management, cultural sensitivity, personnel management, mentoring, and supervisory principles.

4. A current peer helper cannot also be designated as the peer helper supervisor.

B. The role of the WIC breastfeeding peer helper supervisor:

1. Responsibilities of the peer supervisor include:

a. initial training of the peers,
b. observation of peers,
c. regularly scheduled meetings with peers, and
d. evaluation.

2. Act as a mentor for peers as they learn job duties and skills. It is important to have cultural understanding of women who have never worked before and provide clear expectations.

3. Assimilate peer staff into the WIC setting. Include peers in regular WIC staff meetings by presenting case studies, success stories, or other descriptions of current activities.

4. Develop a method for communication between peers and other WIC staff.

5. Supervisors need to ensure peer caseload is appropriate. If caseload increases, peer supervisors must determine a system to identify those participants that most need peer support. Other WIC staff should continue to attempt to contact mothers not determined to meet the criteria.

6. Appropriate peer supervisor hours will vary depending on the number of peers and their skill levels. The recommended minimum direct supervisory time, per caseload, after initial hiring is:

   1-1,000 = 5 hours per week supervisory time
   1,001-2,000 = 7 hours per week supervisory time
   2,001- 4,000 = 10 hours per week supervisory time
   4,001- 10,000 = 15 hours per week supervisory time
   Over 10,000 = 20 hours per week supervisory time

C. Evaluation of peer helpers:

1. Initially it is important to monitor peers closely. As peers learn their jobs and trust is built, direct observation may decrease.

2. Evaluation activities include:

   a. observing and listening during counseling sessions and phone calls (see Appendix 400 for *Breastfeeding Peer Helper Sample Evaluation Observation Checklist*);
   b. reviewing contact documentation; and
   c. surveying WIC participants, WIC staff, and community partners.

406.9 Local Project Reporting

Local projects are required to submit peer program activity and expenditure reports.

A. Projects must monitor and report peer activities using the *Quarterly Breastfeeding Peer Helper Activity Report* form located in Appendix 400.

B. Proof of peer helper participation in continuing education must be recorded and maintained.

C. Projects must report their actual breastfeeding peer helper program expenditures using the *Breastfeeding Peer Helper Program Budget/Expenditure Form*, found in Appendix 400. This form is submitted with each year's Request For Proposal (RFP) and Final Fiscal Year Expenditure Report via GMIS, or as needed.

D. Refer to Appendix 400 for *Allowable Costs for Breastfeeding Peer Counseling Funds.* Please note this USDA FNS document is not specific to Ohio and, therefore, peer helpers are referred to as peer counselors. See PPM section 406.1 for more information regarding this rule.

407. Counseling Practices

Counseling must be participant centered. Successful counseling includes focusing on the participants' needs and concerns, and involving the participant in all goal-setting decisions.

407.1 Preparation for Counseling

Adequate preparation by the health professional is essential to the success of each counseling session. Reviewing participant information**;** assembling needed materials, forms and supplies; and preparing the counseling environment will increase the efficiency and effectiveness of the counseling session.

(1) By reviewing the record in advance, the health professional can:

- enter appropriate data into the computer,
- complete documentation as much as possible,
- avoid asking unnecessary questions,
- identify relevant health information,
- review information from previous visits, and
- focus on the purpose of each encounter.

(2) The space used and its appearance can influence learning. Counseling areas or techniques that do not provide any privacy may distract the participant/caregiver, convey disrespect and limit their interactions with the health professional.

(a) Arrange the counseling environment so that it will be inviting and comfortable to the participant.

- Have a supply of comfort items readily available that might be needed by participants or their children, e.g., coloring books and tissues.

- Avoid using a wide table between the health professional and the participant.

- Avoid having the participant seated lower than the health professional.

(b) Arrange for privacy since most people are not comfortable sharing personal information in an open, public setting.

- In clinics with limited space, consider using portable screens.
- Lower your voice and sit near the participant to make the exchange of information as confidential as possible.
- Privacy also means freedom from interruptions. Phone calls or conversations with other staff may give the participant the impression that the interview is of secondary importance.
- If interruptions cannot be prevented, then apologize to the participant and deal with the interruption as quickly as possible.
- Ask to return phone calls that come during an interview or ask that your calls be held if possible.
- Hang a sign on your door to let other staff know you are with a participant.

407.2 Basic Counseling Guidelines

The nutrition counseling session must be participant-centered. Participants have different needs requiring a variety of approaches in order to be successful.

The counseling session must go beyond just dispensing nutrition information. Think of it as an exchange, a conversation with a purpose that assists a participant in making informed decisions.

(1) Establishing rapport with participants influences the quality and amount of information collected in the dietary interview and can enhance participant's receptiveness to dietary counseling that may follow the interview. Impressions made in the first few minutes of the interview affect how comfortable participants feel with the health professional and the counseling process. Use these techniques to get interviews off to a good start.

a.) Stand, look directly at the participant, smile, and greet her in a friendly manner.

b.) Address the participant respectfully. Ask her how she would prefer to be addressed. Do not assume that calling participants by their first name makes them feel more comfortable.

c.) Introduce yourself, state your position and explain the purpose of the interview and approximately how long it will take.

d.) If the participant seems disturbed by the need to remain, recognize that there are times when it is better not to interview. When illness, emotional upset, transportation problems, or other commitments make staying a hardship for the participant, offer the option of returning at a more convenient time. If this would delay program benefits, explain the situation and offer her the available options.

e.) Avoid mentioning how busy you are or how many people there are in the clinic. This can make participants feel rushed.

f.) Take a moment to express a friendly interest in what kind of day the participant has had.

g.) Solving a participant's problem with social services or with getting a ride home may not be possible, but acknowledge her concerns in a caring manner. It may be appropriate to refer her to a community resource that might provide assistance. Avoiding a lengthy digression requires the health professional to exercise skill and tact in refocusing conversation on the dietary interview.

h.) Begin the interview by asking an open-ended question that will demonstrate that the participant/caregiver's participation and opinions are an important part of the interview process. Elicit her thoughts and feelings about any diet or health-related problems and find out what her concerns are about herself or her child. To help focus on the participant, ask questions such as:

"How do you feel about how Eric is eating since he turned two?"

"Tell me how you've been feeling since you became pregnant."

"Is the new baby getting you up a lot at night?"

(2) Practice active listening. Listening and being attentive show your interest in the participant and save time. Planning your next response while the participant is still speaking, interferes with actively listening. Attentive behaviors include:

a.) not interrupting a participant while she is speaking,

b.) using simple verbal encouragements including comments such as "mm-hmm," and

c.) allowing some silence for you and the participant to collect your and her thoughts.

(3) Paraphrase comments to clarify what the participant has told you and to communicate to her that you understand what was said. When paraphrasing, the health professional should restate what the participant said in a simple statement, then watch for a response from the participant to make sure the message was interpreted correctly.

(4) Asking questions skillfully promotes participant involvement in a joint exploration of the discussion topic. The health professional must determine the most appropriate questions to ask and the most appropriate way to ask the questions for each participant.

(a) Useful questions will:

- promote discussion,
- encourage involvement of the participant,
- elicit information about the participant's attitudes and perceptions,
- restate or clarify information provided by the participant,
- focus discussion,
- summarize responses,
- help establish the participant's level of understanding,
- help to establish mutually agreed upon goals, and
- help conclude the interview at the appropriate time.

(b) Questions that may not be helpful:

- can be answered with a yes or no,
- have no concrete answer or are too broad,
- imply a judgment of the participant's response,
- imply the "correct" answer, and
- call for more than one response.

(5) Observing participants is as important as listening carefully to them. Health professionals should observe the participant's nonverbal cues, or "body language." They should also be aware of their own body language and the impression it may give to participants.

Please keep in mind that there are cultural differences and what may be appropriate in one culture may not be appropriate in another culture. Following are a few general guidelines for interpreting nonverbal cues.

(a) Some positive nonverbal cues are:

- maintaining comfortable eye contact,
- smiling (not always interpreted as positive),
- nodding appropriately,
- leaning slightly forward,
- maintaining relaxed posture,
- sitting facing the participant, and
- limiting unrelated activities (sipping coffee, doodling, etc.).

(b) Some negative nonverbal cues are:

- avoiding eye contact or staring,
- frowning,
- remaining stiff,
- turning away,
- using nervous gestures such as tapping, and
- crossing/folding arms.

407.3 The Dietary Interview

The dietary interview establishes a base of information about the participant's lifestyle and eating habits that makes it possible for the health professional to provide appropriate and realistic nutrition counseling. Procedures for eliciting, documenting and evaluating dietary intake for certification purposes are detailed in the Certification Chapter.

The interview also provides a valuable opportunity for the health professional to establish trust with participants, thereby improving the quality and amount of information obtained in the interview and enhancing the effectiveness of nutrition counseling that may follow the interview. Consider the following issues when conducting the dietary interview.

(1) Recognize that the dietary interview may be a low priority for the participant. Make an effort to find out her priorities before proceeding with the interview. Information about your participant's concerns can be used to relate those priorities to her dietary habits and nutritional needs.

(2) Avoid making assumptions about an individual's lifestyle or eating habits based on the participant's ethnicity. Use your knowledge of diverse cultures and the eating habits of the people in your community to ask appropriate questions about dietary habits.

(3) Remain nonjudgmental during the interview. Even expressing approval over something the participant has said may cause her to tailor answers to meet the health professional's expectations.

(4) Mothers of infants and children are particularly sensitive to any comments that might be construed as criticism of their ability to care for their child. Frame questions so that they will not be perceived as judgmental. Questions such as the two following examples can be threatening and nonproductive.

"Do you always prop the baby's bottle?"

"He drinks that many sodas every day?"

(5) Adapt techniques to different eating styles. People who do not organize eating by meals or food groups may benefit from dietary guidance that focuses mainly on foods, as in these examples:

"Which of these snacks and fast foods do you like?"

"When would be a good time for you to eat a bowl of cereal with milk and fruit?"

(6) Assure participants that information discussed in the dietary interview is part of their confidential WIC record and will not be shared with anyone not directly involved in their care.

407.4 Deciding the Content of Nutrition Counseling

(1) Decisions about the content of the counseling should include:

a.) Involving the participant by asking open-ended questions and using methods that require her response or action.
b.) Praising the positive aspects of her diet or health practices, then addressing an area for change.
c.) Determining what the participant/caregiver wants to know more about.
d.) Determining what her abilities are to understand the nutrition education information presented.
e.) Helping the participant identify her motivation for behavior change.

(2) The content should be limited to essential "need to know" information. Do not overload participants with too much by including the nonessential "nice to know" information. For example, tell a woman how to reduce her fat intake rather than discussing the relative merits of a 20% versus 30% fat intake for adult women.

All nutrition education must contain nutrition information. Nutrition education topics may incorporate physical activity and child development.

(3) Any change for the better, regardless of how small, is an important change that deserves praise and recognition. It will reinforce and motivate participants to continue their efforts.

For example, a pregnant woman who is praised for increasing her daily number of servings of milk products by one will be more willing to try to continue improving her diet than if she is judged a failure for still not having an adequate diet.

(4) Encourage the participant to plan her own solutions.

For example, instead of only handing her a pamphlet on iron-rich foods, ask her "can you think of ways to increase iron in Nicole's snacks?"

(5) Allow participants to make choices about fitting the nutrition education they receive into their own lifestyles.

For example, helping them make convenience food more nutritious by adding cheese to canned spaghetti.

(6) Pay attention to what the participants communicate nonverbally as well as verbally. If the two seem inconsistent, there may be something they are trying to avoid telling you.

(7) Provide time for reinforcement and allow the participant to talk.

(8) Try to anticipant any potential problems the participant might experience with her goal.

For example, "when Damon is with his grandmother on the weekends, try....."

(9) Limit the number of nutrition education reinforcement materials given to one or two items, unless the participant requests additional information or materials.

(10) Participants should determine their own goals. If necessary, the health professionals may assist the participant or caregiver in choosing a goal. However, the goal should state the participant's expected behavior, match the participant’s needs and interests, and be realistic, simple and specific.

Realistic goals involve changing one behavior or making a few related changes in one behavior at a time.

Encourage the participant to commit to one change.

- What will you change?
- How much change is realistic?
- When will you do it? where? how? who can help?

Break down large behavior changes into smaller, simpler tasks that can be accomplished over time.

Should the participant decline to identify a goal, document this on the Health History form.

(11) Health Professionals should reinforce counseling content.

- Ask participants to practice skills they need to learn. A participant needs to feel comfortable with the behavior before she will repeat it at home.
- Practice can include verbal responses, e.g., "What high iron foods would you be able to give your child for breakfast?" or demonstrations, e.g., "How would you position your baby to nurse?"
- Provide written instructions whenever possible in order to reinforce oral communication; written instructions should be individualized.
  - Participants remember best the first instructions presented.
  - Instructions that are emphasized are better recalled.
  - The fewer the instructions given, the greater will be the proportion remembered.

407.5 Documentation Requirements

Documentation is an important yet often slighted aspect of nutrition education. Documentation provides:

- a summary of the steps the health professional and the participant completed to promote positive change;
- a history of the nutrition services provided to the participant, so there will be continuity and reinforcement rather than a duplication of efforts;
- a way to let other health professionals know about a previous assessment of the participant's nutritional status; and
- protection for the educator should a need arise to show that appropriate information was provided to the participant.

(1) Certification Documentation Requirements

All certification/recertification nutrition education encounters must be documented on the WIC Health History form. Important points to include in documentation are:

- In Assessment: at least one of the participant's nutritional risks and a nutrition assessment (a diet-related nutritional risk code may be used in place of a written nutrition assessment, if applicable);
- In Plan: the participant/caregiver’s goal (may be a participant selected or mutually agreed upon nutrition goal**)**;
- follow-up and referral if appropriate;
- any miscellaneous information, e.g., conversations with a physician to clarify a formula change (record in "Notes" section); and

- the health professional's signature, title and date.

(2) Midcertification Documentation Requirements

Documentation of the individual midcertification or follow-up nutrition education encounter is also essential. Documentation should include:

- the reason for the follow-up visit,
- an explanation of any progress or problem development since the last visit, which may include any changes for the participant's nutrition care plan.

407.6 Cultural Considerations

A basic element of culturally appropriate care is demonstrating a sincere commitment to providing services in an acceptable and appropriate manner to people of cultural or ethnic groups different from one's own. Since cultural groups may differ in many ways, considering some of the questions and approaches listed below may help to achieve a culturally effective program. When asking questions of cultural groups different from one's own, WIC staff should remember that attentive listening is very important.

(1) Questions and Approaches

(a) Definition of family and of family member roles

- Is it a nuclear family unit? Is it an extended family?
- If extended, how many members and generations are included?
- How are decisions made within the family? (Does the male play a dominant role? The grandmother?)

(b) Childrearing practices

- Is child care shared as a method of extending the family's resources?
- Does the grandmother care for the infant soon after birth so the mother can return to work or school?

(c) Beliefs and practices concerning health and illness

- Does religion play a role?
- Is balance between dichotomies such as "hot" and "cold" or "yin" and "yang" believed to contribute to health? If so, how can balance be achieved, and how is this likely to affect food selection?
- Are certain foods viewed as healthful or harmful during pregnancy or lactation?
- Is there a belief that eating too much or taking supplements will lead to difficult labor and delivery?

(d) Styles of interaction between professionals and group members

- Do group members tend to prefer a warm, friendly, and personal form of communication or a more formal one?
- How important is the use of formal titles?
- Do group members tend to prefer to sit or stand closer to or farther away from the provider than the provider is used to?
- Does direct eye contact facilitate communication or does it signal disrespect?
- Is touching the person viewed as offensive or as an important means of communication?

- ❍ Is it important to address elders first?

(e) Orientation toward the future or the present

- ❍ Is there a tendency to live in the present with little regard for the future?
- ❍ Is education viewed as such an important key to the future that it takes priority over other activities?

(f) Dietary practices

- ❍ What foods form the basis for the group's diet?
- ❍ What are the key sources of essential nutrients?
- ❍ Do any customary cooking methods enhance the quality of diet?

(2) Elements of Culturally Effective Programs

Basic elements of a program to promote culturally appropriate care include the following:

- ❍ in-service training of the health care providers on the cultural practices and beliefs of the groups served;
- ❍ creation of a welcoming environment and use of materials that portray a positive image of the clientele;
- ❍ employment of WIC staff who are members of the cultural groups served or well-trained interpreters; and
- ❍ development of a mechanism for input from the community, making certain that all cultural groups are represented.

407.7 Handling Sensitive Counseling Situations

Asking participants about certain topics often causes some degree of discomfort for both the participant and health professional.

Some examples of areas that can make both health professionals and participants uncomfortable include drug and alcohol use, pica, financial status, and literacy. Whether or not they use alcohol or drugs or ingest nonfood items, some participants may resent questions about these personal habits.

In addition, some parents may be sensitive to questions about how they feed or care for their child. Considerable tact in framing questions is required to avoid asking questions that might be perceived as threatening or judgmental.

The following recommendations provide only broad guidelines for interviewing on some of these sensitive topics. Professional discretion in each situation and sensitivity to individual participants are essential. When dealing with addiction, referral to appropriate support services is necessary.

(1) Interviewing about Alcohol Use

Questions about alcohol use may be included with questions regarding general dietary habits. In order to relieve anxiety about sensitive drug and alcohol questions on the part of both interviewer and respondent, it is suggested that these questions be part of the normal intake interview (e.g., health history or diet interview). The order of questions should go from over-the-counter medications to legal drugs (tobacco and alcohol) to illicit drugs. How much beer, wine, and liquor is consumed can be asked at the same time as questions about the amount of milk, juice and soda in the diet.

Researchers advise asking questions about amounts used first. The participant should be asked how much is consumed, not if is it consumed. If the health professional acts as though a positive answer would not be unexpected, then the participant is more likely to feel comfortable in responding with truthful information about undesirable practices.

In the WIC clinic setting, it is recommended that the health professional first ask, "How many days a week do you drink?" If the participant responds with a number, enter "yes" to the questions on the Demographics screen asking if the participant drinks and ask further, "How many drinks per day?" If the participant answers she does not drink at all, no further questions are necessary.

Questions asked during screening must be nonjudgmental. A technique for eliminating judgmental overtones and promoting honest answers is to ask about alcohol and other drug use in the past month rather than present use. Many women are ashamed to admit their current use because of its possible ill effects on the developing fetus, and are reluctant to report current involvement in illegal behavior. Asking about use in the past may promote more honest responses.

It is important to remember that among participants having an alcohol problem, denial will be the most frequent response. It can be helpful, when there is denial on the part of the participant, to discuss why the health professional is asking these questions and explain the reasons for concern about the participant's health and the health of her baby. However, tone of voice and facial expressions should in no way imply that there is doubt about the truthfulness of the participant's answer.

(2) Interviewing about Drug Use

Asking participants questions about drug use can be even more difficult than interviewing about alcohol use. Because there are legal implications, it is important to emphasize to the participant that all of the information obtained in the dietary interview will be part of the participant's confidential WIC record.

It is appropriate when discussing drug use to explain that one of the reasons for asking these questions is that drugs can also affect an individual's appetite and the body's ability to use certain nutrients.

It may be helpful to ask participants first about drug use among their friends or peers. This may provide some clues as to the type of drugs that the participant might be using. Using the technique described for asking about alcohol use might also be useful in finding out about drug use.

Let participants know that the health professional is asking these questions only to offer help. When the health professional identifies a problem with drug abuse, the participant should be referred to an appropriate agency or community resource.

(3) Interviewing about Financial Status

Most of the people who use public agencies for their health care are accustomed to being asked questions about income. Nevertheless, financial status is a sensitive subject and the health professional must use discretion in framing questions about participants' financial situation.

Knowledge that the person is participating in a program restricted to low income participants or even information about exact income does not necessarily tell if sufficient resources are available to purchase an adequate diet. Asking how often the family runs out of Food Stamps or WIC foods might be helpful. If the health professional learns that a participant does not eat fruit, the health professional might ask if she likes fruit and comment on how expensive some fruit is, to try to find out if intake is limited because of personal preference or limited finances.

(4) Determining Participant's Literacy Level

Illiteracy and low literacy skills are an embarrassment to a significant number of people in this country.

Avoid asking people directly if they can read. Be alert for clues that literacy may be a problem. Poor verbal skills may be an indication of low literacy skills. It may also be helpful to observe how the participant relates to written materials by asking the participant to review a pamphlet in the health professional's presence.

Asking about education might be useful, but remember that there are people who graduate from high school who are still functionally illiterate.

Participants for whom English is a second language can pose special problems in evaluating literacy levels. Some participants may be able to speak English but unable to read it. Conversely, it is not uncommon for a person with limited English speaking skills to be able to read English better than her native language. Before offering pamphlets in a foreign language, it is important to ask which language the participant prefers.

(5) Interviewing about Pica

Asking participants about the ingestion of nonfood items should be included with routine questions about dietary habits.

There are three typical situations regarding a woman's practice of pica.

- The woman has never heard of such a thing and may be shocked that you would ask her about eating nonfood items.
- The woman is familiar with the habit but doesn't practice it herself.
- She is consuming nonfood items.

Among pregnant women, pica is commonly a culturally determined practice, therefore, it is useful to ask about other family members ingestion of clay, laundry starch, or other nonfood items.

It may be less threatening to preface your question about pica with a comment that it is not unusual for women to crave things when they are pregnant and suggest a few items-- pickles, ice cream, laundry starch, ice, and clay as examples. Then ask if they have had any cravings.

Similarly, when asking parents about the ingestion of nonfood items by their children, it is helpful to mention that this is a common practice among small children and the purpose is to find out how much the child is consuming and if it is a harmful substance such as a lead-based paint or dirt infested with parasites.

(6) Managing Difficult Behaviors during Counseling Sessions

There will be times, no matter how well prepared or skilled the health professional is, that the interview does not go well. This may be due to factors beyond the health professional's control. Sometimes it is helpful, after an unsuccessful interview, to evaluate what went wrong and try to establish what might have been done to improve the situation.

Following are some of the possible explanations for an unsatisfactory interview.

(a) The Participant Appears Hostile

The participant who seems hostile and uncooperative may be distracted, upset, or angry about something unrelated to the dietary interview. She may be annoyed about something that happened earlier in the clinic or be upset about a family situation.

The health professional can ignore the participant's behavior and try, by being pleasant, to proceed with the interview in the hope that her attitude will improve. This tactic may not be effective because, for many people, having their anger ignored only makes them more irritated.

It is possible to confront the participant in a gentle and friendly way to attempt to find out the cause of her hostility. The health professional might ask:

"You seem upset about something. Is anything wrong?"

or

"I can see that you're upset, can you tell me what the problem is?"

The health professional must then take the time to listen to the participant's response. If she is responsive, determine if she is upset about something related to the dietary interview or if the problem concerns something unrelated to the present interview. If the problem is unrelated to the present interview, just acknowledging the participant's feelings can sometimes decrease hostility.

Sometimes it is helpful just to give people the opportunity to ventilate their feelings. It is important to be sympathetic with the participant, but it is not necessary to feel that advice must be given nor the problem resolved. If a referral or suggestion would be helpful at that point, then the health professional will find that taking the time to assist the participant in that small way will in the long run facilitate the dietary interview and counseling.

If the first inquiry does not resolve the problem, it may be necessary to probe and ask more specific questions, such as:

"Did something happen earlier in clinic that bothered you?"
or
"Are you feeling well?"

If the participant continues to appear too hostile or upset to participate in the interview, offer to reschedule an appointment when she might feel more like discussing dietary intake.

In the case of the very hostile, abusive, or threatening participant the interviewer should calmly and politely terminate the interview.

"I can see that this is not a good time to discuss your diet with you. I will be glad to make you an appointment to come back at a better time."

(b) The Participant Is Uncommunicative

A participant might be uncommunicative because she has had to wait a long time, has other commitments or simply thinks that the dietary interview is a waste of time.

At the beginning of each interview, explain the purpose of the interview and approximately how long the interview will take. If anxiety over other commitments makes the participant reluctant to stay, offer her the option of rescheduling the appointment. If rescheduling would delay program benefits, this should be explained to the participant and she should be given the option of staying or rescheduling.

Explaining the purpose of the dietary interview will in many cases help participants see the importance of participating in the interview. Never assume that participants know why they are talking to the health professional.

It is not uncommon for participants to have to wait to see the health professional. It may help to explain to participants the flow system in the agency.

It is also possible that the participant may have misinterpreted or taken offense at something that was said or done. If the participants manner seems to become hostile or uncomfortable during the interview, it is possible that something has happened during the interview to upset or annoy her. Again, it may be helpful to gently confront the participant's behavior directly with a question:

> "You seem upset by something I've said. Was it that I asked you about.....?"

After listening to the participant's response, the health professional should attempt to clear up any misunderstanding and explain why certain questions are asked, if that is what has offended the participant, or apologize for any offense.

The presence of another family member may inhibit the participant from talking. This is often the case when an adolescent is accompanied by a parent. It may or may not be possible to schedule an interview at a later time alone with the participant. If not, it might be useful to have the participant fill out the health history and dietary questionnaire by herself.

Language or cultural barriers may cause a participant to be uncommunicative. If interpreters are available at your facility, it would, of course, be helpful to use them during the interview. When interpreters are not available, Tele Interpreters OPI Services may be used, or a family member or friend of the participant, who can translate, may be able to accompany her to a later appointment. However, avoid using children as interpreters and be sure that the participant feels comfortable giving information to the interpreter.

407.8 Improving Counseling Skills

Evaluating the interview is an important part of the interview process and can help the health professional continue to improve counseling skills. Improving skills will also increase job satisfaction and contribute to a more enjoyable and productive work day.

(1) Personal and Professional Qualities of an Effective Counselor/Interviewer

The counseling skills of the health professional are critical to the success of nutrition education. Important characteristics include both professional and personal attributes.

(a) A health professional using professional qualities:

- uses open-ended, close-ended, summarizing, probing, and trigger questions as appropriate;
- determines which questions are appropriate for individual participants;
- assesses the participant's level of understanding of related information;
- uses a variety of interviewing techniques based on their appropriateness to individual participants;
- observes the participant and is attentive to nonverbal cues;
- practices active listening;

- demonstrates empathy and concern but does not become personally involved with participants;
- observes professional ethics regarding confidentiality of participant information;
- communicates effectively with other members of the health care team to improve the delivery of nutrition services; and
- continues to evaluate and upgrade professional skills.

(b) The health professional demonstrating beneficial personal qualities:

- enjoys talking with people and is a good listener,
- is affirming rather than judgmental,
- feels comfortable talking with people of different backgrounds or different values,
- is able to maintain a relaxed manner even when rushed,
- conveys a friendly and polite impression,
- regards participants as equals and is not patronizing, and
- conveys warmth and a genuine concern for others.

(2) Methods for Skills Development

Following are suggestions for developing good counseling skills:

(a) Use the Post Interview Self Assessment Check List found in the Appendix to this chapter to evaluate health professional interviews.

(b) Observe other colleagues interviewing. This is essential for health professionals who may not have academic training in interviewing and lack prior interviewing experience.

(c) Be observed by supervisory staff or another colleague while interviewing a participant (with the participant's permission). After the interview, have the observer complete the assessment check list.

(d) Attend professional work shops which offer programs on interviewing.

(e) Ask more experienced colleagues or professionals how they handle particular interviewing situations. Asking colleagues for advice is the sign of an experienced professional. Other professionals will be pleased to share their experiences.

(f) With the participant's permission, record the interview so that the health professional can conduct a self-evaluation of interviewing abilities.

408. Group Nutrition Education Practices

Each nutrition education class must have a written lesson plan. Attendees must indicate attendance at a class on a form that contains the title of the class and date the class was presented. The person who develops the plan must sign the plan. Plans developed by nutrition associates, dietetic technicians, or non-health professionals must be approved and signed by a licensed dietitian. For ease of use by other presenters, each plan should list the topic covered, target audience and approximate length of time needed to conduct.

The plan must contain:

- measurable objectives,
- content outline,
- practice activities, when appropriate,
- teaching methods and materials used, and
- evaluation methods.

The use of practice activities, when appropriate, is strongly recommended.

All lesson plans must be evaluated annually to keep classes up-to-date and interesting. Some lesson plans may simply need some adjustment, while in other cases they should be replaced completely. Evaluation criteria should include the following types of questions:

- Is the information presented still considered accurate?
- Is this information that participants still need to know?
- Did the practice activity work?
- Was the cost what was expected?
- What was learned from the class evaluations?

408.1 Selection of Class Topics

There are basically two types of information: nice-to-know and need-to-know. Nice-to-know information very rarely motivates anyone to change their behavior, so do not waste staff time or the participant's time by including it, unless the participant specifically asks about it.

(1) Need-to-Know Information:

- What does the participant need to do?
- How can the participant do it?

(2) Nice-to-Know Information:

- The history of anything
- Technical information
- Why information. Let the participant ask why. Only provide the "why" if so requested by the participant.

When selecting topics for classes, ask; "What do the participants need to know?" In addition to an assessment of what participants need to know, ask the participants what they think they need to know. There is a question on the participant survey, which is distributed annually, asking about topics of interest for classes.

(3) Other considerations for selecting class topics include:

(a) How the local project schedules classes--do you have the flexibility to tailor the class to a very specific group of people or must the class be more "generic"? How many weeks will a particular class be given?

(b) Facilities--how many people will fit into the room? Are there enough chairs? Is there a table large enough for the whole class? Are food preparation materials, such as a hot-plate, utensils, etc., available?

(c) Is there an adequate number of people who need to know this information to justify developing a class, or could the information be given more effectively one-to-one?

(d) If the class is targeted toward parents, what will the children do during class so the parents can concentrate? If the class is targeted toward children, what will the parents do?

408.2 Writing a Lesson Plan

Once a topic has been selected, the next step is to write a lesson plan. There are five required components of a lesson plan:

(1) Objective/Expected Outcome:

The objective or expected outcome for the class is the foundation for the entire lesson. Objectives are statements of what the health professional wants the learners to be able to do as a result of the class. Objectives keep the lesson focused.

Limit education sessions to a reasonable time. Special nutrition such as a baby shower, picnic, etc., will take longer than the following recommended times.

For most WIC settings, midcertification nutrition education classes should be short, i.e., 10-20 minutes. For classes of this length, only one or two objectives are recommended.

Keep the objectives simple and small enough to be accomplished with the resources available (e.g., time, interest, available space, materials, etc.).

It is not realistic to expect attitudes and behaviors, which have been forming for many years and which are influenced by many factors, to change as a result of a short-term nutrition education program.

> For example, it is unrealistic to expect "80% of participants will correctly plan a day's menu in which the percentage of calories from fat is 30% or less" in a 20-minute session. The following is much more realistic: "From a given menu, 80% of participants will identify at least one way to decrease the fat content."

Teach only what group members need to know in order to make desired changes.

The objective must be stated in measurable terms. A measurable objective is one that is stated in precise terms. "Participants will understand the benefits of breastfeeding" is not as measurable as "75 percent of the participants will accurately list three or more

advantages of breast feeding in response to a written open-ended question."

The following guidelines may be helpful when writing objectives:

- Write the task to be performed using only a verb and noun.

  Example: Identify nutritious snacks.

- Add the quantity standards or criteria to be applied to the objective.

  Example: Identify at least one way to eat more nutritious snacks.

- Add the quality criteria that will be included in the objective.

  Example: Identify at least one way to eat more nutritious snacks made from fruits and veqetables.

Use this checklist for each objective:

- Does this objective address the topic?
- Is the objective simple?
- Is the objective measurable?
- Is the objective achievable with participants in the time frame allotted?

If the answer is "no" to a checklist question, the objective may need to be revised.

2) Content Outline

This is the "what" and "how." Provide the learners only with the information necessary to accomplish the objectives of the lesson. Remember that what the health professional plans to say and the information presented in the form of handouts, films, etc. should support the objective and be limited to need-to-know information only.

(3) Practice Activity

A practice activity may help to demonstrate whether or not the learner has achieved the objective. Use practice activities as an opportunity to provide positive reinforcement and corrective feedback. Tell the learner what was done right.

Do not do activities for the sake of activity. For example, tasting a recipe that has been prepared is not a practice activity. It may actually be part of the need-to-know information, i.e., the learners need to know that beans can taste really good.

Two types of practice activities produce feelings of competence in the learners, resulting in increased motivation:

(a) Manual practice--learners actually "do" the behavior you are teaching; and
(b) Mental and/or verbal practice--when it is impractical to actually "do" the behavior/activity, have them "do" the behavior in their minds, and explain the process either orally or in writing.

Simply presenting information and then expecting practice activities to be completed with the desired degree of accuracy is not usually very effective. There are four steps to a practice activity:

(a) give adequate directions,

(b) demonstrate (model) the desired performance,

(c) guide the initial performance, and

(d) request independent performance.

(4) Materials and Methods

Identify teaching materials and methods to be used. Follow the guidelines in the Materials Section and Methods Section of this chapter.

(5) Evaluation

The evaluation component of each session lets the health professional know if the objective was met or not. If the objective was not met, the health professional may need to revise the objective or plan new activities before conducting this session again.

> Example: If the objective was "80% of the caregivers at the session will name two new nutritious snacks that their child may be willing to eat," the health professional needs to determine a way, **.**i.e., evaluation method, to find out that they indeed can identify these snacks. The health professional could do this by having them write down two new foods on a piece of paper and handing it in, or by having them do this in pairs and then asking the full group if all pairs were able to do this.

Another evaluation method is asking for a verbal or written expression of a new idea they intend to try as a result of the session. If a more formal evaluation is desirable, staff could send out a brief follow-up survey asking if participants tried any of the ideas they learned at the session. See the Appendix to this Chapter for an example.

Likewise, the instructor or an observer could keep notes during the session on how well objectives were being met and whether learners were interested in the information. Did they participate in the activities? Did they ask questions? How many people were bored and eager to leave (evidenced by yawns, sighs, doodling, etc.)? Was there sufficient time to cover the topic and respond to questions? Negative answers to these questions indicate that the health professional may need to revise the activities, content, or

objectives. See the Appendix to this Chapter for a sample staff evaluation form.

408.3 Promotion Techniques to Encourage Attendance

Staff should use techniques to encourage and facilitate participants' attendance. Attendance rates must be determined each month and evaluated each quarter. Actions should be taken to improve poor attendance rates, e.g., offer new speakers or classes; change times, duration, methods, topics, etc.

Determine how to "sell" the sessions so that people want to attend. The sessions need to be marketed so that the participants realize that they will gain something by attending.

- Use informative and interesting names and titles. Avoid dull-sounding terms like "class" and "lecture." These labels will not be inviting if participants were not successful in school. For example, "Sharing Sessions" or "Table Talks" may be better than "nutrition education class."

  Design titles for each session that are inviting, that show the information will be useful. Be sure that the title or announcements of the sessions identify what is to be done. No one likes to come to an event and find out that it is totally different than expected.

- Make sessions convenient to attend. Set times, locations, etc., to meet the needs and expectations of the audience.

- Give information on the session, time, who should come, etc. Identify times sessions start, how long they last, whether child care or activities for children are available, where the sessions are to be held, what the session is about, and any other pertinent information.

- Send or give out reminders if needed (by mail, phone, handouts, etc.). Circle dates on calendars, give handouts of schedule, post schedules in your counseling office or clinic.

- Use motivators for sessions, e.g., drawings, food, special guest, involvement of children.

- Verbally encourage people to participate. If support staff are responsible for scheduling, train them so that they know what is going on and so that they encourage participants to get involved.

- Coordinate topics with other program activities using bulletin boards, newsletters, displays.

408.4 Mechanics of Conducting a Class

The setting is very important to the dynamics of a group session. Make the atmosphere as comfortable as possible, since even minor sources of distraction may take away the focus of the group's participation.

To set the atmosphere for good group interaction:

(1) Make the room as comfortable as possible so that people are able to relax and share ideas.

(a) Place chairs in an arrangement to facilitate group activity. An open circle allows everyone to see everyone else, while long, narrow tables require people to stretch their necks to see others. Prevent making it easy to leave the circle or for children to run around it by placing some of the chairs against a wall.

(b) Put up pictures and posters around the room that stimulate participation and add to the atmosphere of the room.

(2) Make sure visuals are legible and there are enough handouts.

(3) Anticipate equipment problems whenever possible. Make sure there is a spare light bulb for the overhead projector, an extension cord, etc.

(4) Beware of using a podium. A podium can put a barrier between the instructor and the audience that can impact rapport. Try to stand or sit with the group. Standing behind a podium may appear more formal and the audience may tend to have less immediate involvement in the message.

(5) Be prepared for children or other tag-alongs who are not involved in the learning activities. Activities for children include coloring, putting stickers on sheets of paper to take home, or doing a simple art project. Project staff may be able to find "foster grandparents" to do an activity with the children during some sessions.

(6) Be ready and on time!! Starting sessions late can generate a noncommittal atmosphere.

Group members may be resentful if the class runs over the established ending time. Proceed at a stimulating pace and end on time without rushing.

(7) Introduce all speakers and greet the participants.

(8) Bring closure to class. It has been said that good teachers or persuaders tell what they are going to tell, then they tell it, then they tell what they just told. Closure is "telling the learners what was just told to them." It does not have to be very long or in-depth. Summarize the main points and how those points were demonstrated by the practice activity (if done). Another closure technique is to ask the participants "What is one thing you learned today?," or "What information can you share from today's talk?" This would also be an appropriate time to have the participants fill out a class evaluation.

408.5 Handling Difficult Group Members

If members tend to stray from the topic, encourage them to complete the task at hand before discussing other matters. If one or two people tend to dominate the group, move quickly to point out the need for interaction from all group members.

The following are some suggestions for handling difficult people:

(1) KNOW-IT-ALL: Turn the comments made by the know-it-all over to other group members for their opinions.

(2) ARGUMENTATIVE: Never argue back. It is important to maintain the respect of the whole group. Instead of having the session dominated by the arguing of one person and the health professional, shift the discussion to the individual and the rest of the class. Then, it does not matter who is right or wrong and the outcome is a good class discussion.

(3) SHY: Involve shy people in the conversation by calling them by name and asking simple questions. Praise correct answers. Ask how they feel about others' answers.

(4) OBSTINATE: A closed minded individual needs to win the instructor's friendship. Tell this person she will be helped to "get through" the session with a minimum of effort. When the person disagrees or voices discontent, quickly get a majority opinion on the person's statement. Applaud any positive comments that the person might make.

(5) GRUDGE-BEARING: Try to avoid the person's area of "pet peeves." Explain that issues discussed are for the benefit of the majority and not platforms for personal complaints. If there is rivalry between two class participants, keep them apart.

(6) TALKATIVE: Do not call on them and avoid eye contact. If they get control, tactfully interrupt and ask others to comment. Ask others for opinions. If necessary, ask the person to refrain and give others a chance.

(7) DISINTERESTED: Before the class, find out motives for being in the class. If they are there because they "have to be," get them involved by asking for their advice or by finding out about their interests and relating the discussion to those interests.

(8) INDECISIVE: Indecisive people like to debate issues forever -at least past the time allowed! They continually try to get your opinion as the leader. Refer the question back to the class and then to the individual for an opinion.

(9) RESENTFUL: Resentful people resent others' opinions, and may feel that they do the activity (or whatever) the best. Get them to contribute to the others and keep them involved without letting them dominate. Since they feel they are demonstrating their expertise, they may be more cooperative.

408.6 Small Group Instruction for Adults

There are many small group instructional techniques which are particularly applicable to the characteristics of the adult learner. Some examples are situations in which participants act as peer teachers, informally sharing information with their peers or interacting with each other in cooperative learning settings, increase mastery of information in many situations, including situations with low literacy participants. These include group discussion, role play, facilitated discussion and case study.

Cooperative learning techniques can be more effective than the typical didactic formats, e.g., lectures, especially for participants whose learning styles do not favor authoritarian teacher/learner relationships.

In each of these techniques, learners have an opportunity to share an educational experience, reflect on that shared experience, generate new conclusions or possible solutions, or courses of action, new strategies, etc., based on their past experience and new insights, and then test new behaviors or course of action.

(1) Group Discussion

In group discussion, problem solving activities help members learn from each other's experiences and consider new ways of addressing their own problems.

(a) Advantages of the group discussion teaching method are:

- Members can develop individual analytical and problem solving abilities.
- Ideas can be tested in a supportive environment, making behavior change, a likely outcome.

(b) Limitations of this method are:

- Group discussion activities can be frustrating when participants have limited knowledge and experience related to the topic.
- Group discussion may take more time than lectures and demonstrations dealing with the same amount of subject matter.

(c) The procedure for conducting group discussion follows:

- Develop a description of the problem.
- Prepare key questions that identify and clarify the problem or problems, prompt participants to generate novel and creative ideas for solving the problem, promote a fair and analytical evaluation of potential solutions, and direct participants to identify the most appropriate approach to solving the problem at hand.
- Present the problem. Make sure the group knows what the discussion is supposed to accomplish.
- Arrange for each small group to summarize its discussion and share their insights with the rest of the large group.

(2) Role Play

In a role play, members become actively involved in the situation under discussion by temporarily taking on the role of a person involved in a specific event. Role play is a powerful way of examining feelings and attitudes in interpersonal behaviors. Role play can also be used to practice skills and techniques.

(a) Advantages of the role play are:

- Attitudes and feelings can be considered in a nonthreatening environment with supportive feedback from group members.
- Personal experiences and problems can be considered in a "depersonalized" way because they are part of a role. Therefore, criticisms and suggestions for change are not as likely to be perceived as personal rejections.
- When a role play situation is properly prepared and introduced, members of the group will focus their attention on critical aspects of problems that might otherwise be overlooked.

(b) Limitations of the role play are:

- Embarrassment interferes with an individual's ability to participate.
- Defensiveness, denial and other signs of insecurity may keep group members from openly portraying their true behaviors and accepting suggestions for change.
- Groups need time to develop trust and get accustomed to each other and the instructor before the role- playing exercise.

(c) The role play procedure follows:

- List the critical factors of the hypothetical situation so that the problem is clearly identified.
- Design the exercise. Role playing can be set up as a "fish bowl" where two or three group members (actors) dramatize a situation in the center of a relatively large group of observers. In a “multiple”

set up, the group is split into several groups of three or four people with two role players and one or two observers in each small group.

- Give the actors instructions. In role play the actors must be given specific structured descriptions of the relationships between key characters and the background of the situation. In less structured role play, group members develop the relationships to be portrayed and determine relevant aspects of the situation.

- Encourage participants to express their personal feelings. They should make decisions and interact just as they would in real life. Do not make corrections or interfere with the dramatization until it is completed.

- Stress the important function of observers in role play exercise. Observers analyze the dramatization and point out important behaviors and reactions.

- Following the dramatization, clarify what happened in the dramatization, correct misunderstandings, draw conclusions, and develop a plan to act on what was learned.

(3) Case Study

Case studies are used as the basis for any analytical discussion of a given problem or situation.

Experience and prior knowledge of the participants are called upon in identifying the problem, proposing alternative solutions, predicting outcomes/consequences of various alternatives, and identifying a preferred solution. They serve as analysts who identify both the desirable effects and negative consequences of behaviors that are portrayed.

(a) Advantages of the case study method are:

- Members learn to listen to other points of view and approaches to a problem. They gain practice in evaluating alternatives.
- Attitudes and misinformation can be examined.
- Knowledge can be reinforced and expanded through application in a case study.

(b) Limitations of case studies are:

- Case studies may not evoke a strong sense of reality and emotional involvement.
- Complex cases take a considerable amount of time for analysis and discussion.
- The lack of a "right answer" may be frustrating to participants or group facilitators who are used to more didactic (lecture/presentation style) instructions.

(c) The procedure for conducting a case study follows:

- Select or prepare a case that meets planned objectives and brings out the specific points to be made.
- Make sure the case is realistic and practical, not abstract or extreme.
- Introduce the case and allow participants time to study it. Ask participants to identify the problem, propose alternative solutions, evaluate alternatives, and identify the best solutions in a free and open discussion of the case.

- If there is more than one small group, have each group report its best solution to the large group.

408.7 Nutrition Education Classes for Children

Planning learning experiences for children is challenging. Young children can learn about good health but they learn differently than adults.

(1) Tips for Teaching Two and Three Year Olds

Two and three year olds have a wide range of physical, intellectual, and verbal development. Readiness for a given task depends upon physiological development as well as the particular child. A 25 month old will not be at the same stage as a child who is almost four.

Characteristics of two and three year olds are:

- curious,
- physical,
- energetic,
- want to use all their senses,
- have a short attention span,
- have low endurance when hungry and/or tired.

Keep activities short, geared to the age and monitor for safety, particularly choking hazards.

Before activities:

- try recipes, finger plays, and songs in advance,
- gather all materials needed,
- consider safety.

(2) Ideas for Learning Activities for Younger Children

- Books - The Little Red Hen
  The Very Hungry Caterpillar
- Let children cut out cinnamon toast or cheese slices with cookie cutters and talk about what kind of food they are eating and how it helps their bodies grow.
- Give each child the same number of apple or cheese cubes. Let them build or stack on a paper plate while you talk about food groups or snacks.
- Seasonal activities: Spring: let each child make a rabbit from a peeled hardboiled egg. Use raisins for eyes and nose. Fall: cut cheese slices into pumpkin shapes. Serve with crackers.
- Play a tape of children singing "Do You Know the Muffin Man?" Lead the children in singing, and pass around small muffins as a snack.
- Consider flannel-board stories, puppet shows, and finger plays.
- Conduct lick, chew, and taste activities, (be careful about choking) using:
  - (a) fruits: apple, orange, fresh pineapple, banana, cherries, soft berries, etc.,
  - (b) vegetables: cucumbers, celery, cut, blanched and cooled carrots, avocado, tomatoes, etc.,
  - (c) bread: whole wheat, rye, raisin, white.
- Sniff and smell bottles: Use bottles with child-resistant caps. Punch holes in lids and put drops of flavoring on cotton inside. Possible flavorings include: peppermint, orange, cinnamon, cocoa, vanilla, lemon, and chili. Number

the bottles with permanent marker. Put an answer list on wall so mothers can help the children.

- Variation: put out tray of foods that match the smells in the bottles so all children can see and match the food.

(3) Tips for Teaching Older Children

Children over three years old learn by example. They are influenced by what others do and say. This age group will have:

- greater social skills,
- greater manual dexterity, and,
- a longer attention span.

(4) Ideas for Learning Activities for Older Children

- Books - Bread and Jam for Francis
  Cloudy with a Chance of Meatballs
  How to make Elephant Bread
- Let children make vegetable puppets from paper bags. Tell how this food keeps them healthy or helps them grow.
- Summer melon tasting - Use watermelon, honeydew, cantaloupe and other melons. Cut each melon into pieces. Compare color, taste, smell, texture, etc.
- Berry tasting - Use blackberries, blueberries, strawberries, and raspberries. Compare color, taste, smell, texture, etc.
- Vegetable tasting - Use raw or cooked carrots, tomatoes, celery, radishes, cucumber, etc. (Be careful about choking.) Compare color, etc., as described above.
- Popsicle Snack Demonstration - Freeze fruit juice in ice cube trays or small paper cups. Demonstrate process for parents to show ease of preparation.
- Make a healthy snack.

- Color or draw pictures of food.
- Match foods to where they come from, e.g., milk/cow, eggs/chicken, peanut butter/peanuts.
- Describe a food and have kids guess what it is, e.g.,"I'm white and come from a cow. Most people drink me cold. Some people pour me on cereal. I have lots of calcium and protein. What am I?"
- Put a food in a bag; have kids feel it and try to guess what it is. Good foods to try are potato, broccoli, strawberries, bean sprouts and okra.
- Put a food in a plastic container with pinholes in the top; have kids smell it, and try to guess what it is; good foods to try are oranges, cinnamon, onion, banana, lemon and peanut butter.
- Sing a song about healthy foods.
- Look at different foods under a magnifying glass; you can see fibers in an orange, seeds in a strawberry.

(5) Game Ideas for Older Children

- "We're going on a picnic" - Use a basket with a handle and checkered napkin with the children seated on a tablecloth. Have children select food that they want to take on the picnic and then have them place the food in the basket. The object is to pick at least one food from each food group. As children select a food they might say, "I'm going on a picnic and I'm going to pack (name of food)."

- "Dental game" - Out of two tissue boxes make a nice set of teeth and a not-so-nice set of teeth, leaving the hole in the center of the box. With pictures of food, have children select which are good foods for teeth and which are bad and put them in the "mouth." Use banana versus candy, pretzel versus caramel corn, etc.

- "Peek-a-boo foods" - Paste a picture of a food on the back of a file folder. On the front of the file folder cut a hole (any size, depending on the age of the children) and see if they can guess what food might be inside the folder.

An example of a lesson plan for a class designed for four year olds, Sample Lesson Plan Format (Grow Strong Bones and Muscle), is in the Appendix to this chapter.

409. Individual Nutrition Education Modules

An individual nutrition education module is a teaching tool that can be used in WIC projects as a substitute for group nutrition education classes. Modules use a combination of words and complimentary pictures to communicate a simple message. When a module is used for nutrition education, record the title of the module and date it was completed in the participant's chart. File all modules currently being used with nutrition education class outlines. Modules developed by nutrition associates, dietetic technicians, or nonhealth professionals must be approved and signed by a licensed dietitian. All individual education modules should be evaluated annually to keep them current. Some modules may need a few adjustments, while other modules should be replaced completely

Clerical staff can hand out and score modules. If the answers to the module are not objective, that is, true/false or multiple choice answers, then scoring must be completed by a health professional. Health professional counseling provided after the completion of a module includes checking participant comments and answering any additional questions the participant/guardian may have. Use of modules can free some health professional staff time for other WIC clinic duties like breastfeeding follow-up phone calls, certifications, writing class plans, etc.

Using modules requires less health professional time than an individual counseling session because the health professional would be required to review the last written care plan and goal and note any progress the participant/guardian has made.

Modules can be used in the following situations:

- for participants who enjoy individual education offered at their own pace,
- for low-risk WIC participants and working WIC guardians who do not have time for a group nutrition education class,
- for some WIC clinics that do not have sufficient space to offer group nutrition education classes,
- for WIC alternate signers who were unaware of the scheduled group nutrition education offering and cannot stay,
- for participants scheduled for a group nutrition education class that has been canceled due to inclement weather,
- for participants/guardians who arrive late for a scheduled class,
- for special circumstances when a WIC project does not have a health professional on duty and a participant/guardian appears for a nutrition education offering (health professional illness and clinic staff is unable to contact participant/guardian in advance)*, and

- for those participants/guardians that have special circumstances that prevent them from attending a scheduled group nutrition education class.

  * In this special situation, clerks should take great care not to provide any additional nutrition information or attempt to provide any nutrition counseling. Ohio licensure law prohibits clerks from providing nutrition counseling. Record the participant/guardian's name and inform the health professional of the materials provided. The health professional should contact the participant/guardian and discuss any questions or problems.

Advantages of using modules include:

- individual interaction,
- rate of learning controlled by the participant/guardian,
- inexpensive materials used to create a module,
- can be created to invite participation (What activity will you and your child do tonight?), and
- present information in a systematic way.

Limitations of using modules include:

- time consuming to create,
- can be too cluttered or consist of too many pages and lose the intended message,
- can become quickly outdated if using contemporary issues, and
- may not be appropriate for slow-readers or useable for nonreaders.

409.1 Use of State Developed Individual Nutrition Education Modules

The Nutrition and Breastfeeding Advisory Committee (NBAC) regularly produces black and white master copies of individual nutrition education modules which are sent to each clinic. As long as a clinic uses one of these modules, they must be kept on file. These modules can be altered or updated only by NBAC. If local project health professional staff note new research information that necessitates updating any module, the regional NBAC member or NAS Consultant must be contacted to initiate the proposed changes.

Local project health professional staff can use the State developed modules as an individual teaching tool, as the basis for a group nutrition education offering, or as a take-home education offering for participants/caretakers.

409.2 Developing Individual Nutrition Education Modules

Local projects that choose to develop modules must follow a process similar to that used in developing group nutrition education classes:

- select an appropriate topic,
- include only "need-to-know" information, and
- follow the format for writing a class outline.

Like a class outline, the module must contain:

- an **objective** or *message* - what should the participant/guardian know after reading the module?
- **content** or *short statements* that tell a participant/guardian how to use the message to make behavioral changes in their life
- **practice activities** , when appropriate or *statements* that ask the participant/guardian to decide upon and make one desired behavioral change, or questions that ask the participant/guardian to do an activity at home
- **evaluation method** or *questions* that ask a participant/guardian: What did you learn from reading this module? or, What can you try at home now that you read this module?

(All words in bold are used in developing nutrition education class outlines, and those words in italics are used in developing modules.)

Appendix 400 contains the Individual Module Format that is used by NBAC to produce the State-developed modules. When local WIC clinics produce one page modules, this set of guidelines must be used. Local project health professional staff must ensure that literacy level is checked, the pictures used are not copyrighted, and all modules are test piloted by several participants before printing or reproduction.

Other modules can be produced that are written on a higher literacy level or in a booklet format where three to ten pages are used to teach a complex subject. Health professionals must still adapt and use the techniques listed above and in the Group Nutrition Education Practices section of the WIC Policy and Procedure Manual to provide a quality nutrition education tool.

409.3 Procedure for Using Individual Nutrition Education Modules

The setting in which individual modules are given is very important. Make the atmosphere and work space as comfortable as possible since distractions may affect the concentration and learning of the participant/guardian.

(1) Provide a table or clipboard or other suitable arrangement so that completing the module is easily accomplished. Be sure that pencils or pens are readily accessible.

(2) Provide seating away from heavy traffic areas to reduce distractions.

(3) Make sure module copies are clean, free of stray marks, tears, or folds, and in the proper sequence if the modules are reusable or in the booklet form.

(4) Be ready and on time if the module session was previously scheduled. If a pamphlet or coloring sheet accompanies a module, be sure these additional materials are given at the same time as the module.

(5) Be prepared for children or other tag-alongs who are not involved in the learning activity. While the participant/guardian is completing the module, children can color, put stickers on sheets of paper to take home, or do a simple art project. Project staff may also be able to find volunteers to do an activity with the children during some scheduled nutrition education times.

409.4 Procedure for Using Computer or Internet-based Nutrition Education Modules

Computer or Internet-based modules may be used as a vehicle to deliver midcertification nutrition education. Internet–based learning modules that provide nutrition education to WIC participants, developed and piloted by the Midwest Region states, may be used. These individual response-driven modules are based on specific learning and behavior change theory. Parents/caregivers of child participants are able to access the modules regardless of where they are, as long as they have access to the Internet.

These modules meet the midcertification nutrition education requirement for child participants only; they may not be used for high-risk participants.

Health Professional Responsibilities:

- Determine if the Internet program topics are appropriate for the participant's nutrition education plan.
- Identify child WIC participants who are eligible, and determine if the parent/caregiver is able to read English and has access to the Internet.
- Provide the parent/caregiver with the website information and instructions.
- Remind the parent/caregiver to complete the evaluation at the end of the module, print off the certificate of completion, and bring the certificate to the scheduled benefit pickup appointment. Review the module with the parent/caregiver at this appointment.

Parent/Caregiver Responsibilities:

- Log on to a computer that is connected to the Internet.
- Type www.wichealth.org into the address box.
- Answer the Yes and No questions.
- Read the module, follow the directions, and answer the survey at the end.
- Print off the certificate of completion and bring to the WIC appointment

WIC Staff Responsibilities:

- File certificate of completion in participant's chart.
- Issue benefits as appropriate.

410. Selection and Use of Educational Materials

Educational aids can enhance the learning process. When used effectively, videotapes, posters, and pamphlets can add creativity and fun as well as reinforce nutrition education messages. Effectiveness of the materials is directly related to how well the content, format and literacy levels match the participants' interests and abilities.

All materials acquired, purchased or developed by the project must be reviewed and evaluated before being used or distributed to participants by a project health professional.

410.1 Selection of Materials

At a minimum, educational materials must use:
- ❍ simple language
- ❍ positive images
- ❍ predominantly short sentences written in the active voice
- ❍ appropriate graphics
- ❍ three or fewer "need-to-know" concepts

Most of the following concepts apply to written materials as well as videos and verbal instruction.

(1) Content

Limit information to need-to-know facts. Extra information dilutes the message or causes a less able learner to miss the main points.

Visual images should match the verbal/written message.

Information must be accurate and up to date. The information presented must be practical, e.g., do demonstrated recipes pose reasonable demands on participants in terms of cost, time, cooking skills, and cooking and storage facilities?

(2) Literacy and Comprehension

The literacy level of materials used must be consistent with the abilities of participants served in each project. While some higher literacy materials may be appropriate, most materials should fall between the 6-8th grade reading level.

Use familiar and easy to understand words and sentence structure. When use of an unfamiliar word is necessary, include a clear definition the first time the word is used.

Use simple, direct, conversational sentences which convey positive "you can do it" messages. Talk about "your child" doing something, succeeding.

(3) Organization of Ideas and Format

Use print type, layout and graphics to draw interest to the material. Text in columns 40 to 50 characters wide with unjustified margins is easier to read. Text written in all capital letters is more difficult to read.

Signal words and phrases such as "first," "however," and "in conclusion," help the learner follow the flow of ideas. Use of topic headings, limited highlighting, and adequate "white space" help make written text appear less formidable.

Repeating important points, using examples and illustrations, and summarizing help improve participant's comprehension.

410.2 Use of Materials

Use as few materials as possible to convey and reinforce your message. Except in the case of highly motivated individuals, or individuals who express a desire for more information, it is recommended to give only *one or two* pamphlets which emphasize the *one or two* agreed upon nutrition goals. Introduce the materials by briefly emphasizing the importance of the messages and giving an overview of what to expect.

Pamphlets can be used to enhance or supplement the nutrition education provided by health professional staff. However, pamphlets do not take the place of nutrition education. Open the pamphlet and explain the information to the participant. Something may be written on the pamphlet to make it personal. For example, underline or circle pertinent points.

Where possible, ask for the caregiver/woman's reaction to the messages, e.g., do you think this (the recommendation) is something that you can do? Use materials to support verbal recommendations and to provide detail, such as the support a partner/relative could provide to a breastfeeding woman in place of feeding the infant formula from a bottle.

410.3 Evaluation of Materials

Materials must be reviewed and evaluated before they are used in the clinic. Use the appropriate form, **Evaluation Tool for Educational Materials** or **Bulletin Board Evaluation**, located in the Appendix to Chapter 400 to evaluate each teaching material or display the project develops or acquires from non-WIC sources. Keep evaluations on file as long as the material is being used in the clinic.

Breastfeeding materials, including videos on breastfeeding, should be evaluated considering the "Guidelines for Selecting Materials for Participant Education," found in Appendix 400.

The following forms and materials are required to be on file in the local project:

A. Pamphlets, handouts, newsletters

- copy of the material and
- completed **Evaluation Tool for Educational Materials (including those issued by State WIC)**

B. Modules*

- copy of the module
- **Sample Lesson Plan Format** and
- completed **Individual Module Format**

C. Bulletin boards, posters, or displays*

- photo or diagram of the display
- **Sample Lesson Plan Format** and
- completed **Bulletin Board Evaluation**

D. Videotapes/DVDs

- copy of the material or name of the material
- **Sample Lesson Plan Format** and
- completed **Evaluation Tool for Educational Materials**

*When developing an individual module or bulletin board (display/poster) that will replace group nutrition education, the Sample Lesson Plan Format must be completed in addition to an evaluation form. See Ohio WIC Nutrition Education Modules and Ohio WIC Bulletin Boards compact disks (CDs)

No evaluation is required for lobby displays containing free nonnutritional pamphlets such as car seats, safety, toilet training, etc. Alcohol, drug, and tobacco materials are considered nutritional materials and must be evaluated.

Nutrition and Administrative Services Consultants review the local project's nutrition education files during the management evaluation process.

410.4 Materials Available from the State WIC Office

State WIC processes project requests for purchasing nutrition education materials, ordering forms and pamphlets, and borrowing audiovisuals and reference materials.

A. If the cost of an individual nutrition education material is ≥ $300, written approval from the State WIC office is required prior to purchase. Submit the WIC Nutrition Education Materials Request Form, found in Appendix 400, to your Nutrition and Administrative Services Consultant to request approval for purchase of these items.

B. State WIC receives, reviews and authorizes requests for pamphlets and forms that are available through the Ohio Department of Health warehouse. Appendix 100 contains a reproducible master of the WIC Clinic Order Form.

   Materials are shipped from the warehouse approximately four weeks after the request is processed by the State WIC office. Delays may occur when the number of pamphlets/forms requested is disproportionately large in relationship to the project's caseload.

C. State WIC has reference materials and videotapes available on a loan basis. Appendix 400 contains a list of videos, tapes, cassettes and educational modules available. Call your Nutrition and Administrative Services Consultant to determine the availability of printed reference materials on specific topics.

   A project can borrow a maximum of three videos per date or three reference materials at one time for a period of two weeks. State WIC fills requests as they are received. Delays in sending materials requested due to unavailability will be discussed with the project.

   Procedures for the safe return of the materials are sent with the order. The ordering form for borrowing videos or printed materials is located in the Appendix to the chapter.

411. **Nutrition Education Plan**

The focus of the Ohio WIC Nutrition Education Plan is prevention and intervention through education. The Ohio WIC Nutrition Education Plan will be developed and evaluated by the State WIC office. Local WIC projects will implement the Plan as directed by the State WIC office. The State WIC office will reevaluate the Plan on an as needed basis.

412. WIC Participant Survey

Participant input is essential for maintaining high quality services in all Ohio WIC projects. The purposes of the WIC participant survey are:

- to comply with USDA regulations by questioning WIC participants annually for their opinions of the nutrition education they receive;
- to identify general trends in the WIC population as well as strong/weak points in the delivery of certification, nutrition education, and food issuance services; and
- to improve WIC services by analyzing survey results and using this information when planning future WIC services.

412.1 Administering the WIC Participant Survey

The State WIC Participant Survey will be used by all Ohio WIC projects. It has been designed to be easily administered, completed and tabulated. The surveys will be administered to a percentage of each population. In order to obtain an adequate sample size, the survey should be administered in the following manner.

Caseload	% of Caseload Surveyed
< 900	10%
900 - 2500	5%
> 2500	3%

The survey must be distributed randomly (e.g., to every fifth person who comes into the clinic). Each participant who receives a survey should have received at least two months of food before completing a survey.

The survey must be administered during the months of **January, February** and **March** and results received at the State WIC office by **April 30**. A third of the surveys should be distributed during each of the three months. This method will allow a majority of the caseload to be "sampled."

413. Reserved

414. WIC Health Professional Staff Responsibilities

All health professionals have some responsibilities for the planning, implementation and evaluation of nutrition education services as part of the certification process. These responsibilities will vary depending on the size of the clinic, the credentials of the health professional, and the ratio of the health professionals to participants.

Each project must develop position descriptions that describe specific job duties for certification and nutrition education activities and must address more global responsibilities that are not duties per se, but reflect professional standards of practice.

414.1. WIC Health Professional Staff Standards of Practice

Following are the professional performance expectations of the certifying health professional. The health professional must:

(1) demonstrate respect for the unique needs and values of participants and their rights to privacy and confidentiality;

(2) refer participants to other health, social or education services when the scope of the problem/needs exceeds the expertise of the WIC health professional or the scope of services provided by the WIC clinic;

(3) manage resources efficiently with awareness of caseload and budgetary constraints, e.g., length of counseling sessions and number of pamphlets used should be appropriate to the needs and interests of the participants;

(4) interact as a responsible team member by cooperating and coordinating services with WIC and other agency staff;

(5) update and expand professional knowledge base through participation in continuing education and review of current literature pertinent to the needs of the WIC participants;

(6) participate in quality assurance activities to monitor the effectiveness of their own

performance as well as the success of the WIC project; and

(7) master the use the computerized data available well enough to plan, monitor and evaluate nutrition services to participants and within the clinic setting.

414.2 WIC Health Professional Position Responsibilities

Following are the typical, general areas of responsibilities for certification processes. Each project must delineate in writing specific responsibilities which are based on, but not limited to, the following categories of practices.

The certifying health professional must:

(1) practice in accordance with State WIC policies and procedures as well as in accordance with the Ohio Board of Dietetics Dietitian Licensure Law;

(2) provide counseling based on the assessment of information obtained in the dietary interview in conjunction with information obtained from health histories, hematologic measurements and growth measurements;

(3) determine the need for remeasurement of anthropometric and blood data to correct potential measurement errors prior to counseling the participant;

(4) provide each prenatal participant with appropriate information about infant feeding so that informed decisions can be made prior to the baby's birth;

(5) determine participant readiness for the education process and involvement in goal setting and provide services consistent with each participant's needs, interests, and abilities;

(6) implement the project's High-Risk Plan to ensure appropriate service delivery and referral to participants with greatest need;

(7) participate in the development, implementation and evaluation of the project's Biennial Nutrition Education Plan;

(8) prescribe food packages appropriate for the needs of the participant;

(9) complete, sign and date all required documentation in a timely manner; correct errors using proper techniques; (e.g., using a pen, place a line through the incorrect information; write the date and your initials next to the incorrect information; do not use correction fluid to change the information; continue with documentation of correct information); clearly and legibly identify the problem/need and plan and services provided on the appropriate forms; and

(10) determine the type, frequency and topic of midcertification nutrition education contacts for each participant.

415. Home Visiting Guidelines

Home visiting, as used in this policy, is defined as a strategy for service delivery. The Ohio WIC program does not intend to expand WIC services into home visiting services. However, State WIC is aware of projects that may conduct limited home visiting services in special circumstances. All local WIC projects that conduct home visiting activities must ensure that the Ohio Department of Health's Policy on Home Visiting Programs is followed. This document is found in Appendix 400. Any local WIC project that is considering initiating home visiting activities must contact the State WIC office prior to implementation of these activities.