COMPUTER DOWN KIT: INTRODUCTION

Purpose

The computer down kit houses forms required to continue providing WIC services in the event WISPr (or internet access) is temporarily unavailable.

Contents

The documents are housed in the computer down kit in the following order:

- Introduction
- Application Eng & Sp
- WIC Income Eligibility Guidelines (Annual)
- Nutrition Assessments (infant, child, prenatal, postpartum)
- Rights Responsibilities & Consent Eng & Sp
- Growth charts (Boys and girls ages 0-24 months and 2-20 years old)
- Prenatal wt gain (Multi and Single pregnancy)
- Certification Care Plan
- BMI Table
- VOC
- Letter of Ineligibility (Eng & Sp)
- No Proof & Temp (Income) Cert
- Check Audit form
- Medical documentation
- Direct bill
- Complaint form
- Fair Hearing Request Form Eng & Sp

Procedures

If WISPr goes down temporarily, follow these steps once WISPr becomes available:

- Enter all documentation from the down time into WISPr.
    - Eligibility information, care plans, nutrition assessment (health information/questionnaire) and nutrition education etc.
- Shred relevant hard copies of documentation that have been entered into WISPr.
    - Each clinic may vary on the amount of documentation stored in WISPr verses the participant's hard copy chart.
- In Staff Notes (WISPr), document any information that would eliminate any gaps in the documentation during the time WISPr was down.
- Checks may be mailed to participants. The staff member responsible for mailing the check/CVVs needs to initial or sign his/her name (not the participant's) next to the group of checks/CVVs and indicate the date the checks/CVVs were mailed [IWPPM Chapter 7, Section C].

VOC

If a VOC is issued while WISPr is down, the following steps need to occur:

- Complete the VOC Transfer in WISPr.
- If a VOC is generated, shred the form.
- Document in Staff Notes (WISPr) that a VOC was issued when WISPr was down.

Application for the Idaho WIC Program

DATE OF INITIAL CONTACT _____ APPLICATION DATE _____ APPT DATE: _____

SECTION A – Contact Information. Please complete all sections of the application.

Responsible Adult	FIRST	MI	LAST	MAIDEN NAME (if any)	DATE OF BIRTH (opt)

Physical Address	STREET	CITY	COUNTY	STATE	ZIP CODE

Mailing Address (if different)	STREET	CITY	COUNTY	STATE	ZIP CODE

Telephone	HOME	WORK OR MESSAGE

SECTION B – Applicant Information. Please answer the following questions.

1) How many people are living in your household (include unborn child/ren)? _____
2) Is anyone in your household receiving SNAP, TANF, Medicaid or CHIP? ❒ no ❒ yes
3) Is anyone in your household a migrant worker? ❒ no ❒ yes
4) What is the highest grade you have completed in school?_____

List all the individuals who are applying for WIC services. Include due date of unborn children in the space for name. (Ethnicity, sex and race data are for statistical purposes only. They are not used to determine eligibility. If you choose not to answer, WIC staff will select for you.)

FOR WIC USE

LEGAL NAME FIRST NAME MI LAST NAME	SEX	ETHNICITY	RACE (check all that apply)	ID NUMBERS F _____
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	
_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	
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_____ Date of Birth _____	❒ Male ❒ Female	❒ Hispanic/Latino ❒ Not Hispanic/Latino	❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American ❒ Pacific Islander or Native Hawaiian ❒ White	

The WIC Program is aWIC is an equal opportunity provider. For the full nondiscrimination statement and contact information to file a complaint, please visit the Idaho WIC website at www.wic.dhw.idaho.gov.n equal opportunity provider

IDENTITY:	RESIDENCY:	PREGNANCY PROOF:
❒ driver's license ❒ birth certificate ❒ government ID ❒ other _____ _____	❒ driver's license ❒ utility bill ❒ letter ❒ other _____ _____	❒ written ❒ visual

INCOME ELIGIBILITY:

❒ TANF MA FS CHIP
❒ check stub
❒ W-2
❒ unemployment
❒ other _____

INCOME CALCULATION **

For guidence on how to convert income, see table below.

Income must be compared to the income guidelines.

INCOME SOURCE (employer)	Amount	**	Subtotal
1. _____	$ _____	_____	$ _____
2. _____	$ _____	_____	$ _____
3. _____	$ _____	_____	$ _____

Household size: _____ Annual gross income $ _____

Is there other income (overtime, tips, bonuses, child support, SSI)?

Staff Name: _____ Date: _____

WIC is an equal opportunity provider. For the full nondiscrimination statement and contact information to file a complaint, please visit the Idaho WIC website at www.wic.dhw.idaho.gov.

Idaho WIC Program – Income Eligibility Chart

Use this chart to determine how to calculate income.

In most cases, the information list under the "Do this" column will work, but you may need to ask further about the income amounts. Critical thinking questions:

- Is this the income reflective of the normal situation?
- Would it be beneficial to annualize all income for the household?

Seek assistance from your Supervisor, Coordinator or the State WIC Office if you are unsure or have further questions.

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

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

* **Use this column if you need to manually calculate annual income or if the computer is down**.

FORMA NO: 101S (12/15)

Solicitud de Idaho Programa WIC

FECHA DE CONTACO INICIAL:	FECHA DE SOLICITUD:	FECHA DE CITA:

SECCIÓN A – Información de contacto. Por favor complete todas las secciones de la aplicación.

Adulto Responsable	PRIMER NOMBRE	SEGUNDO NOMBRE	APELLIDO	APELLIDO DE SOLTERA (si lo tiene)	FECHA DE NACIMIENTO (opc.)

Dirección Física	CALLE	CIUDAD	CONDADO	ESTADO	CÓDIGO POSTAL

Dirección de Correo (si es diferente)	CALLE	CIUDAD	CONDADO	ESTADO	CÓDIGO POSTAL

Teléfono	DE LA CASA	DEL TRABAJO O PARA DEJAR MENSAJES

SECTION B – Información de la solicitud. Por favor, responda a las siguientes preguntas.

1) ¿Cuántas personas viven en su casa (incluya niños que están por nacer)?

2) ¿Hay alguien en su casa que está recibiendo Cupones de Alimentos, TANF, Medicaid o CHIP? ☐ no ☐ sí

3) ¿Hay alguien en su casa que es un trabajador campesino migrante? ☐ no ☐ sí

4) ¿Cuál es el grado más alto que completó en la escuela?

Anote a todas las personas que están solicitando los servicios de WIC. En el espacio para el nombre incluya las fechas de parto de niños por nacer. (La información sobre la etnicidad, el sexo y la raza se usan sólo para estadísticas. No se usan para determinar elegibilidad. Si prefiere no contestar, el personal de WIC lo elegirá por usted.)

PARA EL USO DE WIC

NOMBRE LEGAL PRIMER NOMBRE 2º. NOMBRE APELLIDO	SEXO	ETNICIDAD	RAZA (marque todas las que aplican)	NÚM. DE IDENT. F _____
_____ Fecha de Nacimiento _____	☐ Masculino ☐ Femenino	☐ Hispano/Latino ☐ No Hispano/No Latino	☐ Indio americano/nativo de Alaska ☐ Asiático ☐ Negro o afro-americano ☐ Isleño del Pacífico/nativo de Hawai ☐ Blanco	
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USDA es un proveedor que ofrece igual dad de oportunidades. Con respecto a la declaración para no ser discriminado y la información de contacto para presenter una queja, visite la página de web de Idaho WIC a www.wic.dhw.idaho.gov.

IDENTITY:	RESIDENCY:	PREGNANCY PROOF:
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INCOME ELIGIBILITY:

❒ TANF MA FS CHIP
❒ check stub
❒ W-2
❒ unemployment
❒ other

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Is there other income (overtime, tips, bonuses, child support, SSI)?

Staff Name: _____ Date: _____

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WIC INCOME ELIGIBILITY GUIDELINES

July 1, 2016 through June 30, 2017

Number of Household Members	Maximum Annual Gross Household Income
1	$21,978
2	$29,637
3	$37,296
4	$44,955
5	$52,614
6	$60,273
7	$67,951
8	$75,647

For each additional individual, add $7,696/year

One pregnant woman counts as 2 household members

Prescreening Tool: wic.fns.usda.gov/wps/pages/start.jsf

These guidelines are to see if you *might* qualify for WIC. To make sure you qualify, please contact your local WIC office. To find your local WIC office, call the Idaho Careline at 211 or 1-800-926-2588, or visit www.wic.dhw.idaho.gov.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1)mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

CHILD

HEALTH ASSESSMENT (for children under age 2)

Was (child's name) ever breastfed? ☐ Yes ☐ No ☐ Unknown

At what age did (child's name) first have formula? _____ weeks (1-78) ☐ Not started ☐ Unknown

At what age did (child's name) stop breastfeeding? _____ weeks (1-78) ☐ Not stopped ☐ Unknown

Why did (child's name) stop or never start breastfeeding? ☐ Medical condition mom/infant

☐ Inadequate milk supply ☐ Breastfeeding management problem ☐ Mom returning to work/school

☐ Other (describe): _____

NUTRITION ASSESSMENT (all children)

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your child's health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How is (child's name) doing? _____

2. Has your doctor identified any health problems or medical conditions for (child's name)?
   ☐ No concerns
   ☐ Concerns (Describe) _____
   [134, 201, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 359, 360, 362, 381, 382]

3. Is (child's name) currently taking any medications?
   ☐ No
   ☐ Unknown
   ☐ Yes (list medications): _____ [357]

4. How do you feel about (child's name)'s growth?
   ☐ No concerns
   ☐ Concerns (Describe): _____

5. Has (child's name) had a blood lead test?
   ☐ No ☐ Declined ☐ Yes

6. How do you take care of (child's name)'s teeth?
   _____ [381]

7. It helps if we know where you go for medical care. Where do you take (child's name) for medical care?
   - ☐ No provider
   - ☐ Declined
   - ☐ Unknown
   - ☐ Provider: _____

8. How often do you take (child's name) for medical care?

   _____ Next appointment: _____

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. What kinds of play does (child's name) do most days? (Describe – examples: indoor games, ball, rides bike, exercise class, etc.)

   _____

   Frequency – times per week (opt.) _____ Length of time in minutes (opt.) _____

2. How many hours of screen time (TV, computer, video games, movies, videos, DVDs, Game Boy, etc.) does (child's name) get in a typical day?

   _____

3. Does anyone living in your house smoke *inside* the home?
   ☐ No ☐ Declined ☐ Yes [904]

Nutrition/Health

I am going to ask you some questions about your child's diet. Then we will come back and address any concerns or questions you may have. Is this all right with you?

1. How is (child's name)'s appetite?
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ Other (Tell me more) _____ [425.06]

2. What foods does (child's name) typically eat? _____

   _____ [425.04, 425.05, 425.06, 902]

3. How often does (child's name) usually eat?

   Number of meals _____ Number of snacks _____ Other: _____ [425.06, 902]

4. How do you help (child's name) with eating? _____

   _____

   What does (child's name) do to feed herself/himself? _____

   _____ [425.04]

5. Does (child's name) ever seem to choke or gag when eating?
   - ☐ No
   - ☐ Yes
     Tell me more: _____ [425.04]

6. How do you know when (child's name) is hungry or full? _____
   _____ [425.04]

7. Are there foods you limit or avoid feeding (child's name) for any reason, including food allergies?
   - ☐ No
   - ☐ Yes
     Tell me more:_____ [353, 355, 362, 425.06, 902]

8. Tell me what (child's name) drinks from, such as a cup or bottle.
   - ☐ Bottle
   - ☐ Breast
   - ☐ Cup
   - ☐ Sippy cup
   - ☐ Refused
   - ☐ Other: _____ [425.03]

9. Tell me what (child's name) routinely drinks most days: _____
   _____ [425.01, 425.02]

10. Does (child's name) regularly eat things other than food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes (Describe – example: dirt, clary, carpet, etc.) _____ [425.09]

11. Does (child's name) take any vitamins, minerals, herbs or dietary supplements?
    - ☐ No
    - ☐ Declined
    - ☐ Yes
      What and how much? _____ [425.07, 425.08]

12. Does (child's name) use pacifiers that have been dipped in liquids or food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes
      Tell me which liquids or foods are used to dip the pacifiers: _____ [425.03]

13. During the last 6 months, have you run out of money to buy food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes [425.06]

12. Given all we have talked about, what nutrition or health questions do you have today?
    - ☐ No questions/concerns
    - ☐ Questions/concerns

    _____

    _____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
103	UNDERWEIGHT OR AT RISK OF UNDERWEIGHT	357	DRUG-NUTRIENT INTERACTIONS
113	OBESE (CHILDREN 2-5 YEARS OF AGE)	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
114	OVERWEIGHT OR AT RISK OF BECOMING OVERWEIGHT	360	OTHER MEDICAL CONDITIONS
115	HIGH WEIGHT-FOR-LENGTH (CHILDREN < 24 MOS OF AGE)	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
121	SHORT STATURE OR AT RISK OF SHORT STATURE	381	ORAL HEALTH CONDITIONS
134	FAILURE TO THRIVE	382	FETAL ALCOHOL SYNDROME
135	INADEQUATE GROWTH	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS
141	LOW BIRTH WEIGHT	425	INAPPROPRIATE NUTRITION PRACTICES FOR CHILDREN
142	PREMATURITY	425.01	PRIMARY MILK SOURCE INAPPROPRIATE
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	425.02	SUGAR-CONTAINING BEVERAGES
341	NUTRIENT DEFICIENCY DISEASES	425.03	INAPPROPRIATE BOTTLE, CUP, PACIFIER USE
342	GASTO-INTESTINAL DISORDERS	425.04	DISREGARDING DEVELOPMENT
343	DIABETES MELLITUS	425.05	FEEDING POTENTIALLY HARMFUL FOODS
344	THYROID DISORDERS	425.06	DIET LOW IN CALORIES/NUTRIENTS
345	HYPERTENSION	425.07	DIETARY SUPPLEMENTS W/ POTENTIALLY HARMFUL CONSEQUENCES
346	RENAL DISEASE	425.08	NO DIETARY SUPPLEMENTS
347	CANCER	425.09	EATING NONFOOD ITEMS (PICA)
348	CENTRAL NERVOUS SYSTEM DISORDERS	428	DIETARY RISK – COMPLEMENTARY FEEDING PRACTICES
349	GENETIC AND CONGENTICAL DISORDERS	501	POSSIBILITY OF REGRESSION
351	INBORN ERRORS OF METABOLISM	502	TRANSFER OF CERTIFICATION
352	INFECTIOUS DISEASES	801	HOMELESSNESS
353	FOOD ALLERGIES	802	MIGRANCY
354	CELIAC DISEASE	902	CHILD OF PRIMARY CAREGIVER W/ LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
355	LACTOSE INTOLERANCE	903	FOSTER CARE
356	HYPOGLYCEMIA	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

INFANT

HEALTH ASSESSMENT

Was (infant's name) ever breastfed? ☐ Yes ☐ No ☐ Unknown

At what age did (infant's name) first have formula? _____ weeks (1-78) ☐ Not started ☐ Unknown

At what age did (infant's name) stop breastfeeding? _____ weeks (1-78) ☐ Not stopped ☐ Unknown

Why did (infant's name) stop or never start breastfeeding? ☐ Medical condition mom/infant

☐ Inadequate milk supply ☐ Breastfeeding management problem ☐ Mom returning to work/school

☐ Other (describe): _____

NUTRITION ASSESSMENT

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your baby's health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How is (infant's name) doing? _____

2. Has your doctor identified any health problems or medical conditions for (infant's name)?
   ☐ No concerns
   ☐ Concerns (describe) _____
   [134, 201, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 355, 356, 359, 360, 362, 381, 382]

3. Is (infant's name) currently taking any medications?
   ☐ No
   ☐ Unknown
   ☐ Yes (list medications): _____ [357]

4. How do you take care of (infant's name)'s teeth?

   _____ [381]

5. It helps if we know where you go for medical care. Where do you take (infant's name) for medical care?
   ☐ No provider
   ☐ Declined
   ☐ Unknown
   ☐ Provider: _____

6. How often do you take (infant's name) for medical care? _____

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. Does anyone living in your house smoke *inside* the home?
   - ☐ No
   - ☐ Unknown
   - ☐ Yes [904]

Nutrition/Health

I am going to ask you some questions about your baby's diet. Then we will come back and address any concerns or questions you may have. Is this all right with you?

1. How do you feed your baby?
   ☐ Breastfeeding ☐ Formula ☐ Combination ☐ Other _____ [411.01]

2. How do you know when (infant's name) is hungry or full?
   _____ [411.04]

3. *(If any breastfeeding)* How is breastfeeding going?
   - ☐ No concerns
   - ☐ Concerns (describe) _____ [603, 702]

4. *(If any breastfeeding)* Describe for me how often (infant's name) nurses and for how long?
   - ☐ Not breastfeeding
   - ☐ Description (how often/how long) _____ [411.07]

5. Do you use bottles to feed your baby?
   - ☐ No
   - ☐ Declined
   - ☐ Yes
     Do you put anything in the bottle other than breastmilk, formula or water?
     ☐ No ☐ Yes (contents of bottle): _____ [411.01, 411.02, 411.03, 411.05]

6. *(If putting breastmilk in a bottle)* Tell me more about how you prepare, store and give bottles with breastmilk.
   - ☐ Appropriately handles, stores and gives bottles
   - ☐ Fresh added to already frozen
   - ☐ Adding refrigerated to frozen in an amount greater than the amount of frozen
   - ☐ Failure to clean breast pump/bottles per manufacturer's instruction
   - ☐ Held from a used bottle to use at another feeding
   - ☐ Props bottle
   - ☐ Refreezing
   - ☐ Thawed held in refrigerator over 24 hours
   - ☐ Thawed in microwave [411.02, 411.03, 411.04, 411.09]

7. *(Ifusing any formula)* Tell me more about how you prepare, store and give (infant's name)'s bottles.

Formula brand/type: _____
Ounces/bottle: _____ Number of bottles in 24 hours: _____

- ☐ Appropriately prepares, stores and give bottles
- ☐ Held too long at room temperature
- ☐ Held in refrigerator longer than manufacturer's instruction
- ☐ Held in bottle from last feeding or over 1 hour from start of feeding
- ☐ Props bottles
- ☐ Using improperly cleaned bottles
- ☐ Unsafe water source [411.02, 411.03, 411.04, 411.06, 411.08, 411.09]

8. *(if any bottle feeding)* Does (infant's name) take a bottle to bed?
☐ No ☐ Declined ☐ Yes What is in the bottle? _____ [411.02]

9. Does (infant's name) drink from anything else other than breast or bottle?
- ☐ No
- ☐ Declined
- ☐ Yes
  - ☐ Sippy cup ☐ Sippy cup - bottle-type lid ☐ Cup without lid (contents: _____)
  - Other (describe): _____ [411.02]

10. What else, if anything, do you feed (infant's name)? ☐ No solids yet ☐ Baby food in jars
☐ Homemade baby food ☐ Table/family food ☐ Other (describe) _____

When did (infant's name) first have foods other than breastmilk or formula? Age in months: _____

☐ Cereal ☐ Other grains ☐ Fruit ☐ Vegetables ☐ Meat ☐ Yogurt ☐ Cheese
[411.03, 411.04, 411.05, 411.08, 902]

11. Tell me about how (infant's name) eats, like picking up pieces of food or holding a cup. ☐ Is not feeding self
☐ Reaches for food ☐ Picks up pieces of food ☐ Helps hold silverware ☐ Helps hold cup [411.04]

12. If you ever add anything to (infant's name)'s food or liquids, what do you add? ☐ Nothing ☐ Cereal
☐ Corn syrup ☐ Salt ☐ Sugar ☐ Honey ☐ Other (describe): _____ [411.02, 411.03]

13. Does (infant's name) take any vitamins, minerals, herbs or dietary supplements?
- ☐ No
- ☐ Declined
- ☐ Yes
  - ☐ Vitamin/mineral supplement ☐ Vitamin D ☐ Fluoride/fluoridated water ☐ Iron [411.10, 411.11]

14. During the last 6 months, have you run out of money to buy food?
☐ No ☐ Unknown ☐ Yes [411.08]

15. Given all we have talked about, what nutrition, health or feeding questions do you have today?
- ☐ No questions/concerns
- ☐ Questions/concerns

_____

_____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
103	UNDERWEIGHT OR AT RISK OF UNDERWEIGHT	360	OTHER MEDICAL CONDITIONS
114	OVERWEIGHT OR AT RISK OF BECOMING OVERWEIGHT	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
115	HIGH WEIGHT-FOR-LENGTH	381	ORAL HEALTH CONDITIONS
121	SHORT STATURE OR AT RISK OF SHORT STATURE	382	FETAL ALCOHOL SYNDROME
134	FAILURE TO THRIVE	411	INAPPROPRIATE NUTRITION PRACTICES FOR INFANTS
135	INADEQUATE GROWTH	411.01	ROUTINELY USING A SUB FOR BREASTMILK/FORMULA
141	LOW BIRTH WEIGHT	411.02	ROUTINELY USING BOTTLES OR CUPS IMPROPERLY
142	PREMATURITY	411.03	GIVING SOLID FOOD TOO SOON OR TOO CHUNKY
153	LARGE FOR GESTATIONAL AGE	411.04	FEEDING FOODS NOT APPROPRIATE TO DEVELOPMENTAL AGE
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	411.05	FEEDING FOODS THAT COULD BE CONTAMINATED
341	NUTRIENT DEFICIENCY DISEASES	411.06	ROUTINELY MIXING FORMULA INCORRECTLY
342	GASTRO-INTESTINAL DISORDERS	411.07	LIMITING BREASTFEEDING FOR FULLY BREASTFED
343	DIABETES MELLITUS	411.08	FEEDING A DIET BERY LOW IN CALORIES OR NUTRIENTS
344	THYROID DISORDERS	411.09	UNSAFE PREP/HANDLING/STORAGE OF BREASTMILK/FORMULA
345	HYPERTENSION	411.10	FEEDING POTENTIALLY HARMFUL DIETARY SUPPLEMENTS
346	RENAL DISEASE	411.11	NOT FEEDING RECOMMENDED DIETARY SUPPLEMENTS
347	CANCER	428	DIETARY RISK ASSOC W/ COMPLEMENTARY FEEDING PRACTICES
348	CENTRAL NERVOUS SYSTEM DISORDER	502	TRANSFER OF CERTIFICATION
349	GENETIC AND CONGENITAL DISORDERS	603	BREASTFEEDING COMPLICATIONS
351	INBORN ERRORS OF METABOLISM	701	INFANT UP TO 6 MO OF WIC MOTHER/WOMAN ELIGIBLE DURING PREGNANCY
352	INFECTIOUS DISEASES	702	BREASTFEEDING INFANT OF WOMEN AT NUTR RISK
353	FOOD ALLERGIES	801	HOMELESSNESS
354	CELIAC DISEASE	802	MIGRANCY
355	LACTOSE INTOLERANCE	902	LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
356	HYPOGLYCMIA	903	FOSTER CARE
357	DRUG-NUTRIENT INTERACTIONS	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE
359	RECENT MAJOR SURGERY, TRAUMA, BURNS		

POSTPARTUM

HEALTH ASSESSMENT

Estimated delivery date: _____ Actual delivery date: _____ ☐ Multi-fetal gestation

Previous pregnancy end: ☐ No previous pregnancy ☐ Date _____ # infants delivered: _____

Delivery outcome(s): ☐ Alive ☐ Dead ☐ Miscarried ☐ Stillborn

NUTRITION ASSESSMENT

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How are you feeling now? _____

2. Are you having any medical problems that make it difficult to care for yourself or your baby?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (Describe) _____
   [201, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 356, 358, 359, 360, 361, 362, 363, 381]

3. What medications are you currently taking?
   - ☐ None
   - ☐ List medications: _____ [357]

4. Was this your first pregnancy? ☐ Yes ☐ No ☐ Declined Number of pregnancies: _____

5. Did you have any health or medical concerns with this last pregnancy, such as gestational diabetes?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [303, 304, 311, 312, 321, 335, 337, 339, 359]

6. Do you have any dental problems that prevent you from eating some foods?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [381]

7. *(Only ask this question if mom is being certified before the infant.)* How is your baby doing?

   _____

8. How much did your baby weigh at birth? _____ pounds _____ ounces [312, 337]

9. When was your first visit for prenatal care? Date: _____

10. It helps if we know where you go for medical care. Which medical clinic or provider do you go to?
    - ☐ No provider
    - ☐ Declined
    - ☐ Unknown
    - ☐ Provider: _____

11. How often do you go for medical care? _____

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. Do you smoke?
   ☐ No ☐ Declined ☐ Yes: # of cigarettes/day: _____ [371]

2. Did you smoke during the last 3 months of your pregnancy? ☐ No ☐ Declined ☐ Yes

3. Does anyone living in your house smoke *inside* the home?
   ☐ No ☐ Declined ☐ Yes [904]

4. Do you drink alcohol?
   - ☐ No
   - ☐ Declined
   - ☐ Yes How many drinks at a time? _____ How often? _____ [372]

5. Did you drink alcohol in the last 3 months of your pregnancy?
   ☐ No ☐ Declined ☐ Yes # drinks/week _____

6. Have you used street drugs since the baby was born?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [372]

7. What kind of activity or exercise do you like to do on most days?
   ☐ Bike riding ☐ Dance ☐ Exercise class/gym ☐ Exercise DVD/video ☐ Jog/run
   ☐ Play outdoors with children ☐ Swim ☐ Walk ☐ Yoga ☐ Declined to answer ☐ Other

   Frequency – times per week (opt.) _____ Length of time in minutes (opt.) _____

Nutrition/Health

I am going to ask you some questions about your health and nutrition. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. Tell me about feeding your new baby. How is it going?
   Method: ☐ Breastfeeding ☐ Combination feeding ☐ Formula feeding

   ☐ Other (describe) _____ [601, 602]

2. *(If any breastfeeding)* Would you like to learn more about or have help with breastfeeding?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____

3. How has your appetite been?
   - ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   - ☐ Other (describe) _____ [427.02]

4. Are there foods that you avoid for any reason, including food allergies?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [353, 355, 358, 362, 427.02, 902]

5. What foods do you typically eat? _____

   _____ [427.02, 427.05, 902]

6. What do you drink most days?
   ☐ Coffee ☐ Juice ☐ Kool-Aid/punch ☐ Soda: diet ☐ Soda: regular ☐ Sports drinks ☐ Tea ☐ Water
   ☐ Milk (*circle:* whole lowfat skim lactose reduced/free goat raw soy) ☐ Other _____ [427.02, 427.05]

7. Sometimes women experience unusual cravings after having a baby that may include non-food items like eating paper.. Do you regularly eat things other than food?
   - ☐ No
   - ☐ Declined
   - ☐ Yes
     - ☐ Dirt ☐ Clay ☐ Carpet fibers ☐ Dust ☐ Ashes ☐ Laundry starch
     - ☐ Cigarette butts ☐ Paint chips ☐ Other [427.03]

8. Tell me about any vitamins, minerals, herbs or dietary supplements you are taking. (*If taking a prenatal vitamin*) What type of prenatal vitamin are you taking?
   - ☐ None
   - ☐ Folic acid supplement
   - ☐ Iodine
   - ☐ Children's vitamin/mineral supplement
   - ☐ General vitamin/mineral supplement
   - ☐ Iron
   - ☐ Prenatal vitamin/mineral supplement, herb/dietary supplement or other: _____ [427.01, 427.04]

9. Did you take a multivitamin during pregnancy? (includes prenatals)
   ☐ No ☐ Declined ☐ Yes

10. Did you take a multivitamin before your pregnancy?
    ☐ No ☐ Declined ☐ Yes

11. During the last 6 months, have you run out of money to buy food?
    - ☐ No
    - ☐ Declined
    - ☐ Yes (describe) _____ [427.02]

12. Given all we have talked about, what nutrition or health questions do you have today?
    - ☐ No questions/concerns
    - ☐ Questions/concerns _____

    _____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
101	UNDERWEIGHT (WOMEN)	356	HYPOGLYCEMIA
111	OVERWEIGHT (WOMEN)	357	DRUG-NUTRIENT INTERACTIONS
133	HIGH MATERNAL WEIGHT GAIN	358	EATING DISORDERS
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
303	HX OF GESTATIONAL DIABETES	360	OTHER MEDICAL CONDITIONS
304	HX OF PREECLAMPSIA	361	DEPRESSION
311	HX OF PRETERM DELIVERY	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
312	HX OF LOW BIRTH WEIGHT	363	PRE-DIABETES
321	HX OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS	371	MATERNAL SMOKING
331	PREGNANCY AT A YOUNG AGE	372	ALCOHOL AND ILLEGAL DRUG USE
332	CLOSELY SPACED PREGNANCIES	381	ORAL HEALTH CONDITIONS
335	MULTIFETAL GESTATION	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS
337	HX OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT	427	INAPPROPRIATE NUTRITION PRACTICES FOR WOMEN
339	HX OF BIRTH W/ NUTRITION RELATED CONGENITAL/BIRTH DEFECT	427.01	DIETARY SUPPLEMENTS W/ POTENTIALLY HARMFUL CONSEQUENCES
341	NUTRIENT DEFICIENCY DISEASES	427.02	CONSUMING DIET LOW IN CALORIES/NUTRIENTS
342	GASTRO-INTESTINAL DISORDERS	427.03	COMPULSIVELY INGESTING NON-FOOD ITEMS (PICA)
343	DIABETES MELLITUS	427.04	INADEQUATE VITAMIN/MINERAL SUPPLEMENTATION
344	THYROID DISORDERS	427.05	INGESTING FOODS THAT COULD BE CONTAMINATED
345	HYPERTENSION (INCL CHRONIC/PREGNANCY INDUCED)	501	POSSIBILITY OF REGRESSION
346	RENAL DISEASE	502	TRANSFER OF CERTIFICATION
347	CANCER	601	BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK
348	CENTRAL NERVOUS SYSTEM DISORDERS	602	BREASTFEEDING COMPLICATIONS
349	GENETIC AND CONGENITAL DISORDERS	801	HOMELESSNESS
351	INBORN ERRORS OF METABOLISM	802	MIGRANCY
352	INFECTIOUS DISEASES	902	LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
353	FOOD ALLERGIES	903	FOSTER CARE
354	CELIAC DISEASE	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE
355	LACTOSE INTOLERANCE		

PRENATAL

HEALTH ASSESSMENT

Estimated delivery date: _____ Multifetal gestation? ☐ No ☐ Yes

Previous pregnancy end: ☐ No previous pregnancy ☐ Date _____

NUTRITION ASSESSMENT

During the assessment interview, probe deeper using open-ended questions: *Tell me more..., Explain more about..., How do you..., What are your thoughts about..., What has your medical provider recommended..., What has your experience been..., What have you heard about... What have you tried..., What has worked for you...*

Health/Medical

I am going to ask you some questions about your health. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. How is your pregnancy going? _____
   Are you having any symptoms like nausea or vomiting?
   ☐ No
   ☐ Declined
   ☐ Yes [301]

2. Tell me about any health or medical concerns you are currently having.
   ☐ No concerns
   ☐ Concerns (describe) _____
   [201, 302, 336, 341, 342, 343, 344, 345, 346, 347, 348, 349, 351, 352, 353, 354, 356, 358, 359, 360, 361, 362, 381]

3. Is this your first pregnancy?
   ☐ Yes
   ☐ No Number of pregnancies: _____
   ☐ Declined

4. *(If first pregnancy, mark no complications and continue to next question)* Tell me about any complications or health problems you have had with any past pregnancies, such as gestational diabetes or high blood pressure.
   ☐ No complications
   ☐ Complications
   ☐ 303: Hx Gestational Diabetes ☐ 304: Hx of Preeclampsia ☐ 311: Hx Preterm Delivery (≤ 37 wks)
   ☐ 312: Hx Low Birth Weight ☐ 321: Fetal/Neonatal Loss ☐ 337: Hx Birth LGA Infant
   ☐ 339: Hx Birth-Congenital Defect ☐ Other: _____ [303, 304, 311, 312, 321, 337, 339]

5. Have you seen a medical provider for this pregnancy?
   ☐ No
   ☐ Declined
   ☐ Yes Clinic/Provider: _____Date of first appt _____Number of appts_____[334]

6. What medications are you currently taking?
   - ☐ None
   - ☐ List medications: _____ [357]

7. Do you have any dental problems that prevent you from eating some foods?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [381]

Lifestyle

We ask everyone the following questions. They have to do with health and safety.

1. Do you currently smoke?
   - ☐ No
   - ☐ Declined
   - ☐ Yes # of cigarettes/day: ____ [371]

2. Did you smoke in the 3 months before you were pregnant?
   - ☐ No
   - ☐ Declined
   - ☐ Yes # of cigarettes/day: ____

3. Does anyone living in your house smoke *inside* the home?
   - ☐ No
   - ☐ Declined
   - ☐ Yes [904]

4. Did you drink alcohol in the 3 months before you were pregnant?
   - ☐ No
   - ☐ Declined
   - ☐ Yes # of drinks/week: _____

5. Have you had alcohol since becoming pregnant?
   - ☐ No
   - ☐ Declined
   - ☐ Yes How much do you drink? _____ How often? _____ [372]

6. Have you used street drugs since your pregnancy began?
   - ☐ No
   - ☐ Declined
   - ☐ Yes (describe) _____ [372]

7. What kind of activity or exercise do you like to do on most days?
   - ☐ Bike riding ☐ Dance ☐ Exercise class/gym ☐ Exercise DVD/video ☐ Jog/run
   - ☐ Play outdoors with children ☐ Swim ☐ Walk ☐ Yoga ☐ Declined to answer ☐ Other

   Frequency – times per week (opt.) _____ Length of time in minutes (opt.) _____

Nutrition/Health

I am going to ask you some questions about your diet. Then we will come back and address any concerns or questions that you may have. Is that all right with you?

1. Tell me about any changes you have made to your diet since becoming pregnant. Experiencing any cravings?
   ☐ No changes ☐ Changes (list any reasons to assign NRC 427) _____ [427.02, 427.05]

2. How has your appetite been? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   ☐ Other (describe) _____ [427.02]

3. Are you avoiding food for any reason, including food allergies? (*If yes*) Tell me more.
   ☐ No
   ☐ Declined
   ☐ Yes (describe) _____ [353, 355, 358, 362, 427.02, 902]

4. What foods do you typically eat? _____
   _____ [427.02, 427.05, 902]

5. What do you drink most days?
   ☐ Coffee ☐ Juice ☐ Kool-Aid/punch ☐ Soda: diet ☐ Soda: regular ☐ Sports drinks ☐ Tea ☐ Water
   ☐ Milk (*circle:* whole lowfat skim lactose reduced/free goat raw soy) ☐ Other _____ [427.02, 427.05]

6. Do you regularly eat things other than food?
   ☐ No
   ☐ Declined
   ☐ Yes
   ☐ Dirt ☐ Clay ☐ Carpet fibers ☐ Dust ☐ Ashes ☐ Laundry starch
   ☐ Cigarette butts ☐ Paint chips ☐ Other [427.03]

7. Tell me about any vitamins, minerals, herbs or dietary supplements you are taking. (*If taking a prenatal vitamin*) What type of prenatal vitamin are you taking?
   ☐ None ☐ General vitamin/mineral supplement
   ☐ Children's vitamin/mineral supplement ☐ Iodine
   ☐ Folic acid supplement ☐ Iron
   ☐ Prenatal vitamin/mineral supplement, herb/dietary supplement or other: _____ [427.01, 427.04]

8. How do you plan to feed your baby?
   ☐ Breastfeeding ☐ Formula feeding ☐ Combination ☐ Other _____

9. Would you like to learn more about breastfeeding?
   ☐ No ☐ Declined ☐ Yes. Tell me more: _____

10. During the last 6 months, have you run out of money to buy food?
    ☐ No
    ☐ Declined
    ☐ Yes (describe) _____ [427.02]

11. Given all we have talked about, what nutrition or health questions do you have today?
    ☐ No questions/concerns
    ☐ Questions/concerns

    _____

USDA CODE	NUTRITION RISK CRITERIA	USDA CODE	NUTRITION RISK CRITERIA
101	UNDERWEIGHT (WOMEN)	349	GENETIC AND CONGENITAL DISORDERS
111	OVERWEIGHT (WOMEN)	351	INBORN ERRORS OF METABOLISM
131	LOW MATERNAL WEIGHT GAIN	352	INFECTIOUS DISEASES
132	MATERNAL WEIGHT LOSS DURING PREGNANCY	353	FOOD ALLERGIES
133	HIGH MATERNAL WEIGHT GAIN	354	CELIAC DISEASE
201	LOW HEMATOCRIT/LOW HEMOGLOBIN	355	LACTOSE INTOLERANCE
301	HYPEREMESIS GRAVIDARUM	356	HYPOGLYCEMIA
302	GESTATIONAL DIABETES	357	DRUG-NUTRIENT INTERACTIONS
303	HX OF GESTATIONAL DIABETES	358	EATING DISORDERS
304	HX OF PREECLAMPSIA	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
311	HX OF PRETERM DELIVERY	360	OTHER MEDICAL CONDITIONS
312	HX OF LOW BIRTH WEIGHT	361	DEPRESSION
321	HX OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS	362	DEVELOPMENTAL, SENSORY, MOTOR DISABILITIES INTERFERING W/ ABILITY TO EAT
331	PREGNANCY AT A YOUNG AGE	371	MATERNAL SMOKING
332	CLOSELY SPACED PREGNANCIES	372	ALCOHOL AND ILLEGAL DRUG USE
334	LACK OF OR INADEQUATE PRENATAL CARE	381	ORAL HEALTH CONDITIONS
335	MULTIFETAL GESTATION	401	FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS
336	FETAL GROWTH RESTRICTION	427	INAPPROPRIATE NUTRITION PRACTICES FOR WOMEN
337	HX OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT	427.01	DIETARY SUPPLEMENTS W/ POTENTIALLY HARMFUL CONSEQUENCES
338	PREGNANT WOMAN CURRENTLY BREASTFEEDING	427.02	CONSUMING DIET LOW IN CALORIES/NUTRIENTS
339	HX OF BIRTH W/ NUTRITION RELATED CONGENITAL/BIRTH DEFECT	427.03	COMPULSIVELY INGESTING NON-FOOD ITEMS (PICA)
341	NUTRIENT DEFICIENCY DISEASES	427.04	INADEQUATE VITAMIN/MINERAL SUPPLEMENTATION
342	GASTRO-INTESTINAL DISORDERS	427.05	INGESTING FOODS THAT COULD BE CONTAMINATED
343	DIABETES MELLITUS	502	TRANSFER OF CERTIFICATION
344	THYROID DISORDERS	801	HOMELESSNESS
345	HYPERTENSION (INCL CHRONIC/PREGNANCY INDUCED)	802	MIGRANCY
346	RENAL DISEASE	902	LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD
347	CANCER	903	FOSTER CARE
348	CENTRAL NERVOUS SYSTEM DISORDERS	904	EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

DERECHOS, RESPONSABILIDADES Y CONSENTIMIENTO DEL PARTICIPANTE EN WIC

¿Qué espera WIC de usted?

Sólo va a comprar los alimentos que aparecen en sus cheques de WIC y en la Lista de Alimentos Autorizados de Idaho (*Idaho Authorized Food List*) de un supermercado autorizado en Idaho.

Sólo va a usar los alimentos de la(s) persona(s) en el programa. Si comparte la custodia de su(s) hijo(s), se tiene que asegurar que los beneficios del programa de los alimentos de WIC se compartan con su(s) hijo(s).

Va a cumplir con las reglas para los cheques de WIC/CVV indicadas en la Carpeta de Identificación de WIC de Idaho.

Usted puede asignar a otra persona para que use los cheques/CVVs de WIC. Se tiene que asegurar que esta persona sepa usar correctamente los cheques/CVVs de WIC.

Va a recibir los cheques de una sola clínica a la vez. Si se cambia de casa, tiene que pedir una tarjeta de transferencia.

Va a llegar a sus citas o va a llamar antes si tiene que cambiar su cita..

Va a tratar al personal de WIC y de la tienda con amabilidad y respeto.

¿Qué puede esperar usted de WIC?

Las normas de elegibilidad y participación en el Programa WIC son las mismas para todos, independientemente de la raza, color, origen nacional, edad, discapacidad o sexo.

Puede apelar cualquier decisión que tome la agencia local con respecto de su elegibilidad al Programa.

La agencia local pondrá a su disposición los servicios de salud, educación en nutrición y apoyo para la lactancia, y se le recomienda que participe en estos servicios.

El personal de WIC lo va a tratar con amabilidad y respeto.

Si califica para el programa WIC, va a recibir cheques/CVVs de WIC para comprar alimentos saludables. Usted entiende que WIC no proporciona todos los alimentos o la fórmula que se necesita en un mes.

Entender mis derechos y responsabilidades:

- Voy a notificar a WIC de cualquier cambio en la información que yo proporcioné.
- Voy a llevar mi Carpeta de Identificación de WIC a cada cita de WIC y cuando utilice los cheque/CVV de WIC en un supermarcado autorizado por WIC.
- No voy a regresar los alimentos de WIC al supermarcado por dinero, crédito u otros artículos. No voy a vender, cambiar o regalar los cheques/CVVs de WIC o los alimentos de WIC.
- No voy a alterar mis cheques/CVVs de WIC. Se me puede acusar de fraude.
- Si no cumplo con las reglas, doy declaraciones falsas, o no proporciono hechos sobre mi elegibilidad al Programa WIC, entiendo que a mi o mi(s) hijo(s) me/nos pueden sacar el Programa WIC.
- Voy a reportar antes el personal de WIC la pérdida o el robo de mis cheques/CVVs de WIC aunque no me los puedan reponer. Si después encuentro los cheques/CVVs de WIC, ya no los voy a usar y voy a llamar a la oficina de WIC para preguntar qué hacer con ellos.
- Si no recojo los cheques/CVVs de WIC en dos citas consecutivas, puedo ser expulsado del programa.
- No voy a recibir alimentos de un Programa dr Alimentos de Primera Necesidad Complementario (Commodity Supplemental Food Program) y de WIC al mismo tiempo.
- Me van a avisar cuándo y por qué se terminaron mis beneficios del programa WIC.

(más al reverso)

Por favor lea las declaraciones siguientes y firme para indicar que entiende y que está de acuerdo en seguir estas condiciones si se determina que usted y sus hijos son elegibles para participar en el Programa WIC de Idaho.

- Autorizo que me tomen la estatura y el peso y que se haga la prueba de sangre para la anemia para mí y mi hijo. Esto se hace para establecer la necesidad nutricional para el programa WIC.
- Autorizo al programa WIC de compartir la información sobre la elegibilidad (tal como el nombre, la dirección, nivel de ingresos y la fecha de nacimiento) mía y de mis hijos nombrados en este formulario con los patrocinadores de WIC locales, estatales y federales. Esta información también puede que sea compartida con los Programas de Medicaid y, SNAP y planificación de la familia del titulo X del Departamento de Salud y Bienestar de Idaho para usarlos en referencias.
- Autorizo al programa WIC de compartir con estado de vacunación del Programa de Inmunizaciones para fines de referencia.
- Autorizo al programa WIC de usar información sobre la salud y de elegibilidad para recibir servicios de WIC y para evaluar la efectividad del programa, y supervisar y examinar el programa. Yo libero a estas agencias de cualquier responsabilidad relacionada a la liberación de información que he autorizado que sea liberada.
- Yo puedo revisar mi expediente y tengo el derecho de revocar esta autorización por escrito a cualquier hora.
- Sus derechos y responsabilidades también se incluyen en el Idaho WIC Identification Folder.

- **Por favor <u>marque abajo la casilla correspondiente</u> respecto a cómo el programa WIC se comunicará con usted:**
  - ☐ Autorizo o ☐ no autorizo al programa WIC para dejar mensajes de correo de voz en el número de teléfono que proporcioné a WIC. Entiendo que los mensajes pueden contener información que incluye pero no se limita al nombre del programa WIC, nombre(s) del solicitante, participante y/o de la familia e información relacionada con las citas.
  - Tengo el derecho a cambiar mi elección en cualquier momento mediante notificación a la clínica.

Al firmar este formulario, usted acepta:

- Se me ha informado de mis derechos y obliganciones en el Programa.
- Entiende mis derechos y obligaciones y acepto cumplir con ellos.
- Certifico que la información que he proporcionado para determinar mi elegibilidad es la correcta según mi leal saber y entender.
- Este formato de certificación se presenta en relación con la asistencia Federal recibida. Los funcionarios del Programa pueden verificar la información en este formato.
- Entiendo que hacer una declaración falsa o engañosa o desvirtuar, ocultar o retener hechos intencionalmente puede causar el pago en efectivo a la agencia Estatal el valor de los beneficios de alimentos que se me hayan entregado incorrectamente y me pueden someter a un proceso civil o penal de acuerdo con la Ley Estatal y Federal.

X _____

Firma del adulto responsable **Fecha**

X _____

Firma de la persona autorizada **Fecha**

FID#:_____

(For WIC Staff use only)

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en inglés), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, discapacidad, edad, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA.

Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA, (AD-3027) que está disponible en línea en: http://www.ascr.usda.gov/complaint_filing_cust.html y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por: (1) correo: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; o (3) correo electrónico: program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

WIC PARTICIPANT RIGHTS, RESPONSIBILITIES AND CONSENT

What does WIC expect from you?

You will buy only the foods listed on your WIC checks and on the current Idaho Authorized Food List from an Idaho authorized grocery store.

You will use the foods only for the person(s) on the program. If you share custody of your child(ren), you will make sure that the WIC food benefits are shared for your child(ren).

You will follow the WIC check/CVV rules listed on the Idaho WIC Identification Folder.

You can name another person to use WIC checks/CVVs. You will make sure that person knows how to use WIC checks/CVVs correctly.

You will get checks from only one clinic at a time. If you move, you will ask for a transfer card.

You will come to your appointments or call ahead when you need to reschedule.

You will treat WIC and store staff with courtesy and respect.

What can you expect from WIC?

Standards for eligibility and participation in the WIC Program are the same for everyone, regardless of race, color, national origin, age, handicap, or sex.

You may appeal any decision made by the local agency regarding your eligibility for the Program.

The local agency will make health services, nutrition education and breastfeeding support available to you, and you are encouraged to participate in these services.

WIC staff will treat you with courtesy and respect.

If you qualify for WIC, you will get WIC checks/CVVs to buy healthy foods. You understand that WIC does not give all the food or formula needed in a month.

I understand my rights and responsibilities:

- I will notify WIC of <u>any</u> changes to the information I have given.
- I will bring my WIC Identification Folder to every WIC appointment and when I use WIC checks/CVVs at a WIC-authorized grocery store.
- I will not return WIC foods to the grocery store for money, credit, or other items. I will not sell, trade, or give away WIC checks/CVVs or WIC foods.
- I will not alter my WIC checks/CVVs. I can be charged with fraud.
- If I break the rules, make false statements, or withhold facts about my eligibility for the WIC Program, I understand that I or my child(ren) can be taken off WIC.
- I will report lost or stolen WIC checks/CVVs to WIC staff even though they cannot be replaced. If I find the WIC checks/CVVs later, I will not use them and will call the WIC office to find out what to do with them.
- If I fail to pick up WIC checks/CVVs for two consecutive appointments, I may be terminated from the program.
- I will not get food from a Commodity Supplemental Food Program and WIC at the same time.
- I will be notified when and why my WIC program benefits will end.

(over)

Please read the statements below and sign to indicate you understand and agree to follow these conditions if you and your child(ren) are determined eligible to participate in the Idaho WIC Program.

- I consent to the taking of height and weight measurements and a finger stick blood test to check iron status for myself and/or my child(ren). These are used to establish nutritional need for the WIC Program.
- I authorize the WIC Program to share eligibility information (such as name, address, income level and birth date) for myself and my child(ren) with local, state, and federal WIC programs. This information may also be shared with the Idaho Department of Health and Welfare's Medicaid, SNAP and Title X Family Planning programs for the purpose of referral.
- I authorize the WIC Program to share immunization status with the Immunizations Program for referral purposes.
- I authorize the WIC Program to use health data and eligibility information for receiving WIC services and for evaluating the effectiveness of the program, monitoring, and auditing the program. I release these agencies from any and all responsibility and liability concerning the release of information I have consented to be released.
- I may review my record and I have the right to revoke this consent in writing at any time.
- Your rights and responsibilities are also written inside the Idaho WIC Identification Folder.

- **Please <u>check the appropriate box</u> below regarding how the WIC program will contact you:**
  - I ☐ do ☐ do not authorize the WIC program to contact me, for example leave a voicemail message or text message, at the phone number I provide to WIC. I understand messages may contain information including but not limited to the WIC program name, applicant, participant and/or family name(s) and information related to appointments.
  - I have the right to change my selection at any time by notifying the clinic.

By signing this form, you agree with the following:

- I have been advised of my rights and obligations under the Program.
- I understand my rights and responsibilities and I agree to follow them.
- I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.
- This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form.
- I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

X _____

Signature of Responsible Adult **Date**

X _____

Signature of Authorized Signer **Date**

FID#:_____

(For WIC Staff use only)

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

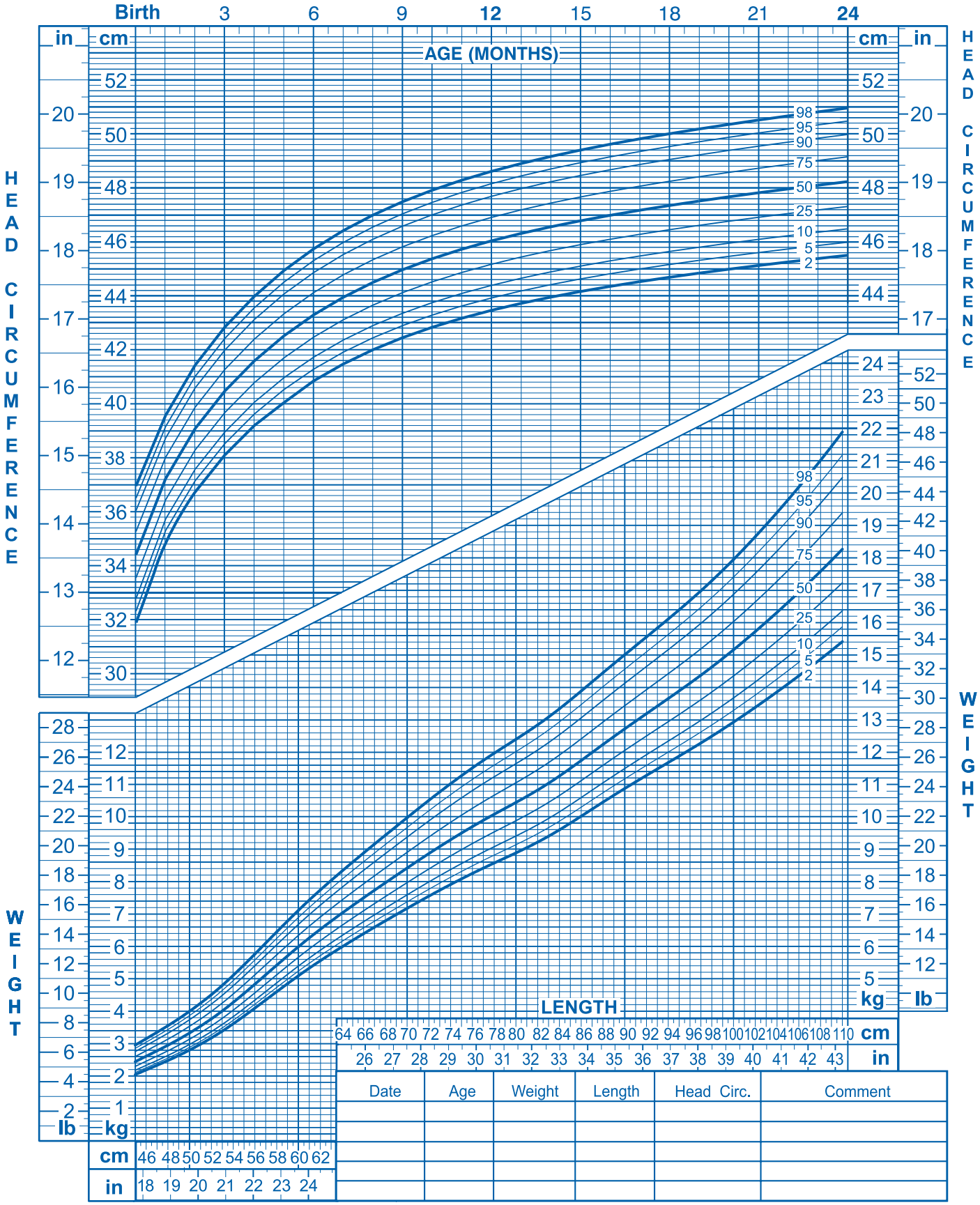
To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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

NAME _____

RECORD # _____



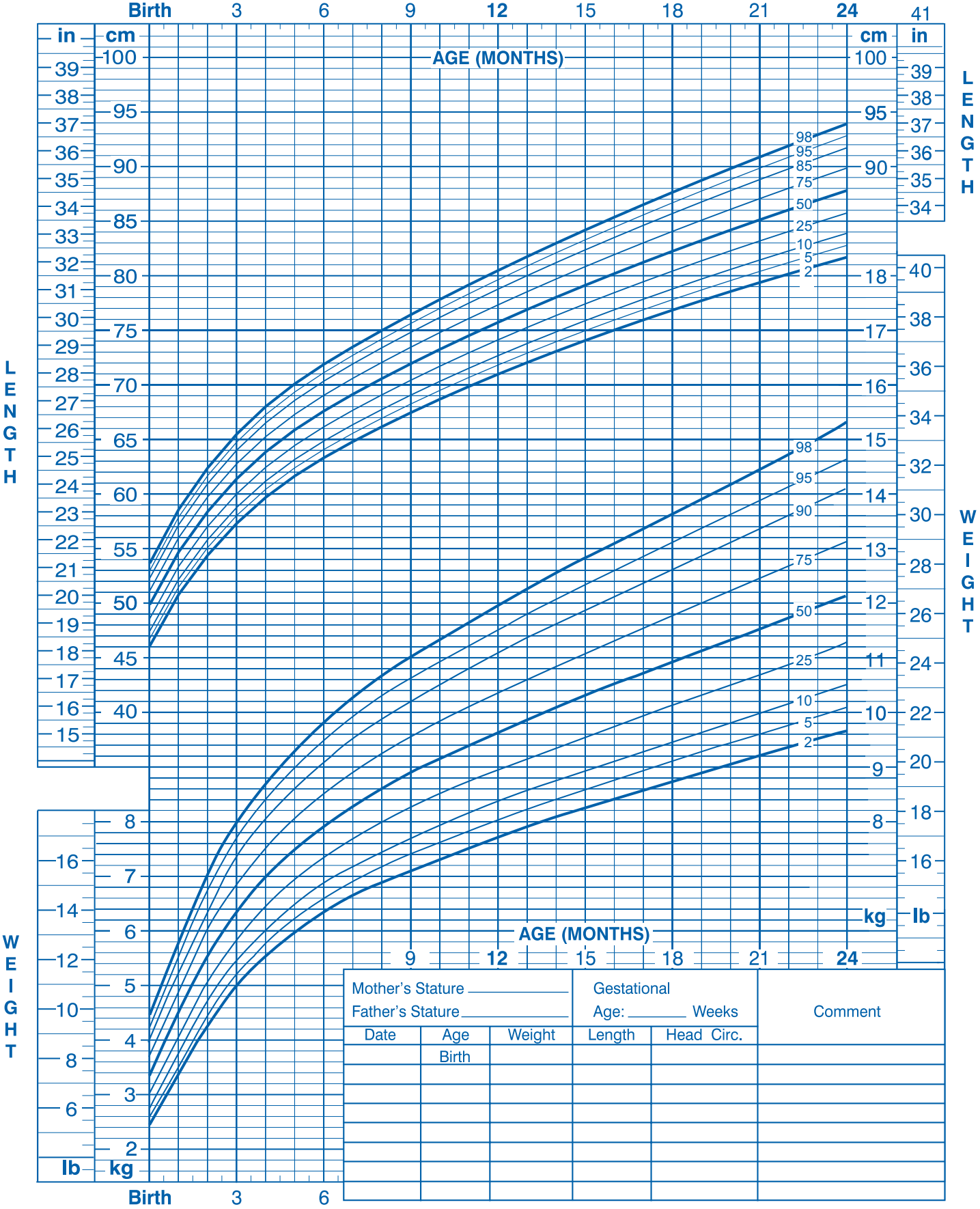
Date	Age	Weight	Length	Head Circ.	Comment

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

Birth to 24 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
	Birth				

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

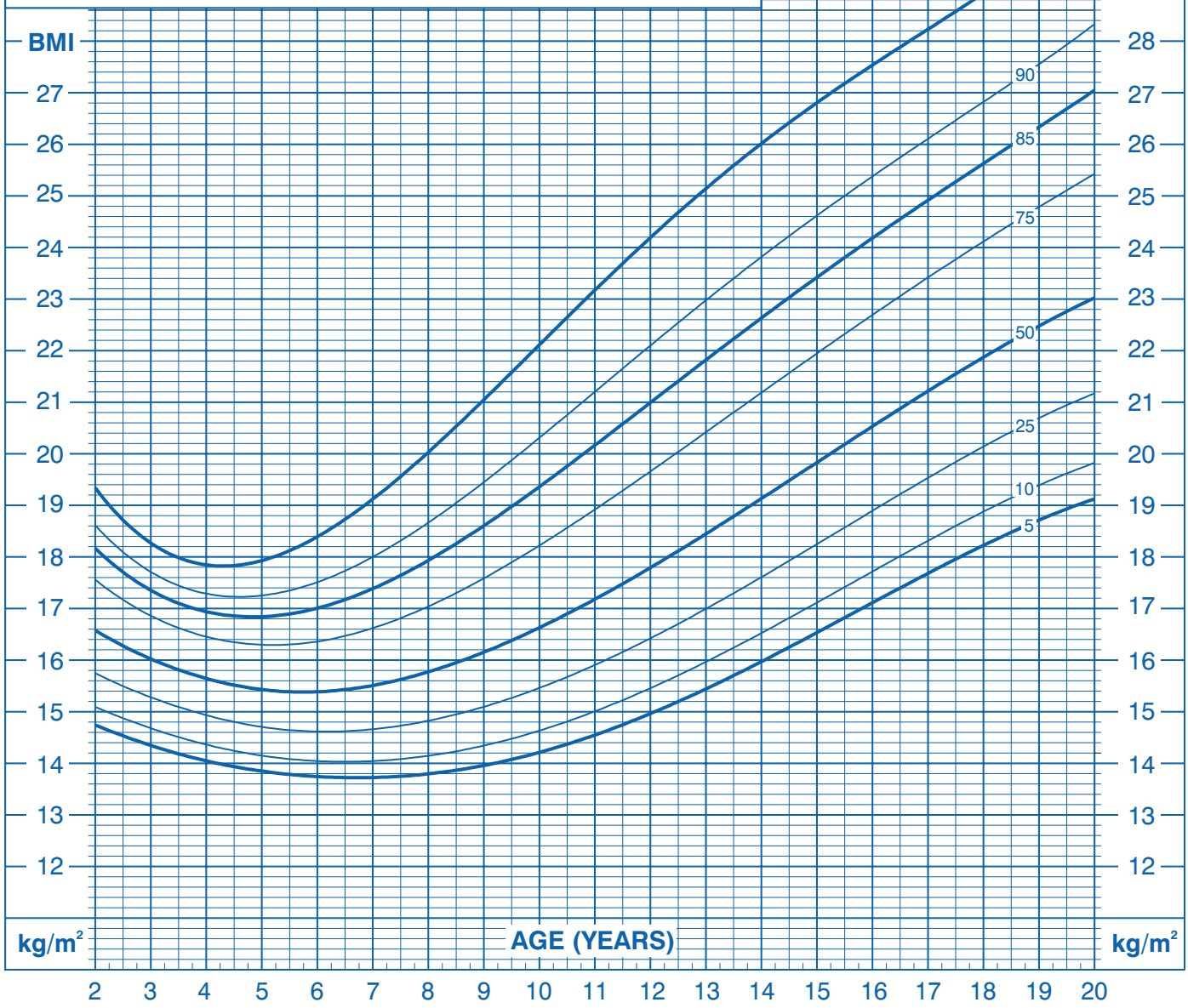
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

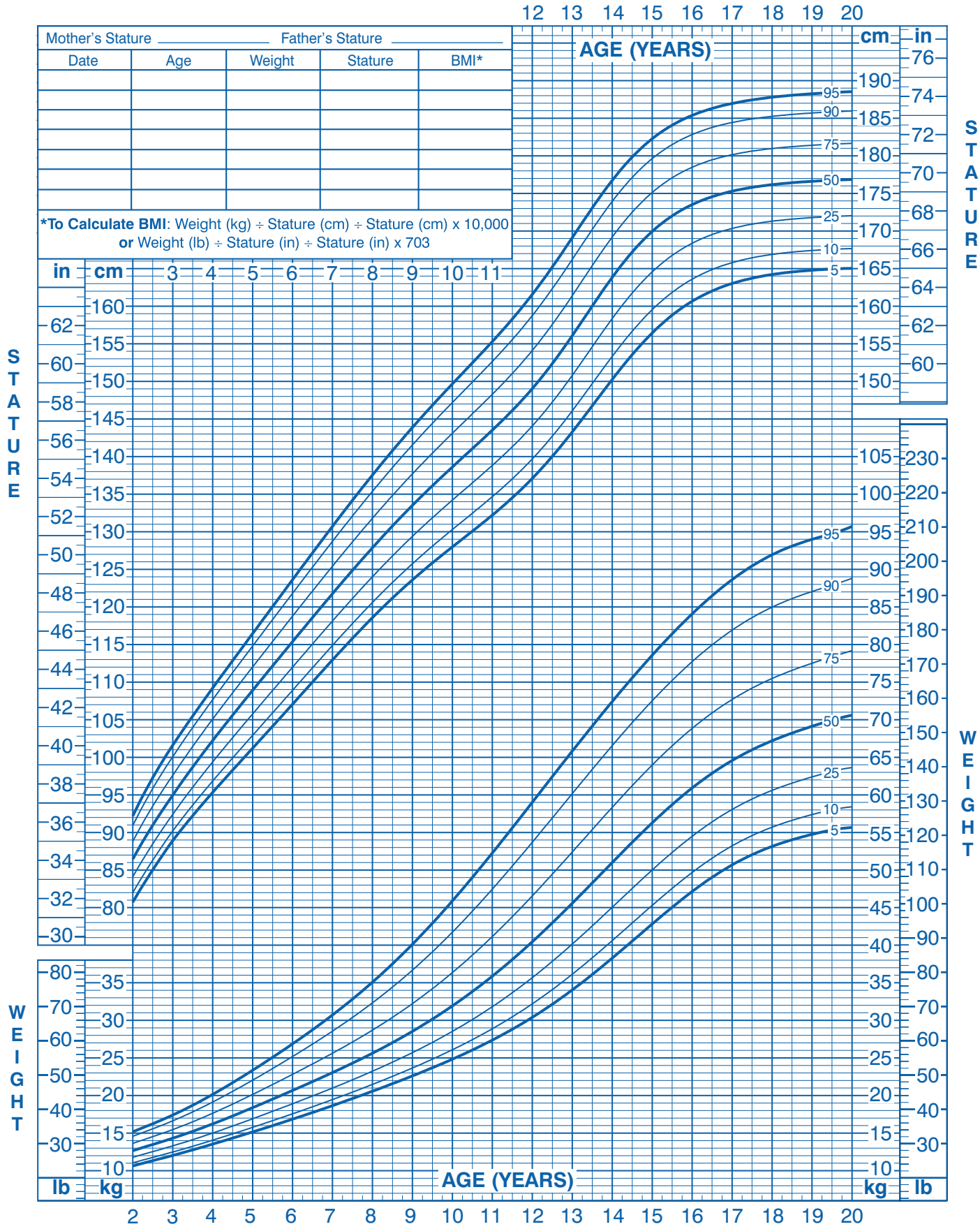
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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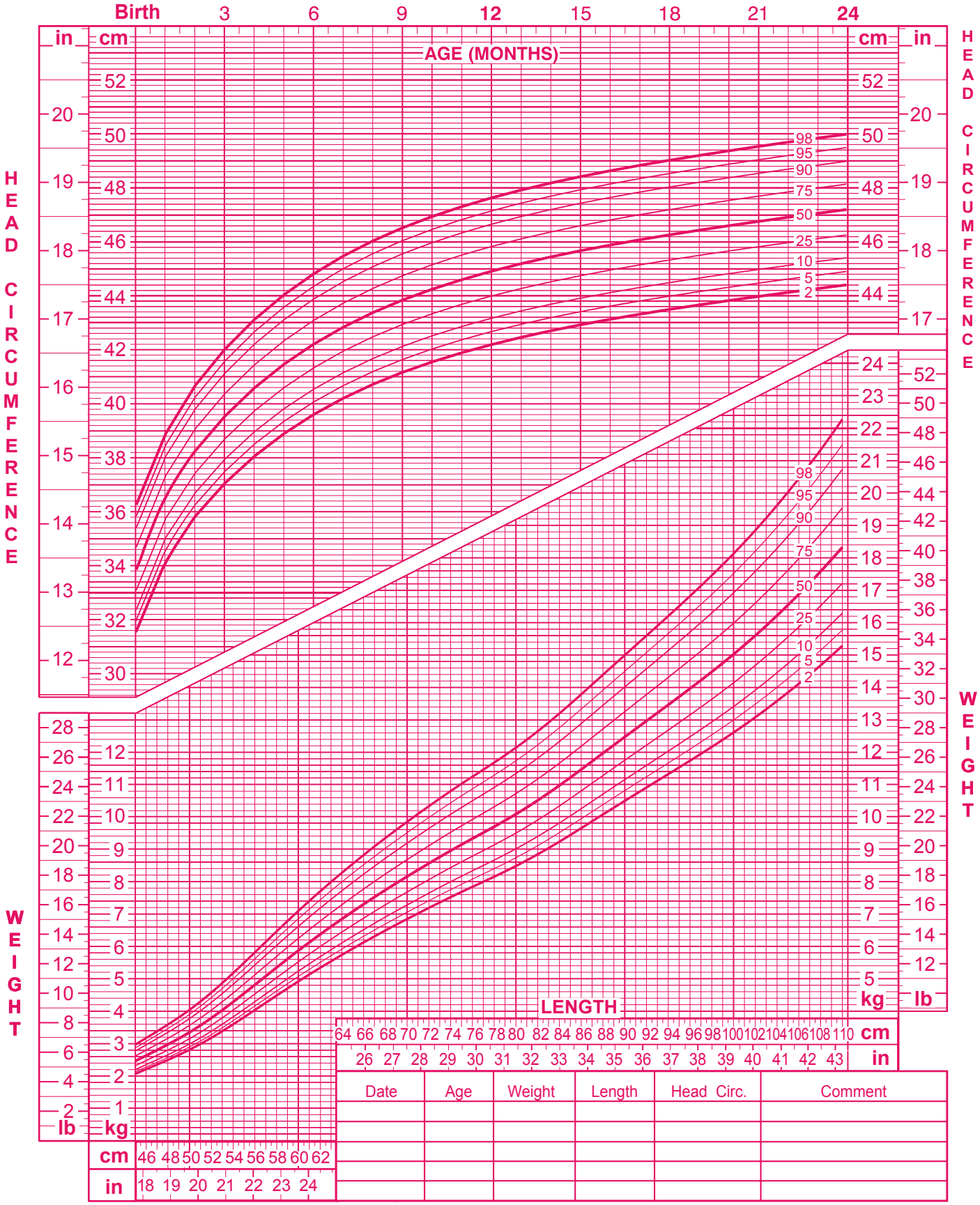
Birth to 24 months: Girls
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____

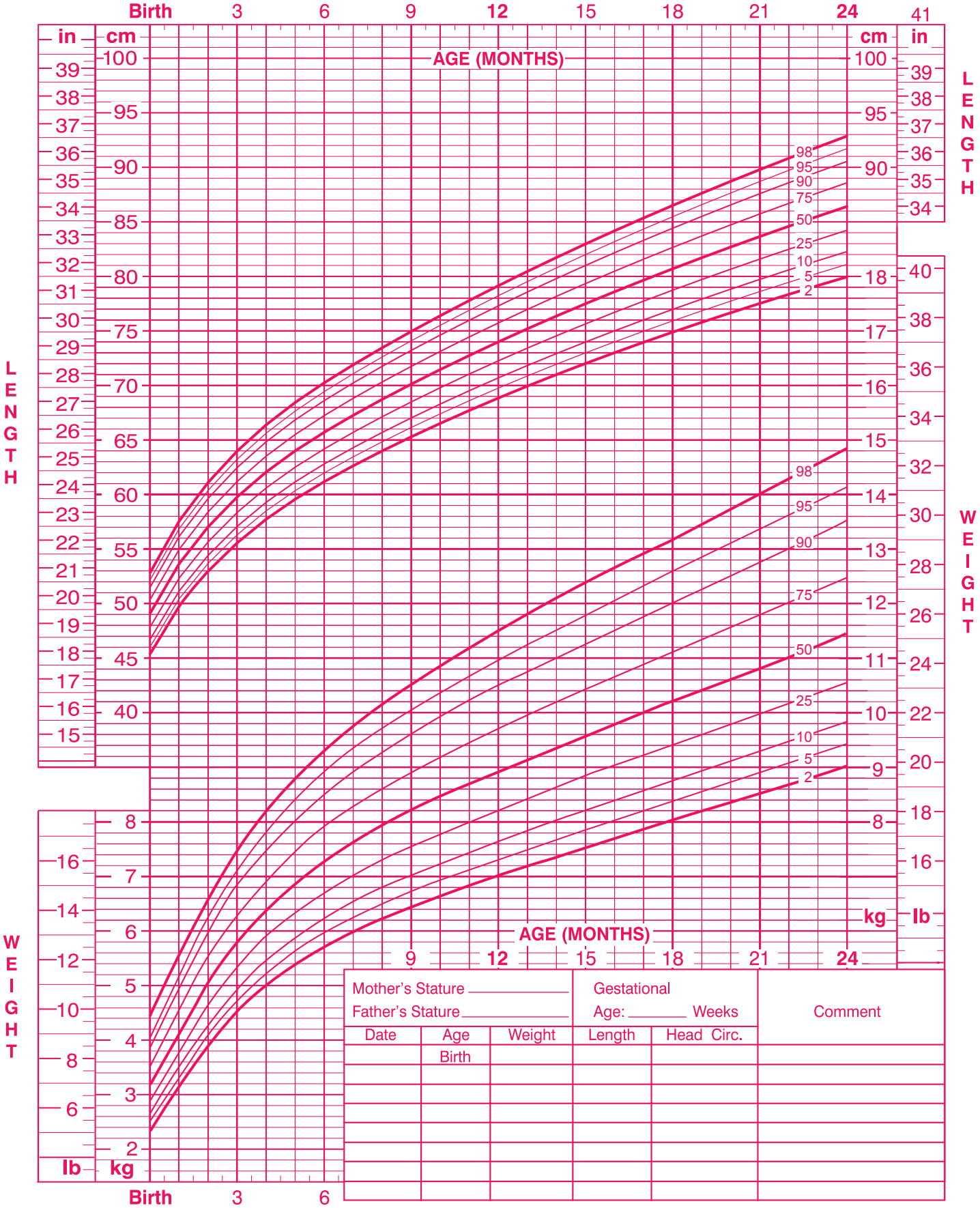


Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
	Birth				

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

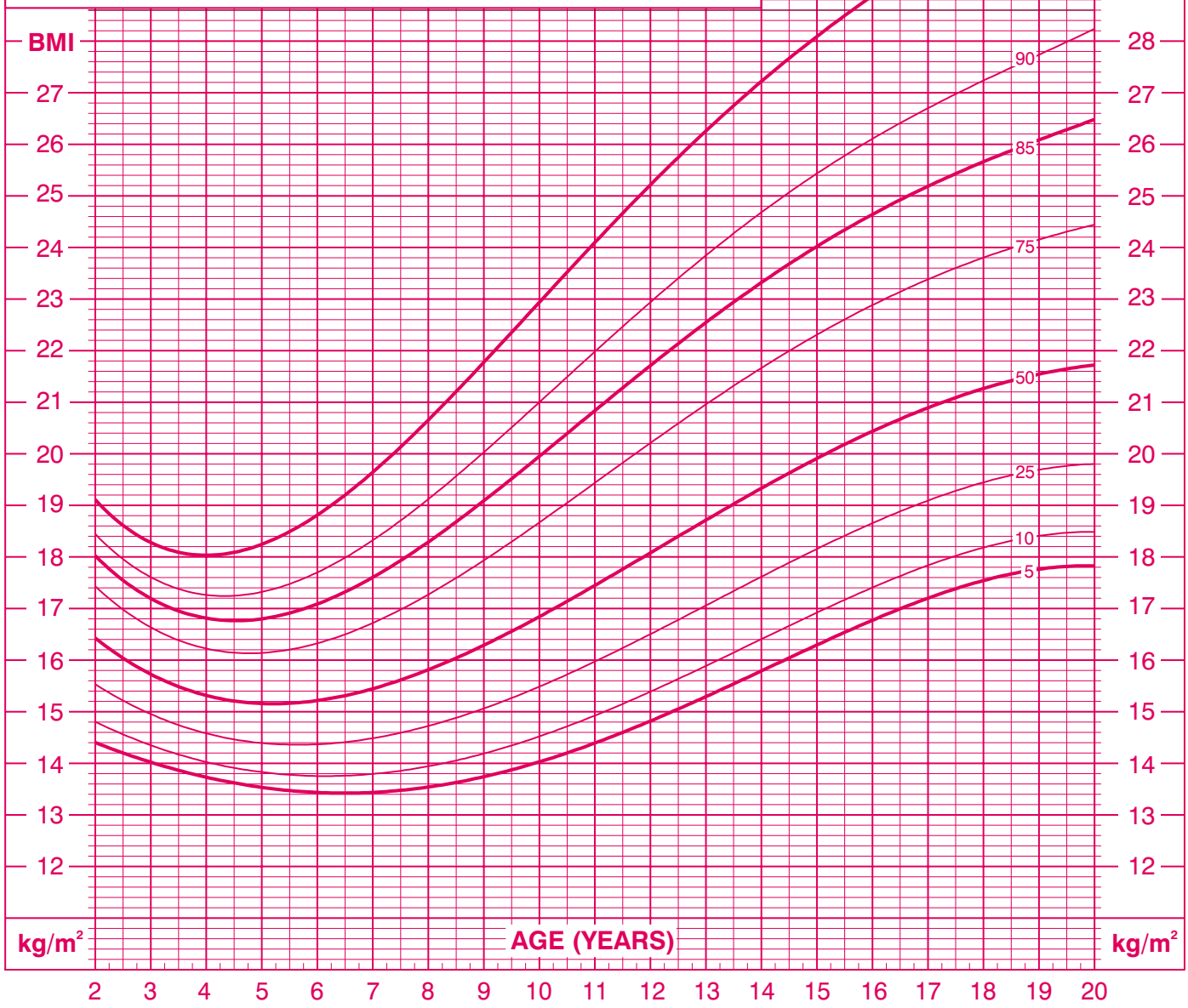
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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http://www.cdc.gov/growthcharts

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2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

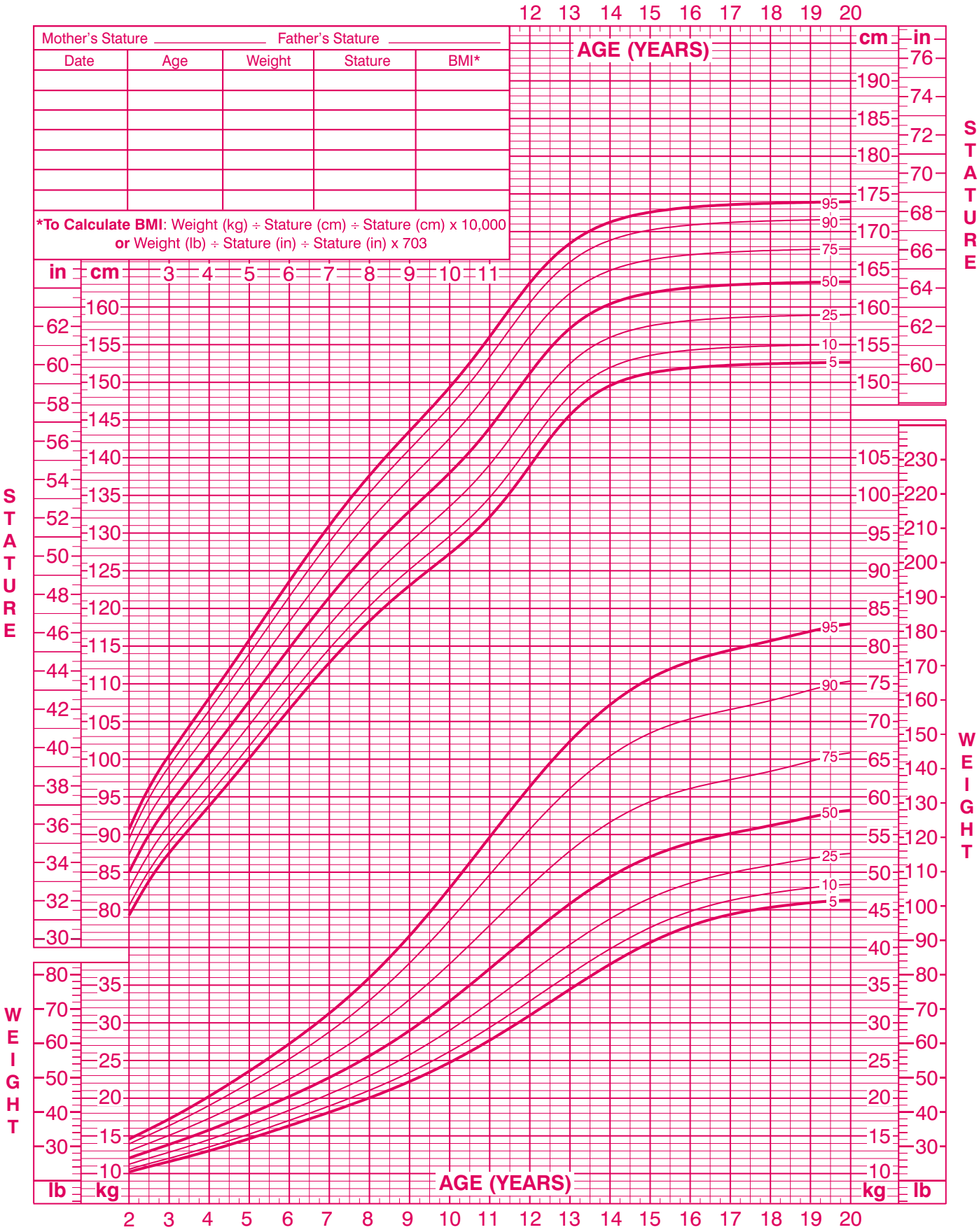
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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http://www.cdc.gov/growthcharts

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IDAHO WIC GROWING HEALTHY FAMILIES

SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

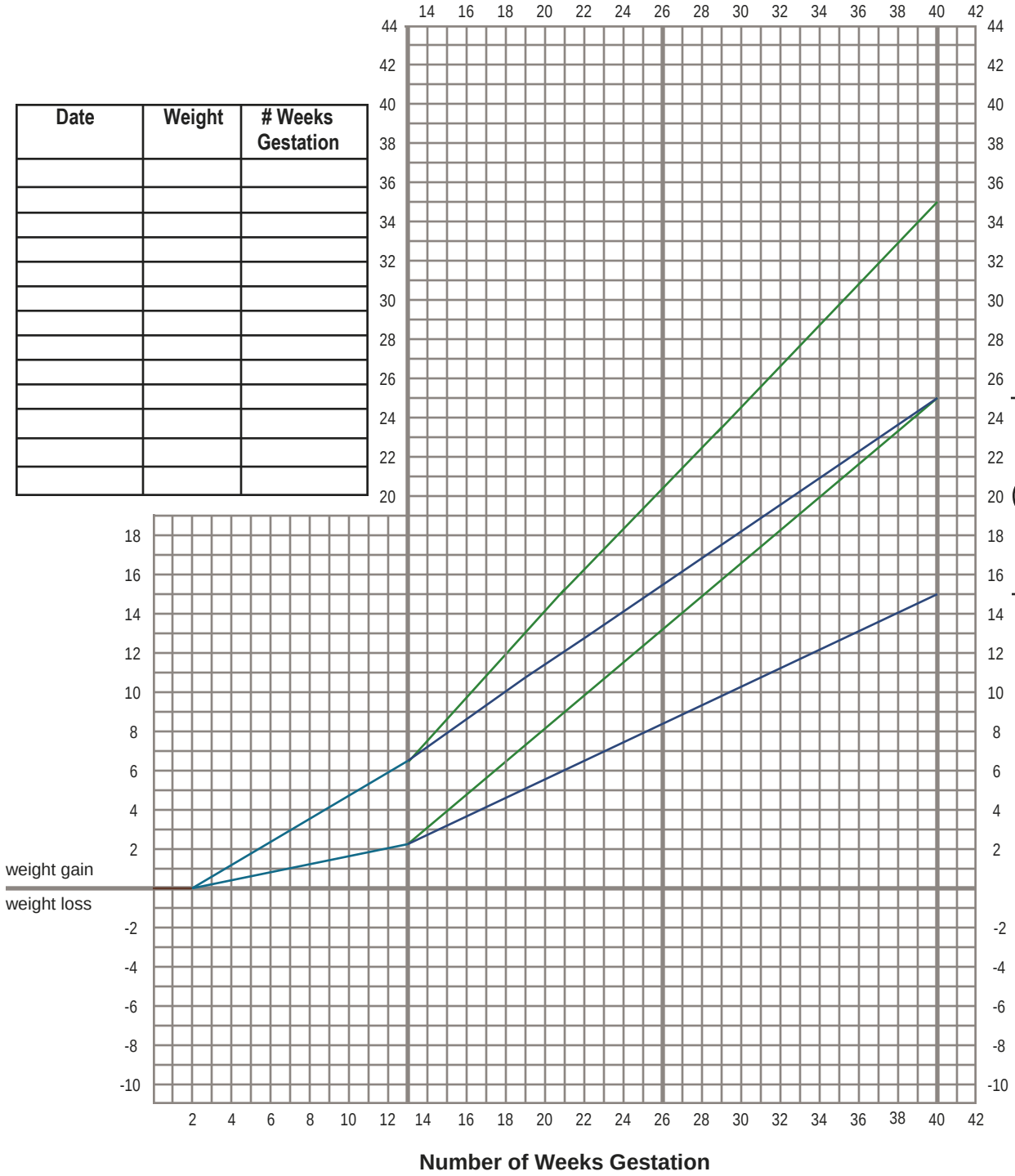
Prenatal Weight Gain—Single

Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.

Date	Weight	# Weeks Gestation



Weight Gain Recommendations

BMI 18.5 - 24.9
25-35 lbs total gain

1st Trimester
2.2 - 6.6 lbs

2nd Trimester
1 lb/week

3rd Trimester
1 lb/week

Nutrition Risk 17
BMI 25 - 29.9
15-25 lbs total gain

1st Trimester
2.2 - 6.6 lbs

2nd Trimester
.6 lb/week

3rd Trimester
.6 lb/week

IDAHO WIC GROWING HEALTHY FAMILIES
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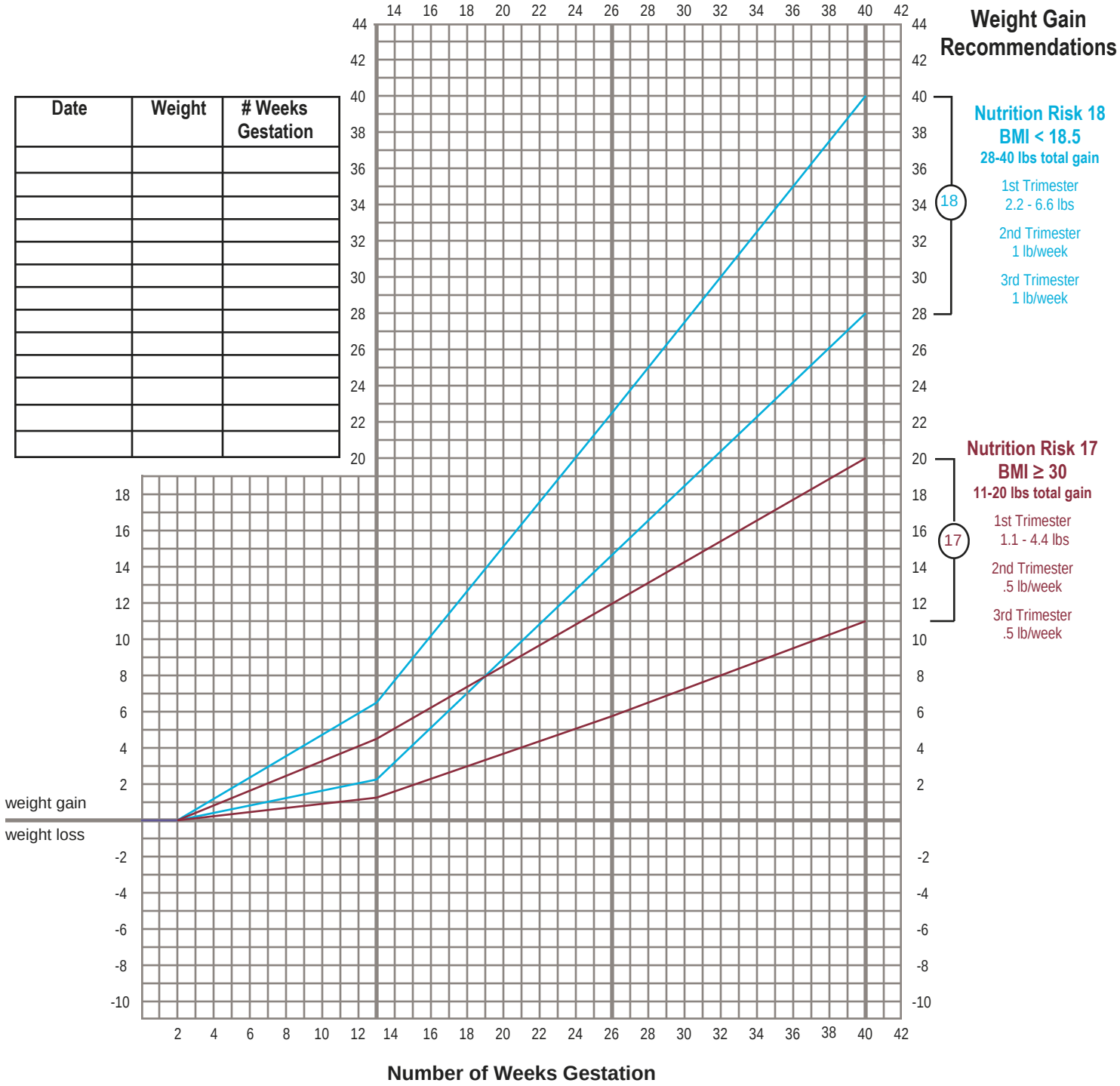
Prenatal Weight Gain—Single

Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.

Date	Weight	# Weeks Gestation



Prenatal Weight Gain—Multi

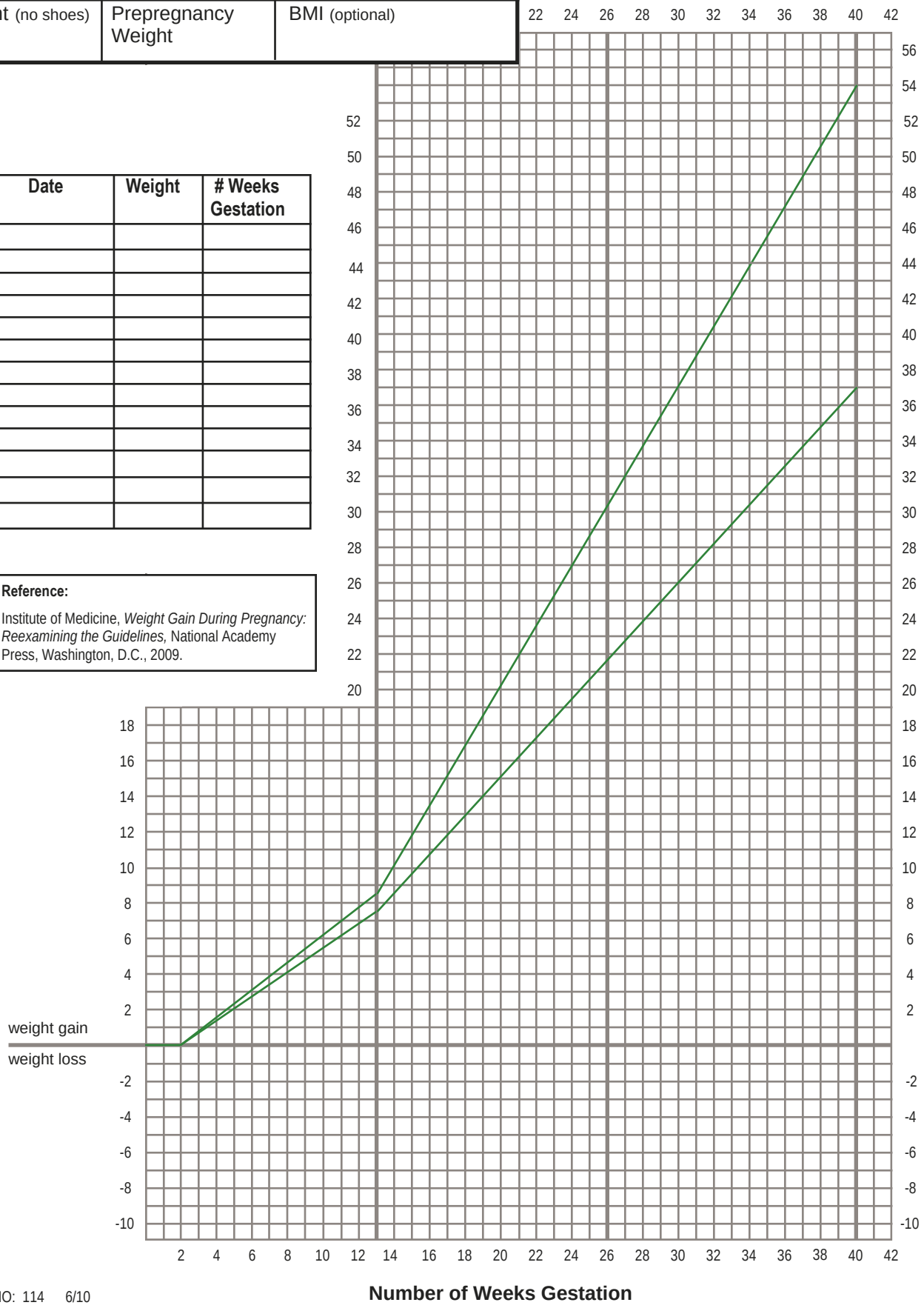
Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

Date	Weight	# Weeks Gestation

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.



Recommended Weight Gain

BMI 18.5 - 24.9
37-54 lbs total gain

1st Trimester
8-9 lbs

2nd Trimester
1.4 lbs/week

3rd Trimester
1.4 lbs/week

Prenatal Weight Gain—Multi

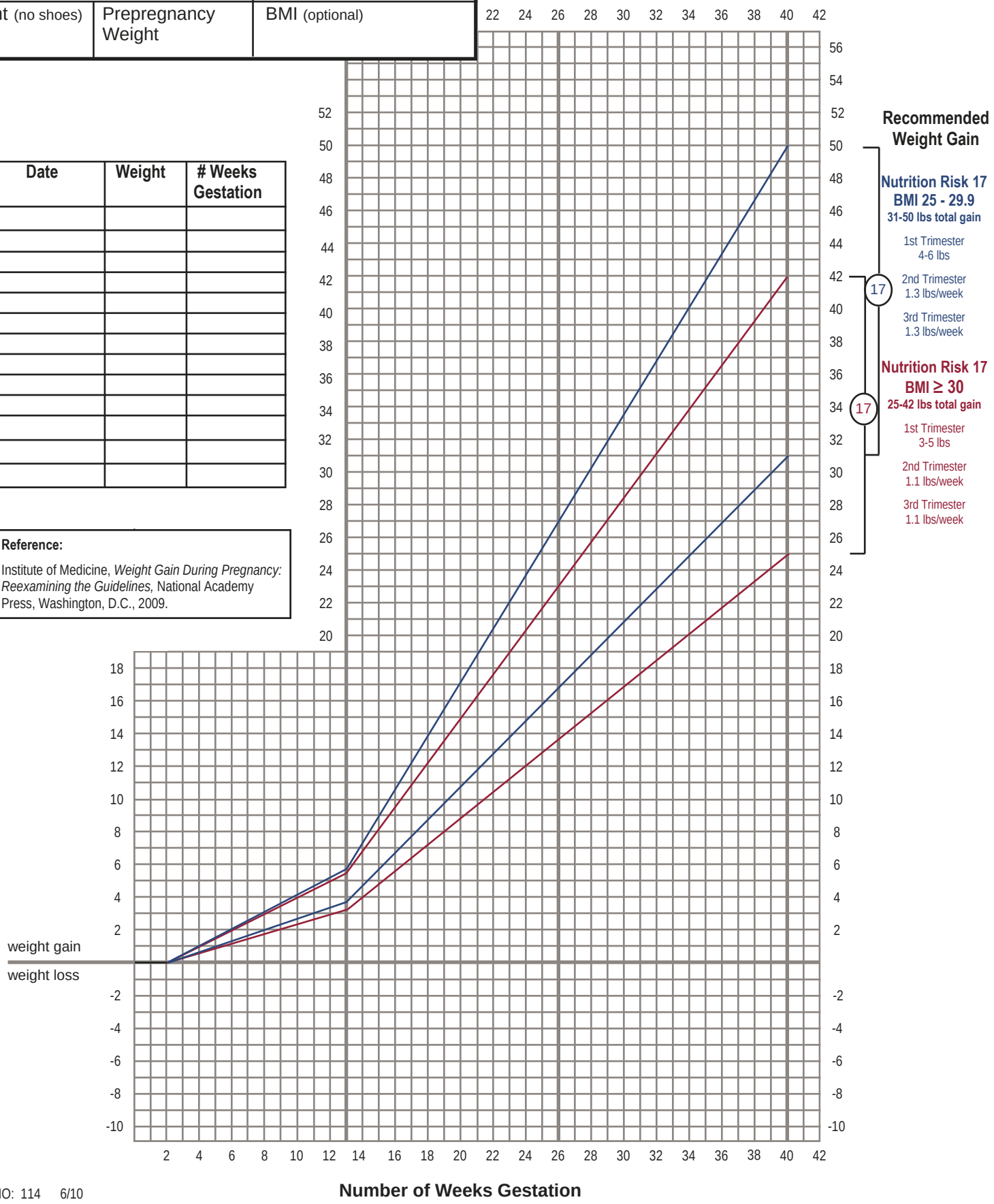
Name		ID #
EDC		Conception Age (optional)
Height (no shoes)	Prepregnancy Weight	BMI (optional)

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

Date	Weight	# Weeks Gestation

Reference:

Institute of Medicine, *Weight Gain During Pregnancy: Reexamining the Guidelines,* National Academy Press, Washington, D.C., 2009.



PARTICIPANT CARE PLAN

SUBJECTIVE:

_____

_____

OBJECTIVE:

Height: _____ Weight: _____ Hemoglobin/Hematocrit: _____

ASSESSMENT: _____

PLAN FOR FUTURE APPOINTMENTS:

❒ Schedule appt with RD ❒ Breastfeeding education ❒ Weight re-check ❒ 1 mo ❒ 2 mo ❒ 3 mo

❒ Schedule appt with LC ❒ Low risk nutrition education ❒ Hgb/hct re-check ❒ 2 mo ❒ 3 mo

❒ Route chart to RD ❒ _____ ❒ _____

REFERRALS: ❒ MA ❒ FS ❒ TANF ❒ SA ❒ MD ❒ Dental ❒ Other

_____

PARTICIPANT GOAL: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Done by: _____ Date: _____

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
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

(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.

7/09

Date last checks issued _____

This document is a WIC Program Verification of Certification for the above named person.
See reverse side for Nutrition Risk Criteria.

Signature of Local Agency Official: _____

Printed Name of Local Agency Official: _____

Name and Address of Certifying Local Agency: (may be stamped)

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

Telephone Number: _____ Fax Number: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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This institution is an equal opportunity provider.

CODE	NUTRITION RISK CRITERIA	CODE	NUTRITION RISK CRITERIA
101 ★	UNDERWEIGHT WOMAN	347	CANCER
103 ★	UNDERWEIGHT/AT RISK – INFANTS/CHILDREN	348	CENTRAL NERVOUS SYSTEM DISORDERS
111 ★	OVERWEIGHT WOMAN	349	GENETIC AND CONGENITAL DISORDERS
113 ★	OBESE – CHILDREN (2-5)	351	INBORN ERRORS OF METABOLISM
114 ★	OVERWEIGHT – CHILDREN (2-5)	352	INFECTIOUS DISEASES
115 ★	HIGH WEIGHT-FOR-LENGTH	353	FOOD ALLERGY
121 ★	SHORT STATURE/AT RISK OF SHORT STATURE	354	CELIAC DISEASE
131 ★	LOW MATERNAL WEIGHT GAIN	355	LACTOSE INTOLERANCE
132 ★	MATERNAL WEIGHT LOSS IN PREGNANCY	356	HYPOGLYCEMIA
133 ★	HIGH MATERNAL WEIGHT GAIN	357	DRUG NUTRIENT INTERACTIONS
134	FAILURE TO THRIVE	358	EATING DISORDERS
135 ★	INADEQUATE GROWTH	359	RECENT MAJOR SURGERY, TRAUMA, BURNS
141 ★	LOW BIRTH WEIGHT	360	OTHER MEDICAL CONDITIONS
142 ★	PREMATURITY	361	DEPRESSION
153 ★	LARGE FOR GESTATIONAL AGE	362	DEVELOPMENTAL, SENSORY, OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT
201 ★	LOW HEMATOCRIT/HEMOGLOBIN	363	PRE-DIABETES
301	HYPEREMESIS GRAVIDARUM	371	MATERNAL SMOKING
302	GESTATIONAL DIABETES	372	ALCOHOL OR ILLEGAL DRUG USE
303	HX GESTATIONAL DIABETES	381	ORAL HEALTH CONDITIONS
304	HX PREECLAMPSIA	382	FETAL ALCOHOL SYNDROME
311	HX PRETERM DELIVERY (≤ 37 WKS)	401	FAILURE TO MEET DIETARY GUIDELINES
312	HX LOW BIRTH WEIGHT	411	INAPPROPRIATE NUTRITION PRACTICES - INFANT
321	HX FETAL OR NEONATAL LOSS	425	INAPPROPRIATE NUTRITION PRACTICES - CHILD
331 ★	PREGNANCY – YOUNG AGE	427	INAPPROPRIATE NUTRITION PRACTICES - WOMAN
332 ★	CLOSELY SPACED PREGNANCY	428	DIET RISK ASSOC W/ COMP FEEDING PRACT
334	LACK OF OR INADEQUATE PRENATAL CARE	501	POSSIBILITY OF REGRESSION
335 ★	MULTIFETAL GESTATION	502 ★	TRANSFER OF CERTIFICATION (VOC)
336	FETAL GROWTH RESTRICTION	601	Bf MOM OF INFANT AT NUTRITIONAL RISK
337	HX BIRTH LGA INFANT	602/603	BREASTFEEDING COMPLIC. – WOMAN/INFANT
338	PREGNANT AND BREASTFEEDING	701	BORN TO WIC MOM/BORN TO POTENTIAL WIC MOM
339	HX BIRTH – CONGENITAL DEFECT	702	BF INFANT OF MOM AT NUTRITIONAL RISK
341	NUTRIENT DEFICIENCY DISEASES	801 ★	HOMELESSNESS
342	GASTROINTESTINAL DISORDER	802 ★	MIGRANCY
343	DIABETES MELLITUS	902	FEEDING SKILLS LIMITATION
344	THYROID DISORDERS	903 ★	FOSTER CARE
345	HYPERTENSION AND PREHYPERTENSION	904	EXPOSURE TO ENVIRON TOBACCO SMOKE (ETS)
346	RENAL DISEASE		

★ computer generated code

Letter of Ineligibility for WIC Participation in Idaho

Date: _____

Thank you for applying for or participating in the Idaho WIC Program. If you have participated in the Idaho WIC Program, we hope that WIC helped you and/or your family. If this is your first visit to WIC and you do not qualify, please check back with us should your situation change related to reason(s) listed below.

_____ does not qualify or will no longer receive WIC benefits from this clinic for the following reason(s) marked below:

- ❒ You/your child is categorically ineligible for WIC.
- ❒ Your family income is over the income guidelines.
  Reported household size: _____ Reported income/frequency: _____
- ❒ You are six (6) months past delivery and are not breastfeeding.
- ❒ Your child is now five (5) years old.
- ❒ You have been/are breastfeeding an infant who is now 12 months old.
- ❒ You do not live within the service area served by this agency.
- ❒ You have asked to discontinue your participation in WIC.
- ❒ You/your child does not have an identified nutritional need.
- ❒ Other: _____

If you feel that this decision is not fair, you may request a Fair Hearing by contacting the State of Idaho WIC Program at 450 W. State St., 1st Fl., Boise, Idaho 83720 or the Civil Rights Coordinator at (907) 465-3100. You must request a Fair Hearing in writing within sixty (60) days from the date on this letter. If you wish to request a Fair Hearing, we will provide you with additional details.

Local WIC Agency Name: _____

Signature of WIC Participant/Applicant/Responsible Adult: _____

Signature of WIC Staff: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1)mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3)email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Carta de Inelegibilidad para Participar en WIC en Idaho

Fecha: _____

Gracias por solicitar beneficios o por participar en el Programa WIC de Idaho. Si ha participado en el Programa WIC de Idaho, esperamos que WIC le haya sido de ayuda a usted y a su familia. Si esta es su primera visita a WIC y no califica, por favor regrese después si su situación cambia en lo que se refiere a las razones anotadas abajo.

_____ no califica o ya no recibe beneficios de WIC en esta clínica por las siguientes razones marcadas abajo:

- ❒ Usted/su hijo no es categóricamente elegible para WIC.
- ❒ El ingreso de la familia se sobrepasa de la guía de ingresos.
  El tamaño del hogar reportado: _____ El ingreso reportado/frecuencia: _____
- ❒ Ya pasaron seis (6) meses después del parto y no está amamantando.
- ❒ Su hijo ya tiene cinco (5) años de edad.
- ❒ Ha estado o está amamantando un bebé que ya tiene 12 meses de edad.
- ❒ Usted no vive dentro del área de servicio de esta agencia.
- ❒ Usted pidió no continuar participando en WIC.
- ❒ Usted/su hijo no tiene una necesidad de nutrición identificada.
- ❒ Otro: _____

Si siente que esta decisión no es justa, puede pedir una Audiencia Justa al contactar al Programa de WIC del Estado de Idaho, en 450 W. State St., 1st Fl., Boise, Idaho 83720 ó al Coordinador de Derechos Civiles al (907) 465-3100. Usted debe solicitar una audiencia justa por escrito dentro de sesenta (60) días de la fecha en esta carta. Si desea solicitar una Audiencia Justa, le daremos más detalles.

Nombre de la Agencia Local de WIC: _____

Firma del Participante/Solicitante/Adulto Responsable: _____

Firma del Personal de WIC: _____

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Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA, (AD-3027) que está disponible en línea en: http://www.ascr.usda.gov/complaint_filing_cust.html y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por: (1)correo: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2)fax: (202) 690-7442; o (3)correo electrónico: program.intake@usda.gov.

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No Proof and Temporary (Income) Certification

SECTION A – COMPLETE FOR ALL PARTICIPANTS

Responsible Adult: FID#:

Section B – TEMPORARY OR FORGOT DOCUMENTS (INCOME ONLY)

Complete if income documentation is temporarily missing, such as forgot to bring document(s). The applicant may self-declare their household's income in the space provided below. Staff must screen the applicant for income eligibility based on their self-reported income, and if they are determined eligible, may grant a 30-day certification. **Please have the Responsible Adult complete the statement below.**

☐ **TEMPORARY NO PROOF OF INCOME**

My household is comprised of _____ members and our household income totals $_____ per ☐ month ☐ year ☐ week ☐ every 2 weeks ☐ twice each month ☐ other (describe) _____.

Section C – CANNOT PROVIDE DOCUMENTS (IDENTITY, RESIDENCY OR INCOME)

Complete in limited situations if the RA/participant/applicant cannot provide required documentation. **Please have the Responsible Adult specify which document(s) is missing and describe why the required documentation is unobtainable.** *Note: Reasons must be supported by Idaho WIC Program Policy Manual, Chapter 4, Section B.*

☐ **NO PROOF OF IDENTIFICATION**

The reason I have no proof of identification is:

☐ **NO PROOF OF RESIDENCE OR ADDRESS**

The reason I have no proof of residence is:

☐ **NO PROOF OF INCOME OR INCOME DOES NOT EXIST**

The reason I have no proof of income or it does not exist is:

☐ **ZERO INCOME**

I declare the gross monthly income for myself and all the members of my family or household has been ZERO ($0.00) for the past 30 days. Our basic living needs for the past 30 days have been met by:

SHELTER:

FOOD:

Please read the following statement before signing the form.

I understand if the required proof is not brought in within 30 days, a second or following set of benefits cannot be given and my benefits will end. The information I have written above is correct. I understand I may be prosecuted under law and have to pay back what I have received if I have intentionally lied or withheld the truth.

_____ _____

Date Responsible Adult Signature

_____ _____

Date WIC Program Staff Signature

WIC is an equal opportunity provider. For the full nondiscrimination statement and contact information to file a complaint, please visit the Idaho WIC website at www.wic.dhw.idaho.gov.

Certificación Temporal y Sin Comprobantes (de Ingreso)

SECCIÓN A – COMPLETA PARA TOTOS LOS PARTICIPANTES

Adulto Responsable: FID#:

SECCIÓN B – DOCUMENTOS TEMPORALES U OLVIDADOS (SÓLO DE INGRESO)

Complete si falta temporalmente la documentación sobre el ingreso, por ejemplo, si se le olvidaron los documentos. El solicitante puede declarar el ingreso de su hogar en el espacio que se proporciona abajo. El personal debe evaluar la elegibilidad del ingreso del solicitante con base en el ingreso reportado por él mismo y, si se determina que es elegible, se le puede otorgar una certificación de 30 días. **Por favor, pida al Adulto Responsable complete la siguiente declaración.**

☐ **SIN COMPROBANTE TEMPORAL DE INGRESO**

Mi hogar consta de _____ integrantes y el total de nuestros ingresos en el hogar es de $_____ cada ☐ mes ☐ año ☐ semana ☐ cada 2 semanas ☐ dos veces al mes ☐ otro (describa) _____.

SECCIÓN C – NO PUEDE PROPORCIONAR DOCUMENTOS (IDENTIDAD, RESIDENCIA O INGRESO)

Complete en situaciones limitadas si el Adulto Responsable/participante/solicitante no puede proporcionar la documentación requerida. **Por favor, pida al Adulto responsable que especifique cuáles son los documentos que faltan y que describa por qué no se puede obtener la documentación requerida.** *Nota: Los motivos deben estar respaldados por el Manual de Políticas del Programa WIC de Idaho, Capítulo 4, Sección B.*

☐ **SIN COMPROBANTE DE IDENTIFICACIÓN**

El motivo por el que no tengo comprobante de identificación es porque:

☐ **SIN COMPROBANTE DE RESIDENCIA O DIRECCIÓN**

El motivo por el que no tengo comprobante de residencia es porque:

☐ **SIN COMPROBANTE DE INGRESO O EL INGRESO NO EXISTE**

El motivo por el que no tengo comprobante de ingreso o no existe es porque:

☐ **CERO INGRESO**

Declaro que el ingreso mensual bruto de todos los integrantes de mi familia o casa y el mío en los últimos 30 días ha sido de CERO ($0.00). Nuestras necesidades básicas de vivienda durante los últimos 30 días han sido cubiertos por:

VIVIENDA:

ALIMENTOS:

Lea la siguiente declaración antes de firmar el formato.

Entiendo que si no se presenta el comprobante requerido en 30 días, no se podrá recibir una segunda o siguiente serie de beneficios y se terminarán mis beneficios. La información arriba descrita es correcta. Entiendo que si he mentido o retenido la verdad intencionalmente puedo ser procesado de acuerdo con la ley y que debo devolver lo que he recibido.

_____ _____

Fecha Firma del adulto responsable

_____ _____

Fecha Firma del Personal del Programa WIC

USDA es un proveedor que ofrece igual dad de oportunidades. Con respecto a la declaración para no ser discriminado y la información de contacto para presenter una queja, visite la página de web de Idaho WIC a www.wic.dhw.idaho.gov.

Clinic Number

Date

Check Audit Form

Email completed Check Audit form to WIC Coordinator within 5 days of voiding checks

Participant ID Participant Name

Select the void reason used in the computer. Select from Drop Down List
(Void reason must match check history.)

List all checks that were voided when the check itself was not available.
(Check number voided must match check history.)

Check number used	Please explain why the check was voided [*Idaho WIC Program Policy Manual, Chapter 7*]. Be as detailed as possible.

Comments:

List all checks issued	**Formula intolerance**
New check number issued (must match check history)	Formula returned to WIC office? ◯ Yes ◯ No
	Number of cans of formula returned =
	Name of formula being returned =
	Number of cans of new formula issued =
	Name of new formula issued =

Staff User ID: Registered Dietitian User ID (formula intolerance)
(The User ID is the unique identifier used to log in to the WIC computer system and begins with HWC)

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FORM 213 4/2016

IDAHO WIC GROWING HEALTHY FAMILIES
SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

Medical Documentation

WIC-Eligible Nutritionals and Therapeutic Formula

WIC Clinic:

Fax #:

WIC ID #:

Medicaid is the first payer for therapeutic formulas and nutritionals. **If the patient is not on Medicaid, please complete this form for WIC authorization and return the completed form to the patient's WIC clinic.**

This documentation is federally required to ensure the patient under your care has a medical condition/diagnosis that dictates the use of therapeutic formula, nutritionals or requires changes to the WIC supplemental food package.

SECTION I—TO BE COMPLETED FOR ALL ORDERS

PATIENT (First/MI/Last): **DOB:**

PARENT/CAREGIVER (First/MIlLast):

Dx: This prescription is: ☐ new ☐ refill

SECTION II—THERAPEUTIC FORMULA/NUTRITIONALS

Section A: Must be completed by a healthcare provider.

Section B: The healthcare provider has the option to refer to a WIC Registered Dietitian (RD). If selected, The WIC RD will determine the appropriate issuance, prescribed amount and length of time required for WIC foods based on the patient's qualifying condition(s).

☐ Supplemental foods, amount and length of need to be determined per WIC RD .

A.) Formula/Nutritionals:

Product Name:

Duration: months (maximum 12 mos)

Amount: oz/day

☐ Prematurity ☐ GERD or reflux

☐ Failure to thrive ☐ Food allergy:

☐ Dysphagia ☐ Other:

Special instructions/comments:

B.) WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis .

Category	WIC Foods	Do Not Give	Restrictions / Comments
Infants (6-12 mos)	Baby cereal	☐	
	Baby fruit/vegetable	☐	
Children (1-5 yrs)	Cow's milk	☐	
	Cheese	☐	
	Eggs	☐	
	Peanut butter	☐	
	Whole grains	☐	
	Cereal	☐	
	Beans	☐	
	Vegetables / fruits	☐	
	Juice	☐	

Health Provider's Name (please print)	Location	Phone:
		Fax:

Health Care Provider's Signature

MD DO PA NP Date:

WIC USE ONLY RD review: Date:

The information above is only for use by the intended recipient and contains confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy copies of the original form. The WIC Program is an equal opportunity provider.

Medical Documentation for Women, Infants and Children (WIC)

The Medical Documentation form (on the back) is the **only** acceptable form by the Idaho WIC program needed:

- To issue an exempt infant formula or WIC-eligible nutritional
- When an infant turns six months of age
- Every 12 months for children or women
- Upon a change in amount or type of product or supplemental foods issued

Per federal regulation, Medicaid is the primary payor for exempt infant formulas and WIC-eligible nutritionals issued to WIC participants who are also Medicaid beneficiaries. Participants should contact Medicaid directly and/or the applicable staff member at the healthcare provider's office to obtain a product from a medical supply company.

For Medicaid, please refer participants or healthcare providers who need assistance to:

- https://www.idmedicaid.com/Default.aspx or DME website at www.dme.idaho.gov
- Idaho Medicaid website: http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx
- Call center telephone number: **1-866-686-4272**

The Idaho WIC program is a supplemental nutrition program. It does not provide all of the formula or nutritionals a woman, infant or child may need each month. The Idaho WIC program is part of the Western States Contracting Alliance (WSCA). This contract is a cost saving measure that allows the WIC program to serve more participants.

Contract brand infant formula is an iron-fortified milk-based, soy-based, lactose-free or added rice starch formula intended as a food substitute for human milk for healthy, term infants and produced by the manufacturer awarded the infant formula cost containment contract. Contract formulas are routinely provided to infants enrolled in the WIC program whose caregiver chooses to use formula.

Contract formulas:

- Similac Advance
- Enfamil ProSobee

Non-contract infant formula is an iron-fortified milk-based, soy-based, lactose-free or added rice starch formula that is not covered by an infant formula cost containment contract and is nutritionally comparable to a contract brand formula (noted above). **Such infant formulas are not provided by WIC and prescriptions or medical documentation for these formulas will not be accepted under any circumstances.**

Exempt infant formula is intended as a food substitute for human milk for use by infants who have inborn errors of metabolism, prematurity, low birth weight, or who otherwise have an unusual medical or dietary condition.

WIC-eligible nutritionals refers to certain enteral products that are specifically formulated to provide nutritional support for participants (women, infants or children) with a diagnosed medical condition where conventional food is precluded, restricted, or inadequate. Such WIC-eligible nutritionals must serve the purpose of a food, meal or diet (may be nutritionally complete or incomplete) and provide a source of calories and one or more nutrients; be designed for enteral digestion via an oral or tube feeding; and may not be a conventional food, drug, flavoring, or enzyme.

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This institution is an equal opportunity provider.

DIRECT BILL FOR WIC-ELIGIBLE NUTRITIONALS AND THERAPEUTIC FORMULA

This form replaces WIC checks and must be completed and signed by a WIC Registered Dietitian.

Clinic No. First Day to Use: Last Day to Use:

Responsible Adult is authorized to receive the following special nutritional supplement for

Participant Name ID # Age Category % Breastfeeding

Quantity (please specify cans, oz, 4-pk, etc.)	Full Nutrition Benefit / Maximum Monthly Allowance *(WIC RD use only)*	Therapeutic Formula / Nutritionals

Need for product must be evaluated monthly.

Registered Dietitian

Vendor Name

Address

City Zip Code

I verify that the information listed above is correct to receive and/or order special nutritional supplement(s).

Responsible Adult Signature Date

VENDOR – Please send this form with an invoice and/or register tape showing product, amount and price to:

Idaho WIC Program
Department of Health & Welfare
P.O. Box 83720
Boise, ID 83720-0036

Reimbursement will not be made unless a completed copy of this form is included with the invoice.

WIC is an equal opportunity provider. For the full nondiscrimination statement and contact information to file a complaint, please visit the Idaho WIC website at www.wic.dhw.idaho.gov.

Click to Submit

Idaho WIC Program Complaint or Incident Report
Informe de Queja u Occurido del Programa de WIC de Idaho

FORM 204 4/16

Provide as much information as possible. If the incident involves using a WIC check at a grocery store, the clinic number, participant information, and store name are all written on the check. Mail or fax this report to the State WIC Office or ask a local WIC staff person to send the report for you.

Provea lo más información posible. Si lo ocurrido envuelve la utilización de un cheque de WIC en una tienda, el número de la clínica, la información del participante, y el nombre de la tienda estarán todos escritos en el cheque. Envíe este informe por correo o fax a la oficina de WIC del estado o pida a un empleado de WIC local a mandarlo por usted.

MAIL/CORREO: WIC Program
Idaho Department of Health & Welfare
P.O. Box 83720
Boise, ID 83720-0036
FAX: 208-332-7362
EMAIL: wicvendor@dhw.idaho.gov

When did it happen? (date and time) ▪ ¿Cuándo ocurrió? (fecha y hora)

Where did it happen? (location of WIC office or specific grocery store) ▪ ¿Dónde ocurrió? (sitio de la oficina de WIC o tienda específica)

People involved: (include names or descriptions) ▪ Personas envueltas en la queja: (incluya nombres o descripciones)

Describe what happened. ▪ Describa lo que pasó.

What action do you think the WIC Program should take to resolve this? ▪ ¿Qué acción piensa usted que el programa de WIC debe tomar para resolver esto?

See next page for civil rights complaints ▪ Consulte la página siguiente de las quejas de derechos civiles

Your name is optional. Confidentiality will be protected to the extent possible investigating the complaint. ▪ Poner su nombre es opcional. La confidencia será protegida lo más posible al investigar la queja.

Name/Nombre: Phone/Teléfono:

Address/Dirección:

Name of WIC staff person this was reported to (if applicable) ▪ Nombre del empleado de WIC a quien la queja fue comunicado (si fue así):

For WIC Clinic Use

Describe action taken by local agency staff. This section is not required to be completed before sending to State WIC Office.

For State WIC Office Use

Complainant relationship to WIC: ☐ applicant ☐ participant ☐ vendor ☐ anonymous ☐ other

Nature of the complaint or incident:

Vendor related: ☐ vendor ☐ WIC customer

WIC policy (describe):

Other (describe):

Civil rights discrimination : ☐ race ☐ color ☐ national origin ☐ sex ☐ age ☐ disability

*** Civil rights discrimination complaints must be reported immediately to USDA Regional Office ***

Resolution

State Office Investigator: _____ Date: _____

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FORM WIC 155
4/16

Idaho WIC Program
Fair Hearing Request

If the clinic takes any adverse action against you, you have the right to ask for an informal meeting or formal hearing. The adverse action may result in a claim against you for repayment of the cash value of improperly issued benefits or result in denial of participation or disqualification from the program.

You may wish to contact a local legal service office to help you decide if you should ask for an informal meeting or a hearing. You may be able to receive free legal aid. Ask your local WIC clinic for referral information or dial Idaho's CareLine 211 for assistance.

When possible, you are encouraged to request an informal meeting with the local agency coordinator and/or clinic supervisor. This meeting is to try and resolve your concerns by reviewing the facts, regulations, and circumstances of the action taken. If the action taken by the local agency was wrong, it will be corrected as a result of this meeting. If you are not satisfied with the result of the informal meeting, you may proceed with the fair hearing request. An informal meeting is optional.

If the meeting with the local agency does not resolve your concerns or if you would like to proceed with a formal hearing, you must ask for the hearing within 60 days of the date the action was taken against you. Hearing requests may be made verbally or in writing and delivered or sent to the local agency or State WIC Office.

Except for participants whose certification period has expired, participants who appeal the termination of benefits within 15 days of this action shall continue to receive program benefits until the hearing officer reaches a decision or the certification period expires, whichever occurs first. Applicants who are denied benefits at initial certification may appeal the denial, but shall not receive benefits while awaiting the appeal process.

Return the Fair Hearing Request to:

Mail: **Idaho WIC Program**
P.O. Box 83720
450 West State St., 1st Floor
Boise, Idaho 83720-0036

Fax: **(208) 332-7362**

You are encouraged to keep a copy of the Fair Hearing Request for your records.You may ask the local WIC agency to make a copy for you.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1)mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3)email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Fair Hearing Request

I disagree with the Idaho WIC Program's decision concerning my application/participation as described below.

Mark the action you disagree with:

- ❒ Repayment of cash value of improperly issued benefits
- ❒ Disqualification
- ❒ Denied participation
- ❒ Other (explain):

_____

_____

_____

_____

I understand that if my certification is current and this request is made within 15 days from the date the action in question is taken, I will continue to receive WIC benefits until the hearing officer reaches a decision or my certification period has expired, whichever occurs first.

Name	**Contact Phone Number**	
Street/Mailing Address	**City**	**Zip Code**
Signature	**Date**	

FOR OFFICE USE ONLY

Date Received in WIC	Date Received at DHW Legal	Hearing Request Number

WIC is an equal opportunity provider. For the full nondiscrimination statement and contact information to file a complaint, please visit the Idaho WIC website at www.wic.dhw.idaho.gov.

Programa WIC de Idaho
Solicitud para una Audiencia Justa

Si la clínica toma una acción adversa en su contra, usted tiene el derecho de pedir una junta informal o una audiencia formal. La acción adversa puede resultar en un reclamo en su contra por reembolso del valor en efectivo de beneficios emitidos incorrectamente o puede resultar en la negación o la descalificación de su participación en el Programa.

Usted tal vez quiera contactar a la oficina local de servicio legal para ayudarle a decidir si debe pedir una junta informal o una audiencia. Tal vez pueda recibir ayuda legal gratis. Pida información en la clínica de WIC local o marque el 211 de Idaho CareLine para obtener ayuda.

Cuando sea posible, se le recomienda que pida una junta informal con el coordinador de la agencia local o con el supervisor de la clínica. Esta junta es para tratar de resolver sus preocupaciones revisando los hechos, las regulaciones y las circunstancias de la acción tomada. Si la acción tomada por la agencia local fue incorrecta, ésta será corregida como resultado de esta junta. Si usted no está satisfecho con el resultado de la junta informal, tal vez quiera proceder solicitando una audiencia justa. La junta informal es opcional.

Si la junta con la agencia local no resuelve sus preocupaciones o si le gustaría proceder con una audiencia formal, usted debe solicitar la audiencia dentro de 60 días de la fecha de la acción adversa en su contra. Las solicitudes para las audiencias pueden hacerse verbalmente o por escrito y son entregadas o enviadas a la agencia local o a la oficina estatal de WIC.

Excepto por los participantes cuyo periodo de certificación ha expirado, los participantes que apelan la terminación de beneficios dentro de 15 días de esta acción continuarán recibiendo los beneficios del programa hasta que el oficial de audiencias llegue a una decisión o el período de certificación expire, cualquiera que ocurra primero. Los solicitantes con beneficios negados al inicio de la certificación pueden apelar la negación, pero no recibirán beneficios mientras esperan el proceso de apelación.

Regrese la Solicitud para una Audiencia Justa a:

Correo: **Idaho WIC Program**
P.O. Box 83720
450 West State, 1st Floor
Boise, Idaho 83720-0036

Fax: **(208) 332-7362**

Se le recomienda que mantenga una copia para sus archivos de la Solicitud para una Audiencia Justa. Usted le puede pedir a la agencia local de WIC que le haga una copia.

El Departamento de Agricultura de los Estados Unidos (por sus siglas en inglés “USDA”) prohíbe la discriminación contra sus clientes, empleados y solicitantes de empleo por raza, color, origen nacional, edad, discapacidad, sexo, identidad de género, religión, represalias y, según corresponda, convicciones políticas, estado civil, estado familiar or paternal, orientación sexual, o si los ingresos de una persona provienen en su totalidad o en parte de un programa de asistencia pública, o información genética protegida de empleo o de cualquier programa o actividad realizada o financiada por el Departamento. (No todos los criterios prohibidos se aplicarán a todos los programas y/o actividades laborales).

Si desea presentar una queja por discriminación del programa de Derechos Civiles, complete el USDA Program Discrimination Complaint Form (formulario de quejas por discriminación del programa del USDA), que puede encontrar en internet en http://www.ascr.usda.gov/complaint_filing_cust.html, o en cualquier oficina del USDA, o llame al (866) 632-9992 para solicitar el formulario. También puede escribir una carta con toda la información solicitada en el formulario. Envíenos su formulario de queja completo o carta por correo postal a U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, por fax al (202) 690-7442 o por correo electrónico a program.intake@usda.gov.

Las personas sordas, con dificultades auditivas, o con discapacidad del habla pueden contactar al USDA por medio del Federal Relay Service (servicio federal de transmisión) al (800) 877-8339 o (800) 845-6136 (en español).

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

Solicitud para una Audiencia Justa

Yo no estoy de acuerdo con la decisión del Programa WIC de Idaho con respecto a mi solicitud/participación como se describe abajo:

Marque la acción con la cual no está de acuerdo:

- ❒ Reembolso del valor en efectivo de beneficios emitidos incorrectamente
- ❒ Descalificación
- ❒ Participación negada
- ❒ Otro (explique):

_____

_____

_____

_____

Entiendo que si mi certificación está al día y esta solicitud es hecha dentro de 15 días de cuando la acción en cuestión fue tomada, continuaré recibiendo beneficios de WIC hasta que el oficial de audiencias llegue a una decisión o hasta cuando mi período de certificación expire, cualquiera que ocurra primero.

Nombre	**Número de Teléfono de Contacto**	
Calle/Dirección de Correo	**Ciudad**	**Código Postal**
Firma	**Fecha**	

.....

PARA EL USO DE OFICINA SOLAMENTE

Fecha recibida en WIC	**Fecha Recibida en DHW Legal**	**Número de la Solicitud de la Audiencia**

USDA es un proveedor que ofrece igual dad de oportunidades. Con respecto a la declaración para no ser discriminado y la información de contacto para presenter una queja, visite la página de web de Idaho WIC a www.wic.dhw.idaho.gov.