

**WIC MANUAL
STATE OF TENNESSEE
2016 - 2017**



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Foreword

The Tennessee Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition counseling and supplemental foods that promote health as indicated by relevant nutrition science, public health concerns, and cultural eating patterns. The WIC Manual is a tool for all staff to use to keep current on policies, procedures and changes in the Tennessee WIC Program. Although the Manual provides guidance for conducting the business of WIC, it is not all-inclusive.

The purpose of this manual is to guide the Competent Professional Authority (CPA) and other staff members through registration, certification and nutrition education, to educate new staff, to give direction for WIC Food Instrument/Cash Value Voucher issuance, and to navigate the Patient, Tracking and Billing Management Information System (PTBMIS). Additionally, the manual helps to bring uniformity to WIC clinic operations.

Chapter 1 Registration

This chapter provides an overview of the process of determining eligibility for an applicant from the first telephone call of inquiry. It describes how to assess three of the four eligibility requirements – category, residency, and income. Customer satisfaction, confidentiality, and appointment scheduling are also included. Training for staff members who provide WIC services is described.

Chapter 2 Certification/Food Packages

Direction in this chapter relates to the assessment and documentation of medical and nutrition risk criteria. This chapter describes food package codes, guidance for the approval of therapeutic formulas and modification of food packages.

Chapter 3 Nutrition Education

This chapter emphasizes nutrition counseling based on the Value Enhanced Nutrition Assessment (VENA) which includes the SOAP format, Stages of Change, and documentation in the WIC Questionnaires and Records. This chapter also includes guidelines for completing the Regional Nutrition Services Plan. The nutrition education curriculum and the VENA Counseling Skills Checklist are tools in the appendix of this chapter.

Chapter 4 Vouchers

This chapter consolidates information for Food Instrument/Cash Value Voucher (FI/CVV) issuance, FI/CVV printers and cartridges, reports and disposition of voids and receipts. Separation of duties, FI/CVV accountability, and dual participation are also featured as important federally regulated functions.

Chapter 5 Systems

The WIC Data System is described in this chapter. The PTBMIS registration, WICQ and FI/ CVV issuance screens are included and referenced. The VOC command and its printing and use are outlined.

Chapter 6 Breastfeeding

This chapter highlights the department's Breastfeeding Policy and the importance of breastfeeding promotion and support. The appendix in this chapter includes forms and charts needed to counsel prenatals and the breastfeeding mother.

Chapter 7 Miscellaneous

This chapter gives guidance on WIC participant rights, participant abuse, outreach referrals, monitoring and abbreviations. It also contains listings of Central Office personnel, Regional Health Offices, County Directors and clinics by county.

Registration

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INTRODUCTION

The Tennessee WIC Program operates under the guidance of the Code of Federal Regulation¹ and Policy Statements issued by the Food and Nutrition Service of the United States Department of Agriculture. This state policy and procedure manual incorporates program requirements and is primarily intended to guide the activities of the program within the integrated services of the county health departments and its clinic operations keeping in mind the following WIC mission: “To safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.”² This manual is not intended to be all-inclusive. Therefore, if there are questions, please contact the Central Office for assistance. (See [Appendix 7-31](#)).

CUSTOMER SERVICE

Participants have a right to expect courteous and caring service when receiving or applying for WIC program benefits. Show enthusiasm for your work, smile, maintain a professional atmosphere and create a sense of equality. All staff should be warm, helpful, caring and accepting of program participants. Staff should model acceptance of different points of view, individual expression, and cultural differences. Avoid defensive behavior if participants are challenging. Demonstrate appreciation for one another and show mutual respect.

CONFIDENTIALITY

The Tennessee WIC Program has written Letters of Agreement to share participant information with certain agencies to facilitate continuation of health and social services needs of an individual. State agencies are required to restrict the use or disclosure of information obtained from program applicants and participants³. Information in the medical records of health department patients may be shared with other health department employees in the state of Tennessee, without the written authorization of the patient, patient’s parent, or guardian, for the purpose of providing or obtaining necessary medical treatment for the patient⁴. The Health Insurance Portability and Accountability Act (HIPAA) requires that all Department of Health employees complete the HIPAA awareness training and sign a “Confidentiality Statement.” All new workforce members shall complete the awareness training within a reasonable time and sign the “Confidentiality Statement” at the end of the HIPAA training session. For providing information out-of-state, the *General Consent for Health Services* ([Appendix 1-1](#)) or ([Appendix 1-3](#)) contains the release of information (Understanding #4).

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1. United States Department of Agriculture, Food and Nutrition Services, 7 CFR 246
 2. WIC Nutrition Services Standards, USDA Food and Nutrition Services 2013, Introduction pg v.
 3. United States Department of Agriculture, Food and Nutrition Services, 246.26 (d), and FNS Instruction 800-1 located in Regional offices
 4. Bureau of Health Services, Policies and Procedures Manual, Records and Forms Management Section Clinical Records Policy, 1995

SCHEDULING APPOINTMENTS

When applicants request WIC services by calling or coming to the WIC clinic, they must be given an appointment for eligibility determination within the time required by Federal Processing Standards⁵ which is within 10 calendar days for pregnant women, infants under six months, and migrants; and within 20 calendar days for all others. Clinic locations utilizing the “open access” appointment system and walk-in clinics must also follow these processing standards.

Certification and nutrition education and Food Instrument/Cash Value Voucher (FI/CVV) pickup appointments must be available to minimize obstacles to participation for students, rural residents, and employed individuals. The scheduling of appointments needs to be sensitive to the participant’s individual needs, such as late afternoon, evening, and/or Saturday.⁶

When a new prenatal who is not registered in the Patient Tracking and Billing Management Information System (PTBMIS) calls or comes into the WIC clinic to schedule an initial WIC appointment, her name, address and phone number must be recorded on the Registration Screen in PTBMIS. The PTBMIS Registration Screen will capture and retain the date of this initial request for service as is federally required. When a new prenatal who already has an established Registration Screen in PTBMIS calls or comes into the WIC clinic to schedule an appointment, the appointment will be retained in the “PA” or “PAA” screens. If a new prenatal (new to PTBMIS or established patient) misses her appointment, efforts must be made to contact her to reschedule another appointment. These efforts must be documented and on file in a log, electronically, or in the medical record.⁷

REGISTRATION AND SCREENING

Race/Ethnicity

All WIC applicants/participants must be allowed to self-declare their races and ethnicity. Participants should be allowed to declare up to 5 races and only one of two ethnicities. If the applicant/participant declines to self-identify, the staff must make a visual identification of the race and ethnicity and update PTBMIS. The posters that have been provided by Regional Office, WIC Director, or Clerical Consultant should be used in the self-declaration process. The staff must notify the applicant that the collection of race and ethnicity is solely for the purpose of determining the Department of Health’s compliance with Federal Civil Rights laws and has no effect on the application for WIC benefits.

5. United States Department of Agriculture, Food and Nutrition Services, 246.7 (f) (2)

6. United States Department of Agriculture, Food and Nutrition Services, 246.4 (a) (21) & (22).

7. United States Department of Agriculture, Food and Nutrition Services, 246.7 (b) (4) & (5).

Residency

Applicants must be residents of Tennessee and should be residents of the service area for the health department where they receive WIC benefits. While that area is typically the county of residence, applicants may be served in other counties as long as there is caseload availability and they reside within the state. Applicants may also be temporary residents (e.g., homeless, migrant farm workers, students, evacuees, and refugees) and do not have to be U.S. citizens.

Transfer of Participants

The Verification of Certification (VOC) is used to transfer the certification of WIC participants who move within a certification period. Participants who move into the state or within the state who present with a current VOC (See example in Chapter 5) must show proof of identity and residency to receive program benefits in the new location. Physical presence is **not** required at the time of transfer since physical presence for the current certification is assumed. The VOC presented at the clinic is filed in the participant's new clinic record as proof of certification.

In the case of military or Foreign Service participants, eligibility for the WIC Overseas Program will be determined at the facility where they present for certification. There is no guarantee that their duty station overseas will have a WIC Overseas Program. They must present their VOC cards for certification determination.

Accepting Transfer Participants

1. Make the entry onto the FI screen, Verification Source= VO. Print the label. In the appropriate places have the participant and the staff member sign the *General Consent for Health Services* (**Appendix 1-1**) or (**Appendix 1-3**).
2. Use Certification Code 502 for a transfer from another state when no corresponding Tennessee reason for certification exists or if the certification reason is unknown.
3. If a transfer participant's VOC from another state is incomplete, the receiving clinic is encouraged to contact the designated point of contact from the sending state to obtain the missing information. The point of contact can be found at:
<http://www.fns.usda.gov/wic/wic-contacts>.
4. A VOC, which includes the following items, will be accepted at the time of transfer:
 - Participant's name
 - Beginning and ending certification dates
 - Name and address of the certifying agency
5. Provide participants with a referral/resource list for the new county.

If a transfer from another state has unused FI/CVVs, write “void” on the FI/CVV and mail them to your Regional WIC Director. New Tennessee FI/CVVs should be issued.

If the eligibility date on the VOC has expired, or the transfer participant from out of state has no VOC, reestablish eligibility including all certification procedures. The processing standard is the same as for any other applicant. **The initial certification is the first time an applicant becomes a participant in Tennessee or when there has been at least twelve (12) months since the end of the last certification.**

If a transfer participant within Tennessee has a valid FI/CVV from a previous clinic, it is not necessary to void them and reissue new ones. Schedule the participant to return to clinic according to need for subsequent certification or nutrition education. If it has been verified that the participant does not have an FI/CVV, enter the transfer information into the computer system and issue FI/CVV. File the transfer information in the patient record.

Providing a VOC for Tennessee WIC Participants

Upon a request or knowledge that a participant is transferring to another State or another Region within Tennessee, a Verification of Certification (VOC) for each member of the household/economic unit should be printed. The name and address of the certifying agency must be included. The participant must be terminated before a VOC will print. Then type VOC at the comment line and press “Enter”. The VOC is printed on site through PTBMIS. (See Chapter 5 for an example.)

Interpreters

Based on the Federal requirement for Limited English Proficiency (LEP) and the Bureau of Health Service Administration, Limited English Proficient (LEP) persons who are eligible for federally-assisted programs or services, must “receive language assistance necessary to afford them meaningful access to public health services”⁸. Family members **cannot** be used as interpreters for participants. This policy is applicable to the TN WIC program and staff in the local health departments and regional offices.

Enrollment

Participants must be present at certification. (See exceptions noted in “Proof of Identity” section of this chapter.) Pregnant, breastfeeding, and postpartum women, infants, and children qualify for the program based on their own health risks. Infants and children can be accompanied by their parent/guardian or caregiver at the certification visit. The infant/child can also be accompanied by another adult/proxy as long as the parent/guardian has signed the General Consent for Health Services within the last 30 days. The proxy must have a signed statement from the parent/guardian giving permission to receive nutrition education and/or WIC benefits. Refer to *Proxy Permission Statement (Appendix 1-5)*.

If infants/children are left in the care of another adult (i.e., a relative, foster parent) by their parent(s) for reasons such as military duty, child abandonment, incarceration of the parent, that adult can serve as the infant’s/child’s representative to apply for WIC benefits. To complete the eligibility determination for the child/infant, the designated adult must attend the appointment, sign in all instances and be issued Food Instruments (FI). Foster parents

8. <http://hsaintranet.health.tn.gov/login.asp> (HSA Policy 7.21)

will have a “Child Placement Agreement” or a “Board Payment Receipt” which verifies placement and shows income for the foster child.

In the absence of both parents, with no established legal guardian, WIC services may be provided to the caregiver when the following information has been collected, evaluated and documented in the patient file:

- living arrangements and relationship of caregiver to child
- circumstances and duration of parents’ absence
- verification of information by a reliable source

Any notes from parents for medical treatment, powers of attorney, etc., should be copied for the file to augment the above information. If there are additional questions concerning caregiver status, more proof may be requested, vouchers for one month may be issued, or for further departmental action Central Office may be contacted.

Applicants/participants who fail to provide proof of identity, residency, or income must be given another appointment for eligibility determination within **10 days for pregnant women and infants under 6 months of age and migrants. All others** should receive another appointment **within 20 days**. The registration screen should be completed at this time (if not already completed) to insure that the initial date of the request for WIC services is captured in the Patient Tracking Business Management Information System (PTBMIS).

If applicants/participants have an unusual circumstance and are unable to provide verifications (examples: confidential teens, homeless individuals, migrants, or persons who are paid in cash and the employer refuses to give a statement), the circumstances must be documented in the patient’s record and signed by the applicant/participant.

A **proxy** is a person designated by a participant/parent/caregiver to act on her/his behalf to

- bring a participant for certification,
- receive nutrition education,
- receive food instruments/cash value vouchers (FI/CVV) and
- shop for authorized food.

During each certification period, a proxy must present a written note prior to certification and must present proof of identity when signing receipt of Food Instruments/Cash Value Vouchers. Refer to *Proxy Permission Statement (Appendix 1-5)* from the person being represented. This note is filed in the medical record. Proxies are not allowed to sign the *General Consent for Health Services (Appendix 1-1)* or *(Appendix 1-3)* at certification. Once the participant/parent/caregiver has signed the General Consent for Health Services, proxies may complete the certification or nutrition education and receive FI/CVV.

Employee Certification⁹

Any health department employee or immediate family member must have his/her application for WIC services reviewed by the Regional WIC Director or Regional Nutrition Director before FI/CVV can be issued. The definition of a relative is based on the state’s Department of Human Resources rules and includes a parent, foster parent, parent-in-law, child, spouse,

9. United States Department of Agriculture, Food and Nutrition Services, 246.4(a)(26)

brother, foster brother, sister, foster sister, grandparent, grandchild, son-in-law, brother-in-law, daughter-in-law, sister-in-law, or any other family member whether they reside in the employee's household or not or any other family member not listed who resides in the employee's household. The Regional WIC Director or Regional Nutrition Director should review the entire certification process and approve or disapprove the certification within 7 days. The employee should not print/issue food instruments or cash value vouchers to a family member unless there is no other Health Department employee who can perform this task.

ELIGIBILITY CRITERIA

Categorical Eligibility

To be eligible for WIC, an applicant must be a member of one of these categories:

Status:

- 1 - Woman who is pregnant
- 2 - Woman who is less than six months postpartum and not breastfeeding
- 3 - Woman who is breastfeeding an infant
- 4 - Infant under one year of age
- 5 - Child one to five years of age
- 6 - Fully breastfeeding woman of an infant
- 7 - Fully breastfed infant
- 9 – Partially breastfed infant
- B – Barely breastfeeding woman of an infant (BF at least once per day)

Proof of Identity

Document the type of proof on the financial information (FI) screen in PTBMIS.

Newborn infants of WIC Moms may be certified without being physically present initially; however, the infant must visit the health department within 60 days from the date of birth. Notification must be given to the parent/guardian at the time of the initial certification of the newborn stating that the infant will be suspended from the program at the end of 60 days without further benefits if failing to be physically present within the 60 days. Staff must document an exception in the patient record. Staff must track exceptions and insure that infants failing to be physically present within 60 days are suspended from the program and do not receive benefits after 60 days. Staff must document the actual date when the physical presence requirement is met in the patient's record. Infants failing to be physically present within 60 days, but later meet the physical presence requirement may be reinstated.

Exception: If a health department employee certifies an infant at the hospital and sees the infant, no visit to the health department is required until the mid-cert assessment

Participants with a documented medical condition/illness or disabilities which prevent physical presence can also be given special consideration. Staff must document the reason for the exception to physical presence in the patient's record and track the progress of the patient to being able to meet the physical presence requirement. As soon as permissible, the infant/child must meet the physical presence requirement. See Chapter 2.

Acceptable types of proof of identity include but are not limited to (PTBMIS codes are included):

- Photo ID (PI)
- Passport (PP)
- Driver's License (DL)
- Registration in local/state/fed programs (GV)
- Birth Certificate (BC)
- Crib Card (HC)
- Hospital ID Bracelet (HI)
- Hospital Birth Certificate (HB)
- Social Security Card (SS)
- Immunization Record (IM)
- TennCare or Medical Insurance Card (MI)
- VOC Card (VO)
- Voter Registration Card (VR)
- WIC Signature Card (WF) (for FI/CVV pickup if the Signature Card has been signed)
- WIC ID (WI) (for certification if label is attached)

Proof of Residency

The type of proof must be documented on the FI screen. Acceptable types of proof of residency include but are not limited to (PTBMIS codes are included):

- Official correspondence (OC)
- Rent receipt/mortgage statement (RR)
- Utility bills/receipt (UB)
- Written letter of support from a third party (LS)
- Hospital Applicant (HA)

Income Eligibility

In order to be eligible for WIC services, the gross countable income of the economic unit of which the applicant/participant is a member must be less than or equal to the current Tennessee WIC Program income guidelines for the economic unit size. Refer to *WIC Income Eligibility Guidelines* ([Appendix 1-6](#)) or ([Appendix 1-7](#)) Do not allow hardship deductions from the Income Eligibility Guidelines. A standard deduction has been included in all of the income levels.

At each certification, the gross income is determined and entered on the informed consent form. The PHOA and the applicant/participant must sign the informed consent form at each certification. Refer to *General Consent for Health Services* ([Appendix 1-1](#)) or ([Appendix 1-3](#))

Definition of an Economic Unit

For the WIC Program, an economic unit means an individual or a group of related or non-related individuals who are not residents of an institution, who are usually living together, and who share income and/or other household goods and services. The fetus of a pregnant woman is counted in determining the household size. If she is expecting twins or triplets, etc., each fetus is counted as one and the household size increases accordingly. The applicant shall be allowed to waive this increase in household size.

EXCEPTION: Residents of a homeless facility or an institution shall not all be considered as members of a single economic unit. Children at schools/institutions who are supported by parents are counted in the economic unit.

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

Related individuals who live together and who have legal responsibility for some or all of the individuals through marriage, birth, adoption, or legal guardianship/custody are considered to be a single economic unit. These economic units can consist of an expectant couple, two parents with minor children, a single parent with minor children, or a guardian with children. In some circumstances, a pregnant minor or minor mother who lives with her parents may claim that she is totally supporting herself and her infant. However, children under the age of 18 are the legal responsibility of their parents and should be considered a part of the parent's economic unit. The infant is not the legal responsibility of the grandparents and could be counted with the minor mother as an economic unit of 2 with the minor mother's income. The minor mother should be providing for the needs of the infant.

Individuals who are related and who live together, but have no legal responsibility for each other, can be considered to be a single economic unit if they consider themselves a single unit. Examples of related individuals who live together, but who have no legal responsibility for each other include: parents with adult children (18 years of age and older), grandparents who care for grandchildren, and adult siblings who live together. Single parents or couples can be assessed on their own income if they pay their own bills, but live with their parents or unrelated persons.

Non-related individuals who live together are usually not considered to be one economic unit unless they consider themselves to be a single unit. The local level must accept the statement of the applicant/participant who lives with other non-related individuals and assess income accordingly.

A foster child who lives with a foster family may be considered to be an economic unit of one as long as the legal responsibility remains with the agency. Payments made by the agency for the care of the child are considered as the income for that foster child and will be reflected on the "Board Payment" receipt.

An unmarried couple who lives together and who is pregnant or who has a common child/
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children is considered to be an economic unit. The economic unit size consists of the unmarried couple, the common child/children and any other individual living with the unmarried couple for whom either or both have legal responsibility.

Military children in the temporary care of friends or relatives offer several options.

1. Count the absent parents and their children as an economic unit.
2. Count the children as a separate economic unit. This unit must have its own income.
3. Consider the children as part of the economic unit where they are living.

Sample questions for determining household/economic unit size: Do you pay rent? Do you pay for your own food? Do you pay room and board? Do you buy your own clothes, baby diapers, etc.? Do you pay for your own transportation expenses? Do you pay your own medical bills?

Income—General Principles¹⁰

Income means

- Gross cash income before deductions for income taxes, social security taxes, insurance premiums, bonds, etc.
- Any money received (child support, alimony) or withdrawn from any source (savings, pensions, retirement income)
- All income earned or received by the applicant/participant's economic unit (must be considered in determining income eligibility for the WIC program)

The economic unit's gross income may not be reduced for hardships, daycare payments, alimony payments, child support payments, or other deductions.

EXCEPTIONS:

- Unemployed persons must have income determined on rate of income during unemployment/unemployment compensation.
- The net income is the basis for income eligibility for self-employed individuals. (Net income equals the total amount of money made minus business operating expenses.) This information will be shown on IRS form "Schedule C" and also on Form 1040.

Any pregnant woman should have the application for TennCare presumptive eligibility completed. Women determined to be presumptively eligible for TennCare must have the TennCare eligibility confirmed within 60 days of certification. FI/ CVV should be printed for only 2 months in this case. If, at the 60 day evaluation, the pregnant woman has been denied TennCare or has not completed the TennCare process, her income must be assessed to determine if she is eligible to continue receiving WIC benefits. Change FI screen in PTBMIS to indicate the verification source before FI/ CVV issuance.

If the applicant/participant is adjunctively eligible for Medicaid, Supplemental Nutrition Assistance Program (SNAP), or Families First, **no additional income screening is necessary**. In order to save time, check first for adjunctive income eligibility at the beginning of every certification. Proof of adjunctive eligibility must be confirmed at the time of application, except as defined above for the presumptive prenatal. If adjunctively eligible

10. . SFP Regional Letter #140-50; FNS WIC Policy Memo 2011-7

and income is needed for fee-for-service sliding scale, enter the income amount that the applicant/participant states.

The applicant/participant, including the parent, legal guardian, or foster care agency responsible for an infant or child, is responsible for giving information necessary to determine WIC income eligibility. Income is verified and computed by PTBMIS on a standard month basis.

In determining income eligibility, income must be received or be reasonably anticipated for future months by the economic unit. This means that the economic unit's current monthly income is the basis for the income eligibility determination. If the applicant/participant is employed then the income eligibility is based on current gross earnings. If unemployed or on strike, income eligibility is based on the current income from unemployment compensation, public assistance, or strikers' benefits.

The gross income entered into PTBMIS for each member of the economic unit and the total amount are calculated by PTBMIS. As with all income calculations, the system compares the income with the current income guidelines to determine income eligibility.

The **“Letter of Support”** should only be **used as a last resort** or when no other proof of income is available. It is appropriate for persons who cannot obtain an income statement and, possibly, for a teen who lives outside her own family. Each case must be looked at on its own basis to determine if the letter of support is appropriate.

At all subsequent WIC appointments, participants/parents/caregivers must be asked, **“Has there been an increase in your household income since the last time you were here for WIC?”** If the answer to the question is “No”, proceed with the needed service.¹¹

If the income has increased, staff should check the proof of income with the income guidelines for the economic unit to determine if the additional income makes the participant ineligible. If so, print the “IVL” label attach it to the informed consent and obtain signatures. Check to see if the participant has least 15 days worth of FI/CVV and complete the Notification of Ineligibility (NOI). Refer to *Notification of Ineligibility (Appendix 1-8)*. Follow the NOI procedures described in the latter part of this chapter. If the participant has at least 15 days worth of FI and a CVV, simply complete the NOI form. If not, print one (1) FI for the half month and one (1) CVV. Notify the participant that he/she is over income (>185% of Federal poverty) and remind the participant to come back for a redetermination of eligibility if the income changes.

Special Income Situations

Migrants in stream are automatically income eligible based on previous income certification. Migrants will not be required to show proof of income until the next certification period. The income of the instream migrant farm worker must be determined at least once every 12 months. The date of the last income screening must be recorded and on file by VOC or the medical record. Enter “VO” on the FI screen in the verification source field.

A self-employed person's income, including farmers and seasonally employed persons should be evaluated using the current or annual income to determine which indicator more

11. . United States Department of Agriculture, Food and Nutrition Services, 246.7 (h)

accurately reflects the household economic unit status (current income is defined as income received by the household during the month prior to application).

Proof of Income

All applicants/participants should be assessed for adjunctive eligibility first. Refer to the TennCare system for eligibility history, for eligibility timeframe, and for the appropriate code to enter onto the FI screen in PTBMIS. The following are **adjunctively** income eligible:

- TennCare (Medicaid) recipients eligible at Department of Human Services (DHS)
- Presumptive eligibility for pregnant women is good for 60 days, for WIC purposes.
- Newborn infants using their mother's TennCare code
- SNAP (Food Stamps) and DHS/Families First recipients and members of their household (with current notice of disposition)
- Family member of pregnant woman or infant certified eligible for Families First or TennCare (Medicaid)

For TennCare eligibles, enter the correct Medicaid code from the TennCare system in the spaces provided for the Verification Source. Verbal declaration of income and zero (0) income are not acceptable for determining WIC income eligibility.

The type of proof must be documented on the FI screen.

Acceptable types of proof include but are not limited to (PTBMIS codes are included):

- Medicaid eligible (refer to the appropriate TennCare screen for correct code)
- Check stub/employer (CS) (within 30 days or last one if unemployed)
- Employer Income statement (EM)
- Employment Security statement (ES)
- SNAP (Food Stamps) benefit statement (no EBT cards) (FS)
- Bank statement (BS) with current transactions
- Hospital Applicant (HA)
- Copy of Court Order (CO)
- Investment statement (IN)
- Social Security Supplemental Income Statement (SI)
- Social Security benefit statement (SS)
- Families First benefit statement (GL)
- Veterans Benefit statement (VA)
- VOC Card (VO)
- Government Program Award Letter (GL) (includes unemployment compensation)
- Previous year tax return with W-2 form(s) (TX) (if self-employed and no other source of income)
- Written letter of support from a third party (LS) **(The letter from the third party must contain sufficient information to accurately determine an individual's household income status or describe why documentation is not available. It should be used if no other information is available.)**

The following must NOT be considered as income:

- Payments to VISTA volunteers and volunteers in other Federal Programs
- Funds received from federal grants or scholarships or loans or college work study for students who attend at least half-time¹² Costs related to higher education tuition, books, supplies, and transportation
- Childcare paid to Families First recipients who are working or participating in approved education or training programs
- Military housing allowance and other military payments (see below)
- Value of school lunch and SNAP benefits.

Military Income Codes and Guidelines¹³

According to Public Law 111-80, combat pay is defined as an additional payment that is received by a household member who is deployed to a designated combat zone. Combat pay is excluded if it is:

- Received in addition to the service member's basic pay;
- Received as a result of the service member's deployment to or service in an area that has been designated as a combat zone; and
- Not received by the service member prior to his/her deployment to or service in the designated combat zone.

Combat pay is defined as an additional payment that is received by a household member who is deployed to a designated combat zone¹⁴. Combat pay received by the service member is normally reflected in the entitlements column of the military Leave and Earnings Statement (LES). Local WIC clinics should count service members, while deployed, as household members for purposes of determining income eligibility for the WIC Program.

BAH	Basic Housing	Do not count
	Combat Pay	Do not count
FSSA	Family Supplemental Allow.	Do not count
REBATE	Rebate	Do not count
TLA	Temp. Lodging Allowance	Do not count
FSH	Family Separate Housing	Do not count
OLA	Overseas Living Allowance	Do not count

12. . .United States Department of Agriculture, Food and Nutrition Services, 246.7 (d) (iv)

13. . . United States Department of Agriculture, Food and Nutrition Services, 246.7 (d) (iv)

14. . . Public Law 111-80.

To be counted as a part of the gross income:

- COLA Cost of Living Allowance
- BAS Separate Rations
- BASE Base Pay
- CLOTHING Clothing Allowance (divide by 12)
- FLPP Foreign Language Proficiency Pay
- FLY Fly Pay
- FSA Family Separation Allowance
- SDAP Special Duty Assignment Pay
- SEB Service Member Enlistment Bonus (divide by 12)
- SEP Separation Pay
- SPEC Special Forces
- SRB Std. Reenlistment Bonus (divide by 12)
- TDY Temporary Duty
- SAVE Foreign Duty Pay
- CMAI Civ. Clothing Maintenance Allowance (divide by 12)
- UEA One Time Clothing Allowance (divide by 12)
- CEFIP Career Enlisted Flyer Incentive Pay
- GI BILL Veteran's Educational Assistance Program
- SBP Military Survivor Benefits Plan Career Sea Pay

Informed Consent/Signature Sheet

The form, *General Consent for Health Services* ([Appendix 1-1](#)) or ([Appendix 1-3](#)), should be completed at each WIC certification visit. After the financial information (FI) screen is completed and updated, the command IVL (Income Verification Label) will print a label. This label contains information from various screens. The patient can see that the information they provided was accurately put into PTBMIS. Information that will print on the label includes the patient #, name, effective date, DOB, income, household (economic unit) size, proofs of residency, income, and identity.

The label should be affixed to the first available space on the General Consent/Signature Sheet. A form must be completed for each new patient. The patient should be instructed to read the back of the General Consent form. Once they have read it, the health department personnel should ask if there are any questions about what has been read.

If there are no questions, or, once their questions are answered, they should sign underneath the label. The signature verifies that the information on the label is correct and that they have read, understand and agree with all of the information on the back. The Health Department personnel attending them should then sign and put her/his title on the line below the participant signature.

Financial Information (FI) Screen

The FI Screen must be completed for each WIC certification. It should be completed in accordance with instructions in the PTBMIS User Manual; however, the following fields are required for WIC certification: Number in Economic Unit; Proof of Residency; Proof of Identity; Verification Source of Income; and Gross Income amount.

Notification of Ineligibility

If the applicant is ineligible, fill out the most recent version of the Notification of Ineligibility (NOI) *Refer to Notification of Ineligibility, (Appendix 1-8)*. A completed NOI and the right to a fair hearing must be given to all persons who enter the health department to apply for WIC and are found ineligible. An NOI is also given to all persons who become ineligible after receiving program benefits. An NOI is not required for participants who drop out of the program.

The person's name, date, the reason for ineligibility, effective date, signature, and signature of authorized WIC personnel are recorded in duplicate on the NOI. The original is given to the applicant/participant. The second copy is filed in the applicant/participant's health record or a separate SDI (Screened and Determined Ineligible) file in the clinic.

If the participant is determined to be income ineligible during the certification period, staff must provide a 15-day written notification of the reason for ineligibility. Refer to *Notification of Ineligibility (Appendix 1-8)*, and at least 15 days worth of benefits (one [1] FI and one [1] CVV).

WAITING LIST GUIDELINES

As long as adequate federal funds are available, Tennessee WIC Program intends to serve all eligible applicants. If funds become inadequate to meet increasing caseload, all applicants may not be given WIC benefits. In this case, after approval by USDA, a waiting list will be developed to maintain a list of persons interested in the program from which those in the highest priorities can be selected to participate.

In the event that Central Office determines that waiting lists are necessary, and after approval from USDA, Central Office will notify the regional administrators and provide additional guidance to the regions to share with clinics. The following procedures are provided to ensure fair and consistent access statewide to WIC benefits by persons with the greatest need, according to the Federal WIC priority system.

Creating a Waiting List

When notified by the Regional Office that a waiting list is necessary, the clinic must follow these procedures:

A clinic staff member should explain to the applicant the possibility of being placed on the waiting list, why placement on the waiting list is necessary and what it means in terms of realistic possibilities of receiving benefits. The clinic staff member may not refuse to place any applicant on a waiting list if the applicant requests to be placed on such a list. Referral to other health/social services is made where appropriate. Telephone requests for placement on the waiting list are not accepted.

Screening Applicants

The following information is collected or verified on the registration screen:

- Applicant name
- Address
- Telephone number (cell phone and home phone)
- Date of Birth
- Proof of Identity
- Proof of Income
- Proof of Residency

Screen the applicant for category status and for anthropometric, biochemical, and physical/medical problems. A nutrition assessment determines the individual's reason for certification which dictates the individual's priority. All of the certification data (and the Special Data Fields for Women and Infants) should be entered into the WICQ screen of the PTBMIS and the screen updated. The system will then calculate the "Priority" based upon the WIC Status and the certification reasons. If the priority is being served, FI/CVV's are issued. If the priority is not being served, place the applicant on the waiting list according to her/his priority in chronological order of application.

The following Priority System will determine who will get WIC benefits first when more people can be served. The purpose of the priority system is to make sure that WIC services and benefits are provided first to participants with the most serious health conditions.

Priority I: With Serious Medical Problems (such as anemia, underweight, history of poor pregnancy):

- Pregnant Women
- Breastfeeding Women
- Infants

Priority II: Moms had serious medical problems

- Infants (up to 6 months of age) whose mothers participated in WIC or could have participated and had serious medical problems.

Priority III: With Serious Medical Problems

- Children

Priority IV: With Dietary Problems (like poor diet)

- Pregnant Women
- Breastfeeding Women
- Infants

Priority V: With Dietary Problems

- Children

Priority VI: Any Nutritional Risk

- Postpartum Women

Priority VII

- Current WIC participants who without providing the WIC supplemental foods could continue to have medical and dietary problems.
- Homeless and migrant participants

Current Participants

Current participants should never be disqualified from participation unless: (1) they are no longer categorically or income eligible; (2) they no longer live in the service area; or (3) the State experiences funding shortages that require it to decrease or cut its actual existing current participating caseload. At no point should participants be removed from the program to accommodate new applicants during a valid certification period. The competent professional authority shall fill vacancies which occur after the clinic has reached its maximum participation level by applying the participant priority system to persons on the clinic's waiting list.

Placing Applicant on Waiting List

If the applicant is placed on the waiting list, print a label and place it on the copy of the most current version of the NOI. Refer to *Notification of Ineligibility*, ([Appendix 1-8](#)). Check “___Applicant is being placed on a waiting list.” Add the following:

- Address
- Telephone number (cell phone and home phone)
- Status and priority
- Date of Application

Organization of the Waiting List

The NOI's must be organized by priority and within each priority by the date the applicants are placed on the waiting list.

Selection from Waiting List to Receive Benefits

- Transfers: Out of state transfers who are within their certification period and have a valid VOC or in-state transfers within their certification period will be reviewed to determine reason for certification and priority. If the priority is being served, FI/CVV's are issued. If the priority is not being served, place the participant on the waiting list ahead of any other applicant in the appropriate priority. This participant must be served before all non-transferring applicants. If a participant's certification has expired prior to recall from the waiting list, the participant can reapply for WIC benefits if still categorically eligible.
- Contact the highest priority person(s) from the waiting list with the earliest date of screening for certification to inform them they may pick up FI/CVV's. Revalidate all information that was required for certification.
- If certification period has elapsed and if applicant/participant is still categorically eligible, set up a certification appointment to determine program eligibility.

TENNESSEE WIC STAFF TRAINING

WIC Staff E Learning provides recent and up-to-date trainings available to Tennessee Department of Health staff members who provide WIC services. The purpose of this training is to introduce the Tennessee WIC Program and to explain its goals and objectives to staff members who provide WIC services in health departments across the state. The training is intended as an orientation for new staff members and for staff members seeking a refresher of the material. Staff members who provide WIC services are Public Health Office Assistants (PHOA), Nursing Assistants (NA), Breastfeeding Counselors, Breastfeeding Peer Counselors, Vendor Representatives as well as Nutritionists, Nutrition Educators, and Registered Nurses who are recognized as Competent Professional Authorities (CPAs).

Of great importance is the capability to demonstrate a competency-based training which is defined as: “The delivery, assessment and certification of training as it relates to the demonstration of attained knowledge and skills and their application. Importance is placed on an individual’s demonstration of learned skills, rather than how much time is spent in training or the amount of knowledge acquired in a formal setting. Competency-based training is outcome-oriented.”¹⁵

Goals and Objectives

This training is designed for self-study, practice, observation and evaluation within the staff member’s respective work environment. Each of the modules consists of educational content, an associated test or quiz, and activities to be completed in the WIC clinics with the approval of a preceptor or supervisor. Complementary modules are provided by WIC Learning Online (WIC Works Resource System) and by *Using Loving Support to Grow and Glow in WIC*.

The goals of this training are:

- To ensure that staff members will adhere to and support the mission of the Tennessee WIC Program.
- To train staff members to provide competent service of high quality to WIC participants.
- To provide cognitive knowledge and practical experience essential to competent role functions.
- To standardize the training of new Staff Members so that services across the state are consistent.

The objectives of this training are that

After completing the modules, staff members will be able to:

- Demonstrate competency in all required curriculum and practicum fields, as documented by their preceptor or supervisor.
- Demonstrate communication skills and cultural sensitivity.
- Promote and support breastfeeding as the normal method of infant nutrition.

15. WIC Nutrition Services Standards, USDA Food and Nutrition Services 2013, pg 68.

State Approved Training

The WIC State Central Office

- Registers all new staff members in WIC Online Training (**Appendix 1-9**)
- Develops and provides training courses and modules
- Provides ongoing modifications to online modules to stay current with the Tennessee WIC Policy and Procedure Manual
- Provides technical assistance and reports as requested

Training provided to all WIC Staff:

The following training is provided to all WIC staff members (CPAs and WIC support staff) and includes, but is not limited to, the following:

- Customer Services (provided by TN Dept of Human Resources)
- Nutrition and Breastfeeding Promotion and Support (Using Loving Support to Grow and Glow in WIC)
- Multicultural Awareness (Civil Rights ELearning)

Minimum Training Requirements for Staff Training:

- Following the completion of each on-line module, the staff member must take a quiz to demonstrate a grasp of the information. Upon successful completion of the quiz, a skills checklist must be followed to demonstrate competency. This must be observed and signed by the preceptor or supervisor.
- Documentation of the successful completion of all training developed by the State WIC office should be filed at the regional office or clinic.

WIC Preceptor or Supervisor Roles and Responsibilities:

The Tennessee WIC Online Training Program is delivered in a web-based format. In order to ensure that staff members have mastered the skills taught in this program, a preceptor or supervisor (person distinguished as a specialist in the area who has practical experience and training) is required for all self-paced modules. This practical experience under supervision is an essential training component.

The WIC preceptor or supervisor for modules that are to be completed by all staff members must be either:

- A Registered Dietitian, Registered Nurse, Regional WIC Director, County Health Department Director, or County PHOA Supervisor AND have
- A minimum of six months experience in a WIC Program

The WIC preceptor or supervisor for modules that are to be completed by Staff Members who are CPAs must be either:

- A Registered Dietitian or a Registered Nurse AND have
- A minimum of six months experience in a WIC Program

A preceptor or supervisor should be identified for each staff member in training at the beginning of his or her training program. Other qualified staff may assist in the training process. For example, a CPA who has expertise in therapeutic formula requests may assist in that portion of the training but ultimately the preceptor or supervisor will be responsible for final observations, signing off and ensuring that the staff member in training has mastered all skills necessary for working as a WIC CPA.

WIC Nutrition Standards for Training the WIC CPA:

“State and local agencies ensure that staff providing nutrition services complete a WIC State-approved training program.”¹⁶ Tennessee is in the process of developing modules to meet the following standards for training CPAs.

“Training curriculum and materials include, but are not limited to:

Principles of life-cycle nutrition, including issues specific to maternal and child nutrition

Nutrition assessment and procedures

Anthropometric and Hematological data collection

Communication/rapport building

Multicultural awareness

Critical thinking

Positive counseling approaches

Nutrition risk determination

Food package Prescriptions and individual nutrition tailoring

- Appropriate referrals
- Breastfeeding promotion and support
- The need for an individual care plan and its development for low-risk and high risk participants
- Participant-centered services (VENA) and customer service practices
- Food Safety
- Immunization and lead screening and referral
- Documentation skills (Demonstration and documentation that knowledge and performance skills have been met.)”¹⁷

Continuing Education Training and CPA Long-Term Competency Evaluation

Each year, WIC CPAs are given required or needed continuing education hours to support the WIC CPA roles and responsibilities. WIC CPAs’ continuing education training provided by the regional offices is documented. The State encourages the regional offices to provide in-services or other training tools for WIC CPAs to obtain these hours for education. Some ideas for continuing education include staff in-service trainings, conferences, and webinars.

Additional Evaluation Plan for CPAs

“The *VENA Counseling Skills Checklist*, ([Appendix 3-9](#)), is to be used as a tool to evaluate CPAs who certify and provide nutrition education to WIC participants. Completing this checklist reveals staff knowledge of the VENA Competencies and dictates additional training that may be needed. The checklist is to be completed at a minimum once per year, but as many times as needed to correct skills that need improving. This process is to be completed by the Nutrition Director or his/her designee. During the regional reviews, observations of the CPA’s counseling process will be observed by the Clinic Monitoring Specialist. ([Appendix 3-9](#))

16. . USDA, 7 CFR 246.11 (c)(2)

17. . WIC Nutrition Services Standards, USDA Food and Nutrition Services 2013, pg 25

Tennessee WIC Training Program Procedures

As new staff members are oriented to the WIC program, the Regional WIC Director sends them a registration form to enroll in the Tennessee WIC E Learning Program. (See Registration Form, (**Appendix 1-9**) The new employee completes the form and sends to Sherrie Patton in the WIC Central Office. The data is then sent to Tim Gill who registers them into the system. An email is sent from Tim to change their password. The system enrolls them in modules according to their job function. The modules available to their job function are listed on their Adobe Connect Home Page. They are then able to access the modules on demand and begin training. As staff members leave the WIC program, the Regional WIC Director alerts Central Office so that they may be removed from E Learning.

WIC Staff Orientation

- WIC 101 (WIC Learning Online/WIC Works Resource System)
- Save the Children – the story of WIC (Find on Youtube)
- Reaching Participants through WIC (WIC Learning Online/WIC Works Resource System)
- Civil Rights (TN WIC E Learning Module)

Nutrition Assessment (See Chapter 2)

- Certification and Assessment (TN WIC E Learning Module)
3 modules – Children, Women and Infants
- WIC Food Package (TN WIC E Learning Module)
4 modules – Children, Women, Infants and Therapeutic Food Packages

Nutrition Education and Counseling (See Chapter 3)

- Counseling Skills (WIC Learning Online/WIC Works Resource System)
- Communicating with Participants (WIC Learning Online/WIC Works Resource System)
- Reaching Participants through WIC (WIC Learning Online/WIC Works Resource System)
- Value Enhanced Nutrition Assessment (WIC Learning Online/WIC Works Resource System)
- Food Allergies (TN WIC E Learning Module)

Breastfeeding (See Chapter 6)

- WIC Breastfeeding Basics(WIC Learning Online/WIC Works Resource System)

Using Loving Support to Grow and Glow in WIC

- How WIC Supports Breastfeeding
- Feelings about Breastfeeding
- Communicating with WIC Families about Breastfeeding
- Barriers to Breastfeeding
- Promoting and Encouraging Exclusive Breastfeeding
- Promoting Breastfeeding during Pregnancy
- Providing Support for New Breastfeeding Moms
- Helping Mothers Continue the Breastfeeding Relationship
- Talking with Mothers about Breastfeeding when Mothers and Baby are Separated
- Solutions for Common Breastfeeding Problems

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GENERAL CONSENT FOR HEALTH SERVICES



TENNESSEE DEPARTMENT OF HEALTH INFORMED CONSENT/SIGNATURE SHEET

LABEL HERE	LABEL HERE
I have read, understand, and agree with the statements on the back. Participant Signature Here	I have read, understand, and agree with the statements on the back. Participant Signature Here
Health Dept. Employee (Signature/Title)	Health Dept. Employee (Signature/Title)
LABEL HERE	LABEL HERE
I have read, understand, and agree with the statements on the back. Participant Signature Here	I have read, understand, and agree with the statements on the back. Participant Signature Here
Health Dept. Employee (Signature/Title)	Health Dept. Employee (Signature/Title)
LABEL HERE	LABEL HERE
I have read, understand, and agree with the statements on the back. Participant Signature Here	I have read, understand, and agree with the statements on the back. Participant Signature Here
Health Dept. Employee (Signature/Title)	Health Dept. Employee (Signature/Title)
LABEL HERE	LABEL HERE
I have read, understand, and agree with the statements on the back. Participant Signature Here	I have read, understand, and agree with the statements on the back. Participant Signature Here
Health Dept. Employee (Signature/Title)	Health Dept. Employee (Signature/Title)

GENERAL CONSENT FOR HEALTH SERVICES

By my signature as patient, parent, or legal guardian, I freely give consent for the receipt of health services provided by the staff of the Tennessee Department of Health. I do not have to use any other health department services in order to receive Family Planning services.

PATIENTS WITH HEALTH INSURANCE

By presenting my health insurance information as payment for medical services, I understand that the Health Department will release necessary information to process insurance claims and to request payment of benefits to the provider.

If I do not want specific medical services billed to my health insurance company, I must state that in writing at the Health Department.

REQUIRED TO BE READ BY OR TO WIC/CSFP/SFMNP PARTICIPANTS

1. I understand that the Supplemental Nutrition Programs (Women, Infants, and Children “WIC”, Commodity Supplemental Foods “CSFP”, and Senior Farmers Market Nutrition Program “SFMNP”) provide nutrition education, food and collect medical data. As a parent or guardian, I hereby authorize the Department of Health professional to perform medical screening procedures on me or my child, including height, weight, hemoglobin, physical, medical history and evaluation procedures, and I authorize the use of the medical data collected as permitted by law. I understand that immunization information will be sent to the State Immunization Registry and to the State Immunization Program.
2. I have been advised of my rights and obligations under the Program. I certify that the information I have provided for my eligibility determination is correct and 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.
3. Receiving WIC vouchers from two different locations during the same period of time is considered abuse of the program. I realize that if I am found to be receiving foods from two WIC locations at the same time, my benefits will stop immediately. I may still receive assistance from SNAP and quarterly distributions of commodities from other agencies (excluding WIC and TEFAP) for which I am eligible.
4. I understand that if I sell or attempt to sell my formula or other WIC foods verbally, in print, or through online selling sites such as Craigslist, Facebook, Twitter, Varagesale or any other online site or selling/trading post, it will be considered fraud and abuse of the program.
5. I authorize the Supplemental Nutrition Program to release this information to federal and state agencies who administer assistance programs, for the purpose of determining my and/or my child’s eligibility for their services.
6. I understand that standards for eligibility and participation in the WIC/CSFP/Senior Farmers Market Nutrition Program are the same for everyone regardless of race, color, national origin, age, disability and sex and that in accordance with federal law and the U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of the above reasons. I may request a fair hearing on any decision made regarding eligibility for the Program.

I understand that my signature on the reverse side of this form indicates that I have read and understand, or have had the above information read and explained to me.

This institution is an equal opportunity provider.

GENERAL CONSENT FOR HEALTH SERVICES SPANISH

HOJA DE FIRMA DEL CONSENTIMIENTO INFORMADO DEL DEPARTAMENT DE SALUD DE TENNESSEE

 COLOQUE LA ETIQUETA AQUÍ	COLOQUE LA ETIQUETA AQUÍ
He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí	He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí
Empleado del Departamento de Salud (Firma/Título)	Empleado del Departamento de Salud (Firma/Título)
COLOQUE LA ETIQUETA AQUÍ	COLOQUE LA ETIQUETA AQUÍ
He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí	He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí
Empleado del Departamento de Salud (Firma/Título)	Empleado del Departamento de Salud (Firma/Título)
COLOQUE LA ETIQUETA AQUÍ	COLOQUE LA ETIQUETA AQUÍ
He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí	He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí
Empleado del Departamento de Salud (Firma/Título)	Empleado del Departamento de Salud (Firma/Título)
COLOQUE LA ETIQUETA AQUÍ	COLOQUE LA ETIQUETA AQUÍ
He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí	He leído, entiendo y estoy de acuerdo con las declaraciones en el reverso. Firma del Participante Aquí
Empleado del Departamento de Salud (Firma/Título)	Empleado del Departamento de Salud (Firma/Título)

CONSENTIMIENTO GENERAL PARA SERVICIOS DE SALUD

Mediante mi firma abajo como paciente, padre, madre, o tutor legal, yo voluntariamente doy mi consentimiento para recibir servicios de salud proporcionados por el personal del Departamento de Salud de Tennessee. No tengo que usar ningún otro servicio del departamento de salud para recibir servicios del Planificación Familiar.

PACIENTES CON SEGURO DE SALUD

Mediante la presentación de la información de mi seguro de salud como pago de servicios médicos, yo entiendo que el Departamento de Salud divulgará información necesaria para procesar reclamaciones de seguro y para pedir pago de beneficios al proveedor

Si no quiero que se facturen servicios médicos específicos a mi compañía de seguro de salud, tengo que declarar esto por escrito en el Departamento de Salud.

OBLIGACIÓN PARA SER LEÍDO POR O A LOS PARTICIPANTES DE WIC/CSFP/SFMNP

1. Entiendo que los Programas de Nutrición Suplementaria (Mujeres, Bebés, y Niños; Women, Infants, and Children “WIC”, Alimentos Suplementarios de Cómodo; Commodity Supplemental Foods “CSFP”, y el Programa de Nutrición del Mercado de Agricultores para Aquellos de la Tercera Edad; Senior Farmers Market Nutrition Program “SFMNP”) proporcionan educación de nutrición, alimentos, y recaudan datos médicos. Como padre, madre, o tutor legal, por el presente autorizo que un profesional del Departamento de Salud realice los procedimientos de despistajes médicos a mí o a mi hijo, incluyendo altura, peso, hemoglobina, exámen físico, historial médico y procedimientos de evaluación, y autorizo el uso de los datos médicos recaudados como sea permitido por la ley. Entiendo que la información de inmunizaciones se le enviará al Registro de Inmunizaciones del Estado y al Programa de Inmunizaciones del Estado.
2. Se me ha notificado de mis derechos y obligaciones bajo el Programa. Certifico que la información que he proporcionado para la determinación de mi elegibilidad es correcta y a mi mejor entender. Este formulario de certificación se está presentando en conexión con la entrega de asistencia federal. Los oficiales del programa pueden verificar la información en este formulario. Entiendo que hacer intencionalmente una declaración falsa o engañosa, o falsificar, ocultar, o retener intencionalmente hechos puede resultar que pague a la agencia del estado, el valor de beneficios de alimentos emitidos indebidamente a mí y puede someterme a acusación civil o criminal bajo la ley estatal y federal.
3. El recibir los cupones de WIC de dos ubicaciones diferentes durante el mismo período de tiempo se considera un abuso del programa. Me doy cuenta de que si se determina que yo recibo alimentos de dos ubicaciones de WIC diferentes al mismo tiempo, mis beneficios terminarán inmediatamente. Es posible que todavía reciba asistencia de SNAP y distribuciones trimestrales de alimentos de otras agencias (excluyendo WIC y TEFAP) para el cual soy elegible.
4. Entiendo que si vendo o intento vender mi fórmula de leche u otros alimentos de WIC verbalmente, por escrito, o mediante sitios de web para vender, tales como Craigslist, Facebook, Twitter, Varagesale o cualquier otro sitio de web o lugar de vender/intercambiar, se considerará como fraude y abuso del programa
5. Autorizo al Programa de Nutrición Suplementaria a que divulgue esta información a las agencias federales y estatales que suministran programas de asistencia para el fin de determinar mi elegibilidad y/o la elegibilidad de mi hijo(a) para sus servicios.
6. Entiendo que los estándares de elegibilidad y participación en el WIC / PESC / Programa de Nutrición del Mercado de Agricultores para Aquellos de la Tercera Edad son los mismos para todos, independientemente de su raza, color, nacionalidad de origen, edad, discapacidad y sexo y que, de conformidad con las leyes federales y la política del Departamento de Agricultura de los EE.UU., esta institución prohíbe la discriminación en base a la base de las razones anteriores. Puedo solicitar una audiencia justa en cualquier decisión tomada con respecto a la elegibilidad para el programa.

Entiendo que mi firma en el reverso de este formulario indica que he leído y entiendo, o he tenido la información anterior leído a mí y se me explicó.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

PROXY PERMISSION STATEMENT



PROXY PERMISSION STATEMENT/ DECLARACIÓN DE PERMISO DE UN REPRESENTANTE

I give permission to/ Yo autorizo a _____ to sign for me/ a firmar por mí,
Proxy Name/ Nombre del representante

or to act for/ o a que actúe en nombre de _____
WIC Participant or Caregiver/ Nombre del participante de WIC o guardián

for the following reasons/ en las siguientes situaciones:

- _____ *WIC vouchers/ Cheques de WIC*
- _____ *Shots/ Vacunas*
- _____ *Other medical care/ Otro cuidado médico*

_____ *Mid-certification Income Verification/ Comprobante de ingresos para mediados de certificación*

- _____ *My income has not changed/ Mis ingresos no han cambiado*
- _____ *My income has changed. I am sending proof of income or check stub. /Mis ingresos han cambiado y estoy mandando comprobante de ingresos o talón de cheque.*

Signed/ Firma _____

Date / Fecha _____

This institution is an equal opportunity provider.
Esta institución es un proveedor que ofrece igualdad de oportunidades.

Tennessee Department of Health
PH- 3462 ED# 1000051866
Rev. 07/16

RDA 150

WIC INCOME ELIGIBILITY GUIDELINES ENGLISH

WIC Income Eligibility Guidelines (Effective from July 1, 2016 – June 30, 2017)

Persons in Family or Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$713
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
Each Add'l Member Add	\$7,696	\$642	\$321	\$296	\$148

WIC INCOME ELIGIBILITY GUIDELINES SPANISH

Pautas de Elegibilidad del Programa WIC Según los Ingresos (Vigentes desde el 1 de julio de 2016 al 30 de junio de 2017)

Unidad Familiar Tamaño	Anual	Mensual	Dos veces al mes	Dos veces a la semana	Semanal
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$713
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
Cada persona adicional	\$7,696	\$642	\$321	\$296	\$148

NOTIFICATION OF INELIGIBILITY

NOTIFICATION OF INELIGIBILITY/NOTIFICACION DE INELEGIBILIDAD



Date/Fecha _____

Name/Nombre

Name of Agency/Nombre de la Agencia

Address/Dirección

Signature of Authorized WIC/CSFP Personnel/
Firma del Empleado Autorizado de WIC/CSFP

A person may not receive benefits from both the WIC and CSF Programs at the same time, nor may a person receive benefits from two WIC or two CSFP sites at the same time.

No se puede recibir los beneficios de los dos programas de WIC y CSFP a la misma vez. Tampoco se puede recibir los beneficios de dos centros de WIC ó dos de CSFP a la misma vez.

You have the right to a fair hearing anytime you disagree with the local WIC/CSFP/FMNP about your eligibility. You may request a fair hearing from any WIC/CSFP/FMNP employee. At the time of the hearing, you may bring another person to represent you.

Usted tiene el derecho a una audiencia justa en cualquier momento con su WIC/CSFP/FMNP local si no está de acuerdo sobre su elegibilidad. Usted puede pedir una audiencia justa con cualquier empleado de WIC o CSFP o FMNP. A la hora de la imparcialidad, usted puede llevar a otra persona quien le pueda representar.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

De acuerdo con las Leyes Federales y las Reglas del Departamento de Agricultura de los Estados Unidos, esta institución prohíbe la discriminación a base de raza, color, nacionalidad, sexo, edad o minusvalía.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Para presentar una queja de discriminación, escriba al USDA, USDA, Director, Office of Adjudication, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 o llame al teléfono gratuito (866) 632-9992 (Voz). Las personas que son sordas, con problemas para oír o discapacidad del habla pueden comunicarse con el USDA a través del Servicio Federal de Retransmisión en el (800) 877-8339 o (800) 845-6136 (español). USDA es un empleador y proveedor con igualdad de oportunidades.

Signature of Participant, Parent or Caregiver

Firma del Participante, Padre, o Guardián

DOB/Date of Birth

Fecha de Nacimiento

ZIP (CSFP Only)

ZIP (CSFP Solamente)

WIC CSFP is not eligible for the following reason/s:

FMNP

- ____ Lives outside of health service area.
- ____ Is not categorically eligible.
- ____ Does not meet the income guidelines.
- ____ Does not meet age requirement.
- ____ No documented nutritional risk.
- ____ A woman who is neither pregnant nor is breastfeeding an infant under 1 yr of age.
- ____ Applicant is being placed on a waiting list.

WIC CSFP No es elegible para los beneficios del programa por la(s) siguiente(s) razón(es)
 FMNP

- ____ Vive fuera del área de salud de servicio.
- ____ No es elegible categóricamente.
- ____ No satisface las guías del ingreso.
- ____ No satisface el requisito de edad.
- ____ No tiene un riesgo nutricional documentado.
- ____ Una mujer que no está embarazada ni dando pecho a un infante menor de 1 año de edad.
- ____ El solicitante se colocará en la lista de espera.

Effective _____

Efectivo _____

WIC eLEARNING REGISTRATION FORM



To: Staff Members
From: Peggy Lewis, Tennessee WIC Director
RE: E-Learning Registration

Welcome to the Tennessee Department of Health, Family Health and Wellness Section, Supplemental Nutrition for Women, Infants and Children Program (WIC) E-Learning Training. Here you will find a registration form so that you may access training courses available to Tennessee staff members who provide WIC services.

The purpose of this standardized training is to introduce the Tennessee WIC Program and to explain its goals and objectives to staff members who provide WIC services in health departments across the state. The training is intended as an orientation for new staff members and for staff members seeking a refresher of the material. Staff members who provide WIC services are Public Health Office Assistants (PHOA), Nursing Assistants (NA), Breastfeeding Counselors, Peer Counselors, Vendor Representatives as well as Nutritionists, Nutrition Educators, and Registered Nurses who are seeking official recognition as a Competent Professional Authority (CPA). In addition, Regional staff members and County Directors may be included.

The training is designed for self-study, practice, observation and evaluation within the staff member's respective work environment. Each of the modules, currently under construction, consists of educational content, an associated test, and activities (skills) to be completed in the WIC clinics.

We are asking that all staff members who provide WIC services complete the following registration form on the following page.

Please download a copy of the completed form and return to Sherrie Patton at Sherrie.Patton@tn.gov.

You will receive an email asking you to enter the following:

User Name: Your email address
Password: enter

Your User Name will always remain the same. You will change your password after you have logged into the web site for the first time. Logging in will allow you access to course materials.

E Learning Registration

Please fill out the fields below

- In the **Phone** field do not use hyphens. Example – 6155328170
- In the **Region** field select your Regional number (see below,) or CO for Central Office.
- In the **Title** field select the job title that most closely matches yours. Examples can be seen below.
- In the **Job Function** field select the job title that most closely matches yours. Examples can be seen below

First Name	Last Name	Email	Phone	Region	Title
				Select One	Select One

Function	Function
Select One	Select One

Regional Numbers

- 01 NORTHEAST
- 02 EAST
- 03 SOUTHEAST
- 04 UPPER CUMBERLAND
- 05 MID-CUMBERLAND
- 06 SOUTH CENTRAL
- 07 WEST - Union City
- 08 WEST - Jackson
- 09 SHELBY COUNTY
- 10 DAVIDSON COUNTY
- 11 KNOX COUNTY
- 12 HAMILTON COUNTY
- 13 SULLIVAN COUNTY
- 14 MADISON COUNTY

Title Examples

- Administrative
 - o Central Office Staff
 - o Regional Office Staff
 - o County Directors
- Nutrition
 - o Nutritionist 1 or 2
 - o Nutrition Educator
- Breastfeeding
 - o Peer Counselor
- Nursing
 - o County Nursing Director
 - o Clinic Registered Nurse
 - o Clinic Licensed Practical Nurse
 - o Clinic Nursing Assistant
 - o Clerical (Public Health Office Assistant)
 - o County Clerical Supervisor
 - o County Public Health Office Assistant
- Other
 - o Health Educator

Job Functions Examples

- Clinic:
1. Competent Professional Authority (CPA – those who certify participants)
 2. Registration/ Encounter/Voucher Issuance (PHOA/Clerical)
 3. Anthropometric Measures/Hemoglobin
 4. BF Peer Counseling
 5. Clinic Supervision (RN, Clerical, County Directors)
 6. Other Health Dept Staff Members
- Region:
7. WIC Director
 8. Nutrition Director
 9. Breastfeeding Coordinator
 10. MCH Director, QI Director, Training Director
 11. Vendor Management
 12. Regional Management (Regional Directors, etc.)
 13. Regional Nursing Director
 14. Regional Clerical Consultant

Certification/Food Package

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CERTIFICATION ASSESSMENT

WIC is part of a network of integrated health services available through the Department of Health and various health and social services agencies. To qualify for WIC, participants must be assessed and certified to be at nutrition risk by a Competent Professional Authority (CPA).¹ For nutrition risk criteria and corresponding risk codes refer to *Nutrition Risk Criteria & Codes* (**Appendix 2-1**).

CPAs may be:

- Registered Dietitians /Nutritionists (RD or RDN)
- Nutritionists
- Nutrition Educators
- Registered Nurses (RN)
- Physicians

Certification Data

Height or length, weight, and hemoglobin or hematocrit (according to protocol) are required at WIC certification. Applicable data from any procedure done as a part of the Tennessee Department of Health, Child Health or Prenatal Care Exam are acceptable in determining eligibility for WIC certification. Referral measures from a private provider, an outpatient clinic, or hospital birth measures may also be used. If the applicant did not bring referral measures, measures must be taken while the applicant is in the clinic for WIC services.

Referral Measures

Referred anthropometric measures taken within the last 60 days can be used for certification or mid-certification assessment. Measures for pregnant women must be taken during pregnancy, and measures for breastfeeding and postpartum women must be taken when participants are in those categories. Referral blood work must conform to the next recommended anemia screening schedule for infants and children. The physician letterhead, prescription pad, or printout from electronic health record may be used to convey data needed for WIC certification. Height or length, weight, and hemoglobin or hematocrit should be recorded by the provider and noted with an “REF” or “HOSP” next to the date on the growth chart for WIC certification purposes². The document on which referral measures are written must be signed by the physician or designee (unless electronic) and becomes part of the WIC record.

EXCEPTION: A physician’s signature is not required when using hospital birth measures. Birth measures as stated by the mother are acceptable.

Physical Presence

Participants must be present at each certification. The date of the physical presence must be noted for all participants and retained in the participant file.

EXCEPTIONS:

1 Department of Agriculture, Food and Nutrition Services 7 CFR Part 246.2

2 Automated Growth Chart (AGC) is used in clinics. Plotting is electronic. User ID is entered into the AGC system.

In the case of disabilities or ongoing health problems which prevent physical presence, high-risk participants must have referral measures in the medical record. The physician or health care professional (HCP) determines and documents the disability of the participant. This documentation is retained in the participant medical record. Disabilities are:

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

Newborn infants of WIC Moms may be certified without being physically present initially; however, the infant must visit the WIC clinic within 60 days from the date of birth. In addition, premature infants with a medical exception must visit the WIC clinic once the medical exception expires and the infant is physically able to be present. Staff must document the actual date when the physical presence requirement is met in the patient's record.

NUTRITION RISK CRITERIA CODES

The *Nutrition Risk Criteria & Codes* (**Appendix 2-1**) are used statewide for the WIC Program in Tennessee. Priorities are indicated for each participant category. If funds are available, all priorities are served according to state policy. The code for certification applies for the entire certification period. If a client becomes categorically ineligible, benefits continue to the end of the month in which ineligibility occurs.

The CPA identifies all applicable risks in the participant's record so that they may be addressed during the counseling. Enter up to three of the highest priority risk codes in any order in the Cert Reason fields on the Patient Encounter Form. The system will recognize the highest priority of the three.

If more than three risks are identified and appear equal (same priority) then the choice of codes to enter on the encounter form is at the discretion of the certifier. However, if a prenatal is pregnant with multiple fetuses, risk code 335 must be entered first for the system to issue the correct food package (which is the same as the Fully Breastfeeding Woman).

Calculating Gestation-Adjusted Age

The assignment for nutrition risk criteria #121 (Short Stature) and #152 (Low Head Circumference) for infants and children (up to 2 years of age) with a history of prematurity shall be based on adjusted gestational age.

- Document the infant's gestational age in weeks. (Mother/caregiver can self-report, or referral information from the medical provider may be used.)
- Subtract the child's gestational age in weeks from 40 weeks (gestational age of term infants) to determine the adjustment for prematurity in weeks.
- Subtract the adjustment for prematurity in weeks from the child's chronological postnatal age in weeks to determine the child's gestation-adjusted age.

As an example, Randy was born prematurely on March 19, 2014. His gestational age at birth

was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2014 clinic visit, his chronological postnatal age is 12 weeks. What is his gestation-adjusted age?

- 30 = gestation age in weeks
- 40-30 = 10 weeks adjustment for prematurity
- 12-10 = 2 weeks gestation-adjusted age for plotting measures

Although Randy's chronological age at the time of his clinic visit is 12 weeks, his measurements would be plotted on a growth chart as a 2-week-old infant. If measures cannot be plotted, documentation should state unable to plot.

DOCUMENTATION

The CPA marks all nutrition risk criteria that apply in the participant's WIC record, *Nutrition Risk Criteria & Codes* (**Appendix 2-1**). Adequate documentation must be present in the participant's medical record, which includes the electronic portion of the record, to support all nutrition risks.

The signature and title of the CPA and date of certification must be written in the WIC record. To maintain separation of duties, a CPA that certifies participants to receive WIC benefits cannot issue FIs/CVV's.

The "Local Resource Referral List" in Chapter 7 must be provided and documented at initial certification to each individual applying for the WIC Program for themselves or on behalf of others³.

Refer to *Certification Guide* (**Appendix 2-41**) for certification requirements.

PRENATAL AND POSTPARTUM ASSESSMENT

A woman's comprehensive personal history, including immunizations, shall be reviewed. This review is completed within the integrated health services of the local health department of which WIC is a part. The current recommendations from the Centers for Disease Control and Prevention (CDC) shall be the guide for the immunization assessment.

To be certified for WIC, the woman must be assessed and determined to be at nutritional risk. The WIC Medical/Nutrition Assessment with results documented in the medical record must include:

- Height (initial prenatal certification for women 20 and over, each certification for teens)
- Weight (each certification, each visit recommended for prenatals)
- Weight gain plotted on prenatal weight gain grid (each certification, recommended at other visits)
- Body Mass Index, *BMI Chart* (**Appendix 2-44**)
- Nutrition assessment (dietary assessment as indicated)
- Breastfeeding assessment for prenatals and postpartum breastfeeding women

³ Department of Agriculture, Food and Nutrition Services 7 CFR Part 246.7 (b) (1)

- EDD (expected date of delivery) (prenatal certification)
- Medical history (as needed for certification)
- Hemoglobin or hematocrit (each certification)

Pregnant Women

A pregnant woman is a WIC status 1. If not obvious, pregnancy must be documented by a physician, nurse practitioner, or physician assistant or positive pregnancy test performed by a health professional. An ultrasound with mother's name pre-printed (not hand written) may be used as proof of pregnancy. Pregnancy tests are available in all health departments as a part of the integrated services. Proof of pregnancy can be confirmed by telephone call to physician's office and followed by written confirmation (by fax, email or mail). If the physician's office is closed when attempting to confirm pregnancy, the clinic may give one (1) month of FIs/CVVs until confirmation can be made.

Initial certification is effective for the length of the pregnancy and up to six weeks postpartum. Program benefits are provided through the month in which the six weeks postpartum date falls. Documentation of kept appointments is retained in PTBMIS. An attempt to contact each pregnant woman who misses her initial WIC appointment must be made and documented.⁴

Breastfeeding Women

A woman is considered to be breastfeeding if she feeds her infant breast milk at least once per day. Fully breastfeeding women (WIC status 6) are not receiving formula or Human Milk Fortifier for their infant. Partially (mostly) breastfeeding women (WIC status 3) are issued the partial formula food package or Human Milk Fortifier (HMF) for their infant. Since HMF is to be used for a very short time, the woman can be transitioned back to the fully breastfeeding package as soon as the infant is no longer receiving HMF from WIC.

Barely breastfeeding women (WIC status B) receive the full formula food package for their infant. All of these women should be reported as breastfeeding up to one year postpartum. If a woman initiated breastfeeding but stopped prior to her postpartum certification, the WIC Special Data box on the Patient Encounter Form must reflect breastfeeding was initiated and stopped.

The breastfeeding assessment and the mother's plans for breastfeeding serve as the basis for determining food package issuance and the counseling and support provided to the mother. Efforts should be made to schedule mothers who intend to breastfeed for subsequent certification as soon after delivery as possible in order to provide timely breastfeeding support. If the mother was on WIC prenatally, the fully breastfeeding food package should be given in the first week after delivery or as soon as possible so she may benefit from the additional foods. The "PBF" voucher includes 1 gallon milk, 16 oz cheese, 1 dozen eggs, and 30 oz canned fish. Combining the PBF voucher with prenatal vouchers is equivalent to the fully breastfeeding food package.

⁴ Department of Agriculture, Food and Nutrition Services 7 CFR Part 246.7 (b) (5)

Breastfeeding women are certified for up to one year, ending in the month of the breastfed infant's first birthday. Program benefits are terminated at 6 months postpartum if the woman is no longer breastfeeding or whenever she stops breastfeeding after the 6 month postpartum period.

All breastfeeding women must be assessed at certification. Refer to *Nutrition Risk Criteria & Codes* (**Appendix 2-1**). If she has no risk of her own, but her infant has a risk, use Code 601 (certification on the basis of the infant's risk). Both mother and infant (the dyad) are placed in the priority of the infant's risk.

As an example, there are no risk codes that apply to the breastfeeding mother. However, her infant is certified for the "Priority 1" risk code 103 (underweight or at risk of underweight). The mother qualifies for WIC based on her infant's risk (underweight) and she is certified for code 601 (breastfeeding mother of infant at risk). Both mother and infant are considered Priority 1 status.

If a woman quits breastfeeding prior to 6 months, and the risk for which she was certified as a breastfeeding woman also applies to a non-breastfeeding woman, her status should be changed to postpartum and services continue to 6 months after delivery. A breastfeeding woman who was certified as 601 should be assigned another nutrition risk code in order to continue program benefits until 6 months postpartum.

Breastfeeding is a dyad of infant and mother. Both mother and infant are counseled at each clinic visit for as long as the mom continues in a breastfeeding status of 3, 6 or B. If the status of the breastfeeding dyad changes, the status of the woman and infant will need to be changed in PTBMIS (as directed by the CPA) in order to issue the correct food packages.

Postpartum Women (Non-Breastfeeding)

When a pregnancy ends (even if in a stillbirth, miscarriage or abortion) the postpartum period begins. Initial prenatal WIC certification extends up to 6 weeks past delivery date. A postpartum woman may be certified anytime after delivery up to 6 months. A postpartum woman who is not breastfeeding is certified as a WIC status 2. Postpartum certification (non-breastfeeding) continues until the end of the 6th month post-delivery.

Certification appointments are scheduled to maximize services. To continue program benefits without interruption, the certification appointment for postpartum women is required at a maximum of 6 weeks postpartum, but may be scheduled earlier. Ideally, the postpartum woman should be certified at the same time as the newborn. If the woman has prenatal FIs/ CVVs in hand, issue postpartum vouchers for subsequent months.

INFANT AND CHILD ASSESSMENT

As a part of the integrated health services of the local health department of which WIC is a part and according to the Tennessee Department of Health, Child and Adolescent Health Manual, "all staff of the local health department with patient contact shall ask questions and check the record to determine if the child needs immunizations. If immunizations are needed, they should be given before the child leaves the county health department by the clinic nurse or a referral made to the Primary Care Physician (PCP) for the child to receive them."

To be certified for WIC, the infant or child must be assessed and determined to be at nutritional risk. The WIC Medical/Nutrition Assessment with results documented in the medical record must include at each certification:

- Length/Height (including birth length for infant certification)
- Weight (including birth weight for infant certification)
- Percentiles plotted on weight-for-height or length, height or length-for-age, and weight-for-age charts
- BMI (2-5 years of age)
- Medical history
- Nutrition assessment
- Hemoglobin or hematocrit:
 - Infants - required 9th through 12th month (unless obtained 6-9 months)
 - Children - required 15th through 18th month (or 6 months after infant test)
 - Children - after 18 months on annual basis if within normal limits at last certification.

Children (0-24 months) must have at least two hemoglobin checks completed prior to 24 months of age.

EXCEPTION: There are two exceptions to the regulatory requirements regarding refusal of hematological testing during a WIC certification. The exceptions are:

- Participant's religious beliefs won't allow the blood to be drawn. In this case a written and signed statement from the parent/guardian of the participant must be included in their WIC record.
- Participant has a medical condition, e.g., hemophilia, fragile bones (osteogenesis imperfecta), or a serious skin disease, in which the procedure of collecting the blood sample could cause harm to the participant.

Documentation of the medical condition from the HCP must be included in the individual's certification file. If the medical condition is treatable, such as a serious skin disease, a new statement from the HCP would be required for each subsequent certification. If the condition is considered "life-long", such as hemophilia, a new statement from the HCP is not required. In most cases, a person with a serious medical condition will be receiving regular medical care and referral data should be used for WIC certification.

If after assessing for certification no risk is identified, the parent/guardian/caretaker should be asked if she/he wants the child's hemoglobin or hematocrit checked. Parent/ guardian/ caretaker's response should be documented in the participant's record. If the response is yes, the test should be performed.

Infants are certified through the end of the month of their first birthday, provided the quality and accessibility of healthcare services are not diminished. The fully formula fed infant is a WIC Status 4, the fully breastfed infant is a WIC Status 7, and the partially breastfed infant is a WIC status 9.

All breastfed infants should be certified soon after birth. Breastfed infants who have no risk of their own may be certified on the basis of the mother's risk; use risk code 702, breastfed infant of mother at nutrition risk. The Priority is that of the mother's risk.

As an example, if there are no risk codes that apply to the infant and the mother is certified for risk code 201 (low hemoglobin), the infant qualifies for WIC based on the mother's risk (anemia). In this example, the infant is certified for code 702 (breastfeeding infant of woman at nutritional risk). If the infant quits breastfeeding during the certification period, another risk code must be identified.

Children may be certified from the month of their first birthday through the month of their fifth birthday, provided the local agency insures that the child receives the required health and nutrition assessments. The certification period is one year for children.

Extended Certification Period

In cases where there is difficulty in appointment scheduling, the certification period for infants and children may be extended or shortened by a period not to exceed thirty (30) days.

Correcting Errors

The policy for correcting charting errors is as follows:

- Draw a line through the mistake
- Write CID (Correction in Documentation) immediately above the error
- Initial
- Date (if different from date of original entry)

An error on a growth chart should be corrected as follows:

- Make an "X" on the erroneous dot
- Draw a line from the dot to an area below or above the percentile curves
- Write CID
- Initial
- Date

Late Entry: Should a CPA overlook documentation of the WIC Record that is discovered at a later date, documentation must be made by the CPA that provided service. The documentation is noted "Late Entry," dated and initialed.

MID-CERTIFICATION ASSESSMENT

Infants, children, and breastfeeding women certified for one year must have a mid-certification assessment. The assessment requires the participant's current:

- Height/Length
- Weight
- Assessment of growth or BMI

For an infant or child with a positive anemia screening result at the last certification, a blood test (or referral Hgb/hct) is required at 6-month intervals until the Hgb/hct is within normal range. For a breastfeeding woman who had a positive anemia screen after delivery, WIC staff should ensure that appropriate treatment and follow-up occurs. A follow-up blood test is an allowable WIC expense and may be performed by clinic staff.

Refer to *Mid-Certification Assessment Guide* ([Appendix 2-42](#)) for requirements.

CERTIFICATION IN HOSPITALS

The State agency shall ensure that each local agency operating the program within a hospital and/or that has a cooperative arrangement with a hospital⁵:

- Advises potentially eligible individuals that receive inpatient or outpatient prenatal, maternity, or postpartum services, or that accompany a child under the age of 5 who receives well-child services, of the availability of WIC program services; and
- To the extent feasible, provides an opportunity for individuals who may be eligible to be certified within the hospital for participation in the WIC Program.

A plan of operation must be submitted to Central Office for approval prior to beginning service in a hospital facility. The region must have a written agreement with the facility, which clearly outlines expectations and responsibilities of both agencies. Health Department staff should:

- Establish a contact person to help new mothers with breastfeeding management
- Advise mothers of procedures for transferring infants back into their home clinic
- Inform mothers prior to delivery of the WIC services available at the hospital

Prior to operating WIC in the hospital, the Regional System Administrator should be asked to set up a new clinic site for the hospital. Counties with three or fewer clinic sites may elect to enroll hospital-certified patients directly into the appropriate county site. In that case, information is collected in person or by telephone and FIs/CVV's are printed at the county site and delivered to the hospital. Out-of-county residents may be enrolled in the hospital clinic and transferred. (For additional information on voucher accountability, see Chapter 4).

The following may be certified in the hospital:

- Prenatal women if the hospital has a prenatal clinic
- Infants--Born to WIC Mom or Non-WIC Mom
- Breastfeeding or Postpartum women

Infants must be seen in the hospital or must be present at first WIC clinic visit within 60 days of birth. Applicants may use the hospital ID bracelet or crib card as proof of identity. Applicants should be assessed for adjunctive eligibility (Refer to Chapter 1, Proof of Income). If not adjunctively eligible, applicant must have proof of income and residency.

Hospital Patient Certification Records

Patient certification records should be easily tracked from hospital certification to the new clinic site. An infant certified at the hospital must have the WIC certification documented in a WIC Record. Documentation should be completed on the following forms:

- Growth Chart
- WIC Infant Nutrition Questionnaire
- WIC Infant Record
- *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**) if receiving therapeutic formula

⁵ Department of Agriculture, Food and Nutrition Services 7 CFR Part 246.6 (f)

Breastfed infants, Postpartum and Prenatal women should be enrolled with certification documented. Refer to Chapter 3 for documentation on WIC records. Measures for WIC certification taken from the hospital record by WIC personnel should be indicated by the source in the record, e.g., “hospital measures” with the signature of the WIC staff person who retrieved them or “HOSP” beside the date to show that they are hospital measures.

When appropriate, schedule infants certified in the hospital back to the health department to coordinate with immunizations at two, four, and six months. If other children in the family are on the WIC Program, also take into consideration the next appointments already scheduled for the family when scheduling the infant. In cases where there is difficulty in appointment scheduling, the certification period may be extended or shortened by a period not to exceed (30) days.

In-Region Participants

When in-region infants and women are transferred from the hospital clinic into a clinic within the region, the original certification forms should be sent to the participant’s home clinic.

Out-of-Region Participants

When out-of-region infants and women are enrolled in the hospital clinic, provide participant a phone number for the participant’s home clinic and issue a VOC (Refer to Chapter 5, VOC).

CERTIFICATION PROCEDURE FOR THE HOMELESS

A homeless individual means an individual who lacks fixed or regular nighttime residence, or whose primary nighttime residence is:

- A supervised publicly or privately operated shelter designed to provide temporary housing, like shelters for victims of domestic violence
- A temporary accommodation in the residence of another individual
- A public or private place not designed for, or ordinarily used as a, regular sleeping accommodation for human beings

Homeless individuals are certified according to program requirements described in risk criteria code 801, *Nutrition Risk Criteria & Codes* (**Appendix 2-1**). Attention must be directed to the homeless participant’s current situation in order to assure that program benefits can be used. If a participant is staying in a homeless facility, there are three requirements that must be assessed:

- WIC foods are exclusively for participant use
- There are no constraints on the ability of the participant to partake of the supplemental foods, nutrition education and breastfeeding support
- Facility agrees to the conditions above and to be monitored annually by the local regional staff

Tennessee WIC does not serve applicants who reside in traditional, residential, long-term institutions, such as rehabilitative and correctional facilities. The food package for the homeless participant, as well as nutrition education, should be tailored to meet the individual’s needs and living conditions. It is important to issue a VOC to homeless

individuals if they are transients or if service at another clinic is expected (Refer to Chapter 5, VOC). CPA's should be alert to needs for referral of this population to health or social services as indicated.

Food Package Modifications for the Homeless

Food packages for the homeless should be selected based on individual needs and living conditions. Cooking and storage facilities and access to refrigeration must be evaluated. If the participant does not have access to refrigeration, or has limited refrigeration, food package code NORE can be used. Refer to *Food Package and Voucher Codes- Sheet 1 (Appendix 2-45)*.

For infants, issuance of powdered formula will permit mixing a small amount at a time if refrigeration is lacking. Ready-to-feed (RTF) formula may be issued if conditions for mixing powder or concentrate are questionable and refrigeration is available.

FIs/CVV's should be issued for only one month at a time since living conditions for the homeless may change, with a resulting need to re-evaluate the food package. Keep in mind some products on the homeless FIs are not available to other participants; therefore, the homeless participant should be made aware of these products.

WIC FOOD PACKAGES

WIC food packages and nutrition education are the chief means by which WIC affects the dietary quality and habits of participants. WIC is a supplemental nutrition program and the food packages were never intended to be the primary source of food. The ability of the WIC food packages to reinforce nutrition education messages to participants is critical to affecting the dietary quality and habits of infants, children and women. Food package codes are found on *Food Package and Voucher Codes- Sheet 1 (Appendix 2-45)* and *Formula Codes- Sheet 2 (Appendix 2-46)*.

Infant Food Packages

WIC Food Packages for Infants (Appendix 2-66) is a reference guide for staff only. Food packages for infants are determined by what the infant is fed - breast milk, formula or both. Breastfeeding is the natural and normal way to feed infants and human milk is the gold standard for infant feeding. The Tennessee WIC Program strongly encourages breastfeeding of infants unless there are medical contraindications. For issuance of formula to supplement breastfed infants refer to Chapter 6.

Food packages for infants 6 months of age and older include vouchers for infant cereal and infant fruits and vegetables. Older infants (9-11 months) are allowed to receive a CVV for fresh fruits and vegetables in lieu of a portion of the infant fruit and vegetables.

Standard Formula

For infants that are not breastfed the standard formula issued by Tennessee WIC Program must meet the following criteria:

- Nutritionally complete iron-fortified (contains at least 10 mg. iron per liter of formula at standard dilution)
- Supplies 0.67 Kilocalories per milliliter (approximately 20 calories per fluid ounce)
- Requires only the addition of water before serving

Federal WIC regulations require that states use a competitive bid process and award the contract to the bidder who provides the lowest net wholesale cost. Currently, the contract is with Abbott Nutrition to provide the standard infant formulas:

- Similac Advance (powder and concentrate)
- Similac Soy Isomil (powder and concentrate)

Issuance of alternate contract formulas (19 calories per ounce) requires written documentation from the HCP, see *Tennessee WIC Medical Request for Formula/Foods (Appendix 2-49)*:

- Similac Sensitive (lactose reduced)-powder and RTF available
- Similac Total Comfort (partially hydrolyzed protein, lactose reduced)-powder only available
- Similac for Spit-Up (added rice starch, reduced lactose) - powder and RTF available

Children who are born prematurely may require infant formula until one-year gestation-adjusted age. Medical documentation is required for infant formulas when issued to a child. For guidance regarding issuance of ready-to-feed contract formulas, see the section **Ready-to-Fed Formulas and WIC-Eligible Nutritionals** in this chapter.

Tennessee WIC program DOES NOT PROVIDE non-contract standard milk-based or soy-based infant formulas, standard no-iron or low-iron formulas, homogenized cow's milk or goat's milk for infants.

Contract Formulas

Similac Advance, Similac Sensitive, Similac Total Comfort and Similac for Spit-Up are cow's milk-based infant formulas. Similac Sensitive is a reduced lactose formula for infants with lactose sensitivity and is not intended for use by infants with galactosemia. Similac Total Comfort is made with partially hydrolyzed protein for easy digestion and is lactose reduced. Similac for Spit-Up has added rice starch to help reduce frequent spit-up and is lactose reduced.

Similac Sensitive, Total Comfort, and Similac for Spit-Up provide 19 calories per fluid ounce and require a medical request from the HCP. The HCP must complete the *Tennessee WIC Medical Request for Formula/Foods (Appendix 2-47)*. This request does not require approval by a Registered Dietitian. If the parent/caregiver does not bring the medical request to clinic, issue one month of FIs while waiting on the request from the HCP. If the HCP changes the infant's formula from one 19 calories per fluid ounce formula to another 19 calorie formula and the parent/caregiver does not bring the "new" request to clinic, issue one

month of FIs while waiting on the request from the HCP.

Similac Soy Isomil is a nutritionally complete soy-based formula for infants needing a milk-free formula for disorders such as cow's milk protein allergy, lactase deficiency, lactose intolerance, galactosemia, and for infants of vegetarian families.

All Similac formulas have Lutein and DHA to support brain and eye development and contain prebiotics to help promote digestive health. All formulas are gluten-free and are certified Kosher and Halal.

Ready-To-Feed Formulas and WIC-Eligible Nutritionals

All WIC contract formulas must be issued in concentrated liquid or powdered forms.⁶ In addition, ready-to-feed (RTF) WIC formulas may be authorized when the CPA determines and documents one of the following:

- Participant's household has an unsanitary or restricted water supply or poor refrigeration
- Participant or person caring for the participant may have difficulty in correctly diluting concentrated forms or reconstituting powdered forms
- Formula is only available in RTF form
- RTF formula or WIC-eligible nutritionals better accommodates the participant's condition

One way to determine safety of water is to ask what water the family uses to make coffee, tea, or powdered drinks. If the water can be safely used after properly boiling, it may not meet USDA's justification for need of RTF. Using a concentrated formula with cooled water may be a solution. The Regional Nutrition Director should be consulted if there is a question.

The maximum monthly allowances for RTF formula provide fewer ounces per month. Families should be counseled and referred to other resources that may be able to assist with the purchase of additional product.

Food Packages for Children

WIC Food Packages for Women and Children (Appendix 2-67) is a reference guide for staff only. The Standard Food Package for a child is based on the child's age. The food package code for a one-year old child is TSTD. Food package 5STD is issued to 2 thru 4 year old children.

Whole milk is the standard milk for issuance to 1-year-old children (12 through 23 months). Fat reduced milks may be issued to 1-year-old children for whom overweight or obesity is a concern. The need for reduced fat milk must be based on an individual nutrition assessment by the CPA and consultation with the child's health care provider if necessary.

⁶ Department of Agriculture, Food and Nutrition Services 7 CFR Part 246.10 (e) (1) (iv)

Low fat (1%) milk or nonfat (fat-free or skim) milk is the standard milk for issuance to children \geq 24 months of age. The need for 2% milk for children \geq 24 months of age must be based on an individual assessment by the CPA. Children with certain conditions and nutritional risks (such as listed below) may need 2% milk:

- 103- underweight or at risk of becoming underweight
- 135- inadequate growth or inadequate weight gain
- 342- gastrointestinal disorders that interfere with the intake, digestion and/or absorption of nutrients
- 344- hyperthyroidism
- 347- cancer
- 348- central nervous system disorders which affect energy requirements and may affect the individual's ability to feed self, such as cerebral palsy
- 349- genetic and congenital disorders that alter nutrition status metabolically or mechanically or both, such as muscular dystrophy
- 352- infectious diseases severe enough to affect nutrition status, such as tuberculosis, HIV, AIDS
- 360- other medical conditions that affect nutritional status, such as cystic fibrosis
- 362- developmental delays, sensory or motor delays interfering with the ability to eat

Food Packages for Women

WIC Food Packages for Women and Children (Appendix 2-68) and *WIC Food Packages for Breastfeeding Women (Appendix 2-69)* are reference guides for staff only. The Standard Food Package for a Woman is based on her WIC status. A pregnant woman is a WIC Status 1 and her standard food package is 1STD. If a prenatal is pregnant with multiple fetuses, risk code 335 must be entered first for the system to issue the correct food package, which is the same as the Fully Breastfeeding Woman. Also, a prenatal mostly breastfeeding a single infant should be issued the Fully Breastfeeding food package (6STD). A woman who has delivered her baby and is not breastfeeding is a WIC Status 2. She receives a 2STD food package. A woman who chooses to breastfeed and supplement with formula is considered Partially (mostly) Breastfeeding and is a WIC Status 3. She receives a 3STD food package. However, when a 2 is entered in the "Outcome Field" on the WIC Q Screen of a partially breastfeeding mother of multiples, the system will issue the Fully Breastfeeding Woman's food package. A woman who is breastfeeding at least once a day is considered Barely Breastfeeding and is a WIC Status B. She receives a 2STD food package for six months after delivery. A fully breastfeeding woman is a WIC Status 6. She is issued a 6STD food package and receives the most food.

Low fat (1%) milk or nonfat (fat-free or skim) milk is the standard milk for issuance to women. The need for 2% milk must be based on an individual assessment by the CPA.

Reduced fat (2%) milk is authorized only for women with certain conditions and nutrition risks, including:

- 101- underweight
- 131- low maternal weight gain in underweight or normal weight women
- 132- maternal weight loss during pregnancy in underweight or normal weight women
- 301- hyperemesis gravidarum
- 335- multifetal gestation
- 342- gastrointestinal disorders that interfere with the intake, digestion, and/or absorption of nutrients
- 347- cancer
- 348- central nervous system disorders which affect energy requirements and may affect the individual's ability to feed self, such as cerebral palsy
- 349- genetic and congenital disorders that alter nutrition status metabolically or mechanically or both, such as muscular dystrophy
- 352- infectious diseases severe enough to affect nutritional status, such as tuberculosis, HIV, AIDS
- 360- other medical conditions that affect nutritional status, such as cystic fibrosis
- 362- sensory or motor delays interfering with the ability to eat

Lactose Reduced or Lactose Free Milk

Substitution of Lactose Reduced or Lactose Free milk is permitted by self-declaration of the participant (no written orders required). Lactose Reduced or Lactose Free milk should never be issued to participants with milk protein allergies or on milk protein avoidance diets.

Goat's Milk

Women or children (1 through 4 years of age) may be issued low-fat goat's milk fortified with Vitamins A and D (no written orders required). Goat's milk is inadequate in folic acid. Participants should be counseled regarding adequate dietary intake and/or supplements.

Soy Beverage

The standard food package for women and children can be tailored (no written orders required) to issue soy beverage. The CPA is authorized to determine the need for soy-based beverage and tofu for children and issuance of additional tofu for women. Such determinations must be based on individual nutritional assessment. If necessary, consult with the participant's health care provider. Such determinations can be made for situations that include, but not limited to, milk allergy, lactose intolerance, galactosemia, and vegan diets.

Food Package III

WIC Food Package III for Women and Children (Appendix 2-68) is a reference for staff only.

Food Package III ⁷ is reserved for issuance to women, infants, and children who have a documented nutrition related condition that requires the use of therapeutic formula, WIC-eligible nutritionals, or contract infant formula because use of conventional food is:

- Precluded (when totally tube-fed)
- Restricted (such as partially tube fed, oral motor feeding problems, severe allergies, seizure disorders, metabolic disorders, Crohn's Disease, Celiac disease)
- Inadequate to meet their special nutritional needs (such as very low birth weight infants, malabsorption syndromes, hyperemesis gravidarum, HIV/AIDS)

In Food Package III, infants 6 months of age or older who are not developmentally ready to consume solids may receive additional infant formula or WIC-eligible nutritionals in lieu of infant foods at the same maximum monthly allowance for infants ages 4 through 5 months of age.

Tennessee WIC does not provide therapeutic products for WIC participants who receive TennCare and have a WIC qualifying condition which involves malabsorption syndromes, inborn errors of metabolism, or a gastrointestinal disorder that interferes with the intake, digestion, and/or absorption of nutrients. Refer to *WIC Qualifying Conditions (Appendix 2-48)*.

In addition, TennCare is responsible for providing therapeutic formula for participants partially or completely tube-fed. Issue 2-3 months of FIs until the client can be transitioned to TennCare. The *HCP Communication Tool (Appendix 2-49)* is a “fillable” communication tool for CPAs to use to notify the HCP that the participant needs to be transitioned to TennCare. WIC will continue to provide therapeutic products to non-TennCare eligible participants.

Participants who are eligible to receive Food package III must have one or more WIC Qualifying Condition(s) determined by a HCP licensed to write prescriptions under Tennessee state law. The responsibility remains with the participant's HCP for the medical oversight and instruction concerning all WIC authorized supplemental foods. The HCP must use the *Request for WIC Eligible Therapeutic Products (Appendix 2-50)* to request a therapeutic product and to indicate any restriction of WIC supplemental foods.

⁷ Federal Regulations 246.10 (e) (3) (i)

Food Package III is not authorized for:

- Infants whose only condition is a diagnosed formula intolerance or food allergy to lactose, sucrose, milk protein or soy protein that does not require the use of a therapeutic formula
- A non-specific formula or food intolerance
- Women and children who have food intolerance to lactose or milk protein that can be successfully managed with the use of soy beverages, tofu, or additional cheese substituted for the maximum monthly allowance for fluid cow's milk in standard Food Packages
- Any participant solely for the purpose of enhancing nutrient intake or managing body weight without an underlying WIC Qualifying Condition

Medical Documentation Forms

Medical documentation is required for:

- Food Package III Infants receiving therapeutic or contract (standard) formula
- Children receiving contract (standard) formula, therapeutic formula, WIC-eligible nutritionals or baby foods
- Women receiving WIC-eligible nutritionals or baby foods
- Infants and children receiving alternate contract formula (19 calories/ounce)

The *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**) serves as written documentation for therapeutic formula, WIC-eligible nutritionals, or contract infant formula for children. The *Tennessee WIC Medical Request for Formula/Foods* (**Appendix 2-47**) is used for infants and children receiving alternate contract formulas. One month of Similac Sensitive, Similac Total Comfort, or Similac for Spit-Up may be issued while waiting on the request from the Health Care Provider. All medical documentation must be kept on file at the local clinic in the participant's WIC record.

Request for WIC Eligible Therapeutic Products and Supplemental Foods

In order to receive a therapeutic product/ formula, the *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**) must be completed by the participant's HCP.

The *Request* must include the following:

- Patient's name and date of birth
- Name of the formula/nutritional product requested (standard infant formula, therapeutic infant formula, WIC-eligible nutritionals)
- Prescribed amount per day, including caloric density if greater than the standard for the product
- If the product is delivered by feeding tube
- Length of the time the WIC authorized standard formula, therapeutic product(s) and/or supplemental food is required by the participant
- WIC Qualifying Condition(s)
- WIC supplemental food(s) that is NOT appropriate for the participant
- HCP's signature
- Date of Request; and
- Contact information (phone, fax, address)

The *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**) must be reviewed and approved by an RD. At the end of the HCP's requested time frame, new written medical documentation from the HCP must be submitted to WIC in order to continue issuance of the therapeutic product(s) to the WIC participant. Once an initial request for a therapeutic product has been denied, should the patient return with a request for the same product, another one-month supply of the product cannot be issued until the request is approved by the reviewing RD.

Regional Approval Process for Therapeutic Products

When a participant calls with a therapeutic request, the PHOA/WIC clerk should make an appointment within 5 days. If the participant/caregiver walks into the clinic, try to accommodate the patient at that time; if not, make an appointment within 5 days.

Therapeutic requests must be reviewed and approved by RD. The Regional Nutrition Director will approve or designate another RD to approve each therapeutic product request for appropriateness. If RD is not on site, the CPA needs to send the following information to the designated RD for approval or denial of the request:

- Current height and weight (within 30 days)
- WIC Questionnaire
- Completed *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**)
- *Therapeutic Formula Assessment Tool* (**Appendix 2-51**)

When the participant has a WIC Qualifying condition, the CPA may issue one month of therapeutic product without RD approval or if medical documentation is not complete. The RD has up to 3 weeks to review and approve the therapeutic product. If medical documentation is not complete or the RD has questions, she/he must work with the CPA and the HCP to obtain the information needed for approval or denial. Additional information needed to complete the medical documentation for therapeutic products may be provided by telephone to a CPA and documented in the participant's record. The RD approval is to be documented in the WIC Record, or *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**), or *Therapeutic Formula Assessment Tool* (**Appendix 2-51**).

The request for therapeutic formula/product and the assessment tool sent from the CPA to the RD must be kept in a file for 2 years with the approving RD or kept electronically on the share drive for review during the monitoring process. The RD onsite providing nutrition services to the WIC participant with a request for therapeutic formula/product has the option not to complete the Therapeutic Formula Assessment Tool if he/she can appropriately assess the patient's need and provide adequate documentation for the therapeutic formula.

If an infant does not have a WIC Qualifying Condition and a therapeutic product cannot be authorized, WIC personnel cannot offer standard formula without the HCP's approval and instruction. If the therapeutic product is denied, the infant fruits, vegetables, and cereal FIs may be issued if appropriate.

Documentation on the WIC Record for participants receiving therapeutic formula or products is the same as for any other participant. In addition, the WIC-Approved Therapeutic Formula box must be completed each time a therapeutic product is approved. The CPA should note in the WIC Record the evaluation and plan assessed by the RD, name of the approving RD, and the date of approval.

Therapeutic formula/products may be approved for up to six months. At the return visit (2-3 month intervals), the WIC Questionnaire required at the initial therapeutic request can be used by the CPA in whole or part to gather pertinent subjective information or a new questionnaire can be filled out by the parent/caregiver. New subjective information, assessment and/or plans are recorded in the “Additional Notes” section of the WIC Record, including signature/title/date for each entry. Refer to Chapter 3.

At each therapeutic product renewal or formula change, the infant/child/woman must be nutritionally reassessed, including current height/weight/WIC Questionnaire. New written medical documentation from the HCP must be submitted with a renewal request. The SOAP plan (see Chapter 3) must be updated.

All infants and children certified for one year are required to have measures at the 6 month mid-certification assessment. Referral measures taken less than 60 days old are acceptable for infants/children receiving a standard food package. Referral measures for infants and children on therapeutic formula/products must be taken within the last 30 days. At the CPA’s discretion, infants and children receiving therapeutic formula/products may be weighed and measured at each interval WIC visit.

If the woman, infant or child has documentation that they cannot attend clinic, referral measures taken within the last 30 days may be obtained from the HCP. If measures are not obtainable, issue one month FIs/CVVs until measures can be obtained.

Ordering Therapeutic Products through Central Office

Certain therapeutic products are available through Tennessee WIC that do not have voucher codes and must be special ordered by WIC Central Office. Formulas listed with an asterisk (*) on the *Tennessee WIC Program Formulary* (**Appendix 2-53**) must be ordered by Central Office and Drop Shipped to the clinic. In some cases, therapeutic products with a voucher code are not available in the local WIC stores or pharmacies and must be dropped shipped.

When an approved therapeutic product must be delivered by drop shipment, the CPA completes the *Therapeutic Formula Ordering Form* (**Appendix 2-54**) and e-mails the form to Cindy.Dossett@tn.gov or her designee.

Some products may be ordered and shipped to the health department within a few days. However, anticipate 5 to 7 days for delivery as a general rule. The participant may need to obtain the product from another source until the drop shipment arrives. You will always receive an email confirming the product was ordered. If you do not receive the email within two business days, please do not hesitate to contact Central Office to confirm that the product has been ordered. If the product does not arrive at the health department within 5 to 7 days, notify Central Office immediately so the order can be traced.

Once the product arrives at the health department, open boxes to verify that the correct product and all cases ordered have been delivered. Notify Central Office immediately if problems are discovered or if the wrong product has been shipped. Remove packing slips or box shipping labels. Fax a copy of these to Central Office, Fax # (615) 532-7189, “Attention: Kelly Soliman” or scan and email to Cindy.Dossett@tn.gov

Formula is shipped in full cases. Enter the formula units received and staff signature on the *Formula Inventory Log* (**Appendix 2-55**) or electronic formula inventory log. Issue only up to the maximum issuance or calculate the need for each patient for months that are being issued. Log the formula units issued to the caregiver/participant along with his/her signature.

Issue FIs/CVVs for foods that are allowed by the HCP. If no FIs/CVVs are issued, then food package code DSF is used to indicate a drop shipped formula.

For additional shipments, contact the caregiver/participant at least 3 weeks prior to next pickup to confirm the therapeutic product is still required. Contact Cindy Dossett to order the next delivery.

Should a participant no longer require a Central Office product that has been ordered, the CPA contacts the Regional WIC Director. The Regional WIC Director determines if other participants in the region are currently using the formula and arranges to move it.

Other Program Sources for Therapeutic Products

Due to the fragile nature of the health of participants who qualify for Food Package III, the quantity of therapeutic product required to meet their nutritional needs may exceed WIC’s maximum monthly allowance. It is the responsibility of the HCP to provide the close medical supervision essential for the participant’s dietary management. It is the responsibility of the CPA to contact the HCP should amount of therapeutic product required exceed amount provided by WIC. The HCP can then request additional product from third party payers such as TennCare. See *HCP Communication Tool* (**Appendix 2-49**).

Women, infants, and children who require more therapeutic product than provided by WIC may be eligible to receive additional product through programs such as Children’s Special Services. Referrals should be made to the local health department CSS Care coordinator. Each clinic’s Resource Referral List should contain local community resources that may provide assistance in obtaining additional product.

Tailoring Food Package III

Medically fragile infants 6 months of age or older whose medical condition prevents them from consuming complementary foods may receive therapeutic formula at the same rate as infants ages 4 through 5 months of age. For the higher amount of formula to be issued, the HCP must check the boxes **Do Not Give** Infant Cereal and Infant Food Vegetables/Fruits on the *Request for WIC Eligible Therapeutic Products* (**Appendix 2-50**). CPAs should assess the infant's food consumption; if the infant is consuming complementary foods contrary to the HCP's recommendations, the HCP should be contacted for clarification.

Whole milk or reduced fat (2%) milk may be substituted for low fat (1%) or nonfat (fat free or skim) milk for children 2 years of age or older and women receiving Food Package III as determined by the health care provider per medical documentation.

Children and women whose special dietary needs require the use of pureed foods may receive commercial jarred infant fruits and vegetables in lieu of the cash-value voucher as determined appropriate by the health care provider per medical documentation. Children may receive 128 oz of infant food fruits and vegetables and women may receive 160 oz infant food fruits and vegetables in lieu of the cash- value voucher.

Only CPAs can assign FIs/CVVs (Chapter 4, Separation of Duties). For proper coding of the participant's food package, refer to *Food Package and Voucher Codes Sheet 1* (**Appendix 2-45**), *Formula Codes Sheet 2* (**Appendix 2-46**). For a description of therapeutic products and approved uses, refer to the *Therapeutic Products Information Guide* (**Appendix 2-57**). See Chapter 3 for Food Package III documentation requirements as part of the SOAP Plan.

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NUTRITION RISK CRITERIA & CODES

Pregnant, Breastfeeding & Non-Breastfeeding Women

Anthropometric Nutrition Risks

Pregnant/Breastfeeding – Priority I
Non-breastfeeding – Priority III

101. Underweight

- Pregnant Women- Prepregnancy Body Mass Index (BMI) <18.5
- Non-Breastfeeding Women- Prepregnancy or current BMI <18.5
- Breastfeeding Women less than 6 months postpartum- Prepregnancy or current BMI <18.5
- Breastfeeding Women 6 months postpartum or more- Current BMI <18.5

Note: Adolescents

For the purposes of WIC eligibility determination, the 2009 IOM cut-offs noted above will be used for women of all ages. However, professionals should use all the tools available to assess pregnant and postpartum adolescents' anthropometric status and tailor nutrition counseling accordingly.

111. Overweight

- Pregnant Women- Prepregnancy Body Mass Index (BMI) ≥ 25
- Non-Breastfeeding Women- Prepregnancy BMI ≥ 25
- Breastfeeding Women less than 6 months postpartum- Prepregnancy BMI ≥ 25
- Breastfeeding Women 6 months postpartum or more- Current BMI ≥ 25

Note: Adolescents

For the purposes of WIC eligibility determination, the 2009 IOM cut-offs noted above will be used for women of all ages, including pregnant and postpartum adolescents, not the CDC BMI-For-Age charts.

131. Low Maternal Weight Gain (Pregnant Women)

Low maternal weight gain is defined as follows:

A low rate of weight gain during the 2nd and 3rd trimesters (14-40 weeks gestation), for singleton pregnancies, defined as:

Prepregnancy Weight	BMI	Total Weight Gain (lbs.)/Week
Underweight	<18.5	<1
Normal Weight	18.5 to 24.9	< 0.8
Overweight	25.0 to 29.9	< 0.5
Obese	≥ 30	< 0.4

OR

Low weight gain at any point in pregnancy, such that using an Institute of Medicine (IOM) based weight gain grid, a pregnant woman's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective pre-pregnancy weight category, as follows:

Prepregnancy Weight	BMI	Total Weight Gain Range (lbs.)	
		Singleton	Twins
Underweight	<18.5	28-40	(See note)
Normal Weight	18.5 to 24.9	25-35	37-54
Overweight	25.0 to 29.9	15-25	31-50
Obese	≥ 30	11-20	25-42

Note: Multi-Fetal Gestation

There is insufficient information for the IOM to develop provisional guidelines for underweight women with multiple fetuses. A consistent rate of weight gain is advisable. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy.

132. Maternal Weight Loss during Pregnancy (Pregnant Women)

1st trimester (0-13 weeks), any weight loss below pregravid, or
 2nd or 3rd trimester (14-40 weeks gestation), weight loss ≥ 2 pounds

133. High Maternal Weight Gain (Singleton Pregnancies)

Pregnant Women:

Weight Classification	BMI	Total Weight Gain (lbs.)/Week
Underweight	<18.5	>1.3
Normal Weight	18.5 to 24.9	> 1.0
Overweight	25.0 to 29.9	> 0.7
Obese	≥ 30	> 0.6

Breastfeeding or Non-Breastfeeding Women (most recent pregnancy only):

Weight Classification	BMI	Total Weight Gain (lbs.)
Underweight	<18.5	>40
Normal Weight	18.5 to 24.9	> 35
Overweight	25.0 to 29.9	> 25
Obese	≥ 30	> 20

Note: Multi-fetal Pregnancies

For twin gestations: normal weight women should gain 37-54 lbs; overweight women, 31-50 pounds; and obese women 25-42 pounds.. In triplet pregnancies the overall gain should be around 50 lbs with a steady weight gain of approximately 1.5 lbs per week.

Biochemical Nutrition Risks

Pregnant/Breastfeeding- Priority I
 Non-Breastfeeding – Priority III

201. Low Hematocrit/Low Hemoglobin

Concentration below the 95 percent confidence interval (i.e., below the .025 percentile) for healthy, well-nourished individuals of the same age, sex, and stage of pregnancy. Cut off values are included in the following table (adjusted for smoking):

	Pregnant 1 st Trimester (0-13 Wks) Hgb< HCT<	Pregnant 2nd Trimester (14-26 Wks) Hgb< HCT<	Pregnant 3rd Trimester (27-40 Wks) Hgb< HCT<	NonPregnant 12-<15 yrs Hgb< HCT<	NonPregnant 15-<18 yrs Hgb< HCT<	NonPregnant =>18 yrs Hgb< HCT<
Nonsmokers	11.0 33.0	10.5 32.0	11.0 33.0	11.8 35.7	12.0 35.9	12.0 35.7
Smokers	11.3 34.0	10.8 33.0	11.3 34.0	12.1 36.7	12.3 36.9	12.3 36.7

211. Elevated Blood Lead Levels

Blood lead level of (equal to or greater than) 5 micrograms per deciliter, within the past 12 months.

Pregnancy-Induced Conditions

Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician’s orders.

Pregnant/Breastfeeding– Priority I
 Non-breastfeeding – Priority III

301. Hyperemesis Gravidarum (Pregnant Women Only)

Hyperemesis Gravidarum is defined as severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic.

302. Gestational Diabetes (Pregnant Only)

Gestational diabetes mellitus (GDM) is defined as any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

303. History of Gestational Diabetes

- History of diagnosed gestational diabetes mellitus (GDM)
- Pregnant Women: Any history of gestational diabetes
- Breastfeeding/Non-Breastfeeding: Most recent pregnancy

304. History of Preeclampsia

History of diagnosed preeclampsia (pregnancy-induced hypertension >140mm Hg systolic or 90mm Hg diastolic with proteinuria developing usually after the 20th week of gestation).

Obstetrical Risks

Pregnant/Breastfeeding- Priority I
Non-breastfeeding – Priority III

311. History of Preterm Delivery

- Birth of an infant less than 37 weeks and one day gestation
- Pregnant Women: Any history of preterm delivery
- Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy

312. History of Low Birth Weight

- Birth of an infant weighing 2500 grams or less OR 5 lbs. 8 oz. or less
- Pregnant Women: Any history of low birth weight
- Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy

321. History of Spontaneous Abortion, Fetal or Neonatal Loss

- A Spontaneous Abortion (SAB) is the spontaneous termination of a fetus at <20 weeks gestation or <500 grams. A fetal death is a death at equal to or greater than 20 weeks gestation. A neonatal death is a death occurring from birth through the first 28 days of life.
- Pregnant Women: Any history of fetal or neonatal death or 2 or more spontaneous abortions
- Breastfeeding: Most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living
- Non-Breastfeeding: Most recent pregnancy

331. Pregnancy at a Young Age

- Conception 17 years of age or less
- Pregnant Women: Current pregnancy
- Breastfeeding/Non-Breastfeeding: Most recent pregnancy
- Note: Because the actual date of conception is difficult to determine, the applicant's age at her last menstrual period may be used to determine pregnancy before her 18th birthday.

332. Short Interpregnancy Interval

- Conception before 18 months postpartum
- Pregnant Women: Current pregnancy
- Breastfeeding/Non-Breastfeeding: Most recent pregnancy.

333. High Parity and Young Age

- Women < 20 years of age with 3 or more previous pregnancies of 20 weeks duration, regardless of birth outcome
- Pregnant Women: current pregnancy
- Breastfeeding/Non-Breastfeeding: Most recent pregnancy

334. Lack of or Inadequate Prenatal Care (Prenatal Only)

- Prenatal care beginning after the 1st trimester (after 13th week), or
- First prenatal visit in the third trimester (7-9 months), or
- Inadequate Prenatal Care based on the following:

Weeks of Gestation	Number of Prenatal Visits
14-21	0 or unknown
22-29	1 or less
30-31	2 or less
32-33	3 or less
34 or more	4 or less

335. Multifetal Gestation

- More than one (1) fetus
- Pregnant Women: Current pregnancy
- Breastfeeding/Non-Breastfeeding: Most recent pregnancy

336. Fetal Growth Restriction (Pregnant Women Only)

Fetal weight below 10th percentile for gestational age

337. History of birth of a Large for Gestational Age Infant

- Pregnant Women: Any history of giving birth to an infant weighing (equal to or greater than) 9 lbs. or 4,000 grams
- Breastfeeding/Non-Breastfeeding: Most recent pregnancy, history of giving birth to an infant weighing (equal to or greater than) 9lbs. or 4,000 grams

338. Pregnant Woman Currently Breastfeeding (Pregnant Only)

Breastfeeding woman now pregnant

Clinical/Medical/Health Conditions

Presence of disease, disorder, or condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Pregnant/Breastfeeding – Priority I

Non-breastfeeding – Priority III

339. History of Birth with Nutrition-Related Congenital or Birth Defect

- A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake (e.g., inadequate zinc, folic acid, excess Vitamin A)
- Pregnant Women: Any history of birth with nutrition-related congenital or birth defect
- Breastfeeding and Non-Breastfeeding women: Most recent pregnancy

341. Nutrient Deficiency Diseases

Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micronutrients. Diseases include, but are not limited to:

- Protein Energy Malnutrition
- Scurvy
- Rickets
- Beri Beri
- Hypocalcemia
- Osteomalacia
- Vitamin K Deficiency
- Pellagra
- Cheilosis
- Menkes Disease
- Xerophthalmia.

342. Gastro-Intestinal Disorders

Diagnosis must be determined by medical professional but may be self-reported

Diseases and/or conditions that interfere with the intake, digestion, and/or absorption of nutrients. The diseases and/or conditions include, but are not limited to:

- Gastroesophageal reflux disease (GERD)
- Peptic ulcer (stomach or intestinal)
- Post-bariatric surgery
- Short bowel syndrome
- Inflammatory bowel disease, including ulcerative colitis or Crohn's disease
- Liver disease
- Pancreatitis
- Biliary tract diseases (Such as gallstones, inflammation of gall bladder)

343. Diabetes Mellitus

Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

344. Thyroid Disorders

The medical conditions include, but not limited to the following:

- Hyperthyroidism- excessive thyroid hormone production (Graves' Disease)
- Hypothyroidism- low levels of thyroid hormone
- Postpartum Thyroiditis- transient or permanent thyroid dysfunction occurring in the first year after delivery

345. Hypertension and Prehypertension (Includes Chronic and Pregnancy Induced)

- Hypertension- systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90 mm Hg
- Prehypertension- blood pressure between 130/80 to 139/89 mm Hg

346. Renal Disease

Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.

347. Cancer

Cancer is a chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status.

348. Central Nervous System Disorder

Conditions which affect energy requirements and may affect the individual's ability to feed self that alter nutritional status metabolically, mechanically or both. Includes, but is not limited to:

- Epilepsy
- Cerebral palsy (CP)
- Neural tube defects (NTD), such as spina bifida
- Parkinson's disease
- Multiple sclerosis (MS)

349. Genetic and Congenital Disorders

Hereditary or congenital conditions at birth that cause physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically or both. May include, but is not limited to: cleft lip or palate, Down's syndrome, thalassemia major, sickle cell anemia (not sickle cell trait), and Muscular dystrophy

351. Inborn Errors of Metabolism

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body, including but not limited to:

- Amino Acid Disorders
- Organic Acid Metabolism Disorders
- Fatty Acid Oxidation Disorders
- Lysosomal Storage Disease
- Urea Cycle Disorders
- Carbohydrate Disorders
- Peroxisomal Disorders
- Mitochondrial Disorders

352. Infectious Diseases

- A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. **The disease must be present within the past 6 months**, and diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.
- Includes, but is not limited to:
 - Tuberculosis
 - Pneumonia
 - Meningitis
 - Parasitic infections
 - Hepatitis
 - Bronchiolitis (3 episodes in last 6 months)
 - HIV* (Human Immunodeficiency Virus) and AIDS* (Acquired Immunodeficiency Syndrome)

*Sexually transmitted diseases (STD) are not automatically included as a group under this criterion. However, an individual STD may be considered if there is evidence to support its negative impact on nutrition status.

353. Food Allergies

Food allergies are adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food. Foods that often cause allergic reactions include: cow's milk, eggs, peanuts, tree nuts, fish, crustacean shellfish wheat and soy. Symptoms include but not limited to: nausea, vomiting, diarrhea, abdominal pain, hives, angioedema, wheezing, cough, hypotension, anaphylaxis

354. Celiac Disease

Celiac Disease is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. Celiac Disease is also known as: celiac sprue, gluten-sensitive enteropathy, non-tropical sprue

355. Lactose Intolerance

Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating that occur after lactose ingestion. Lactose intolerance occurs because of a deficiency in the level of the enzyme lactase. (Tailor food packages to substitute or remove lactose-containing foods.)

356. Hypoglycemia

Hypoglycemia is an abnormally diminished concentration of glucose in the blood.

357. Drug Nutrient Interactions

Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised

358. Eating Disorders

Eating disorders (anorexia and bulimia) are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: self-induced vomiting; purgative abuse; alternating periods of starvation; use of drugs such as appetite suppressants or diuretics; self-induced marked weight loss.

359. Recent Major Surgery, Trauma, Burns

- Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status
- Any occurrence within the past two (2) months may be self-reported
- Any occurrence more than two (2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician

360. Other Medical Conditions

Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but is not limited to:

- Juvenile rheumatoid arthritis (JRA)
- Lupus erythematosus
- Cardiorespiratory diseases
- Heart disease
- Cystic fibrosis
- Moderate persistent or severe persistent asthma requiring daily medication

361. Depression (Clinical)

Presence of clinical depression. (Depressed pregnant women are more likely to smoke during pregnancy, attend prenatal care less frequently, and have a higher incidence of low birth weight infants).

362. Developmental Delays, Sensory or Motor Delays Interfering with the Ability to Eat

Developmental, sensory or motor disabilities that restrict the ability to chew or swallow food or require tube feeding to meet nutritional needs. Disabilities include, but are not limited to:

- Minimal brain function
- Head trauma
- Brain damage
- Birth injury
- Feeding problems due to developmental disability such as pervasive development disorder (PDD) which includes autism

363. Pre-Diabetes (Breastfeeding and Non-Breastfeeding only)

Impaired fasting glucose (IFG) and/or impaired glucose tolerance (IGT) are referred to as pre-diabetes. These conditions are characterized by hyperglycemia that does not meet the diagnostic criteria for diabetes mellitus. Fasting plasma glucose level between 100-125 mg/dl is referred to as IFG. Plasma glucose levels of 140-199 mg/dl after a 2-hour oral glucose tolerance test is referred to as IGT.

371. Maternal Smoking

Any smoking of tobacco products (i.e., cigarettes, pipes, or cigars). Only women who continue to smoke after conception would be eligible under this criterion. Includes a woman who smoked early in pregnancy and quit after learning of her pregnancy

372. Alcohol and Illegal Drug Use

- Pregnant Women: Any alcohol or illegal drug use
- Breastfeeding and Non-Breastfeeding Women:
 - Routine current use of (equal to or greater than) 2 drinks per day (standard drink is 1 can or 12 fl. oz. of beer, or 5 oz. wine, or 1-1/2 fluid oz. liquor), or
 - Binge drinking- 5 or more drinks on the same occasion on at least one day in the past 30 days, or
 - Heavy Drinking- 5 or more drinks on the same occasion on 5 or more days in the previous 30 days, or
 - Any illegal drug use

381. Dental Problems

- Diagnosis of dental problems by a physician, dentist, or a health care provider working under the orders of a physician or adequate documentation by the competent professional authority, including, but not limited to:
- **All Women** – Tooth decay, periodontal disease, tooth loss, and/or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality
- **Pregnant Women** – Gingivitis of pregnancy

Dietary Risks

Pregnant/Breastfeeding-Priority IV
Non-Breastfeeding-VI

401. Failure to Meet Dietary Guidelines for Americans

Consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans). This risk can only be used when a complete nutrition assessment has been completed and no other risk criteria have been identified, including assessment for Inappropriate Nutrition Practices for Women (code 427).

427. Inappropriate Nutrition Practices for Women

Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. These practices with examples are outlined below:

<p>Inappropriate Nutrition Practices for Women</p>	<p>Examples of Inappropriate Nutrition Practices (Including but not limited to)</p>
<p>427.1 Consuming dietary supplements with potentially harmful consequences</p>	<p>Examples of dietary supplements which when ingested in excess of recommended dosages, may be toxic of have harmful consequences: Single or multiple vitamins Mineral supplements Herbal or botanical supplements/remedies/teas</p>
<p>427.2 Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery</p>	<p>Examples: Strict vegan diet Low carbohydrate, high protein diet Macrobiotic diet Any other diet restricting calories and/or essential nutrients</p>
<p>427.3 Compulsively ingesting non-food items (pica)</p>	<p>Non-food items: Ashes/Dust/Clay/Soil Baking soda/ Starch (laundry and Cornstarch) Paint Chips/Chalk/Carpet fibers/Burnt matches/Cigarettes Large quantities of ice and/or freezer frost</p>
<p>427.4 Inadequate vitamin/mineral supplementation recognized as essential by national public health policy</p>	<p>Examples: Consumption of less than 27 mg of supplemental iron per day by pregnant woman Consumption of less than 150µg of supplemental iodine per day by pregnant and breastfeeding women Consumption of less than 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant woman</p>

<p>427.5 Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms</p>	<p>Potentially harmful foods: Raw fish or shellfish, including oysters, clams, mussels and scallops Refrigerated smoked seafood, unless an ingredient in a cooked dish, such as a casserole Raw or undercooked meat or poultry Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot Refrigerated pate or meat spreads Unpasteurized milk or foods containing unpasteurized milk Soft cheeses such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as made with pasteurized milk Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces and beverages such as unpasteurized eggnog Raw sprouts (alfalfa, clover, and radish) or Unpasteurized fruit or vegetable juices</p>
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Regression/Transfer

Pregnant/Breastfeeding – Priority I
Non-Breastfeeding – Priority III

501. Possibility of Regression (Breastfeeding and Non-Breastfeeding only)

A participant who has previously been certified eligible for the Program may be considered to be at nutritional risk in the next certification period if the Competent Professional Authority (CPA) determines there is a possibility of regression in nutritional status without the benefits that the WIC Program provides. All other reasons for certification (including code 427) must be assessed. May be used at subsequent certifications only one time for each risk code. May not be used after codes 601 and 602.

502. Transfer of Certification

A person with current a valid Verification of Certification (VOC) card from another state and the **certification reason is unknown or no corresponding Tennessee reason for certification exists**. The VOC is valid until certification period expires and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. **Refer to Chapter One for documentation of Transfer Participants.**

Breastfeeding Mother/Infant Dyad

Pregnant/Breastfeeding – Priority I, II, or IV

601. Breastfeeding Women of Infant at Nutritional Risk- Priority I, II, IV

A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk. Infant's risk should be documented. Must be same priority as at risk infant.

Pregnant/Breastfeeding – Priority I

602. Breastfeeding Complications or Potential Complications

- Breastfeeding woman with any of the following are considered complications or potential complications for breastfeeding:
 - Severe breast engorgement
 - Recurrent plugged ducts
 - Mastitis
 - Flat or inverted nipples
 - Cracked, bleeding or severely sore nipples
 - Age (equal to or greater than) 40 years
 - Failure of milk to come in by 4 days postpartum
 - Tandem nursing (breastfeeding two siblings who are not twins)

Other Risks

Pregnant/Breastfeeding – Priority IV

Non-Breastfeeding – Priority VI

801. Homelessness

A woman who lacks a fixed and regular nighttime residence, or whose primary nighttime residence is:

- A supervised publicly or privately-operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations;
- An institution that provides a temporary residence for individuals intended to be institutionalized;
- A temporary accommodation of not more than 365 days in the residence of another individual; or
- A public or private place not deemed as, or ordinarily used as, sleeping accommodation for human beings.

802. Migrancy

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

901. Recipient of Abuse

Battering within the past 6 months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel. "Battering" generally refers to violent physical assaults on women.

902. Woman with Limited Ability to Make Feeding Decisions and/or Prepare Food

Any woman (pregnant, breastfeeding, or non-breastfeeding), assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- 17 years of age or younger
- Mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)
- Physically disabled to a degree which restricts or limits food preparation abilities; or currently using or having a history of abusing alcohol or other drugs

903. Foster Care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months. This risk cannot be used for consecutive certifications while the child/teenager remains in the same foster home. It should not be used as the only risk criterion unless no other risk can be identified.

904. Environmental Tobacco Exposure

Exposure to smoke from tobacco products inside the home. The definition used for this risk criterion is based on the Centers for Disease Control and Prevention (CDC) and the Pregnancy Nutrition Surveillance System (PNSS) questions to determine Environmental Tobacco Smoke (ETS) exposure.

Infants and Children

Anthropometric Nutrition Risks

Infants – Priority I
Children – Priority III

103. Underweight or At Risk of Becoming Underweight

Underweight

- Birth through 23 months: Weight-for-length less than or equal to 2nd percentile hard copy or 2.3rd percentile electronic chart as plotted on 2006 WHO gender specific Birth to 24 months growth chart.
- Children 2-5 years: Less than or equal to the 5th percentile Body Mass Index (BMI)-for-age as plotted on 2000 CDC gender specific 2 to 20 years growth chart (Growth Chart **Girls** Edison #1000051616, Growth Chart **Boys** Edison #1000051618).

At Risk of Underweight

- Birth through 23 months: Weight-for-length greater than 2nd percentile hard copy or 2.3rd percentile electronic chart and less than or equal to 5th percentile as plotted on 2006 WHO gender specific Birth to 24 months growth chart.
- Children 2-5 years: 6th through 10th percentile Body Mass Index (BMI)-for-age as plotted on 2000 CDC gender specific 2 to 20 years growth chart (Growth Chart **Girls** Edison #1000051616, Growth Chart **Boys** Edison #1000051618).

113. Obese (Children 2-5 years of age)

Equal to or greater than the 95th percentile Body Mass Index (BMI) or equal to or greater than the 95th percentile weight for stature based on the 2000 CDC gender specific 2 to 20 years growth chart (Growth Chart **Girls** Edison #1000051616, Growth Chart **Boys** Edison #1000051618).

114. Overweight or At Risk of Overweight

Overweight:

Child (≥ 2) whose BMI or weight for stature is $\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ percentile as plotted on 2000 CDC gender specific 2 to 20 years growth chart (Growth Chart **Girls** Edison #1000051616, Growth Chart **Boys** Edison #1000051618). Use standing height, do not use recumbent length measurement **Use BMI Chart(See Chapter 2 - 43)**

At Risk of Overweight:

- Infant (< 12 months) born to a woman whose BMI is ≥ 30 at time of conception or at any point in the 1st trimester (0-13 weeks) of pregnancy. BMI is based on self-reported preconceptional weight and height or on a measured weight and height documented by a health care provider. **Use BMI Chart at end of Chapter 2.**
- Infants and Children (Birth to 5 years) having a biological mother or father whose BMI is ≥ 30 at the time of certification. BMI based on a self reported weight and height or on a measured weight and height taken by staff at time of certification. If the mother is pregnant or had a baby within the past 6 months, use her preconceptional weight to assess for obesity since her current weight will be influenced by pregnancy related weight gain. **Use BMI Chart at end of Chapter 2.**

115. High Weight for Length (Infants and Children less than 24 months)

Birth through 23 months: Weight-for-length greater than or equal to 98th percentile hard copy or 97.7th percentile electronic chart as plotted on 2006 WHO gender specific Birth to 24 months growth chart.

121. Short Stature or At Risk of Short Stature

Short Stature:

- Birth through 23 months: Length-for-age less than or equal to 2nd percentile hard copy or 2.3rd percentile electronic chart as plotted on 2006 WHO gender specific Birth to 24 months growth chart. **For premature infants and children up to 2 years of age with a history of prematurity, assignment of this risk will be based on adjusted gestational age. See instructions for calculating Gestation-Adjusted Age at the end of Chapter 2.**
- Children 2-5 years: Equal to or less than the 5th percentile stature-for-age based on 2000 CDC gender specific 2 to 20 years growth chart (Growth Chart **Girls** Edison #1000051616, Growth Chart **Boys** Edison #1000051618).

At Risk of Short Stature

- Birth through 23 months: Length-for-age greater than 2nd percentile hard copy or 2.3rd percentile electronic chart and less than or equal to 5th percentile as plotted on 2006 WHO gender specific Birth to 24 months growth chart. **For premature infants and children up to 2 years of age with a history of prematurity, assignment of this risk will be based on adjusted gestational age. See instructions for calculating Gestation-Adjusted Age at the end of Chapter 2.**
- Children 2-5 years: 6th through 10th percentile stature-for-age based on the 2000 CDC gender specific 2 to 20 years growth chart (Growth Chart **Girls** Edison #1000051616, Growth Chart **Boys** Edison #1000051618).

134. Failure to Thrive

Presence of failure to thrive (FTT) diagnosed by a physician as self reported by applicant/participant/caregiver, or as reported or documented by a physician, or someone working under physician's orders.

FTT is a serious growth problem with an often complex etiology. Regardless of the etiology of FTT, there is inadequate nutrition to support weight gain. Some of the indicators that a physician might use to diagnose FTT include:

- Weight consistently below the 3rd percentile for age
- Weight less than 80% of ideal weight for height/age
- Progressive fall-off in weight below the 3rd percentile
- A decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile

135. Inadequate Growth

An inadequate rate of weight gain as defined below:

Infants from birth to 1 month of age:

- excessive weight loss after birth
- not back to birth weight by 2 weeks of age

Infants from birth to 6 months of age:

Based on 2 weights taken at least 1 month apart, the infant's actual weight gain is less than the calculated expected minimal weight gain based on the table below:

Age	Average/Day	Average/Week	Average/Mo	Average Wt. Gain
Birth-1 mo	18 gm/day	4 ½ oz/wk	19 oz/mo	1 lb 3 oz/mo
1-2 mos	25 gm/day	6 ¼ oz/wk	27 oz/mo	1 lb 11 oz/ mo
2-3 mos	18 gm/day	4 ½ oz/wk	19 oz/mo	1 lb 3 oz/mo
3-4 mos	16 gm/day	4 oz/wk	17 oz/mo	1 lb 1 oz/mo
4-5 mos	14 gm/day	3 ½ oz/wk	15 oz/mo	
5-6 mos	12 gm/day	3 oz/wk	13 oz/mo	

- Infants and Children from 6 months to 59 months of age.
- Based on 2 weights taken at least 3 months apart, the infant or child's actual weight gain is less than the calculated expected weight gain based on the table below:

Age	Average/Day	Average/Week	Average/Mo	Average/6 Mo
6-12 mos	9 gm/day	2 ¼ oz/wk	9 ½ oz/mo	3 lbs 10 oz/6 mos
12-59 mos	2 ½ gm/day	0.6 oz/wk	2.7 oz/mo	1 lb/6 mos

141 Low Birth Weight and Very Low Birth Weight

Low Birth Weight (Infants and Children Less than 24 Months Old)
Birth weight less than or equal to 5 pounds 8 ounces (equal to or less than 2500 grams).

Very Low Birth Weight (Infants and Children Less than 24 Months Old)
Birth weight less than or equal to 3 pounds 5 ounces (equal to or less than 1500 grams.)

142. Premature Birth (Infants and Children less than 24 Months Old)

Infant born less than 37 weeks and one day gestation.

151. Small for Gestational Age (Infants and Children less than 24 Months Old)

Presence of small for gestational age diagnosed by a physician as self reported by applicant/participant/caregiver, or as reported or documented by a physician, or someone working under physician's orders.

152. Low Head Circumference (Infants and children < 24 months of age)

Head circumference less than or equal to 2nd percentile hard copy or 2.3rd percentile electronic chart as plotted on 2006 WHO gender specific Birth to 24 months growth chart. For premature infants and children up to 2 years of age with a history of prematurity, assignment of this risk will be based on adjusted gestational age. See instructions for calculating Gestation-Adjusted Age at the end of Chapter 2 WIC Manual.

153. Large for Gestational Age (Infants Only)

Birth weight equal to or greater than 9 lbs (4000 grams) or presence of large for gestational age diagnosed by a physician as self reported by applicant/participant/caregiver, or as reported or documented by a physician, or someone working under physician's orders.

Biochemical Nutrition Risks

Infants – Priority I
Children – Priority III

201. Low Hematocrit or Hemoglobin,

- 6 months through 23 months – Hemoglobin 10.9 gms/dl or less, Hematocrit 32.8 gms/dl or less
- 24 months to 60 months – Hemoglobin 11.0 gms/dl or less, Hematocrit 32.9 gms/dl or less

211. Elevated Blood Lead Levels.

Blood lead levels of 5 micrograms or greater per deciliter, within the past 12 months.

Clinical/Medical/Health Conditions

Infants – Priority I

Children – Priority III

341. Nutrient Deficiency Diseases

Diagnosis of nutrition deficiencies or a disease caused by insufficient dietary intake of macro and micronutrients. Diseases include, but are not limited to:

- Protein Energy Malnutrition
- Scurvy
- Rickets
- Beri Beri
- Hypocalcemia
- Osteomalacia
- Vitamin K Deficiency
- Pellagra
- Cheilosis
- Menkes Disease
- Xerophthalmia

342. Gastro-Intestinal Disorders

Diseases and/or conditions that interfere with the intake, digestion, and/or absorption of nutrients. The diseases and/or conditions include, but are not limited to:

- gastroesophageal reflux disease (GERD)
- peptic ulcer (stomach or intestinal)
- post-bariatric surgery
- short bowel syndrome
- inflammatory bowel disease, including ulcerative colitis or Crohn's disease
- liver disease
- pancreatitis
- biliary tract diseases (Such as gallstones, inflammation of gall bladder)

343. Diabetes Mellitus

Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

344. Thyroid Disorders

Thyroid dysfunctions include, but are not limited to, the following:

- Hyperthyroidism- excessive thyroid hormone production
- Hypothyroidism- low levels of thyroid hormones
- Congenital Hyperthyroidism- excessive thyroid hormone levels at birth
- Congenital Hypothyroidism- infants born with an under active thyroid gland

345. Hypertension and Prehypertension (Chronic)

Presence of hypertension or prehypertension. Hypertension during childhood is age-specific, and is defined as blood pressure readings greater than the 95th percentile for age, gender, and height on at least three separate occasions. Blood pressure reading between the 90th and 95th percentile is considered prehypertension.

346. Renal Disease

Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder

347. Cancer

A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraint. The current condition, or the treatment of the condition, must be severe enough to affect nutrition status.

348. Central Nervous System Disorders

Conditions which affect energy requirements and may affect the individual's ability to feed self that alters nutrition status metabolically, mechanically, or both. Includes, but is not limited to, epilepsy, cerebral palsy (CP), and neural tube defects (NTD), such as spina bifida or myelomeningocele.

349. Genetic and Congenital Disorders

Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically or both. May include, but is not limited to, cleft lip or palate, Down's syndrome, thalassemia major, sickle cell anemia (not sickle cell trait) and muscular dystrophy.

351. Inborn Errors of Metabolism

Inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body, including but not limited to:

- Amino Acid Disorders
- Organic Acid Metabolism Disorders
- Fatty Acid Oxidation Disorders
- Lysosomal Storage Disease
- Urea Cycle Disorders
- Carbohydrate Disorders
- Peroxisomal Disorders
- Mitochondrial Disorders

352. Infectious Diseases

A disease (**present within the past 6 months**) caused by growth of pathogenic microorganisms in the body severe enough to affect nutrition status. Includes, but is not limited to:

- tuberculosis
- pneumonia
- meningitis
- parasitic infections
- hepatitis
- Bronchiolitis (3 episodes within last 6 months)
- HIV (Human Immunodeficiency Virus)
- AIDS (Acquired Immunodeficiency Syndrome)

353. Food Allergies

Food allergies are adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food. Foods that often cause allergic reactions include: cow's milk, eggs, peanuts, tree nuts, fish, crustacean shellfish wheat and soy. Symptoms include, but not limited to: nausea, vomiting, diarrhea, abdominal pain, hives, angioedema, wheezing, cough, hypotension, anaphylaxis.

354. Celiac Disease

Celiac Disease is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. Celiac Disease is also known as celiac sprue, gluten-sensitive enteropathy, or non-tropical sprue.

355. Lactose Intolerance

Lactose intolerance is the syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating that occur after lactose ingestion. Lactose intolerance occurs because of a deficiency in the level of the enzyme lactase. (Tailor food packages to substitute or remove lactose-containing foods.)

356. Hypoglycemia

Hypoglycemia is an abnormally diminished concentration of glucose in the blood.

Other Clinical/Medical/Health Conditions

Infants – Priority I

Children – Priority III

357. Drug Nutrient Interactions

Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutrition status is compromised.

359. Recent Major Surgery, Trauma, Burns

Major surgery, trauma or burns severe enough to compromise nutrition status. Any occurrence within the past two (2) months may be self-reported. Any occurrence more than two (2) months previous must have the continued need for nutrition support diagnosed by a physician or a health care provider working under the orders of a physician.

360. Other Medical Conditions

Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Includes, but is not limited to:

- Juvenile rheumatoid arthritis (JRA)
- Lupus erythematosus
- Cardiorespiratory diseases
- Heart disease
- Cystic fibrosis
- Moderate persistent or severe persistent asthma requiring daily medication
- Neonatal Abstinence Syndrome (NAS)- infants only

361. Clinical Depression (Children Only)

Presence of clinical depression in children. (Appetite changes and weight loss are distinguishing features of depression).

362. Developmental Delays, Sensory or Motor Delays Interfering with the Ability to Eat

Developmental, sensory or motor disabilities that restrict the ability to chew or swallow food or require tube feeding to meet nutrition needs, Includes, but is not limited to: minimal brain function, feeding problems due to developmental disability such as pervasive development disorder (PDD) which includes autism, birth injury, head trauma, brain damage and other disabilities.

381. Dental Problems

Diagnosis of dental problems by a physician, dentist, or a health care provider working under the orders of a physician or adequate documentation by the competent professional authority, includes, but not limited to:

- Infants and Children – presence of nursing or baby bottle caries, smooth surface decay of the maxillary anterior and the primary molars.
- Children – Tooth decay, periodontal disease, tooth loss, and or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality.

382. Fetal Alcohol Syndrome (FAS)

FAS is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.

Dietary Risks

401. Failure to Meet Dietary Guidelines for Americans (Children 2 years of age or older) – Priority V

Consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans). This risk can only be used when a complete nutrition assessment has been completed and no other risk criteria have been identified, including assessment for Inappropriate Nutrition Practices for Children (425).

411. Inappropriate Nutrition Practices for Infants (Priority IV)

Routine nutrition practices that may result in impaired nutrient status, disease or health problems. These practices with examples are outlined below:

<p>Inappropriate Nutrition Practices for Infants</p>	<p>Examples of Inappropriate Nutrition Practices (including but not limited to)</p>
<p>411.1 Routinely using a substitute(s) for breast milk or for FDA approved iron-fortified formula as the primary nutrient source during the first year of life.</p>	<p>Examples of substitutes: Low iron formula without iron supplementation Cow's milk, goat's milk, or sheep's milk (whole, reduced fat, low-fat, skim), canned evaporated or sweetened condensed milk and Imitation or substitute milks (such as rice- or soy based beverages, non-dairy creamers), or other "homemade concoctions"</p>
<p>411.2 Routinely using nursing bottles or cups improperly.</p>	<p>Examples: Using a bottle to feed fruit juice Feeding any sugar-containing fluids, such as soda/soft drinks, gelatin water, corn syrup solutions, sweetened tea Allowing the infant to fall asleep or be put to bed with a bottle at naps or bedtime Allowing the infant to use the bottle without restriction (e.g. walking around with a bottle) or as a pacifier Propping the bottle while feeding Allowing an infant to carry around and drink throughout the day from a covered or training cup Adding any food (cereal or other solid foods) to the infant's bottle</p>
<p>411.3 Routinely offering complementary foods* or other substances that are inappropriate in type or timing. * <i>Complementary foods are any foods or beverages other than breast milk or infant formula.</i></p>	<p>Examples of inappropriate complementary foods: Adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier and Any food other than breast milk or iron-fortified infant formula before 4 months of age</p>

<p>411.4 Routinely using feeding practices that disregard the developmental needs or stage of the infant.</p>	<p>Examples: Inability to recognize. Insensitivity to, or disregarding the infant's cues for hunger and satiety (e.g., forcing an infant to eat a certain type and/or amount of food or beverage or ignoring an infant's hunger cues) Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking Not supporting an infant's need for growing independence with self-feeding (e.g., solely spoon feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils) Feeding an infant food with inappropriate textures based on his/her developmental stage (e.g., feeding primarily pureed or liquid foods when the infant is ready and capable of eating mashed, chopped or appropriate finger foods)</p>
<p>411.5 Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.</p>	<p>Examples of potentially harmful foods: Unpasteurized fruit or vegetable juice Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese Honey (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.) Raw or undercooked meat, fish poultry or eggs Raw vegetable sprouts (alfalfa, clover, bean, and radish) Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot)</p>
<p>411.6 Routinely feeding inappropriately diluted formula.</p>	<p>Examples: Failure to follow manufacturer's dilution instructions (to include stretching formula for household economic reasons) Failure to follow specific instructions accompanying a prescription</p>
<p>411.7 Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source of nutrients.</p>	<p>Examples of inappropriate frequency of nursing: Scheduled feedings instead of demand feedings Less than 8 feedings in 24 hours if less than 2 months of age Less than 6 feedings in 24 hours if between 2 and 6 months of age</p>
<p>411.8 Routinely feeding a diet very low in calories and/or essential nutrients.</p>	<p>Examples: Vegan diet Macrobiotic diet Other diets very low in calories and/or essential nutrients</p>

<p>411.9 Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breast milk or formula.</p>	<p>Examples of inappropriate sanitation: Limited or no access to a safe water supply (documented by appropriate officials), heat source for sterilization and/or refrigerator or freezer for storage Failure to properly prepare, handle, and store bottles or storage containers of expressed breast milk or formula</p>
<p>411.10 Feeding dietary supplements with potentially harmful consequences.</p>	<p>Examples of dietary supplements, which when fed in excess of recommended dosage, may be toxic or have harmful consequences: Single or multi-vitamins Mineral supplements Herbal or botanical supplements/remedies/teas</p>
<p>411.11 Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements.</p>	<p>Examples: Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride Infants who are exclusively breastfed, or are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D</p>

425. Inappropriate Nutrition Practices for Children (Priority V)

Routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below:

<p>Inappropriate Nutrition Practices for Children</p>	<p>Examples of Inappropriate Nutrition Practices (including but not limited to)</p>
<p>425.1 Routinely feeding inappropriate beverages as the primary milk source.</p>	<p>Examples of inappropriate beverages as primary milk source: Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk Goat's milk, sheep's milk, imitation or substitute milks (that are unfortified or inadequately fortified) or other "homemade concoctions"</p>
<p>425.2 Routinely feeding a child any sugar-containing fluids.</p>	<p>Examples of sugar-containing fluids: Soda/soft drinks Gelatin water Corn syrup solutions Sweetened tea</p>

<p>425.3 Routinely using nursing bottles, cups or pacifiers improperly.</p>	<p>Examples: Using a bottle to feed fruit juice or diluted cereal or other solid foods Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier Using a bottle for feeding or drinking beyond 14 months of age Using a pacifier dipped in sweet agents such as sugar, honey or syrups Allowing a child to carry around and drink throughout the day from a covered or training cup</p>
<p>425.4 Routinely using feeding practices that disregard the developmental needs or stages of the child.</p>	<p>Examples: Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's request for appropriate foods) Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking Not supporting a child's need for growing independence with self-feeding (e.g., solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils) Feeding a child food with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily pureed or liquid food when the child is ready and capable of eating mashed, chopped or appropriate finger foods)</p>
<p>425.5 Feeding foods to a child that could be contaminated with harmful microorganisms.</p>	<p>Examples of potentially harmful foods for a child: Unpasteurized fruit or vegetable juice Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese Raw or undercooked meat, fish poultry, eggs or tofu Raw vegetable sprouts (alfalfa, clover, bean, and radish) Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot)</p>
<p>425.6 Routinely feeding a diet very low in calories and/or essential nutrients.</p>	<p>Examples: Vegan diet Macrobiotic diet Other diets very low in calories and/or essential nutrients</p>

<p>425.7 Feeding dietary supplements with potentially harmful consequences.</p>	<p>Examples of dietary supplements, which when fed in excess of recommended dosage, may be toxic or have harmful consequences: Single or multi-vitamins Mineral supplements Herbal or botanical supplements/remedies/teas</p>
<p>425.8 Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.</p>	<p>Examples: Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride Not providing 400 IU of vitamin D if a child consumes less than 1 liter (or 1 quart) of vitamin D-fortified milk or formula</p>
<p>425.9 Routine ingestion of nonfood items (pica).</p>	<p>Examples of inappropriate nonfood items: Ashes/Dust/Clay/Soil Paint Chips Cigarettes or cigarette butts Starch (laundry and cornstarch) Carpet fibers Foam Rubber</p>

428. Dietary Risk Associated with Complementary Feeding Practices

Infants 4 to 12 months – Priority IV
 Children 12 through 23 months – Priority V

- An infant or child who has begun to or is expected to begin to consume complementary foods and beverages (foods other than breast milk or formula), or eat independently, or be weaned from breast milk or infant formula, or transition from a diet based on infant/toddler foods to one based on *Dietary Guidelines for Americans*, is at risk of inappropriate complementary feeding.
- A complete nutrition assessment, including assessment for Inappropriate Nutrition Practices for Infants (risk code 411) and Children (risk code 425), must be completed prior to assigning this risk.

Regression/Transfer

Infants – Priority I
Children – Priority III

501. Possibility of Regression

A participant who has previously been certified eligible for the Program may be considered to be at nutrition risk in the next certification period if the competent professional authority determines there is a possibility of regression in nutrition status without the benefits that the WIC Program provides. All other reasons for certification (including codes 411, 425) must be assessed. May be used at subsequent certifications only one time for each risk code. May not be used after codes 701 and 702.

502. Transfer of Certification

Person with current valid Verification of Certification (VOC) card from another state and the certification reason is unknown or no corresponding Tennessee reason for certification exists. The VOC is valid until certification period expires and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. Refer to Chapter One for documentation of Transfer Participants.

Breastfeeding Mother/Infant Pair

Infants – Priority I

603. Breastfeeding Complications or Potential Complications (Infants)

- A breastfed infant with any of the following complications or potential complications for breastfeeding:
- Jaundice
- Weak or ineffective suck
- Difficulty latching onto mother's breast
- Inadequate stooling (for age, as determined by a physician or health care professional) and/or less than 6 wet diapers per day.

Infant of a WIC-eligible Mother or Mother at Risk during Pregnancy

Infants – Priority I, II, or IV

701. Infant Up to 6 Months Old of WIC Mother or of a Woman Who Would Have Been Eligible During Pregnancy (Priority II)

An infant under six months of age whose mother was a WIC Program participant during pregnancy or whose mother's medical records document that the woman was at nutrition risk during the pregnancy because of detrimental or abnormal nutrition conditions detectable by biochemical or anthropometric measurements or other documented nutritionally-related medical conditions.

702. Breastfeeding infant of woman at nutrition risk (Priority I, II, or IV)

A breastfeeding infant whose mother has been determined to be at nutrition risk. Mother's risk should be documented. Must be the same priority as at risk mother.

703. Infant born of a Woman with Mental Retardation or Alcohol or Drug Abuse (Priority I)

- Infant born of a woman: (most recent pregnancy)
- Diagnosed with mental retardation by a physician or psychologist as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, psychologist, or someone working under physician's orders; or
- Documentation or self-report of any use of alcohol or illegal drugs during most recent pregnancy

Homelessness/Migrancy

Infants – Priority IV
Children – Priority V

801. Homelessness

- An infant or child who lacks a fixed and regular nighttime residence, or whose primary nighttime residence is
- A supervised publicly or privately-operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations
- An institution that provides a temporary residence for individuals intended to be institutionalized
- A temporary accommodation of not more than 365 days in the residence of another individual
- A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

802. Migrancy

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

Other Risks

Infants – Priority IV
Children – Priority V

901. Recipient of Abuse

- Child abuse/neglect within the past 6 months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel
- Child abuse/neglect:
- “Any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse or exploitation of an infant or child by a parent or caretaker”

902. Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food

Any infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are:

- 17 years of age or younger
- Mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist)
- Physically disabled to a degree which restricts or limits food preparation abilities; or currently using or having a history of abusing alcohol or other drugs

903. Foster Care

Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months. This risk cannot be used for consecutive certifications while the child remains in the same foster home. It should not be used as the only risk criterion unless no other risk can be identified.

904. Environmental Tobacco Exposure

Exposure to smoke from tobacco products inside the home. The definition used for this risk criterion is based on the Centers for Disease Control and Prevention (CDC) Pediatric Nutrition Surveillance System (PedNSS) and the Pregnancy Nutrition Surveillance System (PNSS) questions to determine Environmental Tobacco Smoke (ETS) exposure.

Certification Guide

(See WIC Manual for detailed instructions)

Certification Requirements	Prenatal	PP	BF	Infant	Child
Physical Presence	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Newborn of WIC mom within 60 days	<input checked="" type="checkbox"/>
Check Immunizations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Height/Length PN HT on Women ≥ 20 yrs. may be used for PP/BF cert	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Teens	<input checked="" type="checkbox"/> Teens	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Weight	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
BMI	<input checked="" type="checkbox"/> Pre-pregnancy BMI	<input checked="" type="checkbox"/> Pre-pregnancy BMI	<input checked="" type="checkbox"/> Pre-pregnancy BMI		<input checked="" type="checkbox"/> 2-5 years of age
Measures Plotted	<input checked="" type="checkbox"/> PN Weight Gain Grid			<input checked="" type="checkbox"/> Birth wt and length; wt/age; length/age; wt/length	<input checked="" type="checkbox"/> Wt/age; length/age; weight/length or BMI
Hemoglobin/ Hematocrit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Required 9-12 th month	<input checked="" type="checkbox"/> Required 9-12 th mo & 15 th -18 th mo; 6-mo intervals if anemia, yearly if normal range
EDD	<input checked="" type="checkbox"/>				
Medical History- as needed for certification	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Identify all risks- certify for highest priority	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Local Resource List- initial certification	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

For clinic flow and customer satisfaction purposes, the initial certification visit (one person) should be completed within 90 minutes and nutrition education & voucher pick-up visit should be completed within 45 minutes.

Mid-Certification Assessment Guide

(For detailed instructions refer to WIC Manual)

Infants (0-4 months), children and breastfeeding women certified for one year must have a mid-certification assessment. Referral data (less than 60 days old) are acceptable.

Mid-Certification Assessment	*BF (status 3, 6, B)	Infant	Child
Review Immunizations		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Height/Length	<input checked="" type="checkbox"/> PN HT on Women \geq 20 yrs. may be used	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Weight	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
BMI Calculation or Weight for Length	<input checked="" type="checkbox"/> BMI based on current weight	<input checked="" type="checkbox"/> Wt/length	<input checked="" type="checkbox"/> Wt/length (\leq 24 months) BMI 2-5 years of age
Plot growth chart or AGC		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hemoglobin/ Hematocrit	Required only if anemia at BF certification		<input checked="" type="checkbox"/> <u>Required</u> at 9-12 months & 15 th - 18 th months; 6-mo intervals if anemia, yearly if normal range
Review previous nutrition assessment, goal & plan	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Update new medical diagnoses, if applicable	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Document new concerns raised by client and new medical information (if applicable) under Return Visits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assess changes in eating patterns & physical activity behaviors	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Make referrals as needed	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

*Status may change at mid-certification

Mid-Certification Example

Age of Infant WIC Certification	Initial Voucher Issuance	2nd voucher Issuance	Mid-Cert Based on date of Cert	Age of Infant	Certification
20 days	3 months	3months	5m+1day to 6months	5 + months	1 year
60 days	3 months	3 months	7-8 month	7-8 month old	1 year
4months	3 months	3 months	9-10 month	9-10 month old	1 year
6-10 months	3 months	3 months	No Mid-Cert will be done	N/A	1 year

For infants that have been certified over 6 months of age they will not have a mid-certification. ALL infants must have a certification completed at one year of age.

Examples:

For an infant that is certified at 8 months, they receive 3 months of vouchers and receive a certification at 1 year. Infants can start being certified at 11 months of age.

For an infant that was certified at 2 months of age and they receive 3 months of vouchers. If they do not come back until 8 months of age, they will need a mid-cert because they were certified before 6 months of age.

If you certify an infant at 9 or 10 month of age, hemoglobin is required as stated on page 2-6 of the WIC manual. Hemoglobin would not be required at 12 months, but at 15-18 depending on voucher schedule.

Updated 8-16-2016

BODY MASS INDEX (BMI) CHART

Height	Inches	Underweight BMI < 18.5	Normal Weight BMI 18.5-24.9	Overweight BMI 25.0-29.9	Weight (lbs) <i>equal to</i> BMI 30
4'10"	58	< 89 lbs	89-118 lbs	119-142 lbs	143
4'11"	59	< 92 lbs	92-123 lbs	124-147 lbs	148
5'0"	60	< 95 lbs	95-127 lbs	128-152 lbs	153
5'1"	61	< 98 lbs	98-131 lbs	132-157 lbs	158
5'2"	62	< 101 lbs	101-135 lbs	136-163 lbs	164
5'3"	63	< 105 lbs	105-140 lbs	141-168 lbs	169
5'4"	64	< 108 lbs	108-144 lbs	145-173 lbs	174
5'5"	65	< 111 lbs	111-149 lbs	150-179 lbs	180
5'6"	66	< 115 lbs	115-154 lbs	155-185 lbs	186
5'7"	67	< 118 lbs	118-158 lbs	159-190 lbs	191
5'8"	68	< 122 lbs	122-163 lbs	164-196 lbs	197
5'9"	69	< 125 lbs	125-168 lbs	169-202 lbs	203
5'10"	70	< 129 lbs	129-173 lbs	174-208 lbs	209
5'11"	71	< 133 lbs	133-178 lbs	179-214 lbs	215
6'0"	72	< 137 lbs	137-183 lbs	184-220 lbs	221
6'1"	73	< 140 lbs	140-188 lbs	189-226 lbs	227
6'2"	74	< 144 lbs	144-193 lbs	194-232 lbs	233
6'3"	75	< 148 lbs	148-199 lbs	200-239 lbs	240

The following infants and children are eligible for nutrition risk criteria code 114 (at risk of overweight):

- Infants born to a woman whose BMI is ≥ 30 at time of conception or at any point in the 1st trimester (0-13 weeks) of pregnancy
- Infants and children having a biological mother or father whose BMI is ≥ 30 at the time of certification

FOOD PACKAGE AND VOUCHER CODES

October 3rd, 2016 Food Package and Voucher Codes - Sheet 1

Status	Standard Food Package Codes	Default FPC for Standard FP and Contract Formula	Default Voucher Codes
1	1STD Pregnant Woman	A3	A2 A CVV11
2	2STD Postpartum Non-BF Woman	B	B2 CVV11
3	3STD Partially BF Woman	L3	L2 L CVV11
B	2STD Barely BF Woman (0-6 mos)	B	B2 CVV11
B	8STD Barely BF Woman (7-12 mos)	BBF	
4	4 DSTD Fully Formula Fed Infant (0 - 3 mo)	9SAP	
4	4 DSTD Fully Formula Fed Infant (4 - 5 mos)	10SAP	
4	4 ESTD Fully Formula Fed Infant (6-11 mos)	7SAP	FVC1 FVC2
5	5 1STD 1 Yr-old Child	T3	T2 T CVVB
5	5 5STD 2, 3 and 4 Yr old Children	E3	E2 E CVV8
6	6 6STD Fully BF Woman	G4	G3 G2 G CVV11
7	7 7XSTD 0 to 6 mo Fully BF Infant (no food)	XB1	
7	7 7STD 6 through 11 mo Fully BF Infant	FVCM1	FVCM1 FVCM2
9	9 FSTD Partially BF Infant (0 to 1 Month)	1SAP	
9	9 GSTD Partially BF Infant (1-3 Months)	4SAP	
9	9 HSTD Partially BF Infant (4-5 Months)	5SAP	
9	9 ISTD Partially BF Infant (6-11 Months)	4SAP	FVC1 FVC2

BF Dyad Status
 Mom = 4
 Infant = 4
 2 = 4
 3 = 9
 6 = 7
 B = 4

VC	Woman/Child Voucher Codes Description
M, 2M	gallon milk (1%/lowfat, fat free/skim)
RFM, 2RFM	gallon milk (2%/reduced fat)
WM, 2WM	gallon milk whole
Q1W	Qt equiv buttermilk; totu; evap; yogurt (Status 2, B, and 6)
3QT	Qt equiv buttermilk; totu; evap; yogurt (Status 1 and 3)
Q1C	1 Qt equiv buttermilk; evap; yogurt (2-5 children)
Q1O	1 Qt equiv buttermilk; evap; yogurt (1 yr old)
YOG	32 oz container of low fat or fat free yogurt
YOGW	32 oz container of whole milk yogurt
CH	1 lb cheese
EG	1 doz eggs
CJ, 2CJ	64 oz juice
AJ, 2AJ, 3AJ	48 oz juice
DB	1 lb. Dried beans/peas or canned beans
PB	1 - 16-18 oz Peanut butter
F	30 oz Fish (Fully BF Women only)
AC	36 oz of cereal
WW	16 oz whole wheat/whole grain
11F, 21F, 31F, 41F	16 oz package of tofu
15B, 35B	Quart Soy Beverage
25B, 45B	Qt or 1/2 gal Soy Beverage
MQT	Qt Milk (1%/lowfat, fat free/skim)
MHALF	Half Gal Milk (1%/lowfat, fat free/skim)
EVAP, 2EVAP	can Evap Milk
1UHT, 2UHT	quart UHT Milk
3UHT, 4UHT	quart UHT Milk
CVV4	Cash Value Voucher \$4 infants 9-12 months
CVV5P	Cash Value Voucher \$5.50
CVV7P	Cash Value Voucher \$7.50
CVV8	Cash Value Voucher \$8
CVV9	Cash Value Voucher \$9
CVV11	Cash Value Voucher \$11
GRNW	One ww/wh grain and 36 oz cereal
GRNC	Two ww/wh grain and 36 oz cereal
2LR, 4LR	Two (2) half gals Lactose red/free 1% or skim milk
2LR, 4LR	Two (2) half gals Lactose red/free 2% milk
2WLR, 4WLR	Two (2) half gals Lactose red/free whole milk
2GM, 4GM, 5GM	Goat's milk - Quart
6GM, 8GM	Goat's milk - Quart
1PGM, 2PGM	Goat's Milk - Powdered
3PGM, 4PGM	Goat's Milk - Powdered
5PGM, 6PGM, 7PGM	(Powdered Goat's Milk makes 3 quarts per can)
AJWW	Adult Juice & ww/wh grain
CJWW	Child Juice & ww/wh grain
CC	16 oz Cabot Cheese (Kasher or Halal needs only)
PBF	Supplemental for BFB with Prenatal vouchers

FPC	DESCRIPTION
*NM	No Milk (has both cheese & eggs) - 3 VC
*NC	No Cheese - 4VC
*NMC	No Milk or cheese - 3 VC
*NMCE	No Milk, Cheese or Eggs - 2 VC
*NPB	No Peanut Butter - 4 VC
*NEP	No eggs or peanut butter - 4 VC
*NE	No Eggs - 4 VC
*NJ	No Juice (T or S for children only)- 3VC
*MA	Multiple Allergies(no milk,cheese,eggs or PB) 3 VC
*SB	Soy beverage (no cheese, no milk) - 4 VC
*SBC	Soy beverage (cheese, no milk) - 4 VC
*VG	Vegan (Soy & Maximum Tofu) - 3 VC
*LR	Lactose Reduced or Lactose Free - 4 VC
*RFM	2% Milk Package (1, 2, 3, 6, T and 5) - 4 VC
*WM	Whole Milk Package (5 Status)- 3 VC
*NORE	No Refrigeration (Homeless)- 5VC

* Represents first digit of FPC (the code that is entered to print vouchers)
 VC = Number of Voucher Codes for a full month (what is in the voucher detail on the WIC screen)
 The above codes should be preceded by:
 -WIC Status 1, 2, 3, B, 6 if a Woman
 -T for a 1 yr old; 5 for a 2-4 yr old

FORMULA CODES

October 3rd, 2016

FORMULA CODES - SHEET 2

CONTRACT AND REBATE FORMULAS:

System will precede when * codes are preceded with: C, D, E, G, H, I for age

FPC	Description	Age:	0-3	4-5	6-11	FF	<1	1-3	4-5	6-11	PF	<1	1-3	4-5	6-11	Chd
CSTD	Slot 4 (0-3 mo) STD (default) - 1VC	VC	C	D	E		F	G	H	I						5
DSTD	Slot 4 (4-5 mo) STD (default) - 1VC	95AP	9													
ESTD	Slot 4 (6-11 mo) STD (default) - 3VC	105AP		10												
GSTD	Slot 9 (0-1 mo) STD (default) - 1VC	75AP			7											
GSTD	Slot 9 (1-3 mo) STD (default) - 1VC	15AP				1										
GSTD	Slot 9 (4-5 mo) STD (default) - 1VC	45AP					4									
HSTD	Slot 9 (6-11 mo) STD (default) - 3VC	55AP						5								
ISTD	Slot 9 (6-11 mo) STD (default) - 3VC	45AP								4						
*8012	Sim Advance (12.4) - 1 to 3VC PDR	5AP	9	10	7		1	4	5	4						10
*9013	Sim Advance (13) - 1 to 3VC CONG	5AC	31	34	24		1	4	5	4						10
*9013	Sim Soy Iso (13) - 1 to 3VC CONG	5IC	31	34	24		1	4	5	4						34
*9032	Sim Advance (32) - 1 to 3VC RTF	5AR	26	28	20		1	4	5	4						28
*9032	Sim Soy Iso (32) - 1 to 3VC RTF	5IR	26	28	20		1	4	5	4						28

Only STD (default) C,D,E,F,G,H,I - Powder will automatically change to the correct age appropriate food package.

Alternate Contract Formulas require the Medical Request from HCP

System will precede when * codes are preceded with: C, D, E, G, H, I for age

FPC	Description	Age:	0-3	4-5	6-11	FF	<1	1-3	4-5	6-11	PF	<1	1-3	4-5	6-11	Chd
*3112	Sim Total Cornl (12) - 1 to 3VC PDR	VC	C	D	E		F	G	H	I						5
*3012	Sim Sensitive (12) - 1 to 3VC PDR	STP	9	10	7		1	4	5	4						10
*3032	Sim Sensitive (32) - 1 to 3VC RTF	5SR	26	28	20		1	4	5	4						28
*3212	Simlac For Split Up (12)- 1 to 3VC PDR	SFP	9	10	7		1	4	5	4						10
*3232	Simlac For Split Up (32)- 1 to 3VC RTF	SUR	26	28	20		1	4	5	4						10

THERAPEUTIC FORMULAS (Pre Determined Quantity Per Month)

System will precede when * codes are preceded with: C, D, E, G, H, I for age

FPC	Description	Age:	0-3	4-5	6-11	FF	<1	1-3	4-5	6-11	PF	<1	1-3	4-5	6-11	Chd
*9712	Almenhurn (12.1) PDR	VC	C	D	E		F	G	H	I						5
*9732	Almenhurn (32) RTF	AMP	10	11	8		1	5	6	4						11
*8314	EnfCare Infant (14.1) PDR	ANR	26	28	20		1	2	14	10						28
*7112	EnfCare (12.8) PDR	EP	10	11	8		1	5	6	4						11
*4914	Genber Extensive HA (14.1) PDR	EHP	9	10	7		1	4	5	4						10
*7214	NeoCare Infant (14.1) PDR	NIP	9	10	7		1	4	5	4						11
*9532	NeoSure (13.1) PDR	NAP	10	11	8		1	5	6	4						11
*8512	NutrAmigen (12.6) Entloza PDR	NUP	10	11	8		1	5	6	4						28
*8513	NutrAmigen (13) CONG	NUG	31	34	24		1	4	17	12						11
*8532	NutrAmigen (32) RTF	NUR	26	28	20		1	2	14	10						34
*8616	Progestin (16) PDR	PCP	7	8	6		1	3	4	3						28
*8814	Phenex-1 (14.1) PDR	PNP	9	10	7		1	4	5	4						8
*9814	Simlac 60/40 (14.1) PDR	SPP	8	9	6		1	4	5	3						10

Common Therapeutic Formulas for use by all WIC participants:

56408	Boost (8) 8 OZ RTF 6 PK	4-7-8 Six-packs	114
55308	Ensure (8) 8 OZ RTF 6 PK	4-7-8 Six-packs	114
54908	Nutren Jr/Nutren Jr with Fiber (8.45)	107NJ	107
54308	Peplamen Jr (8.45)	59PJR/48PJR	107
58914	Phenex-2 (14.1) PDR	11PN	11
58316	EnfCare Jr (14.1) PDR	9ELP SEJP	14
57514	NeoCare Junior (14.1) PDR	10NJP 4NJP	14
55608	Pediasure w/Fiber (9) 8 OZ RTF 6 PK	4-7-8 Six-packs	114
55708	Pediasure (8) 8 OZ RTF 6 PK	4-7-8 Six-packs	114
54808	Carnation Essentials (8) 8 OZ RTF 6 PK	4-7-8 Six-packs	114

Portionally breastfeeding issuance	Ounces given per day	Cans per month	KEY:
0-3 ounces	1 can	Fully Formula Fed (FFF)	
4-6 ounces	2 cans	Partially BF (PBF)	
7-9 ounces	3 cans	Children	
10-12 ounces	4 cans	Women	
13-15 ounces	5 cans		
16-18 ounces	6 cans		

6 cans is ONLY for Almenhurn, NeoSure, NutrAmigen, and Entocare

FPC	DESCRIPTION
ECV	Infant CVV 9-12 months Fully Formula Fed Infant
ECVV	Infant CVV 9-12 months Portionally BF Infant
ICVV	Infant CVV 9-12 months Fully BF Infant
7CVC	Infant Fruits/Vegetables & Cereal (Do not use a prefix)
D5F	Drop shipped formula (Do not use a prefix)

FPC	DESCRIPTION
VC	Infant Voucher Codes Description
VC1	16 Infant Fruits/Vegetables and 2 boxes Infant Cereal
VC2	14 Infant Fruits/Vegetables and 1 box Infant Cereal
VC3	14 Infant Fruits/Vegetables and 3 boxes of Infant Cereal
VC21	21 Infant Fruits/Vegetables and 1 box Infant Cereal
VC22	22 Infant Fruits/Vegetables and 1 box Infant Cereal
VCAM1	21 F&V; 1 Inf cereal; 10 meats
VCAM2	22 F&V; 1 Inf cereal; 11 meats
VCAM3	16 F&V; 2 Inf cereal; 16 meats
VCAM4	16 F&V; 1 Inf cereal; 15 meats
IC3	1 Infant cereal
IC	3 Infant cereal
FV16	16 Infant F&V
FV21	18 Infant F&V
FV21	21 Infant F&V
IM15	15 Infant Meats
IM16	14 Infant Meats

Fis/CVVs are prorated according to the day of the month
Days 1-7: 100%
Days 8-14: 75%
Days 15-21: 50%
Days 22-end of month: 30%

TENNESSEE WIC MEDICAL REQUEST FOR FORMULA/FOODS



Tennessee Health Department WIC Medical Request for Formula/Foods

Patient's Name: _____

Date of Birth: _____

REQUEST FOR ALTERNATE CONTRACT FORMULA

Similac Advance (milk-based) and Similac Soy Isomil are provided by parent/caregiver request. An alternate Similac formula (**19 calories per ounce**) requires a written request from the Health Care Provider. Check below to request an alternate formula:

- For lactose sensitivity and/or colic give Similac Sensitive (reduced lactose)
- For digestive issues and/or colic give Similac Total Comfort (partially hydrolyzed protein)
- For gastroesophageal reflux give Similac For Spit-Up (added rice starch, reduced lactose)

Formula amount per day: _____ (Maximum provided, approx. 26 oz/day, unless reduced amount is indicated)

Number Months of Issuance: _____ (Will be issued up to 12 months of age unless otherwise indicated)

WIC SUPPLEMENTAL FOODS

All appropriate WIC foods will be issued with prescribed formula unless checked DO NOT GIVE.

Infants (6-11 months) DO NOT GIVE	Children (born prematurely) DO NOT GIVE the WIC Foods checked below:		
<input type="checkbox"/> Infant Cereal <input type="checkbox"/> Infant Food Vegetables & Fruits	<input type="checkbox"/> Cheese <input type="checkbox"/> Cereal <input type="checkbox"/> Juice	<input type="checkbox"/> Eggs <input type="checkbox"/> Vegetables/Fruits	<input type="checkbox"/> Whole Grain Products <input type="checkbox"/> Dried Beans or Peas

HEALTH CARE PROVIDER (HCP) INFORMATION (Signature and all information below required to process request):

By my signature below I attest that the patient needs the formula that is requested. I also acknowledge that these formulas are 19 calories per ounce, which is less than the standard 20 calories per ounce.

Signature of HCP: _____ Date: _____

Provider's Name (Please Print): _____

Contact Phone: (_____) _____ Fax: (_____) _____

Address: _____

TENNESSEE'S NUTRITION RELATED WIC QUALIFYING CONDITIONS

For Issuing Therapeutic Formula or Nutritionals

WIC Qualifying Conditions	Participant category	Examples
Includes but not limited to:		
*Inborn Errors of Metabolism & Metabolic Disorders	Infants & Children	PKU, Maple Syrup Urine Disease, Galactosemia, Fatty Acid Oxidation Defects, Hypercalcemia, Williams Syndrome, Urea Cycle Disorder, Glycogen Storage Diseases, Lysosomal Storage Diseases
Prematurity & Low Birth Weight	Infants	Infants born equal to or less than 37 weeks are considered Premature & Low Birth Weight is less than or equal to 5 pounds 8 ounces (2500 grams)
*Malabsorption Syndromes	Infants, Children & Women	Cystic Fibrosis, Chronic pancreatitis, Whipple disease (with symptoms of chronic diarrhea, FTT, bloating), diseases & conditions resulting in failure to absorb specific nutrients
Seizure Disorders	Infants & Children	Ross Carbohydrate Free formula or KetoCal can be issued
Developmental Disabilities with Nutritional Complications	Infants & Children	Such as oral motor feeding problems
Hyperemesis Gravidarum	Women	Boost or Ensure may be issued
Severe Food Allergies	Infants & Children	Confirmed severe food allergic disorders including Cow's Milk Protein Allergy (CMPA), gastrointestinal anaphylaxis, allergic eosinophilic esophagitis, allergic eosinophilic gastroenteritis, food protein-induced proctocolitis, food protein-induced enterocolitis, food protein-induced enteropathy, celiac disease & atopic disease
*Gastrointestinal Disorders	Infants, Children & Women	Crohn's Disease, Ulcerative Colitis, Short Bowel Syndrome (hydrolyzed formulas), Celiac Disease
Failure to Thrive	Infants & Children	Weight decrease from participant's established growth channel by two major percentile lines and failure to improve with increased caloric density of standard formula
Life Threatening Disorders, Diseases, Medical Conditions	Women, Infants & Children	Impaired ingestion and/or digestion, impaired absorption/utilization of nutrients that adversely affect nutrition status
Immune System Disorders	Women, Infants & Children	HIV/AIDS

***NOTE: TN WIC does not provide therapeutic products for WIC participants who receive TennCare AND have a WIC Qualifying Condition which involves malabsorption syndromes, inborn error of metabolism, gastrointestinal disorders that interfere with the intake, digestion, and/or absorption of nutrients, or if the participant is completely or partially tube fed. TennCare is responsible for therapeutic products provided to these WIC participants. WIC will provide therapeutic products to non-TennCare eligible participants.**

5/20/16

HCP COMMUNICATION TOOL

Attention:

Client's Name:

Date of Birth:

The Following applies to the client:

- Client is not eligible for the WIC Program.
- Infant formula or nutritional supplements requested for the client are not authorized on the Tennessee WIC Program.
- Infant formula or nutritional supplements requested for the client do not meet the Tennessee WIC Program guidelines.
- Client does not meet qualifying conditions indicated by Tennessee WIC Program guidelines.
- Infant formula or nutritional supplements requested in amounts that exceed amounts issued by the Tennessee WIC Program. Consider requesting additional product from third party payer.
- Please request an appropriate WIC Standard formula or pursue an alternative resource.
- Client to be transitioned to TennCare (Medicaid) for therapeutic products. Client will need a prescription to take to the pharmacy for claim submittal and coverage determination or authorization if applicable.

Comments:

Signature Title

Date

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity employer."

REQUEST FOR WIC ELIGIBLE THERAPEUTIC PRODUCTS



**TENNESSEE DEPARTMENT OF HEALTH
 REQUEST FOR WIC THERAPEUTIC PRODUCTS AND SUPPLEMENTAL FOODS
 MUST BE COMPLETED BY HEALTHCARE PROVIDER**

Patient's Name: _____ Date of Birth: _____

Formula Requested: _____ Dilution Strength (if >standard for product) _____

Amount per 24 hours: maximum allowed (approx. 26 oz/day) or _____ day Tube Fed: Y N
 Requested length of issuance: 1mo 2mo 3 mo 4mo 5mo 6 mo

Most Recent Date of Measures: _____ Weight: _____ Height/Length: _____

Nutrition Related **WIC Qualifying Condition:** _____

If food allergy must specify the confirmed allergic disorder:

- Food protein induced enterocolitis Eosinophilic gastroenteritis Gastrointestinal anaphylaxis
- Food protein induced proctocolitis Eosinophilic esophagitis Atopic disease
- Food protein enteropathy, celiac Acute or chronic urticaria & angioedema

Clinical Findings, Laboratory Results, Diagnostic Evidence of Need: _____

Supplemental WIC foods listed below will be issued in addition to the formula /nutritional product requested. Please indicate any food restrictions or provisions for the patient.	
Infants (6-11 months) DO NOT GIVE: <input type="checkbox"/> Infant Cereal <input type="checkbox"/> Infant Vegetables/Fruits	Children & Women DO NOT GIVE: <input type="checkbox"/> Milk <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Vegetables/Fruits <input type="checkbox"/> Cheese <input type="checkbox"/> Dried Beans/Peas <input type="checkbox"/> Cereal <input type="checkbox"/> Juice <input type="checkbox"/> Whole Grain Products <input type="checkbox"/> Canned Fish (Breastfeeding <input type="checkbox"/> Eggs <input type="checkbox"/> Soy Beverage or Tofu <input type="checkbox"/> Women Only)
DO PROVIDE: <input type="checkbox"/> Higher Fat Milk: <input type="checkbox"/> 2% <input type="checkbox"/> Whole <input type="checkbox"/> Pureed (Infant Food) Vegetables/Fruits	

Prescribing Health Care Provider (HCP):

Name: _____

Address: _____

Contact Phone: _____ Fax: _____

Signature (including credentials) _____ Date of Request: _____

REQUEST IS SUBJECT TO TN WIC APPROVAL AND PROVISION BASED ON PROGRAM REGULATION AND POLICY

WIC Use Only _____

THERAPEUTIC FORMULA ASSESSMENT TOOL

<p style="text-align: center;">Therapeutic Formula Assessment Tool</p> <p>Product Requested: _____</p>	<p style="text-align: center;">LABEL</p> <p>Date: _____</p> <p>Name: _____</p> <p>DOB: _____</p> <p>Chart No. _____</p>
<p>Complete the First Section of the Tool. Fill out other sections according to the age and diagnosis of the participant. Attach the Therapeutic Product Request form and completed WIC Questionnaire.</p>	

1. Medical Condition and Anthropometrics (also refer to growth chart)

WIC Qualifying Condition _____ Family history of this condition: Y N

Y N Tube Fed?

Y N Inborn Error of Metabolism or Metabolic Disorder?

Y N Malabsorption Syndrome?

Y N Diagnosed GI Disorder (Crohn's, Ulcerative Colitis, Short Bowel Syndrome, Celiac Disease)?

Does patient have TNCare? Y N (Note: If "Yes", RD or CPA needs to send letter to HCP to transition to TNCare.)

Birth Measures (infants only): Birth weight: _____ Birth length: _____

Date of Current Measures: _____ Weight: _____ Length/Height: _____

Wt/Length or BMI % _____ BMI _____

2. Assessing Premature Infants

Weeks gestation at birth _____ Corrected gestational age _____

Is Baby Breastfed? Y N Is Baby fed pumped Breastmilk? Y N Is Breastmilk Fortified? Y N

Special Feeding instructions by MD: _____

3. Assessing Infants and Children with Food Allergies

Family History of allergies? Y N If Yes, describe: _____

Description of problem: _____

Allergy or Blood Test Performed? Y N If Yes, When? _____ Results: _____

All formulas tried/duration: _____

Please check any symptoms reported by caregiver; When did symptoms occur? _____

Vomiting (frequency _____) Diarrhea (description/ duration _____)

Rash (location _____) Constipation (description/duration _____)

Visibly bloody stools (date _____) Painful Gas Labored Breathing Cough

Special Feeding instructions by MD: _____

Has there been a re-challenge of standard formula? Y N If Yes, when? _____

Describe any reactions to the re-challenge of standard formula? _____

4. Assessing Infants and Children with Other Conditions

- Failure To Thrive Problems Swallowing Refuses Food Vomiting (frequency_____)
- Diarrhea (frequency_____)
- Low Birth Weight Premature (_____ weeks gestation)
- Developmental Delays: _____
- Other Symptoms/Findings: _____

Describe Medical Tests Performed. Include date(s) and results. _____

Consistent Feeding Routine? Y N Age Appropriate Feeding Routine? Y N

Describe child's typical eating & drinking habits: _____

Special Feeding instructions by MD: _____

5. Assessing Women

- Pregnant Post-Partum Breastfeeding
- Hyperemesis Gravidarum Gastric bypass Eating disorder HIV
- Other medical conditions: _____

Special Feeding instructions by MD: _____

Is the request for more formula than WIC can provide? Y N

(Note: If "Yes" to above, RD or CPA needs to send letter to HCP requesting additional product from third party payer.)

CPA Comments: _____

Issued 1 month while waiting for supporting medical documentation/RD approval

CPA Signature/Date _____

RD Comments: _____

Approved for 3 months Approved for 6 months Eligible for Supplemental Foods/Age

If denied, why? _____

RD Signature/Date _____

TENNESSEE WIC PROGRAM FORMULARY

Breastfeeding is the normal and preferred infant nutrition.

Standard Contract Infant Formulas (20 kcal/oz) are available by parent/caregiver request:

Similac Advance (milk-based) or Similac Soy Isomil

Alternate Contract Infant Formulas (19 kcal/oz) require a written request from the Health Care Provider (PH-4234):

Similac Sensitive (reduced lactose)
Similac Total Comfort (reduced lactose, partially hydrolyzed protein)
Similac for Spit-Up (added rice starch, reduced lactose)

Therapeutic Formulas/Nutritionals require a WIC Therapeutic Formula Request from the Healthcare Provider (PH-4077):

Carnation Breakfast Essentials
Elecare Infant and Elecare Jr
Enfamil Enfacare
Gerber Extensive HA
Neocate Infant and Neocate Jr (all flavors)
Nutramigen and Nutramigen with Enflora LGG
Nutren Jr /and with fiber
Pediasure and Pediasure with Fiber “Shake”
Pediasure 1.0 and with fiber
Peptamen Jr
Phenex 1 and 2
Pregestimil LIPIL
Similac Alimentum
Similac Neosure
Similac PM 60-40

Women Only – Boost & Ensure

*Other formulas and nutritionals may be WIC-Eligible on a case by case basis. TN WIC cannot provide any other brand of standard infant formula, such as Enfamil or Good Start products.

10-01-2016

THERAPEUTIC FORMULA ORDERING FORM



Department of
Health

Therapeutic Formula Ordering Form

Clinic

Contact Person Information

Patient Name DOB

Patient Number

Diagnosis/Condition

Tube Fed Both Tube Fed & Oral Intake TennCare*

*If WIC participant has a condition which involves malabsorption syndromes, inborn error of metabolism, gastrointestinal disorders that interfere with intake, digestion, and/or absorption of nutrients, or if the participant is tube fed, TennCare is responsible for therapeutic product.

Product Requested

Flavors

Vanilla Chocolate
 Strawberry Fiber (only comes in Vanilla)

Quantity needed

Months Ordering For

Last Month of Product Issued

Quantity on Hand

Central Office Use Only

Please fill out and return to:

Cindy.Dossett@tn.gov

Questions: Cindy Dossett, RD 615-532-8180

Fax: 615-532-7189

Date ordered: _____

Account Number: _____

Item Number: _____

Quantity: _____

Cost per case \$ _____

Total cost \$ _____

Confirmation number: _____

INSTRUCTIONS: FORMULA INVENTORY LOG

The purpose of the Formula Inventory Log is to record formula received in the clinic and formula issued from clinic stock. Clinics are to use the Formula Inventory Log found in the current WIC Manual. The log is used to record formula received from Drop Ship Formula (DSF) orders and when formula purchased by a WIC FI is returned to the clinic. The log is also used to record formula issued from clinic stock to WIC participants. When logging formula (received or issued) record the expiration date of the formula. Formula inventory must be done monthly and recorded on the Formula Inventory Log. Any expired formula must be disposed of and recorded as destroyed.

Formula in the clinic must be kept secure. Secure is defined as free from risk of loss; safe or act to make safe against adverse contingencies, to put beyond the hazard of losing.

To ensure that the participant receiving formula from clinic stock is counted as a WIC participant:

- issue a voucher for part of the formula, or
- issue voucher(s) for appropriate WIC foods, or
- use food package code DSF

Use a separate inventory sheet for each formula

Region	Enter region name or code
County	Enter county name or number code
Clinic	Enter clinic name or number code
Formula	Enter product name
Size	Enter container size
Circle One	Indicate form- Powder, Concentrate, or RTF
Date	Enter date of transaction
Units Received	Enter number of formula units received from participant or drop shipped to clinic
Expiration Date	Enter date formula expires (received or issued)
Units Issued	Enter number of units of formula issued to participant
Total On hand	Enter number of units of formula on hand
Participant Number Or Chart Number	Enter participant number or chart number of the participant returning formula or being issued formula
Signature	Enter signature of staff who logged in formula received or signature of participant who is issued the formula
Inventory	Enter date of inventory and staff initials followed by an arrow down to end of month inventoried

Office Mechanics and Filing: Retain original log in clinic for (4) years

THERAPEUTIC PRODUCTS INFORMATION GUIDE

THERAPEUTIC PRODUCTS INFORMATION GUIDE- Tennessee WIC Program 2016-2017

REVISED 08-02-2016

Websites for additional product information: www.abbottnutrition.com; www.meadjohnson.com or www.enfamil.com; www.nestle-nutrition.com/products or www.gerber.com; www.nutricia-na.com or www.neocate.com

NOTE: If higher dilution strength is requested by HCP, divide total calories for product by number of calories/oz requested by HCP for new can yield.

Example: Powdered Neosure has 1914 calories/can. If it is to be mixed to 24 calories per oz, 1914÷24=79 oz yield/can. Maximum issuance for Neosure is based on the standard yield of 87 oz/can. WIC's maximum monthly issuance when mixing products to higher calories per oz may not meet the full nutritional requirements of the participant for the month and the HCP should be notified. The form *HCP Communication Tool* serves to notify HCPs that the requested amount exceeds amount issued by WIC and to consider informing 3rd party payers such as TennCare of the need for additional product.

The following list of therapeutic formula/products is **not all inclusive**. Other products may be WIC approved. Email inquiries to Cindy.Dossett@tn.gov or call 615-532-8180

PRODUCT NAME (COMPANY)	NUTRITIONAL DESCRIPTION AND INDICATIONS	Max/Month
Similac Alimentum (Abbott) Powder: 12.1 oz can Can yield = 90 oz Calories/can = 1800 RTF: 32 fl. oz can Calories/can=640 RTF formula is corn-free	A nutritionally complete, hypoallergenic /protein hydrolysate formula for infants allergic to cow's milk protein or unable to digest intact protein. A supplemental beverage for children with severe food allergies, sensitivity to intact protein, protein maldigestion, or fat malabsorption. <ul style="list-style-type: none"> • Contains predigested protein • Hydrolyzed casein supplemented with free amino acids • Approximately 33% Medium Chain Triglycerides (MCT oil) • DHA and ARA • Lactose free carbohydrate for lactose sensitivity • Gluten free • RTF formula is corn-free Standard dilution 20 kcal/oz: Powder: Add 1 unpacked level scoop of powder per 2 fl oz water Ready-to Feed: Do not add water	Infant- refer to Formula Codes Sheet 2 Child 1.1 cans powder

Therapeutic Products Information Guide- Tennessee WIC Program 2016-2017

<p>Boost (Nestle) RTF: 8 fl. oz. bottles Sold in six-pack Vanilla/chocolate/strawberry</p>	<p>Nutritionally complete drink used as a general oral supplement. FOR WOMEN ONLY IN WIC. Each 8 oz (237 ml) drink provides:</p> <ul style="list-style-type: none"> • 240 kcal • 10 grams High Quality Protein • 26 vitamins and minerals • Antioxidants • Low in saturated fats • Gluten Free • Suitable for lactose intolerance • NOT for individuals with galactosemia 	<p>WOMEN ONLY 114 (19 SIX-PACKS)</p>
<p>Boost Plus (Nestle) RTF: 8 fl. oz bottles Sold in six-pack Vanilla/chocolate/strawberry</p>	<p>Nutritionally complete drink with 360 calories, 14 grams of High Quality Protein, 3 grams prebiotics, 26 vitamins/minerals, antioxidants, low in saturated fat, gluten free, suitable for lactose intolerance. NOT for individuals with galactosemia. FOR WOMEN ONLY IN WIC.</p>	<p>WOMEN ONLY 114 (19 SIX-PACKS)</p>
<p>Boost High Protein (Nestle) RTF: 8 fl. oz bottles Sold in six-pack Vanilla/chocolate/strawberry</p>	<p>Nutritionally complete drink used as a general oral supplement for individuals with increased protein needs. Each 8 oz (237 ml) drink provides 240 calories, 15 grams of High Quality Proteins, 26 vitamins/minerals, antioxidants, low in saturated fat, gluten free, suitable for lactose intolerance. NOT for individuals with galactosemia. FOR WOMEN ONLY IN WIC.</p>	<p>WOMEN ONLY 114/month (19 SIX-PACKS)</p>
<p>Boost Kid Essentials 1.0 (Nestle) 8 fl. oz RTF tetra brik 27 briks/ case</p>	<p>Nutritionally complete drink specially designed for children ages 1-13. Each 8 oz drink (237 ml) provides 240 calories, 7 grams of protein, and meets or exceeds 100% DRI for 25 key vitamins and minerals. Appropriate for lactose intolerance, gluten free, low residue, kosher. NOT for individuals with galactosemia. Drop Ship Formula (DSF) : Vanilla: 33510000, Chocolate: 33520000, Strawberry: 33530000</p>	<p>DSF Children Only 113/month</p>
<p>Boost Kid Essentials 1.5 (Nestle) 8 fl. oz RTF tetra brik 27 briks/case</p>	<p>Nutritionally complete drink specially designed for children ages 1-13. Each 8 oz drink (237 ml) provides 360 calories, 10 grams of protein, and meets or exceeds 100% DRI for 25 key vitamins and minerals. Appropriate for lactose intolerance, gluten free, low residue, kosher. NOT for individuals with galactosemia. Drop Ship Formula (DSF) : Vanilla: 33540000, Chocolate: 33580000, Strawberry: 33590000</p>	<p>DSF Children Only 113/month</p>
<p>Boost Kid Essentials 1.5 with fiber (Nestle) 8 fl. oz RTF tetra brik 27 briks/case</p>	<p>Nutritionally complete drink specially designed for children ages 1-13. Each 8 oz drink (237 ml) provides 360 calories, 10 grams of protein, 2 grams of fiber, and meets or exceeds 100% DRI for 25 key vitamins and minerals. Fiber blend helps support digestive health and normal bowel function. Appropriate for lactose intolerance, gluten free, kosher. NOT for individuals with galactosemia. Drop Ship Formula (DSF) : Vanilla: 33500000</p>	<p>DSF Children Only 113/month</p>
<p>Carnation Breakfast Essentials</p>	<p>Complete and balanced nutritional drink for oral feeding, providing 240 calories, 10g protein, and 21 vitamins and minerals per 8 fl. oz. Kosher, gluten free and suitable for lactose intolerance. For use in children and adults with a medical condition or disease resulting in decreased food intake or increased nutrient requirements. Can be used to meet energy or protein needs associated with malnutrition, celiac disease or impaired growth.</p>	<p>Children and Women 114/month (19-Six Packs)</p>

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<p>Calcilo XD (Abbott) Powder: 13.2 oz can Can yield = 96 fl oz Calories/can = 1920 6 cans/case</p>	<p>Nutritionally complete low-calcium, vitamin D-free formula for infants with hypercalcemia, as may occur in infants with Williams syndrome, osteoporosis, or primary neonatal hyperparathyroidism. Lactose free and gluten free. Kosher, Halal. Standard Dilution 20 kcal/oz when mixed 1 unpacked level scoop per 2 fl oz water. Drop Ship Formula (DSF): #53328 Infants Only: 0-3 mos: 9 cans, 4-5 mos: 10 cans, 6-11 mos: 7 cans or 10 cans if no infant FVC</p>	<p>DSF Infants Only- amt. varies with age</p>
<p>Cyclinex 1 (Abbott) Powder: 14.1 oz can Calories/can = 2040 6 cans/case</p>	<p>Amino acid modified infant formula with iron. For infants and toddlers with a urea cycle disorder, gyrate atrophy of the choroid and retina, or HHH syndrome. Formula is free of non-essential amino acids to decrease the ingestion of waste nitrogen. Additional vitamins and minerals to compensate for nutrient losses due to nitrogen-scavenger medications. Mix according to physician's instructions.</p>	<p>DSF#51144 Infants- amt. varies with age Toddlers- 10 cans/mo</p>
<p>Cyclinex 2 (Abbott) Powder: 14.1 oz can Calories/can= 1760 6 cans/case</p> <p>Elecare (Infant) DHA/ARA (Abbott) Powder: 14.1 oz can Can yield = 95 fl. oz at 20 kcal/oz Calories/can=1900 6 cans/case</p>	<p>A nonessential amino acid-free medical food for children and adults with a urea cycle disorder, gyrate atrophy of the choroid and retina, or HHH syndrome. Lactose free and gluten free, Halal. Follow physician's preparation instructions. A nutritionally complete amino-acid based formula for infants who cannot tolerate intact or hydrolyzed protein. Elecare is indicated for the dietary management of protein maldigestion, malabsorption, severe food allergies, short-bowel syndrome, eosinophilic GI disorders, G-I tract impairment, or other conditions in which an amino acid-based diet is required. <ul style="list-style-type: none"> Does not contain milk protein, soy protein, fructose, galactose, lactose, or gluten 100% free amino acids as nitrogen source DHA and ARA 33% of fat blend as medium-chain triglycerides (MCT oil) Halal Standard Dilution 20 kcal/oz when mixed 2 fl oz water + one unpacked level scoop powder </p>	<p>DSF#51146 Children/Women 10 cans/mo</p>
<p>Elecare Jr (Abbott) Unflavored/Vanilla Powder: 14.1 oz can Can yields= 62 fl. oz at 30 kcal/oz 6 cans/ case</p>	<p>If not available locally, may be DSF: #55251 A nutritionally complete amino-acid based medical food for children over 1 year of age who cannot tolerate intact or hydrolyzed protein. Elecare Jr is for the dietary management of protein maldigestion, malabsorption, severe food allergies, short-bowel syndrome, eosinophilic GI disorders, G-I tract impairment, or other conditions in which an amino acid-based diet is required. <ul style="list-style-type: none"> Does not contain milk protein, soy protein, fructose, galactose, lactose, or gluten 100% free amino acids as nitrogen source 33% of fat blend as medium-chain triglycerides (MCT oil) Halal Standard Dilution 30 kcal/oz when mixed 5 fl. oz water + 4 unpacked level scoops powder = 6 fl. oz </p> <p>If not available locally, may be DSF: Unflavored #55253, Vanilla #56585</p>	<p>Infants Only- refer to Formula Codes Sheet 2</p> <p>Children Only 14 cans/mo</p>

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<p>Enfamil <u>EnfaCare</u> (Mead Johnson) Powder:12.8 oz can Can yield = 83 fl. oz at 22 kcal/oz Calories/can=1800</p>	<p>Milk-based formula providing extra calories, protein, calcium, phosphorous, vitamins and minerals than standard infant formula. Supports catch up growth for infants born prematurely or low birth weight.</p> <ul style="list-style-type: none"> • Standard Dilution 22 kcal/oz (2 fl oz water + one unpacked level scoop powder) • 2.8 gm protein/100 calories • 60% whey/40% casein protein • 20% fat blend from medium-chain triglycerides (MCT oil) • Higher levels of calcium and phosphorus • DHA and ARA • Contains milk and soy 	<p>Infant- refer to Formula Codes Sheet 2 Toddlers- only if extremely low birth weight 11 cans</p>
<p>Ensure (Abbott) 8 oz RTF nutrition shake Sold in six-pack Vanilla/Chocolate/Strawberry/Butter Pecan</p>	<p>Complete balanced nutrition shake for patients with malnutrition, or at nutritional risk, or losing weight involuntary.</p> <ul style="list-style-type: none"> • 250 calories per 8 oz bottle • 9 grams of protein • Gluten free • Low residue • Suitable for lactose intolerance • Not for patients with galactosemia • Kosher/Halal 	<p>WOMEN ONLY 114 (19 SIX-PACKS)</p>
<p>Ensure Plus(Abbott) 8 oz RTF nutritional drink Sold in six-pack Vanilla/Chocolate/Strawberry/Butter Pecan</p>	<p>Complete balanced nutritional drink for patients with malnutrition, or at nutritional risk, or losing weight involuntary.</p> <ul style="list-style-type: none"> • 350 calories per 8 oz bottle • 13 grams of protein • 3 grams of fiber • Gluten free • Suitable for lactose intolerance • Not for patients with galactosemia • Kosher/Halal 	<p>WOMEN ONLY 114 (19 SIX-PACKS)</p>
<p>Gerber Extensive HA (Nestle) Powder: 14.1 oz can Can yield= 96 fl oz Calories/can= 1900</p>	<p>Gerber Extensive HA is the only formula made with 100% whey protein extensively hydrolyzed and probiotic B. lactis. It is a complete source of nutrition for the dietary management of infants with cow's milk protein allergy (CMPA).</p> <ul style="list-style-type: none"> • 100% whey protein extensively hydrolyzed • Probiotic B. lactis to help promote a balanced microbiota • 49% MCT to facilitate fat absorption • DHA for brain and eye development • Osmolality of 220 mOsm/kg water, close to breastmilk • Standard Dilution 20 kcal/oz when mixed one unpacked level scoop per one fl oz water <p>Add one unpacked scoop of powder for each 1-fluid ounce of water</p>	<p>Infants Only- refer to Formula Codes Sheet 2</p>

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<p>Enfamil Human Milk Fortifier Acidified Liquid (Mead Johnson) 5 mL vials, 200 per Case</p>	<p>To be added to expressed breast milk for feeding premature or low birth weight infants. Fortifier is milk-based and when mixed with breast milk increases the level of protein, calories, calcium, phosphorus and other nutrients to support the nutritional needs of the premature infant. Contains DHA and ARA. To add 2 calories/ fl oz: mix 1 vial with 50 ml breastmilk. To add 4 calories/ fl oz: mix 1 vial with 25 ml breastmilk.</p>	<p>DSF#146301 Infants Only</p>
<p>KetoCal 3:1 (Nutricia) Powder: 11 oz. can No standard yield Calories/can=2097 6 cans/case</p>	<p>A nutritionally complete, ketogenic formula in a 3:1 ration (fat: carbohydrate + protein) for the dietary management of intractable epilepsy. High in fat and low in carbohydrates to enable the individual to achieve and maintain ketosis. Energy Distribution: 87.1% fat, 4.1% carbohydrate, 8.8% protein. Designed for children up to 8 years of age. Not suitable for children under one year of age. Dilution to be determined by medical prescription: KetoCal 3:1 Dilutions: 20 kcal/fl. oz: 9.5 gm powder + 91 mL water = 100 mL (final volume) 24 kcal/fl. oz: 11.4 gm powder + 89 mL water = 100 mL 30 kcal/fl. oz: 14.3 gm powder + 86 mL water = 100 mL</p>	<p>DSF #16672 Children Only 13 cans/mo</p>
<p>KetoCal 4:1 (Nutricia) Powder: 11 oz. can Standard Yield/can = 50 fl. oz Calories/can=2160 6 cans/case</p>	<p>A nutritionally complete, ketogenic formula in a 4:1 ration (fat: carbohydrate + protein) for the dietary management of intractable epilepsy. High in fat and low in carbohydrates to enable the individual to achieve and maintain ketosis. Energy Distribution: 90% fat, 1.6% carbohydrate, 8.4% protein. Designed for individuals over 1 year of age. Standard dilution of 4 mL of water to 1 gm of powder (400 mL water + 100 gm powder = 500 mL final volume) = 1.44 kcal/ml (approximately 43 kcal/oz)</p>	<p>DSF #16670 Children/Women 13 cans/mo</p>
<p>KetoCal 4:1 LQ (Nutricia) 8 oz RTF tetra pak (box) Calories/box=356 27 tetra paks/carton</p>	<p>A nutritionally complete, ready-to-feed ketogenic formula in a 4:1 ration (fat: carbohydrate+protein) for the dietary management of intractable epilepsy. Energy Distribution: 90%fat, 3.1% carbohydrate, 1.5% fiber, 8.2% protein. Contains a blend of insoluble and soluble fiber, DHA and ARA. Designed for individuals over 1 year of age. DSF: 80180/vanilla, #53054/unflavored</p>	<p>DSF Children/Women 113 boxes/mo</p>
<p>Monogen (Nutricia) Powder: 14 oz. can Yield at 22 kcal/oz= 70 oz Yield at 30 kcal/oz= 42 oz Calories/can=1680 6 cans/case</p>	<p>A milk protein based powder, low in fat and high in medium chain triglycerides (MCT); 24% of calories from fat, 80% of fat as MCT. Indicated uses include long chain fatty acid oxidation disorders, hyperlipoproteinemia, intestinal lymphangiectasia, intractable malabsorption with steatorrhea, and short bowel syndrome. Not indicated for infants under 1 year. Typical Dilutions: 22kcal/fl. oz = 17.5 gm powder (3 ½ scoops) + 90 mL water (3 fl. oz) 30 kcal/fl. oz = 24 gm powder (5 scoops) + 80 mL water (2 ½ fl oz)</p>	<p>DSF #667097 Children/Women 10 cans/mo</p>

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<p>Neocate Infant DHA/ARA (Nutricia) Powder: 14.1 oz. can Can yield = 97 oz. Calories/can=1932 4 cans/case</p>	<p>A nutritionally complete, lactose-free, sucrose-free, soy-free, gluten-free, hypoallergenic infant formula with iron, containing protein as 100% amino acids. Indicated for cow and soy protein allergies, multiple food protein intolerance, food allergy related GERD, eosinophilic esophagitis, and other GI disorders requiring an amino acid based diet. Specifically designed for infants under 1 year of age. Only Amino Acid based without soy, replaced with canola oil.</p> <p>Standard dilution 20 kcal/oz: Add 1 unpacked level scoop of powder to each fluid ounce of water</p> <p>If not available locally, may be DSF: #12595</p>	<p>Infants Only- refer to Formula Codes Sheet 2</p>
<p>Neocate Jr. (Nutricia) Powder: 14.1 oz. can Unflavored: Yield/can= 64 fl oz Calories/can=1912</p> <p>Tropical and Chocolate: Yield/can= 60 fl oz Calories/can=1804</p>	<p>An elemental medical food containing 100% free amino acids. Complete nutrition support for children with gastrointestinal impairment due to cow and soy protein allergies and other medical conditions affecting the gastrointestinal tract. Not intended for infants under 1 year.</p> <p>Standard dilution 30 kcal/oz: Measure amount of warm or cool water into container. Add amount of Neocate. Cover and shake until powder has dissolved.</p> <p>Unflavored: Add 18 scoops powder to 20 fl oz water = 24 fl oz (final volume) Tropical and Chocolate: Add 20 scoops powder to 20 fl oz water = 24 fl oz (final volume)</p> <p>If not available locally, may be DSF: #11790/unflavored, #12124/tropical, #12690/chocolate, 4 cans/case</p>	<p>Children Only 14 cans/mo</p>
<p>Neocate Jr. with Prebiotics (Nutricia) Powder: 14.1 oz. can Unflavored: Yield/can= 64 fl oz Calories/can=1912</p> <p>Vanilla and Strawberry: Yield/can= 61 fl oz Calories/can=1836</p>	<p>An elemental medical food containing 100% free amino acids. Complete nutrition support for children with gastrointestinal impairment due to cow and soy protein allergies and other medical conditions affecting the gastrointestinal tract. Not intended for infants under 1 year.</p> <p>Standard dilution 30 kcal/oz: Measure amount of warm or cool water into container. Add amount of Neocate. Cover and shake until powder has dissolved.</p> <p>Unflavored: Add 18 scoops powder to 20 fl oz water = 24 fl oz (final volume) Vanilla and Strawberry: Add 20 scoops powder to 21 fl oz water = 25 fl oz (final volume)</p> <p>If not available locally, may be DSF: #1292/unflavored, #60627/vanilla, #86456/strawberry, 4 cans/case</p>	<p>Children Only 14 cans/mo</p>
<p>Similac Neosure (Abbott) Powder: 13.1 oz can Standard can yield=87 fl. oz Calories/can=1914</p> <p>RTF: 32 fl. oz plastic bottle Calories/container: 704</p>	<p>Milk-based, iron fortified formula designed for infants born prematurely. Higher level of calories, protein, vitamins, calcium, phosphorus and most other minerals than standard infant formula. 25% fat blend as medium-chain triglycerides (MCT), contains DHA/ARA. Gluten-free, Kosher/Halal.</p> <p>Standard dilution 22 kcal/oz: Add 1 level unpacked scoop of powder to each 2 fl oz water To mix 24 kcal/oz: Add 3 level unpacked scoops of powder to 5.5 fl oz water (yields approx. 6 fl oz)</p>	<p>Infant- refer to Formula Codes Sheet 2 Toddlers- only if extremely low birth weight 1.1 cans</p>

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<p>Nutramigen (Mead Johnson) Powder (with Enfliora LGG): 12.6 oz Can yield = 87 fl. oz. Calories/can=1740 Concentrate: 13 oz Yield= 26 fl oz RTF: 32 oz</p>	<p>Iron-fortified, lactose-free, galactose-free, hypoallergenic formula for infants who are allergic to intact proteins in cow's milk and soy formula. Has DHY/ARA. Powder contains the probiotic LGG to help support digestive health. In cases of severe and multiple food allergies, Nutramigen is sometimes continued as a milk substitute in the diet of children. Standard dilution 20 kcal/oz: Powder: Add 1 level packed scoop of powder to 2 fl oz water Concentrate: Mix 1 oz concentrated liquid with 1 fl oz water Ready-to Feed: Do not add water</p>	<p>Infant- refer to Formula Codes Sheet 2 Children 11 cans PDR/mo Or 34 conc/mo Or 28 RTF/mo</p>
<p>Nutren Jr. & Nutren Jr with fiber (Nestle) RTF: 8.45 fl. oz. carton/vanilla</p>	<p>Nutritionally complete milk-based oral supplement for children ages 1-13; similar to Pediasure and Boost Kid Essential 1.0. Each 250 mL carton (8.45 fl oz) contains 250 calories, 7.5 grams protein, with 50% whey protein to promote tolerance. Meets IOM recommendations for calcium and vitamin D. Appropriate for lactose intolerance, gluten-free, Kosher. Not for individuals with galactosemia. Nutren Jr with fiber contains 1.5 grams of dietary fiber per carton to help support normal bowel function. If not available locally, may be DSF: # 9871616062/vanilla, # 9871616063/vanilla with fiber, 24 cartons/case</p>	<p>Children Only 107/mo</p>
<p>Pediasure (Abbott) Pediasure/Pediasure Shake/Pediasure Enteral RTF: 8 fl. oz (sold in six-packs) Vanilla/choc/strawberry/banana/berry</p>	<p>Complete nutrition especially designed for children 1 to 13 years of age; 8 fl oz (237 mL) provides 240 calories, 7 g protein, 9 g fat, 33 g carbohydrate; caloric distribution 12% protein, 34% fat, 54% carbohydrate. Suitable for lactose intolerance, gluten free, Kosher, Halal. Contains milk and soy ingredients. Not for children with galactosemia. Pediasure <u>Enteral</u> Formula 1.0 Cal is specially formulated for <u>tube feeding</u> (vanilla only).</p>	<p>Children 114/mo Infants 6 mo. or older if <u>enteral</u> for tube feeding</p>
<p>Pediasure with fiber (Abbott) Pediasure/Pediasure Shake/Pediasure Enteral with fiber RTF: 8 fl oz (sold in six-packs) Vanilla/strawberry</p>	<p>Complete nutrition especially designed for children 1 to 13 years of age; 8 fl oz (237 mL) provides 240 calories, 7 g protein, 9 g fat, 33 g carbohydrate, plus 3 g dietary fiber; caloric distribution 12% protein, 34% fat, 54% carbohydrate. Suitable for lactose intolerance, gluten free, Kosher, Halal. Contains milk and soy ingredients. Not for children with galactosemia. Pediasure <u>Enteral</u> Formula 1.0 Cal with prebiotic fiber is specially formulated for <u>tube feeding</u> (vanilla only).</p>	<p>Children 114/mo Infants 6 mo. or older if <u>enteral</u> for tube feeding</p>
<p>Pediasure 1.5 & Pediasure 1.5 with fiber (Abbott) RTF: 8 fl oz (237 ml) 24 cans/case Vanilla only</p>	<p>Pediasure 1.5 Cal is a higher calorie product designed to meet the energy requirements of children 1 to 13 years of age who are at risk for malnutrition, require a higher caloric density, or have fluid restrictions; 8 fl oz (237 mL) provides 350 calories, 14 g protein, 16 g fat, 38 g carbohydrate; Pediasure 1.5 with fiber contains 3 g dietary fiber. Suitable for lactose intolerance, gluten free, Kosher, Halal. Contains milk and soy ingredients. Not for children with galactosemia. May be used for oral or tube feeding. Drop Ship Formula (DSF): #56409/vanilla, #56411/vanilla with fiber</p>	<p>DSF Children Only 114/mo</p>
<p>Pediasure Peptide 1.0 (Abbott) RTF: 8 fl oz (237 mL) 24-8 oz bottles/case</p>	<p>Pediasure Peptide 1.0 Cal is nutritionally complete, peptide based formula for the nutritional needs of children 1-13 years with malabsorption, maldigestion, or other GI conditions; 8 fl oz (237 mL) provides 237 calories, 7.1 g protein, 9.6 g fat (MCT and canola oil), 31.7 g carbohydrate. Suitable for lactose intolerance, gluten free, Kosher, Halal. Contains milk and soy ingredients. Not for children with galactosemia. May be used for oral or tube feeding. Drop Ship Formula (DSF): #62119/vanilla, #62121/strawberry, #62123/unflavored</p>	<p>DSF Children Only 114/mo</p>

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<p>Pediasure Peptide 1.5 (Abbott) RTF: 8 fl oz (237 mL) 24-8 oz bottles/case</p>	<p>Pediasure Peptide 1.5 Cal is nutritionally complete, peptide based formula for the nutritional needs of children 1-13 years with malabsorption, maldigestion, or other GI conditions; 8 fl oz (237 mL) provides 356 calories, 10.7 g protein, 14.4 g fat (MCT and canola oil), 47.6 g carbohydrate. Suitable for lactose intolerance, gluten free, Kosher, Halal. Contains milk and soy ingredients. Not for children with galactosemia. May be used for oral or tube feeding.</p>	<p>DSF Children Only 114/mo</p>
<p>Peptamen Jr. (Nestle) RTF: 8.45 fl oz (250 ml) carton Vanilla/ Chocolate/ Strawberry/ Unflavored</p>	<p>Drop Ship Formula (DSF): #56655/vanilla For the nutritional management of impaired GI function in children ages 1-13. Each carton (250 mL) provides 250 calories, 7.5 g protein, 9.6 g fat, 34 g carbohydrate. Enzymatically hydrolyzed 100% whey protein to facilitate gastric emptying. High level MCT to decrease potential for fat malabsorption. Contains both milk and soy products. Not appropriate for individuals with cow's milk allergy or galactosemia. Appropriate for lactose intolerance, gluten free, low residue.</p>	<p>Children Only 107/mo</p>
<p>Peptamen Jr. 1.5 (Nestle) RTF: 8.45 fl oz (250 ml) carton 24 cartons/case Unflavored only</p>	<p>For the nutritional management of impaired GI function in children ages 1-13. Each carton (250 mL) provides 375 calories, 11.3 g protein, 17 g fat, 45 g carbohydrate, 1.4 g soluble fiber. Enzymatically hydrolyzed 100% whey protein to facilitate gastric emptying. High level MCT to decrease potential for fat malabsorption. Contains both milk and soy products. Not appropriate for individuals with cow's milk allergy or galactosemia. Appropriate for lactose intolerance, gluten free.</p>	<p>DSF Children Only 107/mo</p>
<p>Phenex-1 (Abbott) Powder: 14.1 oz can (400 grams) No standard yield Calories/can=1920</p>	<p>Drop Ship Formula (DSF): #9871617363/unflavored Phenylalanine free formula with iron for nutrition support of infants and toddlers with phenylketonuria (PKU) or hyperphenylalaninemia. Must be supplemented with protein and fluid in prescribed amounts to completely meet phenylalanine and water requirements. Follow physician's instructions carefully. Lactose-free, gluten-free, Halal. If not available locally, may be DSF: # 51120, 6 cans/case</p>	<p>Infants- refer to Formula Codes Sheet 2</p>
<p>Phenex-2 (Abbott) Powder: 14.1 oz can No standard yield Calories/can=1640 Unflavored/Vanilla</p>	<p>Phenylalanine free medical food for nutrition support of children and adults with phenylketonuria (PKU) or hyperphenylalaninemia. Must be supplemented with protein and fluid in prescribed amounts to completely meet phenylalanine and water requirements. Follow physician's instructions carefully. Lactose-free, gluten-free, Halal.</p>	<p>Children 11 cans/mo Women 10 cans/mo</p>
<p>Portagen (Mead Johnson) Powder: 14.4 oz Can yield= 64 fl oz Calories/can=1920 6 cans/case</p>	<p>If not available locally, may be DSF: # 5575/vanilla, #51122/unflavored, 6 cans/case Milk-based nutritional powder for children and adults with defects in fat metabolism and absorption; 87% of fat from medium-chain triglycerides (MCT). Portagen powder is not nutritionally complete; long term use may lead to essential fatty acid deficiency; NOT recommended for use as an infant formula. Gluten free, lactose free, low residue, NOT suitable for galactosemia. Standard dilution 30 cal/oz: Add 3 packed level scoops powder to 4 fl oz water= 4.5 fl oz</p>	<p>DSF #038721 Children/Women 14 cans/mo</p>
<p>Pregestimil (Mead Johnson) Powder: 16 oz can Can yield=112 fl oz Calories/can=2240</p>	<p>Nutritionally complete infant formula with 55% of fat from MCT oil; designed for infants with fat malabsorption and sensitivity to intact proteins; hypoallergenic and lactose-free; contains DHA/ARA. In cases of chronic malabsorption disorders, Pregestimil may be used as a milk substitute in the diet of children (total calcium content of child's diet should be assessed). Standard dilution 20 cal/oz: Add 1 packed level scoop of powder to 2 fl oz water</p>	<p>Infants- refer to Formula Codes Sheet 2 Children 8 cans/mo</p>

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<p>Pro-Phree (Abbott) Powder: 14.1 oz can No standard yield Calories/can=2040 6 cans/case</p>	<p>Protein-free formula with iron for nutrition support of infants and toddlers who require extra calories, vitamins and minerals, and/or protein restriction. Must be used with a source of intact protein or amino acids and fluid to completely meet nutrient and water requirements. Not a substitute for standard infant formula or intended for use as a sole source of nutrition. May be used by children and adults. Follow physician's instructions carefully. Lactose-free, gluten-free, Halal.</p>	<p>DSF #51148 Infants- amt. varies with age Children- 11 cans/mo</p>
<p>PurAmino (Mead Johnson) Powder: 14.1 oz can Can yield: 98 fl oz 4 cans/case</p>	<p>Hypoallergenic amino-acid based formula for infants and toddlers with severe cow's milk protein allergies and/or multiple food protein allergies. Has DHA and ARA, nutrients found in breast milk that promote brain and eye development. Approve only if Elecare and Neocate have failed to manage the infant's feeding problems. Standard dilution 20 cal/oz: For every 1 fl oz water add 1 unpacked level scoop of powder</p>	<p>DSF #129023 Infants- refer to "Elecare Infant" amounts for age on Formula Codes Sheet 2</p>
<p>RCF-Ross Carbohydrate Free (Abbott) Concentrate: 13 fl. oz. can (384 mL) No standard yield Calories/can= 311 12 cans/case</p>	<p>Carbohydrate-free soy infant formula base with iron for use in the dietary management of patients unable to tolerate the type or amount of carbohydrate in milk or conventional infant formulas; or seizure disorders requiring a ketogenic diet. Formulated to allow physician to prescribe type and amount of Carbohydrate (that can be tolerated) with the assurance that other nutrient needs will be met. Soy protein isolate to avoid symptoms of cow's milk protein allergy or sensitivity. Lactose-free, gluten-free, Kosher, Halal. Add water and other ingredients as directed by physician before feeding.</p>	<p>DSF #00108 Infants- amt. varies with age Children- 35 cans/mo</p>
<p>Similac PM 60/40 (Abbott) Powder: 14.1 oz can Can yield = 102 fl oz Calories/can= 2040</p>	<p>Milk-based, low-iron infant formula for infants (and toddlers) who benefit from lowered mineral intake, including those with impaired renal function. Features 60:40 ratio of whey to casein protein; calcium-to-phosphorus ratio designed to manage serum calcium disorders- both hypercalcemia and hyperphosphatemia. Gluten free, Kosher, Halal. Standard dilution 20 kcal/oz: Add 1 unpacked level scoop of powder to 2 fl oz of water If not available locally, may be DSF: # 00850, 6 cans/case</p>	<p>Infants- refer to Formula Codes Sheet 2 Children 9 cans/mo</p>
<p>Suplena (Abbott) RTF: 8 fl oz (237 ml) 24 cans/case Vanilla only</p>	<p>For people with chronic kidney disease to help maintain their nutritional status while adhering to their renal diet. High in calories, low in protein (10% total calories). Low in phosphorus, potassium, calcium and sodium. A good source of fiber, including prebiotics. Gluten free. Contains milk and soy ingredients. Suitable for lactose intolerance. Not for patients with galactosemia. For supplemental of sole-source nutrition. For oral or tube feeding. Not for IV use. Kosher and Halal.</p>	<p>DSF #62088 Children and Women 114/mo</p>

FOOD PACKAGES FOR INFANTS

Foods for 1 month	Birth to 1 month		
	1-3 months		
	4-5 months		
	6-11 months		
	Fully Formula Fed (FF)	Mostly Breastfed (BF/FF)	Fully Breastfed (BF)
Food Package	Birth thru 5 months	Birth thru 5 months	Birth thru 5 months
Formula	9 cans powder 9 cans powder 10 cans powder -OR- equivalent*	1 can powder 4 cans powder 5 cans powder -OR- equivalent*	NA
Food Package	6 thru 11 months	6 thru 11 months	6 thru 11 months
Formula	7 cans powder (standard formula)	4 cans powder (standard formula)	NA
Infant Cereal	3-8 oz boxes	3-8 oz boxes	3-8 oz boxes
Baby food fruits and vegetables	128 oz 2 nd Stage Foods 32 (4oz) jars 9-11 months option: 16 (4 oz) jars + \$4 CVV	128 oz 2 nd Stage Foods 32 (4oz) jars 9-11 months option: 16 (4 oz) jars + \$4 CVV	256 oz 2 nd Stage Foods 64 (4oz) jars 9-11 months option: 32 (4 oz) jars + \$8 CVV
Baby food meat	NA	NA	77.5 oz 31 (2.5oz) jars

***Fully Formula Feeding (FF)**

or 31 cans concentrate or 26 cans RTF
or 31 cans concentrate or 26 cans RTF
or 34cans concentrate or 28 cans RTF
or 24 cans concentrate or 20 cans RTF

***Mostly Breastfeed (BF/FF)**

1 can powder only
or 14 cans concentrate or 12 cans RTF
or 17 cans concentrate or 14 cans RTF
or 12 cans concentrate or 10 cans RTF

Note:

The number of therapeutic formula cans issued may differ, see Formula Codes-Sheet 2.

For Staff Only

Print in Color for Clarity
(2016)

FOOD PACKAGES FOR WOMEN AND CHILDREN

Foods for 1 month	Food Package IV Children 1-4 years*	Food Package V Prenatal with singleton pregnancy, partially BF mother of one	Food Package VI Postpartum women up to six months	Food Package VII Fully BF mother of one, partially BF mother of multiples, prenatal with multiple pregnancy, prenatal mostly BF single infant
Milk (1 lb tofu = 1 qt milk) (1 lb cheese = 3 qts milk)	Whole milk is the standard for 1- year-old children (12-23 months) 1% or skim milk is the standard for children ≥ 24 months 3 gallons + Choice of <u>one</u> : 1 qt buttermilk or 1 can evaporated milk or 32 oz yogurt	1% or skim milk (2% milk per CPA) 4 gallons + 3 qt box nonfat dry milk -or- Choice of <u>three</u> : 1 qt buttermilk 1 can evaporated milk 16 oz tofu 32 oz yogurt	1% or skim milk (2% milk per CPA) 3 gallons + Choice of <u>one</u> : 1 qt buttermilk 1 can evaporated milk 16 oz tofu 32 oz yogurt	1% or skim milk (2% milk per CPA) 5 gallons + Choice of <u>one</u> : 1 qt buttermilk 1 can evaporated milk 16 oz tofu 32 oz yogurt
Cheese	1 lb	1 lb	1 lb	2 lbs
Eggs	1 dozen	1 dozen	1 dozen	2 dozen
Juice	2-64 oz containers	3 cans of 11.5-12 oz frozen or 3 containers 48 oz	2 cans of 11.5-12 oz frozen or 2 containers 48 oz	3 cans of 11.5-12 oz frozen or 3 containers 48 oz
Cereal	up to 36 oz	up to 36 oz	up to 36 oz	up to 36 oz
Canned or Dried Beans/Peas	Choice of <u>one</u> : 1 lb dried beans/peas Four 15-16 oz canned beans/peas 16-18 oz peanut butter	1 lb dried beans/peas-or- Four 15-16 oz canned beans/peas -and- 16-18 oz peanut butter	Choice of <u>one</u> : 1 lb dried beans/peas Four 15-16 oz canned beans/peas 16-18 oz peanut butter	1 lb dried beans/peas-or- Four 15-16 oz canned beans/peas -and- 16-18 oz peanut butter
Peanut Butter (only children ≥ 2 years)	Four 15-16 oz canned beans/peas 16-18 oz peanut butter	16-18 oz peanut butter	16-18 oz peanut butter	16-18 oz peanut butter
Fish	NA	NA	NA	30 oz canned light tuna, salmon, sardines or jack mackerel
Fruits and Vegetables	\$8 cash value voucher	\$11 cash value voucher	\$11 cash value voucher	\$11 cash value voucher
Whole Wheat Bread or Whole Grain Product	Two 16 oz packages	16 oz package	NA	16 oz package

*Children 1-4: CPA may issue tofu/soy beverage as a milk substitute for situations such as milk allergy, severe lactose maldigestion, galactosemia and vegan.
(For Staff Only- 2016)

FOOD PACKAGE III FOR WOMEN AND CHILDREN

Foods for 1 month	Food Package IV Children 1-4 years	Food Package V Prenatal with singleton pregnancy, partially BF mother of one	Food Package VI Postpartum women up to six months	Food Package VII Fully BF mother of one, partially BF mother of multiples, prenatal with multiple pregnancy, prenatal mostly BF single infant
Formula or WIC-Eligible Nutritional	455 fl oz concentrate or equivalent	455 fl oz concentrate or equivalent	455 fl oz concentrate or equivalent	455 fl oz concentrate or equivalent
Milk (Whole or 2% per HCP) (1 lb tofu = 1 qt milk) (1 lb cheese = 3 qts milk)	3 gallons + Choice of one: 1 qt buttermilk or 1 can evaporated milk 32 oz yogurt	4 gallons + 3 qt box nonfat dry milk -or- Choice of three: 1 qt buttermilk 1 can evaporated milk 16 oz tofu 32 oz yogurt	3 gallons + Choice of one: 1 qt buttermilk 1 can evaporated milk 16 oz tofu 32 oz yogurt	5 gallons + Choice of one: 1 qt buttermilk 1 can evaporated milk 16 oz tofu 32 oz yogurt
Cheese	1 lb	1 lb	1 lb	2 lbs
Eggs	1 dozen	1 dozen	1 dozen	2 dozen
Juice	2-64 oz containers	3 cans of 11.5-12 oz frozen or 3 containers 48 oz	2 cans of 11.5-12 oz frozen or 2 containers 48 oz	3 cans of 11.5-12 oz frozen or 3 containers 48 oz
Cereal	up to 36 oz	up to 36 oz	up to 36 oz	up to 36 oz
Canned or Dried Beans/Peas	Choice of one: 1 lb dried beans/peas Four 15-16 oz canned beans/peas 16-18 oz peanut butter	1 lb dried beans/peas-or- Four 15-16 oz canned beans/peas -and- 16-18 oz peanut butter	Choice of one: 1 lb dried beans/peas Four 15-16 oz canned beans/peas 16-18 oz peanut butter	1 lb dried beans/peas-or- Four 15-16 oz canned beans/peas -and- 16-18 oz peanut butter
Peanut Butter (only children ≥ 2 years)				
Fish	NA	NA	NA	30 oz canned light tuna, salmon, sardines or jack mackerel
Fruits and Vegetables	\$8 cash value voucher-or- 128 oz jarred infant fruit/veg	\$11 cash value voucher-or- 176 oz jarred infant fruit/veg	\$11 cash value voucher-or- 176 oz jarred infant fruit/veg	\$11 cash value voucher-or- 176 oz jarred infant fruit/veg
Whole Wheat Bread or Whole Grain Product	Two 16 oz packages	16 oz package	NA	16 oz package

Women breastfeeding multiples receive a CW9 and CV7+ (total of \$16.50) = 264 oz jarred infant fruit/veg

For Staff Only (Rev 08-02-2016)

FOOD PACKAGE FOR BREASTFEEDING WOMEN

Food each month	Partially BF mother of one (3STD)	Fully BF mother of one, partially BF mother of multiples, prenatal mostly BF single infant (6STD)	Fully BF Mother of Multiples (6BFM)	Supplemental Formula to Issue Partially Breastfed Infants	
				Ounces given Daily	Amount of powder formula to Issue/Month
Milk (1 lb tofu = 1 qt milk) (1 lb cheese = 3 qts milk)	<p>1% or skim milk (2% milk per CPA)</p> <p>4 gallons +</p> <p>3 qt box nonfat dry milk-or-Choice of <u>three</u>:</p> <p>1 qt buttermilk</p> <p>1 can evaporated milk</p> <p>16 oz tofu</p> <p>32 oz yogurt</p>	<p>1% or skim milk (2% milk per CPA)</p> <p>5 gallons +</p> <p>Choice of <u>one</u>:</p> <p>1 qt buttermilk</p> <p>1 can evaporated milk</p> <p>16 oz tofu</p> <p>32 oz yogurt</p>	<p>1% or skim milk (2% milk per CPA)</p> <p>7 gallons +</p> <p>Choice of <u>two</u>:</p> <p>1 qt buttermilk</p> <p>1 can evaporated milk</p> <p>16 oz tofu</p> <p>32 oz yogurt</p>	1-3	1 can
Cheese	1 lb	2 lbs	3 lbs	16-18	6 cans* ONLY
Eggs	1 dozen	2 dozen	3 dozen	*Neosure, Enfacare, Alimentum, Nutramigen	
Juice	3 cans of 11.5-12 oz frozen or 3 containers 48 oz	3 cans of 11.5-12 oz frozen or 3 containers 48 oz	4 cans of 11.5-12 oz frozen or 4 containers 48 oz		
Cereal	up to 36 oz	up to 36 oz	up to 54 oz		
Canned or Dried Beans/Peas	1 lb dried beans/peas-or-Four 15-16 oz canned beans/peas	1 lb dried beans/peas-or-Four 15-16 oz canned beans/peas	2 lbs dried beans/peas-or-Eight 15-16 oz canned beans/peas		
Peanut Butter	-and- 16-18 oz peanut butter	-and- 16-18 oz peanut butter	-and- 16-18 oz peanut butter		
Fish	NA	30 oz canned light tuna, salmon, sardines or jack mackerel	45 oz canned light tuna, salmon, sardines or jack mackerel		
Fruits and Vegetables	\$11 cash value voucher	\$11 cash value voucher	\$16.50 cash value voucher		
Whole Wheat Bread or Whole Grain Product	16 oz package	16 oz package	16 oz package		
			ISSUE AJWW on even months 48 oz juice + 16 oz whole grains		

(For Staff Only- Rev 11-12-15)

Nutrition Education

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USDA REGULATIONS AND STANDARDS

Federal Regulations for WIC Nutrition Services

“Nutrition education means individual and group sessions and the provision of materials that are designed to improve health status and achieve positive change in dietary and physical activity habits, and that emphasize the relationship between nutrition, physical activity, and health all in keeping with the personal and cultural preferences of the individual.”¹

Goals for WIC Nutrition Services

“Nutrition education including breastfeeding promotion and support shall be designed to achieve the following two broad goals:

(1) Emphasize the relationship between nutrition, physical activity and health with special emphasis on the nutritional needs of pregnant, postpartum and breastfeeding, infants and children under five years of age, and raise awareness about the dangers of using drugs and other harmful substances during pregnancy and while breastfeeding.

(2) Assist the individual who is at nutrition risk in improving health status and achieving a positive change in dietary and physical activity habits, and in the prevention of nutrition-related problems through optimal use of the supplemental foods and other nutritious food. This is to be taught in the context of the ethnic, cultural and geographic preferences of the participants and with consideration for educational and environmental limitations experienced by the participants.”²

Drug Rule/Substance Abuse

“As an integral part of nutrition education, the State agency shall ensure that local agencies provide drug and other harmful substance abuse information to all pregnant, postpartum, and breastfeeding women, and to parents or caregivers of infants and children participating in the program. Drug and other harmful substance abuse information may also be provided to pregnant, postpartum, and breastfeeding women, and to parents or caregivers of infants and children participating in local agency services other than the Program.”³

1 Public Law (PL) 108-265, the Child Nutrition and WIC Reauthorization Act of 2004, enacted June 30, 2004 (Revised)

2 United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (b)

3 United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (a) (3)

Local Agency Nutrition Services Plan

“Develop an annual local agency nutrition education plan, including breastfeeding promotion and support. The local agency shall develop an annual nutrition education plan consistent with the state’s nutrition education component of Program operations and in accordance with this part and FNS guidelines. The local agency shall submit its nutrition education plan to the State agency by a date specific by the State agency.”⁴

Value Enhanced Nutrition Assessment (VENA)

“VENA builds on the information provided in the WIC nutrition risk policy and the Nutrition Services Standards (NSS). It defines Food and Nutrition Services (FNS) policy for performing a quality WIC Nutrition assessment. The policy reinforces the importance of nutrition assessment in determining eligibility and providing other nutrition services that are relevant to the participant’s needs.

The VENA policy encompasses all aspects of a WIC Nutrition assessment, which is an essential component of the WIC nutrition services process. As quality WIC nutrition assessment requires a systematic approach or standardized process of collecting nutrition assessment information to assure that all applicants are assessed in a consistent and equitable manner. However, the nutrition services provided to each participant will be personalized, based on need and interest identified through the assessment.”⁵

Nutrition Contacts

“The State agency assures that the nutrition education contact (provided via individual or group session) includes verbal communication between local agency staff and participants. Verbal communication includes individual or group interaction between WIC staff and participants such as discussions, summaries, and question and answer periods about nutrition information provided in newsletters and printed materials, on bulletin boards and displays, and in audiovisuals when these materials are used in nutrition education.”⁶

“The nutrition education including breastfeeding promotion and support, contacts shall be made available through individual or group sessions which are appropriate to the individual participant’s nutritional needs. All pregnant participants shall be encouraged to breastfeed unless contraindicated for health reasons.

During each yearly certification period at least two nutrition contacts shall be made available to all adult participants and the parents or caregivers of infant and child participants, and wherever possible, the child participants themselves.

4 United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (d) (2)

5 United States Department of Agriculture, Food and Nutrition Services, Value Enhanced Nutrition Assessment (VENA) in WIC, April 2006.

6 <http://www.nal.usda.gov/wicworks/Topics/WICnutStand.pdf> ,Standard 4: Nutrition Education, page 7, footnote 5

Nutrition education contacts shall be made available at a quarterly rate, to parents or caregivers of infant and child participants certified for a period in excess of six months. Nutrition education contacts shall be scheduled on a periodic basis by the local agency, but such contacts do not necessarily need to take place in each quarter of the certification period.”⁷

Completion and Documentation of Nutrition Education

“The local agency shall document in each participant’s certification file that nutrition education has been given to the participant in accordance with State agency standards, except that the second or any subsequent nutrition education contact during a certification period that is provided to a participant in a group setting may be documented in a master file. Should a participant miss a nutrition education appointment, the local agency shall, for purposes of monitoring and further education efforts, document this fact in the participant’s file, or, at the local agency’s discretion, in the case of a second or subsequent missed contact where the nutrition education was offered in a group setting, document this fact in a master file. Documentation of kept appointments is retained in the Patient Tracking and Billing Management Information System (PTBMIS).

An individual care plan shall be provided for a participant based on the need for such plan as determined by the Competent Professional Authority (CPA), except that any participant, parent, or caregiver shall receive such plan upon request. Contacts shall be designed to meet different cultural and language needs of program participants.”⁸

Proxy

The procedures established to provide Nutrition Education with Proxies is further defined. “In determining whether a particular participant or parent/caretaker should be allowed to designate a proxy or proxies, the State agency must require the local agency or clinic to consider whether adequate measures can be implemented to provide nutrition education and health care referrals to that participant or, in the case of an infant or child participant, to the participant’s parent or caretaker.”⁹

IMPLEMENTATION OF FEDERAL REGULATIONS

Substance Abuse

Anti-drug and other harmful substance abuse information must be provided to all WIC participants at every certification. This material may be provided by any staff member so designated at the clinic. The Drug...Alcohol...Tobacco handout (HL000050301) should be given at the initial certification. After the initial certification the distribution method determined by health department staff to be the most efficient and effective should be used. Acceptable methods include handouts, bulletin boards, discussions, and messages on FI/CVV and FI/CVV envelope. The above information must be included in a “Plan of Responsibility” developed by the region and/or counties in each region.

7 United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (e) (1-3)

8 United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (e) (4-6)

9 United States Department of Agriculture, Food and Nutrition Services, CFR 246.12 (r) (1)

Appropriate staff in WIC clinics must establish linkages with local substance abuse counseling/treatment programs. A current referral list, including local resources for drug and other harmful abuse counseling/treatment, must be maintained in clinics and be made available for distribution. A file of the current referral list and a plan of responsibility for each WIC clinic should be kept in a file at the Regional office.¹⁰

Regional (Local Agency) Nutrition Services Plan

Guidelines for Completion

The Local Agency (LA) Nutrition Services Plan is the guidance the region establishes for nutrition education providers and program personnel. The plan identifies goals, objectives, and activities to be accomplished by the LA to address needs of the staff and program participants. By the implementation of an appropriate plan, the LA commits its resources to provide and document outcomes of quality nutrition education services.

The LA plan is due in the State Division of Nutrition/Supplemental Food Programs office annually. Local agencies have twelve months (October 1 through September 30) to accomplish their program objectives unless they have indicated otherwise in their time frame for an objective. This is consistent with the Federal fiscal year. Due dates of the LA plan and annual report are determined each year by the State Nutrition Coordinator.

The plan is to be completed by the Regional Nutrition Director with input from the Regional Breastfeeding Coordinator and the WIC Director. The Nutrition Coordinator and the Breastfeeding Coordinator in the State Special Supplemental Nutrition Programs Office may be contacted for technical assistance.

Content of the Plan:

Title Page

- Title of Plan
- Time period (fiscal year) covered by plan
- Name of region
- Names and titles of those who prepared the plan

Section 1: Staff and Resources

- Current list of all nutrition staff, their credentials, work location
- List of staff resources needed in the region

Section 2: Goals, Objectives, and Activities

- Activities, staff person responsible, time frames and indicators of achievement for all objectives listed
- Input from the participant satisfaction surveys should be addressed in these objectives and activities

¹⁰ United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (a) (3)

Nutrition Education Curriculum

VENA (Value Enhanced Nutrition Assessment) describes a comprehensive nutrition assessment process that is individualized and puts the client's concerns and interests at the heart of the nutrition counseling experience. It encourages clients to make behavior changes through meaningful conversation guided by staff. VENA counseling helps make the nutrition assessment experience engaging and valuable not just for participants, but also for staff.

Nutrition education will be centered on the VENA process. The focus will be on the nutrition assessment in determining program eligibility and providing nutrition services that are relevant to the participant's needs. A WIC nutrition assessment is the process of obtaining and synthesizing relevant and accurate information in order to:

- Assess an applicant's nutrition status and risk;
- Design appropriate nutrition/breastfeeding education and counseling;
- Tailor the food package to address nutrition needs; and
- Make appropriate referrals.

The CPA should provide nutrition education that is determined by and of interest to the participant. Remember to make it enjoyable. Provide variety and choice in individual and group settings.

- The initial contact must include:
 - A general description of program services and supplemental food provided
 - Basic nutrition information as it relates to individual risk(s)
 - The harmful effects of alcohol, drugs and tobacco
 - Encouragement to pregnant women to breastfeed unless contraindicated for health reasons
 - A Local Referral/Resource list
- Subsequent Certification must include:
 - Basic nutrition information as it relates to individual risk(s)
 - Encouragement to all prenatals to breastfeed unless contraindicated for health reasons
 - Counseling on folic acid to women participating in WIC, especially those ready to "graduate" from the program
 - The harmful effects of alcohol, drugs and tobacco
 - A Local Referral/Resource List, if needed

If the above items cannot be addressed at the specific times, it must be documented in the notes so that they may be addressed at the future contact.

The principal ideas for nutrition education in the federal guidelines are:

- To emphasize the relationship between proper nutrition and good health, with special emphasis on the nutrition needs of the target population
- To raise awareness of the dangers of using drugs or other harmful substances to all pregnant, breastfeeding and postpartum women, and caregivers of children and infants participating on the program.

With the input of the participant, the CPA should assist the individual who is at nutrition risk to achieve a positive change in food habits. This should result in improved nutrition status and in the prevention of nutrition-related problems through optimal use of the supplemental foods and other nutritious foods. This is to be taught within the preferences and limitations of the participant.

Frequency of Contacts

Nutrition education, which is federally mandated for the WIC Program, shall be made available to participants or their caregivers at least twice during their certification period (or at a quarterly rate for persons certified in excess of six months). The two required contacts cannot occur on the same day.

A prenatal determined to be at high nutrition risk must receive nutrition education by a nutritionist or a nutrition educator. If a nutritionist or nutrition educator is not available at certification, an appointment must be made with the nutritionist or nutrition educator within 60 days of certification. When possible, the initial prenatal certification should be scheduled on a day when the nutritionist or nutrition educator is there. For all other participants at high nutrition risk the nutritionist or nutrition educator must provide at least two of the four nutrition education contacts within the certification period, not necessarily the first. The other contacts may be provided by a registered nurse. **The mid-certification for children at high risk should be scheduled with a nutritionist or nutrition educator.**

Participants at low nutrition risk may receive nutrition education from any CPA or other provider approved by the State Central Office.

If a prenatal has received two nutrition education contacts, then she may receive breastfeeding information and support by a Breastfeeding Peer Counselor (BFPC) on the third clinic visit. The BFPC or Designated Breastfeeding Expert (DBE) will document the contact on the Peer Counselor Contact Log and/or on the WIC Prenatal or Postpartum record.

Subsequent Visits:

If Group Contact:

- Make it interesting and informal.
- Use facilitative discussion. If groups have mixed statuses, make sure the topic is general so that it will cover all families. Some examples might be purchasing fruits and vegetables with CVVs or dental health. Topics or questions that may only be of interest to one person in the group should be discussed individually with the participant after the group.

BFPCs can assist CPAs in their presentation of groups. If the group contact will be used as a nutrition education contact, the CPA provides education during the group and must be present during the portion of the class presented by the BFPC. If the CPA does not provide education and is not present during BFPC provision of breastfeeding information and support, the contact is not a nutrition education/breastfeeding contact. This group contact is only a BFPC group contact. All BFPC contacts are reported on the *Peer Counselor Contact Log* ([Appendix 6-25](#)). If High

Risk participants are provided group education, individual nutritional concerns in relation to their previous care plan should be briefly addressed and documented after the session by the CPA.

Maintain a master file of lists of attendees, dates of the group sessions, and descriptions or outline of what has been discussed, OR document the contact on the WIC records in each participant's chart. Maintain the files for four years.

Reference should be made at the certification or previous contact to attending a group session by marking on the WIC record "Attend group at the next visit". Enter Y (yes) on the WIC screen for received education today and the PTBMIS code according to state instructions.

If On-line Contact:

The CPA will determine if on-line nutrition is an option to offer the participant. On-line nutrition education must NOT be offered to High risk participants or those receiving therapeutic products. Participants can access nutrition education on-line at the following website: <http://apps.health.tn.gov/wicedu/>

The participant will present at subsequent visit (pick-up) a printed certificate or paper with name of session, certificate number, date and time completed. It is only necessary to present documentation of one module. The same module will count as nutrition education for all eligible family members regardless of the status of the participant. The date the module was completed should be within the last three months. Certificates or paper documentation must be kept on file in clinic by month/year. Retention period is four years.

Nutrition Education Providers

Competent Professional Authority (CPA):

Registered Dietitian (RD or RDN)

Nutritionist

Nutrition Educator

Registered Nurse (RN)

*Other Mid-Certification Nutrition Education Providers:

Dietetic Technicians, Registered (DTR's)

Community Agencies-example: EFNEP/TNCEP workers

*If Mid-Certification Nutrition Education Providers are used in a group session, a CPA must be present and provide a nutrition component. The lesson plans must be approved by the Regional Nutrition Director.

Mid-Certification Nutrition Assessment

Infants, children and breastfeeding women certified for one year must have a mid-certification nutrition assessment. This assessment includes a brief update of health and dietary assessment: (see below)

- A review of the last nutrition/health summary (Include goal and plan)
- New concerns raised by the client
- New medical diagnoses
- Changes in their eating pattern/food intake/food package
- Changes in physical activity behaviors
- Follow-up on Immunizations for children less than 2 years of age

Homeless

Special considerations should be given when providing nutrition education to the homeless (Refer to Chapter 2, “Food Packages for the Homeless”): The CPA should:

- Assess living situation and determine current needs before attempting to provide education.
- Discuss food sanitation and safety. This may be extremely important depending upon food preparation and storage facilities.
- Discuss foods with a high potential for spoilage (liquid milk, fresh eggs).
- Discuss breastfeeding as an easy and safe feeding method for infants. For formula fed infants, the caregiver should be instructed to prepare only one bottle at a time and to discard any formula left in the bottle if refrigeration is lacking.
- Instruct caregivers if dry milk is issued for older children (2-5 years) or adults mix only a small amount at a time.
- Discuss grocery shopping possibilities and suggest purchase of smaller amounts of food at more frequent intervals if appropriate.
- Offer suggestions for use of allowed foods for participant category within constraints of living conditions.

The nutrition education provider should be sensitive to health and/or social services needs, which are identified during the counseling sessions and make referrals as appropriate. Meeting nutritional needs continues to be the aim of the supplemental food package issuance.

Proxy

Nutrition education may be provided to a proxy (Refer to Chapter 1) on behalf of adults, teens, infants and children. The nutrition education for an:

- adult may be given to a spouse or significant other,
- adolescent prenatal may be given to a parent, and
- infant or child may be given to someone who has some responsibility for the care of the participant (for example, grandparent, legal guardian). However, if a relative is not available at the time of certification, the proxy’s name and relationship to the family must be documented in the chart.

If the CPA determines, based on the nutrition assessment and individual care plan for the participant, that nutrition education should be provided directly to parent/caregiver, a phone contact should be made and documented in the chart. Also, if a proxy is used for a prenatal, who may be, for example, bedridden, nutrition education could be provided by telephone, mail, home visit, or on-line. Refer to the Proxy Permission Statement Form for the person being represented. ([Appendix 6-5](#)).

Documenting Missed Appointments

Should a participant refuse nutrition education or miss an appointment resulting in a missed nutrition education contact, this must be documented in the PTBMIS.¹¹ See Chapter 2.

Nutrition Care Plans

All participants will have a care plan developed in the SOAP format. The SOAP note is a concise, informative communications tool that helps the provider identify, prioritize and address participant problems and progress. The nutrition care plan includes the participant's level of understanding, stage of change, client-centered goal, plan of action, and referrals. For example, subjective statements plus objective information are used to develop assessments that lead to a workable plan. Each part of SOAP will be explained in the following section.

Completing the WIC Record

Documentation is necessary to communicate information about the participant, what is discussed with the participant, and the participant's plan of action based on individual needs. To be useful, **documentation need not be elaborate**, nor need it take an inordinate amount of time. In Tennessee, the WIC Records have been designed to follow the SOAP format of documentation.

The WIC Prenatal Records and Participant Questionnaires are designed for recording any information pertinent to WIC certification and nutrition counseling, including nutrition information and assessment, care plans, and follow-up. Documentation that is found in one part of the record need not be repeated elsewhere.

Physical Presence: Physical presence is required at each certification visit. Selecting “**Yes**” on the WIC Record indicates proof of presence.

SOAP Format

S: SUBJECTIVE INFORMATION – Documented on the WIC Questionnaire.

Subjective information is the information shared by the patient and/or patient's family/caregiver. As part of VENA, WIC Participant Questionnaires were developed to:

Collect valuable subjective information about the individuals;

Identify both positive behaviors as well as areas of concern or barriers to change;

¹¹ United States Department of Agriculture, Food and Nutrition Services, 7 CFR 246.11 (e) (4)

Provide information necessary to identify nutritional risk criteria.

The **participant questionnaire** provides the majority of the subjective information. It was designed so that the participant could complete it while waiting for services. If this is not possible or practical, the CPA can assist in completing the form.

Once the questionnaire is completed, the Competent Professional Authority (CPA) reviews the responses and obtains any additional information as appropriate by using facilitative discussion and motivational interviewing. This encourages an interactive conversation between the provider and the participant. In this conversation, the provider discovers the participant's individual needs and interests. The participant is encouraged to share problems, knowledge and experiences. The nutrition topic in which the participant is most interested should evolve from this discussion.

After reviewing the questionnaire with the participant/caregiver, the CPA records additional pertinent subjective information on the front or back of the form in the comment section. Examples of subjective information collected are:

- Concerns about nutrition or health,
- Reported problems such as nausea or constipation,
- Appetite, foods liked or disliked,
- Dietary habits,
- Smoking habits, alcohol consumption,
- Feeding skills for infants and children,
- Housing and cooking situations,
- Relevant social or lifestyle habits
- Breastfeeding knowledge, attitudes, and concerns
- Participant's comments/comments from others.

Any response that represents an **inappropriate nutrition practice should be marked with an "I"**. (See Code 411, 425, or 427 for specific inappropriate nutrition practices in *Nutrition Risk Criteria (Appendix 6-1)*)

To verify the questionnaire was reviewed, the CPA must sign (title included) and date it at the bottom of the comment section.

Although the questionnaire is required at certification, it can be used in whole or in part at other visits as well. The questionnaire is completed by the participant or parent/caregiver at certification and yields information on a variety of topics. It may be necessary for the provider to assist the individual in completing the questionnaire or to get clarification and/or additional information regarding the responses. Any additional pertinent information is documented in the Comments section on the back of the questionnaire.

Date of Questionnaire:

The participant questionnaire may have been completed on a day different from the certification visit. In order to tie the correct questionnaire to the certification, record the date the questionnaire was completed in the designated space on the WIC Record.

O: OBJECTIVE INFORMATION

Objective documentation includes facts, tangible findings, observations and verifiable information. Facts do not need to be repeated if they appear elsewhere in the chart/record. If these items are located somewhere other than the growth chart or WIC Record, please indicate. These facts may include height, weight, hemoglobin/hematocrit, etc.

Height/length, weight and hemoglobin/hematocrit are required at certification according to protocol. Referral measures from the Health Care Provider (HCP) may be used if taken within 60 days. Additional information will be found in the sections that provide specifics for each of the WIC Records.

A: ASSESSMENT

The assessment is the interpretation and/or impression of the participant's nutritional status, needs, or problems based on information listed in the subjective and objective data. In order to provide an appropriate and personalized nutrition intervention (i.e., nutrition education, food package tailoring, and referrals), it is necessary to first conduct a nutrition assessment.

The WIC Nutrition Assessment consists of the items listed below:

Collect data

Clarify & synthesize data

Identify risk(s) & related issues for intervention

Document the assessment

Nutrition Risk Criteria – Identify **all** applicable nutrition risk criteria by placing a check mark in the appropriate boxes. Refer to detailed definitions of the codes in the *Nutrition Risk Criteria*, (**Appendix 6-1**) to be certain that a code is used appropriately. Review the participant questionnaire to identify potential codes.

The priority of each code appears on the record, with the nutrition risk. As mentioned in Chapter 2, list code 335 first on the Patient Encounter Form to obtain the correct food package for multiple fetuses.

Level of Understanding/Interest - The CPA, should determine the degree of comprehension or interest the participant demonstrates. Based on the assessment of the individual, the CPA should then mark the applicable response (good, fair or poor). **A brief comment is required** to explain the level of interest.

Example – if the participant asks several questions and identifies actions she can take to make a behavior change her level of interest is “Good”. If she states that she does not want to talk to the nutritionist, her level of interest would be poor on this day. Do not assume that because the level is “poor” at one visit that it will always

be “poor”. By using motivational interviewing techniques, it is possible to help participants open up and become interested when the focus is on their needs, not on what the CPA perceives their needs to be. The CPA should write a brief statement as to why the level of understanding or interest was chosen.

Assessed Level of Nutrition Risk - The level of nutritional risk is documented in the Assessment. Determination of whether a person is at **High** Nutrition Risk or **Low** Nutrition Risk is **at the discretion of the CPA. The expectation is for the CPA to use assessment data including anthropometric, biochemical, clinical, dietary, family and social environment information to determine the individual’s level of nutrition risk.** Mark the level of risk as assessed and **write a brief comment** (required) to explain why the level of nutritional risk is high or low.

Example – 2 children were certified 6 months ago because each had a Hgb of 9.6. Both were considered to be at high risk. At the mid-certification or recertification visit, one still had a Hgb of 9.6. The mother did not administer the vitamin and mineral supplements as recommended by the PHN, has made no changes in the dietary habits, and doesn’t want to discuss it today. This child might be assessed to be still at high risk. The other child now has a Hgb of 11.0. The mother had given and plans to continue to give vitamin and mineral supplements and has made specific dietary changes to help improve the child’s nutritional status. In this case, the child might be considered to be at low nutritional risk. The decision is based upon the CPA’s assessment of the situation.

Stages of Change

The Stages of Change Model is an approach which is used to assist WIC participants in changing behaviors associated with nutrition issues. The basic premise of the stages of change is that behavior change is a process and not an event, and that individuals are at varying levels of readiness to change. Interventions should be tailored to the needs and concerns of individuals at each stage of the change process.

What is unique about this approach is that counselors engage in a dialogue with participants to move participants from the stage they are in to the next stage. Data indicates that the five stages are indeed quite distinct in behavioral habits and attitudes and thus a successful counselor will use strategies that are targeted to the stage of behavior change exhibited by the participant.

It is important to note that this is a circular, not a linear, model and people can enter and exit at any point. For instance, individuals may progress to action but then relapse and go through some of the stages several times before achieving maintenance. **The stages include:**

- **Pre-contemplation** – no intention of taking action in the foreseeable future, usually measured in next six months.
- **Contemplation** – thinking about changing, usually within six months
- **Preparation** – intends to take action within the next month – has a plan of action
- **Action** – has made changes within the past six months
- **Maintenance** – has maintained new behavior for at least six months and is working to prevent relapse

Behavior change strategies will likely be more effective when they are designed to match an individual's stage in the change process. For example, if an individual has a low fruit and vegetable intake, there is no point in providing detailed information and recipes. It would be more appropriate to focus the nutrition message on increasing the individual's awareness of the benefits of eating fruits and vegetables before suggesting action-oriented strategies.

The dialogue can be a set of questions which is used to assess the stage of readiness to change. As the counselor becomes more proficient, the stage is easier to identify. Strategies can be developed for helping participants move to the next level. **Suggested strategies for each stage** are:

- **Pre-contemplation** – provide information, raise awareness
- **Contemplation** – translate thinking into doing
- **Preparation** – small steps for change
- **Action** – reinforce successes
- **Maintenance** – encouragement, build on success

Behavior change theory recognizes the many factors influencing health-related behaviors and the most effective ways of promoting change. The result is that programs, interventions and messages that are guided by behavior change theory have a much greater chance of achieving positive behavior change. Refer to *State of Readiness* ([Appendix 6-1](#))

The CPA must identify a behavior that the participant would like to change. Individuals are at varying stages of readiness to change a behavior. Select the stage that represents the individual's readiness to change the identified behavior and **write a brief statement** (required). The Stage of Change should be related to the Client Centered Goal. Refer to the *State of Readiness Table* in ([Appendix 6-1](#)) for counseling strategies.

Using the example above, the Stage of Change for the first child might be considered to be Pre-contemplative because the mother has no intention of taking the necessary steps to cause improvements in the child's nutritional status. The Stage for the second child would be Action because the mother has made dietary modifications and given supplements and will continue to do so in order for the child's Hgb to reach normal levels. If, in another 6 months, this child's Hgb has improved to within normal

limits and the changes implemented last year are now habits, the stage would be Maintenance.

P: PLAN

Participant-Centered Goal/Plan: The plan includes steps that are to be taken to resolve the nutritional problems identified in the assessment. Documentation includes participant-focused goals, recommended interventions tailored to what is reasonable for the participant's circumstances, counseling topics, materials given, and pertinent food package assigned. Any other information that is relevant to providing care and monitoring progress is written here, including referrals and any follow-up strategies. The Plan should be so clearly stated that whoever follows the CPA on the next contact knows exactly what decisions were made and what food package was ordered by the CPA.

When writing a concise, informative note:

- Complete sentences are not necessary;
- Use descriptive, active verbs;
- Use appropriate, approved abbreviations (*WIC-Approved Abbreviations (Appendix 7-11)*);
- Sign (title included) and date the SOAP note;
- If counseling is targeted, a targeted note is the result

The participant-centered goal is something that the client is willing to work on, not something the CPA thinks she needs to do, and should be relative to the behavior identified in the Stage of Change.

The goal should be **SMART**:

- S** – Specific-what specifically do you want to accomplish? What is the goal?
How often or how much? Where will it take place?
- M** – Measurable-how will you know you've reached it? How will you evaluate the extent to which the goal was met?
- A** – Achievable-is it in your power to accomplish it? What is the action-oriented verb? Describe the goal using action verbs, and outline the exact steps you will take to accomplish the goal.
- R** – Realistic-Is your goal and timeframe realistic for the goal you have established?
- T** – Timely-do you have a timeframe listed in your goal? When exactly do you want to achieve it? Include deadlines, dates and frequency.

The SMART goal can be written as a narrative that includes all of the requirements or it may be written in an abbreviated form. For example, "increase fruits and veggies" is an abbreviated goal. If this type of goal is written, the additional required information should be listed in a plan. The plan would identify steps needed to resolve the nutritional problems identified in the assessment, achieve goals, and attain positive health outcomes. Remember, goals must be SMART and relate to the Stage of Change.

Attend group at next visit: Mark as appropriate.

On-Line education at next visit: Mark as appropriate.

Checklists:

Nutrition Counseling and Materials Given

Record the date and indicate the subjects covered and materials given during the visit. All Nutrition Counseling topics with an asterisk (*) have to be discussed at the initial certification. The exception is substance abuse, which must be addressed at each certification and folic acid which must be discussed at the prenatal visit or when the postpartum mother is getting ready to graduate from the program. If the above items cannot be addressed at the specified times, it must be documented in the notes so that they can be addressed at the next contact.

Materials Given:

Items identified on the checklist with an asterisk (*) must be given at the certification visit. Others are at the discretion of the CPA based on the participant needs.

RETURN VISITS:

Follow-up is also an important part of the nutrition services process; it allows WIC staff to monitor progress, reinforce the nutrition education message, and elicit feedback from the participant. In addition, follow-up “closes the loop” and allows for the continuity of care from initial certification visits to subsequent nutrition education and certification visits.

Progress toward previous goal: Follow-up on the previous goal is required. If the participant attended group education at a mid-certification visit or completed on-line education, follow up on the goal at the next nutrition education visit or at recertification. Indicate the degree of progress made toward achieving the goal by checking the appropriate box. If no progress was made, identify the barriers to change.

New goal: Record new goal if one is identified.

Mid Certification: Mark Yes or No.

Additional notes: Notes may include new subjective information, assessment and/or plans based on individual need. Include signature, title and date with all entries.

Attend group at next visit: Mark as appropriate.

On-line education at next visit: Mark as appropriate.

Additional Notes/Comments: Use this section if documentation for a visit requires more space than is provided or if a 3rd visit is made. Include signature, title and date with all entries.

Completing the WIC Prenatal Record

The WIC Prenatal Records and Participant Questionnaires are designed for recording any information pertinent to WIC certification and nutrition counseling, including nutrition information and assessment, care plans, and follow-up. Documentation that is found in one part of the record need not be repeated elsewhere.

Breastfeeding Assessment, Promotion, Counseling, and Support (Refer to Chapter 6)

Completing the WIC Prenatal Grids

Four prenatal weight gain grids are available, based on the woman's **prepregnancy Body Mass Index (BMI)** (**Appendix 6-44**). Before the correct grid can be selected, the prepregnancy BMI must be calculated. Her weight and height (without shoes) are needed to determine her BMI.

The recommended weight gain range and BMI for each weight status is:

<u>Prepregnancy Weight Groups</u>	<u>Definition (BMI)</u>	<u>Total Weight</u>	<u>Total Weight</u>
		<u>Gain Range (lbs)</u> <u>Singleton</u>	<u>Gain Range (lbs)</u> <u>Twins</u>
Underweight	<18.5	28-40	**
Normal Weight	18.5 to 24.9	25-35	37-54
Overweight	25.0 to 29.9	15-25	31-50
Obese	30.0	11-20	25-42

**There is insufficient information for the Institute of Medicine (IOM) committee to develop even provisional guidelines for underweight women with multiple fetuses. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy

Determining BMI

Using the prepregnancy weight, calculate the BMI by using the formula:

$$\text{BMI} = \text{weight (lbs)} \div \text{height (in)} \div \text{height (in)} \times 703 \quad \text{or}$$

$$\text{BMI} = \text{weight (kg)} \div \text{height (cm)} \div \text{height (cm)} \times 10,000.$$

The correct Prenatal Weight Gain Grid is chosen based on the BMI.

Complete the Prenatal Grid

Record the **Prepregnancy Weight** and **BMI** on the left-hand side of the form. Also record the woman's

- Age at Conception

- Gravida (the number of pregnancies a woman has had), and
- Para (the number of living children a woman has delivered.)

Pregnancy Outcomes:

- Record the date of delivery and birth weight of each infant she has delivered. List the most recent delivery first.
- Indicate if the delivery was premature (≤ 37 weeks gestation).
- List any other significant information about any pregnancy/delivery (C-Section, twins, high blood pressure, toxemia, Low Birth Weight (LBW), sex of infant, total prenatal wt. gain, abortion-spontaneous or elective, tubal pregnancy, etc.).

Record the Estimated Date of Delivery (EDD). Record any revisions of the date at future visits.

On the top right-hand side of the page, record the height, weight, Hgb/HCT, number of weeks gestation, date, and provider’s initials in the spaces provided. Height should be taken without shoes.

Record follow-up weight measures, the number of weeks gestation, the date the weight was taken, and the provider’s initials.

If using **referral** measures:

- complete all of the above information, plus “REF” next to the date to show that they are referral measures, or
- if services are measures are taken from the hospital medical record, enter all of the above information, plus “HOSP” beside the date to show that they are hospital measures.

Plotting the Prenatal Weight Gain Grid

Plotting the prenatal grid is required at initial certification and recommended at subsequent visits.

Calculate the amount of weight gained or lost since the beginning of this pregnancy, using the prepregnancy weight as the starting weight.

- Locate the number of pounds gained or lost on the vertical axis and the number of weeks pregnant on the horizontal axis.
- Using the prepregnancy weight as the baseline (represented by the dark horizontal line), mark the point where the number of weeks gestation intersects the number of pounds gained or lost.

If prepregnancy weight is unknown, do the following:

- Visually assess woman’s weight status category. Use professional judgment to decide if she was most likely underweight, normal weight, overweight or obese prior to conception.
- Determine the number of weeks gestation. Using the line on the prenatal weight grid that represents the recommended weight gain, determine the expected weight gain (mid-point) for that number of weeks gestation.

- Subtract the expected weight gain from the woman's current weight. This is an estimate of prepregnancy weight.
- Place a mark (x or dot) where the number of weeks gestation intersects the number of pounds of weight gained or lost.

Completing the WIC Postpartum Record

The WIC Postpartum Records and participant questionnaires are designed for recording any information pertinent to WIC certification and nutrition counseling, including nutrition information and assessment, care plans, and follow-up.

Documentation found in one part of the record need not be repeated elsewhere. An example would be objective data such as measures,(height and weight), that are documented on the growth chart.

ON INITIAL VISIT

Status: Select the correct status:

- 2** = non-breastfeeding
- 3** = partially breastfeeding
- 6** = fully breastfeeding
- B** = barely breastfeeding

S: SUBJECTIVE INFORMATION – Documented on the WIC Woman Questionnaire.

In reviewing the questionnaire all postpartum women must be asked if they initiated breastfeeding. The WIC Special Data box on the Patient Encounter Form should be marked as appropriate.

O: OBJECTIVE INFORMATION

Record the Weight, Height, and Hgb in the spaced provided. Also record the Pre-Pregnancy Weight **as reported by the postpartum**. The provider who obtains the measures must record his or her initials.

Determine the BMI

Using the prepregnancy weight the participant reports, calculate the BMI by using the formula:

$$\text{BMI} = \text{weight (lbs)} \div \text{height (in)} \div \text{height (in)} \times 703 \quad \text{or}$$

$$\text{BMI} = \text{weight (kg)} \div \text{height (cm)} \div \text{height (cm)} \times 10,000.$$

Record the BMI, which is **based on the prepregnancy weight** unless the woman is more than 6 months postpartum and breastfeeding. In that case, calculate the BMI based on the current weight.

Check the appropriate weight status on the Body Mass Index Table based on the BMI calculation.

Pregnancy Outcome:

- Record the Date of Delivery and birth weight of the infant(s).
- Indicate if the delivery was premature (≤ 37 weeks gestation).
- Record the amount of weight gained during the pregnancy
- Record any information pertinent to this pregnancy and delivery.
- Record the date of previous deliveries.

Mid-Certification:

- Record the date
- Record the height
- Record the weight
- Record the BMI
- Record the Hgb (if required)
- Record the provider's initials

A: ASSESSMENT

The assessment is the interpretation and/or impression of the participant's nutrition status, needs, or problems based on information listed in the subjective and objective data.

Nutritional Risk Criteria - Identify **all** applicable nutrition risk criteria by placing a check mark in the appropriate boxes. Refer to detailed definitions of the codes in Chapter 2 of the WIC Manual to be certain that a code is used appropriately. Review the participant questionnaire to identify potential codes.

Breastfeeding, Assessment, Promotion, Counseling, and Support (Refer to Chapter 6)

Completing the Infant/Child WIC Records

The WIC Infant and Child Records and participant questionnaires are designed for recording any information pertinent to WIC certification and nutrition counseling, including nutrition information and assessment, care plans, and follow-up.

Documentation written in one part of the record need not be repeated elsewhere. An example would be objective data such as measures, (height and weight), that are documented on the growth chart.

ON INITIAL VISIT

Status– Select the correct status:

- 4 = fully formula fed
- 5 = child
- 7 = fully breastfed
- 9 = partially breastfed

O: OBJECTIVE INFORMATION

Pediatric growth charts contain most of the objective information. Record and plot birth measures on all infants certified before 12 months of age. Record and plot current measures on the age-appropriate growth chart. Sometimes birth measures or other referral measures are used. The date those measures were taken is the date of measures and “Hosp” or “Ref” should be written to indicate the information was not gathered in clinic. When a Hgb or HCT is done, it is also recorded on the growth chart. The provider that obtains the measures must record his or her initials.

Automated growth charts (AGC) are used in many clinics, and plotting is electronic.

A: ASSESSMENT

The assessment is the interpretation and/or impression of the participant’s nutrition status, needs, or problems based on information listed in the subjective and objective data.

WIC-Approved Therapeutic Formulas - Use this space to record the name of the requested therapeutic formula and the date the written request expires. If another therapeutic formula request is received and approved, update this section of the record.

Diet Assessment Standards

The Diet Assessment Standards are used to assess the food intake of the participant. The 24 hour recall or Foods usually Eaten are no longer used for certification. Therefore, these standards may be used as guidance for nutrition education and assessment. (**Appendix 6-2**).

These are general guides. Go to <http://www.choosemyplate.gov> for more specific information including My Plate Daily Food Plans and Worksheets. Refer to *USDA Intake Patterns* (**Appendix 6-6**) and *Estimated Daily Calorie Needs* (**Appendix 6-8**) for specific caloric needs for different age groups and daily amounts of food for specific calorie levels.

Using the VENA Counseling Skills Checklist

The *VENA Counseling Skills Checklist*, (**Appendix 6-9**), is to be used as a tool to evaluate CPAs who certify and provide nutrition education to WIC participants. Completing this checklist reveals staff knowledge of the VENA Competencies and dictates additional training that may be needed.

The checklist is to be completed at a minimum once per year, but as many times as needed to correct skills that need improving. This process is to be completed by the Nutrition Director or his/her designee.

Observe each CPA during the patient counseling process and record observations on the checklist. Observations of counseling should include a variety of patient categories — pregnant, breastfeeding, postpartum, infant, child.

Positive results should be reviewed by the counselor and the observer. If weaknesses are identified, counselor and observer should agree on at least one behavior to improve. Goals are to be set and follow up information completed each time a skill is re-evaluated.

Completed forms should be maintained in the Regional Nutrition Director's Office for two years. The forms will be reviewed by the Clinic Monitoring Specialist during the Regional Nutrition Education review. One completed checklists per CPA should be maintained.

During the regional reviews, observations of the CPA's counseling process will be observed by the Clinic Monitoring Specialist. Observations will be discussed with the CPA.

Resources

As per HSA Policy, 7.8, all informational/educational materials developed for distribution outside the Department of Health must first be approved by the TN WIC Central Office. See WIC Manual Chapter 7 for forms and pamphlets approved for distribution. Refer to *Recommended Nutrition Related Website Resources*, ([Appendix 6-12](#))

Educational materials should be sent to Central Office for approval before use to ensure that the content is compliant with the Tennessee WIC Program nutrition and breastfeeding recommendations.

Nutrition Education Appendix

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STATE OF READINESS¹

State of Readiness	Key Strategies for Moving to Next Stage	Counseling Do's at This Stage	Counseling Don'ts at This Stage
Precontemplation	Increased information and awareness, emotional acceptance	Provide personalized information Allow participant to express emotions about his or her disease or about the need to make dietary changes	Don't assume participant has knowledge or expect that providing information will automatically lead to behavior change. Don't ignore participant's emotional adjustment to the need for dietary change, which could override ability to process relevant information.
Contemplation	Increased confidence in one's ability to adopt recommended behaviors	Discuss and resolve barriers to dietary change. Encourage support networks. Give positive feedback about a participant's abilities. Help to clarify ambivalence about adopting behavior and emphasize benefits.	Don't ignore the potential impact of family members and others on participant's ability to comply. Don't be alarmed or critical of a participant's ambivalence.
Preparation	Resolution of ambivalence, firm commitment, and specific action plan	Encourage participant to set specific, achievable goals. Reinforce small changes that participant may have already achieved.	Don't recommend general behavior changes (Eat less fat.) Don't refer to small changes as "not good enough."
Action	Behavioral skill training and social support	Refer to education program for self-management skills. Provide self-help materials	Don't refer participants to information-only classes.
Maintenance	Problem-solving skills and social and environmental support	Encourage participant to anticipate and plan for potential difficulties. Collect information about local resources. Encourage participant to "recycle" if he or she has a lapse or relapse. Recommend more dietary changes of participant is motivated.	Don't assume that initial action means permanent change. Don't be discouraged or judgmental about a lapse or relapse.

¹ Story M, Holt K, Sofka, D. Bright Futures in Practice: Nutrition, US Dept of Health and Human Services. 2002:257.

DIET ASSESSMENT STANDARDS

The Diet Assessment Standards are used to assess the food intake of the participant. The 24 hour recall or Foods usually Eaten are no longer used for certification. Therefore, these standards may be used as guidance for nutrition education and assessment.

	Birth- 4 months	4-6 months	6-8 months		8-12 months
Breastmilk	8-12 fdgs.	5+ fdgs.	3-5 fdgs.	Breastmilk	3-4 fdgs.
Formula with iron	16-40 oz.	26-39 oz.	24-32 oz.	Formula with iron	24-32 oz.
Infant cereal		1-2 Tbsp.	4-6 Tbsp.	Infant cereal	4-6 Tbsp.
Plain strained vegetables			3-4 Tbsp.	Plain strained, mashed, or chopped cooked vegetables	3-4 Tbsp.
Plain strained fruit			3-4 Tbsp.	Plain strained, mashed, or chopped fruits	3-4 Tbsp.
Infant juice			2-4 oz.	Infant juice	2-4 oz.
Strained plain meats or pureed egg yolk or pureed legumes			1-2 Tbsp.	Strained, chopped meat, poultry, egg yolk, cheese, yogurt or mashed legumes	1-3 Tbsp.

The recommendation for the introduction of infant cereals between 4-6 months is in compliance with the guidelines in the “USDA Infant Nutrition and Feeding: A Guide for Use in the WIC and CSF Programs” and follows the recommendations from the American Association of Pediatrics (AAP) Committee on Nutrition (this is a population based recommendation and the timing of introduction of complimentary foods for an individual infant may differ) and the Academy of Nutrition and Dietetics’ Pediatric Nutrition Manual. Offering infant cereal at 6 months can be emphasized in participant education.

Children	1-3 Years	4-8 Years	Females 9-13 Years
DAIRY GROUP 1 cup equivalent: 1 cup milk + 1 cup yogurt 1 ½ ounces hard cheese 2 ounces American cheese 2 cups cottage cheese 1 ½ cups ice cream 1 cup pudding 1 cup frozen yogurt	2 cups	2½ -3 cups	3 cups
MEAT/PROTEIN GROUP 1 ounce equivalent: 1 ounce cooked meat, fish or poultry 1 egg ¼ cup cooked dry beans/peas 1 tablespoon peanut butter 1 ½ hot dogs* 1 ½ ounces sausage* 2 slices bologna*	2-4 ounces No peanut butter under 3 years of age	3-5½ ounces	5-6 ounces
VEGETABLE GROUP** 1 cup equivalent: 1 cup raw or cooked vegetables 1 cup vegetable juice 2 cups raw leafy vegetables	1-1½ cups	1½ -2 cups	1½ -3 cups
FRUIT GROUP** 1 cup equivalent: 1 cup fruit or 100% fruit juice ½ cup dried fruit ½ cup = 1 small fruit	1-1½ cups	1-2 cups	1½ -2 cups
GRAINS GROUP Half should be whole grain 1 ounce equivalent: 1 cup ready to eat cereal ½ cup cooked cereal ½ cup cooked rice or pasta 1 small biscuit or muffin 1 slice bread 1 roll 1 small piece cornbread 1 pancake 1 flour or corn tortilla (6 inches)	3-5 ounces (1½-2½ ounces whole grains)	4-6 ounces (2 -3 ounces whole grains)	5-7 ounces (2½ -3½ ounces whole grains)
FATS 1 teaspoon equivalent: 1 teaspoon margarine 1 teaspoon vegetable oil (canola or olive oil best) 1 teaspoon mayonnaise 1 tablespoon salad dressing	3- 4 teaspoons	4-6 teaspoons	4-6 teaspoons

Females	Pregnant/Lactating 14-18 Years***	Pregnant/Lactating 19-30 Years***	Pregnant/Lactating 31+ Years***
DAIRY GROUP 1 cup equivalent: 1 cup milk + 1 cup yogurt 1 ½ ounces hard cheese 2 ounces American cheese 2 cups cottage cheese 1 ½ cups ice cream 1 cup pudding 1 cup frozen yogurt	3 cups	3 cups	3 cups
MEAT/PROTEIN GROUP 1 ounce equivalent: 1 ounce cooked meat, fish or poultry 1 egg ¼ cup cooked dry beans/peas 1 tablespoon peanut butter 1 ½ hot dogs* 1 ½ ounces sausage* 2 slices bologna*	6-7 ounces	7-8 ounces	6-7 ounces
VEGETABLE GROUP** 1 cup equivalent: 1 cup raw or cooked vegetables 1 cup vegetable juice 2 cups raw leafy vegetables	3-3½ cups	3-3½ cups	3-3½ cups
FRUIT GROUP** 1 cup equivalent: 1 cup fruit or 100% fruit juice ½ cup dried fruit ½ cup = 1 small fruit	2-2½ cups	2-2½ cups	2 cups
GRAINS GROUP Half should be whole grain 1 ounce equivalent: 1 cup ready to eat cereal ½ cup cooked cereal ½ cup cooked rice or pasta 1 small biscuit or muffin 1 slice bread 1 roll 1 small piece cornbread 1 pancake 1 flour or corn tortilla (6 inches)	7-10 ounces (3½ -5 ounces whole grains)	7-10 ounces (3½ -5 ounces whole grains)	7-9 ounces (3½ -4½ ounces whole grains)
FATS 1 teaspoon equivalent: 1 teaspoon margarine 1 teaspoon vegetable oil (canola or olive oil best) 1 teaspoon mayonnaise 1 tablespoon salad dressing	6-8 teaspoons	6-8 teaspoons	6-8 teaspoons

Females	Non-pregnant 14-18 Years***	Non-pregnant 19-30 Years***	Non-pregnant 31+ Years***
DAIRY GROUP 1 cup equivalent: 1 cup milk + 1 cup yogurt 1 ½ ounces hard cheese 2 ounces American cheese 2 cups cottage cheese 1 ½ cups ice cream 1 cup pudding 1 cup frozen yogurt	3 cups	3 cups	3 cups
MEAT/PROTEIN GROUP 1 ounce equivalent: 1 ounce cooked meat, fish or poultry 1 egg ¼ cup cooked dry beans/peas 1 tablespoon peanut butter 1 ½ hot dogs* 1 ½ ounces sausage* 2 slices bologna*	5-6½ ounces	5½ -6½ ounces	5-6 ounces
VEGETABLE GROUP** 1 cup equivalent: 1 cup raw or cooked vegetables 1 cup vegetable juice 2 cups raw leafy vegetables	2½ -3 cups	2½ -3 cups	2½-3 cups
FRUIT GROUP** 1 cup equivalent: 1 cup fruit or 100% fruit juice ½ cup dried fruit ½ cup = 1 small fruit	1½ -2 cups	2 cups	1½-2 cups
GRAINS GROUP Half should be whole grain 1 ounce equivalent: 1 cup ready to eat cereal ½ cup cooked cereal ½ cup cooked rice or pasta 1 small biscuit or muffin 1 slice bread 1 roll 1 small piece cornbread 1 pancake 1 flour or corn tortilla (6 inches)	6-8 ounces (3-4 ounces whole grains)	6-8 ounces (3-4 ounces whole grains)	6-7 ounces (3 -3½ ounces whole grains)
FATS 1 teaspoon equivalent: 1 teaspoon margarine 1 teaspoon vegetable oil (canola or olive oil best) 1 teaspoon mayonnaise 1 tablespoon salad dressing	5-7 teaspoons	6-7 teaspoons	5-6 teaspoons

+ nonfat or lowfat milk for 2 years of age and older

* = High fat meats - contain more fat and calories than other selections from this group and should be used less frequently. Bacon should not be counted as a meat.

** = Daily source of vitamin C needed from Fruit or Vegetable groups.

*** = Use lower range during pregnancy and upper range during lactation. Pregnancy - 3 cups of milk, 6 ounces protein, (7 ounces for 19-30 year olds), 3 cups vegetables, 2 cups fruit, 7 ounces grains. Lactation - 3 cups of milk, 7 ounces protein, (8 ounces for 19-30 year olds), 3 1/2 cups vegetables, 2 1/2 cups fruit (2 cups for 31+ year olds), 10 ounces grains (9 ounces for 31+ year olds).

USDA FOOD PATTERNS¹

The Food Patterns suggest amounts of food to consume from the basic food groups, subgroups, and oils to meet recommended nutrient intakes at 12 different calorie levels. Nutrient and energy contributions from each group are calculated according to the nutrient-dense forms of foods in each group (e.g., lean meats and fat-free milk). The table also shows the number of calories from solid fats and added sugars (SoFAS) that can be accommodated within each calorie level, in addition to the suggested amounts of nutrient-dense forms of foods in each group.

Calorie Level	1,000	1,200	1,400	1,600	1,800	2,000	2,200	2,400	2,600	2,800	3,000	3,200
Fruits	1cup	1 cup	1 ½ cups	1 ½ cups	1 ½ cups	2 cups	2 cups	2 cups	2 cups	2 ½ cups	2 ½ cups	2 ½ cups
Vegetables	1 cup	1 ½ cups	1 ½ cups	2 cups	2 ½ cups	2 ½ cups	3 cups	3 cups	3 ½ cups	3 ½ cups	4 cups	4 cups
Grains	3 oz-eq	4 oz-eq	5 oz-eq	5 oz-eq	6 oz-eq	6 oz-eq	7 oz-eq	8 oz-eq	9 oz-eq	10 oz-eq	10 oz-eq	10 oz-eq
Meats/Protein	2 oz-eq	3 oz-eq	4 oz-eq	5 oz-eq	5 oz-eq	5 ½ oz-eq	6 oz-eq	6 ½ oz-eq	6 ½ oz-eq	7 oz-eq	7 oz-eq	7 oz-eq
Dairy	2 cups	2 ½ cups	2 ½ cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups
Oils	3 tsp	4 tsp	4 tsp	5 tsp	5 tsp	6 tsp	6 tsp	7 tsp	8 tsp	8 tsp	10 tsp	11 tsp
Limit on calories from SoFAS	137	121	121	121	161	258	266	330	362	395	459	596

- 1. Calorie Levels** are set across a wide range to accommodate the needs of different individuals. The table “*Estimated Daily Calorie Needs*”, (See [Appendix 2 - 8](#)) can be used to help assign individuals to the food intake pattern at a particular calorie level.
- 2. Fruit Group** includes all fresh, frozen, canned, and dried fruits and fruit juices. In general, 1 cup of fruit or 100% fruit juice, or 1/2 cup of dried fruit can be considered as 1 cup from the fruit group.
- 3. Vegetable Group** includes all fresh, frozen, canned, and dried vegetables and vegetable juices. In general, 1 cup of raw or cooked vegetables or vegetable juice, or 2 cups of raw leafy greens can be considered as 1 cup from the vegetable group.

- 4. Grains Group** includes all foods made from wheat, rice, oats, cornmeal, barley, such as bread, pasta, oatmeal, breakfast cereals, tortillas, and grits. In general, 1 slice of bread, 1 cup of ready-to-eat cereal, or 1/2 cup of cooked rice, pasta, or cooked cereal can be considered as 1 ounce equivalent from the grains group. **At least half of all grains consumed should be whole grains.**
- 5. Meat /Protein Group** includes meat, poultry, seafood, eggs, processed soy products, and nuts and seeds. In general, 1 ounce of lean meat, poultry, or fish, 1 egg, 1 tablespoon peanut butter, 1/4 cup cooked dry beans, or 1/2 ounce of nuts or seeds can be considered as 1 ounce-equivalent in this group.
- 6. Dairy Group** includes all milks, including lactose-free products and fortified soymilk (soy beverage), and foods made from milk that retain their calcium content, such as yogurt and cheese. Foods made from milk that have little to no calcium, such as cream cheese, cream, and butter, are not part of the group. Milk choices should be fat free or low fat as well as most of the other dairy group choices. In general, 1 cup of milk or yogurt, 1 ½ ounces of natural cheese, or 2 ounces of processed cheese can be considered as 1 cup from the dairy group.
- 7. Oils** include fats from many different plants and from fish that are liquid at room temperature, such as canola, corn, olive, soybean, and sunflower oil. Some foods are naturally high in oils, like nuts, olives, some fish, and avocados. Foods that are mainly oil include mayonnaise, certain salad dressings, and soft margarine.
- 8. SoFAS** are solid fats and added sugars. The limits for calories from SoFAS are the remaining amount of calories in each food pattern after selecting the specified amounts in each food group in nutrient-dense forms (forms that are fat-free or low-fat and with no added sugars).

ESTIMATED DAILY CALORIE NEEDS

Individuals are assigned to a calorie level based on their sex, age, and activity level.

Males				Females			
Activity Level	Sedentary*	Moderate Active*	Active*	Activity Level	Sedentary*	Moderate Active*	Active*
AGE				AGE			
2	1000	1000	1000	2	1000	1000	1000
3	1000	1400	1400	3	1000	1200	1400
4	1200	1400	1600	4	1200	1400	1400
5	1200	1400	1600	5	1200	1400	1600
6	1400	1600	1800	6	1200	1400	1600
7	1400	1600	1800	7	1200	1600	1800
8	1400	1600	2000	8	1400	1600	1800
9	1600	1800	2000	9	1400	1600	1800
10	1600	1800	2200	10	1400	1800	2000
11	1800	2000	2200	11	1600	1800	2000
12	1800	2200	2400	12	1600	2000	2200
13	2000	2200	2600	13	1600	2000	2200
14	2000	2400	2800	14	1800	2000	2400
15	2200	2600	3000	15	1800	2000	2400
16	2400	2800	3200	16	1800	2000	2400
17	2400	2800	3200	17	1800	2000	2400
18	2400	2800	3200	18	1800	2000	2400
19-20	2600	2800	3000	19-20	2000	2200	2400
21-25	2400	2800	3000	21-25	2000	2200	2400
26-30	2400	2600	3000	26-30	1800	2000	2400
31-35	2400	2600	3000	31-35	1800	2000	2200
36-40	2400	2600	2800	36-40	1800	2000	2200
41-45	2200	2600	2800	41-45	1800	2000	2200
46-50	2200	2400	2800	46-50	1800	2000	2200
51-55	2200	2400	2800	51-55	1600	1800	2200
56-60	2200	2400	2600	56-60	1600	1800	2200
61-65	2000	2400	2600	61-65	1600	1800	2000
66-70	2000	2200	2600	66-70	1600	1800	2000
71-75	2000	2200	2600	71-75	1600	1800	2000
76 and up	2000	2000	2400	76 and up	1600	1800	2000

*Calorie levels are based on the Estimated Energy Requirements (EER) and activity levels from the Institute of Medicine Dietary Reference Intakes Macro nutrients Report, 2002.

SEDENTARY = less than 30 minutes a day of moderate physical activity in addition to daily activities.

MOD. ACTIVE = at least 30 minutes up to 60 minutes a day of moderate physical activity in addition to daily activities.

ACTIVE = 60 or more minutes a day of moderate physical activity in addition to daily activities.

VENA SKILLS CHECKLIST

VENA Skills Checklist for Effective Counseling

CPA Name _____ Date of Review _____ Date of Follow-Up _____

Rate how well the counselor performed on each skill on a scale of 1 to 5.

1=Needs significant practice; 5=Excellent, keep up the great work!; NA=Not Applicable.

	1	2	3	4	5	NA	1	2	3	4	5	NA
ESTABLISHING RAPPORT	Initial Review Comments:						Follow-Up Review Comments:					
<ul style="list-style-type: none"> Introduced self to client Displayed understanding for other cultures Ensured privacy (Kept voice low, closed door, moved to private location) Offered help when needed ("Here are some pamphlets", "feed baby here", etc.) Used appropriate non-verbal communication (Nodded head, made eye contact, avoided crossed arms, etc.) Used respectful language Focused on client when translator is used 												
COMPLETING ASSESSMENT FORMS (QUESTIONNAIRE, TOOL, ETC.)	Initial Review Comments:						Follow-Up Review Comments:					
<ul style="list-style-type: none"> Reviewed client's previous plan and client-centered goal Gather missing/additional information without interrupting client Asked probing questions to clarify responses Avoided spending extensive time on irrelevant information Shared findings (ht, wt, Hgb/Hct) in a non-judgmental manner 												
IDENTIFYING AND EXPLORING CONCERNS	Initial Review Comments:						Follow-Up Review Comments:					
<ul style="list-style-type: none"> Asked open-ended questions to explore client's concerns Listened actively and allowed for silence Validated client's concerns Referred client to outside resources when needed (social services, food bank, etc) Used counseling tools to start and guide conversation (questionnaire, probing questions) Identified and acknowledged client's strengths (positive behaviors) Maintained focus on desired health outcome (healthy pregnancy, active family) Assessed level of nutritional risk Identified all nutritional risks Helped client explore feelings and attitudes about health concern Tried to lead discussion based on nutrition assessment data if nothing was offered by client Assessed the client's readiness to change (Stage of Change - SOC) Helped client to identify barriers to change and possible ideas to overcome them. Provided simple, accurate nutrition messages if client was receptive Limited number of nutrition messages given to client per session Tailored messages based on client's age, gender, culture, and feedback 												

	1	2	3	4	5	NA	1	2	3	4	5	NA
SETTING GOALS												
<ul style="list-style-type: none"> Summarized the conversation Assessed for progress toward previous goal/behavior change. Praised progress toward goal. Identified barriers to behavior change Identified suggestions/solutions to change Reinforced desired outcome Helped client set goal that is specific & realistic for the family's lifestyle Used facilitated discussion to help client set goal that is specific & realistic for the family's lifestyle Documented goal in client record 	Initial Review Comments:						Follow-Up Review Comments:					
CLOSING ON A POSITIVE NOTE												
<ul style="list-style-type: none"> Restated the goal and checked for understanding Expressed appreciation for client's time Was enthusiastic about following up at next time 	Initial Review Comments:						Follow-Up Review Comments:					
GROUP EDUCATION												
<ul style="list-style-type: none"> Was client-centered Conducted facilitated discussion Session was interesting and Interactive Maintained master file (list of attendees, date of session, description/outline of topic) 	Initial Review Comments:						Follow-Up Review Comments:					
ADDITIONAL SKILLS AS NEEDED AND APPROPRIATE												
<ul style="list-style-type: none"> Interpreted and compared dietary practices of WIC participants to federal policy guidelines Analyzed and compared dietary practices to evidence-based recommendations 	Initial Review Comments:						Follow-Up Review Comments:					

CPA Name _____

REVIEW: _____ Date _____

1. How well did counseling method or teaching strategy meet the needs of the participant? (Focused on personalized, client-centered, positive approach to desired health outcome rather than on deficiencies; identified participant's individual needs and concerns; created a partnership with the participant in goal-setting; used critical thinking and rapport-building skills; provided a comprehensive nutrition assessment that considered the WIC participant's needs; enhanced the quality of WIC services by linking WIC nutrition assessment to nutrition education, food package and referrals.)

2. What were the counselor's strongest skills?

3. What counseling skill, if any, did the counselor and/or supervisor feel need improving?

4. Findings/recommendations:

5. Set a goal and write below. This goal should be specific, measurable, attainable, relevant, and time-bound. (Use this form at the end of timeframe to evaluate the counselor's progress toward the goal.)

FOLLOW-UP Date _____

1. Was the counselor's goal met? Yes _____ No _____ N/A _____
If not, discuss barriers and solutions for meeting the goal and set new evaluation date.

2. If needed, set a new goal for improving skills. This goal should be specific, measurable, attainable, relevant, and time-bound. (Use this form at the end of timeframe to evaluate the counselor's progress toward the goal.)

3. Findings/recommendations:

2/2010

RECOMMENDED NUTRITION AND BREASTFEEDING RELATED WEBSITE RESOURCES

Government: (websites based on current Dietary Guidelines for Americans and guidelines for treatment of various chronic diseases)

www.cdc.gov/breastfeeding (CDC breastfeeding home page)

www.cdc.gov/diabetes (CDC diabetes home page)

www.cdc.gov/heartdisease (CDC heart disease home page)

www.cdc.gov/nutrition (CDC nutrition home page)

www.cdc.gov/stroke (CDC stroke home page)

www.choosemyplate.gov (My Plate, general nutrition information)

www.cdc.gov/nutrition/everyone/resources/index.html (CDC nutrition resources for a variety of topics)

www.fda.gov/Food/ResourcesForYou/Consumers/UCM239035.htm (FDA Center for Food Safety and Applied Nutrition Education Resource Library- food safety, food label and other nutrition related handouts)

www.fns.usda.gov/fns/core-nutrition/core-nutrition-message (USDA Core Nutrition Messages)

www.fns.usda.gov/core-nutrition/especially-moms (USDA Core Nutrition Messages especially for moms and includes fact sheets, recipes and videos)

www.fns.usda.gov/tn (Team Nutrition- several My Plate materials, Recipes for Healthy Kids Cookbook, Nibbles for Health Newsletter, My Plate for Kids: Make Half Your Plate Fruits and Vegetables)

www.foodsafety.gov (Food safety information and recalls and alerts)

www.fruitsandveggiesmatter.gov (CDC National Fruit and Vegetable website)

www.Healthfinder.gov (US Department of Health and Human Services health finder resource)

<http://minorityhealth.hhs.gov> (Office of Minority Health)

www.nal.usda.gov/wicworks/Topics/BreastfeedingFactSheet.pdf (Tips for breastfeeding moms on making healthy food choices with regular physical activity, available in English and Spanish)

www.ndep.nih.gov (National Diabetes Education Program)

www.nhlbi.nih.gov/health/pubs/pub_gen.htm (National Heart, Lung, & Blood Institute publications)

www2.niddk.nih.gov (National Institute of Diabetes and Digestive and Kidney Diseases)

www.nkdep.nih.gov (National Kidney Disease Education Program)

www.nutrition.gov/ (variety of nutrition resources)

<http://recipefinder.nal.usda.gov> (Locate recipes from SNAP-Ed Connections as well as food safety information)

<http://snap.nal.usda.gov> (SNAP- Ed Connection, Loving Your Family materials)

<http://www.surgeongeneral.gov/library/calls/index.html> (US Department of Health and Human Services, Office of the Surgeon General)

<http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT> (Drugs and Lactation Database at the National Library of Medicine)

<http://wicworks.nal.usda.gov> (WIC Works Resource System)

www.womenshealth.gov/breastfeeding (DHHS National Women's Health Information Center- breastfeeding, methods of expressing milk, pumping and storage)

www.womenshealth.gov/itsOnlyNatural (DHHS National Women's Health Information Center offering breastfeeding help and support for African American moms)

<http://massbreastfeeding.org/handouts/> It's my birthday, give me a hug Massachusetts BC Only Skin to Skin Handouts (Various languages)

<http://breastmilkcounts.com/my-breastfeeding-plan.php> Breast Milk Every Ounce Counts Texas WIC (Eng & Span)

Nonprofit/Educational: (based on current nutrition science and have no conflict of interest)

www.aap.org/ (American Academy of Pediatrics)

www.eatright.org (Academy of Nutrition and Dietetics)

www.heart.org (American Heart Association)

www.bfmed.org (The Academy of Breastfeeding Medicine)

www.diabetes.org (American Diabetes Association)

www.fruitsandveggiesmorematters.org (Produce for Better Health Foundation)

www.healthiergeneration.org (Alliance for a Healthier Generation)

www.ilca.org (International Lactation Consultant Association)

www.llli.org (La Leche League)

www.text4baby.org (free weekly text messages for pregnant women and new moms regarding pregnancy and baby care health topics)

www.waba.org.my (World Alliance for Breastfeeding Action)

Universities and Extension:

<http://food.unl.edu/fnh/educational-resources> (University of Nebraska Extension Food, Nutrition and Health)

<https://store.extension.iastate.edu/ItemDetail.aspx?ProductID=5414> (Iowa State University Extension-downloadable tip sheets for families, Raising Healthy Kids-nutrition)

<https://utextension.tennessee.edu/Pages/foodNutrition.aspx> (University of Tennessee Extension)

www.uwex.edu/ces/wnep/teach/nfspdfs/movkids.pdf (Wisconsin Extension “Let’s Get Our Kids Moving!” brochure)

Other: (based on current scientific information and current nutrition care recommendations)

www.bd.com/us/diabetes/hcp/main.aspx?cat=3066&id=3120 (Becton Dickinson Company- variety of free downloadable diabetes materials)

www.bellinstitute.com (General Mills Bell Institute)

www.bsc.gwu.edu/dpp/lifestyle/dpp_dcor.html (Diabetes Prevention Program’s Lifestyle Change Program Manual)

www.diabetesinitiative.org/resources/tools/ToolsPatientEducation.summary21-LAC.html

(Diabetes Initiative - A National Program of the Robert Wood Johnson Foundation – downloadable “Live Your Life – Control Your Diabetes” book – English and Spanish)

www.lactationtraining.com (Lactation Education Resources- downloadable lactation handouts)

www.Lillydiabetes.com (Eli Lilly Company- downloadable diabetes materials, Daily Meal Planning Guide available in 9 languages)

www.liveglutenfreely.com (General Mills- gluten free recipes, downloadable fact sheets, and videos)

www.numatters.com (Nutrition Matters, Inc. - free Nubite tip sheets posted on first and third of every month)

www.porkandhealth.org (National Pork Board- recipes, Live Well toolkit with downloadable handouts)

www.southeastdairy.org (Southeast United Dairy Industry Association, Inc.-downloadable handouts and tip sheets)

Educational materials from these websites should be sent to Central Office for approval before use to ensure that the content is compliant with the Tennessee WIC Program nutrition and breastfeeding recommendations.

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VOUCHER-FI/ CVV INTRODUCTION

The WIC on-site, on-demand voucher print module of the Patient, Tracking and Billing Management Information System (PTBMIS) is an enhanced way to expedite the process of issuing FI/ CVVs for the PHOA/ WIC clerk. It also tracks the FI/ CVV serial numbers and voiding of FI/ CVVs by co-site and user ID without clerical intervention, which offers a very secure system.

FI/ CVVs are printed on secure voucher paper from MICR (Magnetic Ink Character Recognition) enabled laser printers. The FI/ CVV is actually “created” by the system in clinic when the participant is with the clerk and all of the updated information is entered into PTBMIS.

SEPARATION OF DUTIES AND PROGRAM INTEGRITY

The principle of separation of duties is fundamental to WIC FI/ CVV accountability as required by the WIC Federal Regulations in CFR 246.12 and Bureau of Health Services, Policies and Procedures Manual, Section 2.3. To maintain separation of duties:

Competent Professional Authorities (CPA) who certify participants to receive WIC benefits cannot print or issue FIs or CVVs. Only the CPA can assign the Food Packages to print on the FI or CVV.

Personnel who issue WIC FI/ CVVs must be properly trained and authorized by the WIC Director. These users must also be listed on the PTBMIS tables as approved users for FI/ CVV printing. A clerk or backup clerk should always be available in clinic to issue FI/ CVVs. The Public Health Office Assistant (PHOA/ clerk) or any system user should sign off the system anytime a terminal is to be left unattended and out of sight of the user.

The WIC staff in the Regional Office has the responsibility of validating or replacing FI/ CVVs for vendors. However, there are two conditions governing whether a WIC Vendor Representative or the WIC Director validates or replaces a particular FI/ CVV. They may not validate or replace a FI/ CVV which they individually issued at a WIC clinic. Also, they may not validate or replace a FI/ CVV that was issued by a relative. The definition of relative is based on the State’s Department of Human Resources rules and includes “a parent, foster parent, parent-in-law, child, spouse, brother, foster brother, sister, foster sister, grandparent, grandchild, son-in-law, brother-in-law, daughter-in-law, sister-in-law, or other family member who resides in the same household” as the employee.

The need for modifications to the schedule of day and/or hours when WIC FI/ CVVs can be issued should be requested through the WIC Director. The WIC Director will then issue a request to the System Administrator to modify the table that controls FI/ CVV printing by day/ hours.

WIC patient/ staff communication or FI/ CVV issuance must be done discreetly, if conducted in public. Staff members must respect all participants’ rights to privacy and confidentiality.

PREPARATION TO PRINT

Receipt/Security of FI/CVV Paper

Secure FI/CVV paper is delivered directly from the WIC Contract Bank to each clinic site. WIC Directors have a quarterly schedule of FI/CVV paper shipments. Each clinic must designate a contact person responsible for receipt of shipment. For emergency shipments, contact WIC Director at Regional Office; Regional Office will contact Food Delivery Administrator in Central Office.

Receipt of the FI/CVV paper is confirmed in the clinics by the completion of a FI/CVV Paper Receiving Record for which the number of boxes received and the date is given. With the paper normally being shipped during the last month of each calendar quarter, the form is to be sent to the Regional Office by the tenth of the month following receipt. Each Regional Office is to forward a completed form for their region to the Central Office by the fifteenth of that month.

Voucher paper should be stored in a clean, dry and secure location. The printer is left loaded with voucher stock only if the room is locked when left for an extended period of time.

Storage of Blank Voucher Paper

The blank voucher paper should be kept in a secure, clean, dry location. Do not store it on the floor or in any location that permits moisture to be absorbed by the paper, because it may cause jamming in the printer.

Ordering Toner Cartridges

Extra toner cartridges are kept in inventory at the Regional WIC Office. Because toner cartridges have a shelf life (expiration date), they must be distributed only on an as-needed basis using the oldest cartridge first. The WIC Central Office will order toner cartridges for distribution to the regional offices. These orders will be based on historical usage and drop-shipped.

Defective Toner Cartridges

When a toner cartridge appears to be defective (printing significantly fewer pages or smearing), follow the instructions below for returning a defective toner cartridge to be tested. (Your regional procedure may be to send the suspect cartridge to your regional WIC office for them to test, then they will call Source Technologies.) If it is indeed defective, they will replace it. The Source Technologies/Lexmark printers come with factory default settings for maximum use of toner cartridges.

Recycling Toner Cartridges

The used cartridges (that are not defective, just empty) should be repackaged in the new cartridge box. Send back to the manufacturer for recycling. Ship the package according to

instructions found in the new cartridge box. Prepaid shipping labels are in the box. United Parcel Service (UPS) will pick up.

Defective Toner Cartridge Return Form and Procedure

To return defective cartridges, the Regional WIC Director or designee should call Source Technologies at 1-800-922-8501 and ask for “Returns Dept.”. They will give instructions to return the cartridge.

Printer Problems

WIC keeps a maintenance contract for voucher printers, which covers telephone technical support and replacements for out of order printers. If a printer is not working properly, first call your System Administrator (unless he/she has directed you to call Source Technologies without consulting him/her). If you are directed to call Source Technologies for help, call 1-800-922-8501 and ask for Technical Support. Our account name is TN DOH (Tennessee Department of Health). The technician will attempt to solve the printer problem with you on the phone.

If Source Technologies is unable to assist you in restoring your WIC printer to proper working order, they will ship out a replacement printer to arrive overnight. If it is determined prior to 3 p.m. (Eastern Time) that a replacement printer is to be shipped, it will be received the next business day. After 3 p.m., it will be two business days. In such a case, the regional office may provide a replacement printer.

If Source Technologies sends a replacement printer, it should be set up and performing properly before the out of order printer is repackaged in the shipping box and returned to Source Technologies. This is important because drawers and the toner cartridge must be taken from the old and placed in the new.

State Property Tags for Printers

When the replacement printer arrives at the clinic, it will have a “Shipping Label” provided by Source Technologies for returning the broken printer.

Once the replacement printer has been set up and determined to work properly, the System Administrator or Property Officer should notify the TDH Property and Procurement Division (an email should suffice). Please work with your Property Officers on who will do what to accomplish this procedure.

1. Make a copy (or scan) of the Shipping Label.
2. Give the Serial Number and State Tag of the broken printer being returned to ST and ask for it to be retired/disposed of.
3. Give the Serial Number of the replacement printer and request a new State Tag for it.
4. Take the State Tag off of the printer being returned so that it doesn't get sent to ST with a TN State Tag.
5. Email the above information to Alvin.Hill@tn.gov His phone number is 615-741-9414.

Assignment/Loading FI/ CVV Serial Numbers

WIC FI/ CVV serial numbers are a maximum of eight digits and are distributed by the WIC Central Office. A large sequence of FI/ CVV numbers is issued to each AS/400. A list of typical usage for each clinic (cosite) in that AS/400 area is generated by the system based on usage history and provided to the system administrator for use in distributing a set of FI/ CVV serial numbers to each cosite.

At any time, additional serial numbers may be added to a cosite as needed by calling the System Administrator. The remaining supply of serial numbers should be tracked to avoid running out of numbers. The command is TVIL to show the inventory for the cosite only. The command TVIL ALL will show the inventory of all of the cosites in an AS 400 sorted by cosite. The command TVIL FIRST will show the inventory sorted by serial numbers.

Loading FI/ CVV Paper

Printer tray capacity for the ST9530 and ST9630 printers is 200 sheets each for Tray 1 and Tray 2. Regular paper should be loaded in Tray 1 and FI/ CVV paper should be loaded in Tray 2. When loading paper in the tray, flex the paper back and forth taking care not to crease or damage the paper while loading. The FI/ CVV paper should be placed in the tray face down. The endorsement line on the back of the FI/ CVV should be on the left as the paper tray is loaded back printer.

ISSUING FI/ CVVS

Issuing FI/ CVVs to Participants/ Parents/ Guardians

When participant is ready for FI/ CVVs:

Verify that certification, nutrition education, or other prerequisites have been performed and recorded on the encounter form. (See Chapter 1- 9, under “Proof of Identity” for special procedures for “Infants of WIC Moms... who were not physically present at initial certification.”)

Enter current information on WICQ screen and update to move to the WICV screen for voucher issuance.

The majority of food instruments are issued for “standard” food packages and the system will determine the correct Food Package Code (FPC) and the associated voucher codes. These directions apply for the CPA and the PHOA.

The CPA should:

- Write “STD” in the Next Food Package Code on the Encounter Form.
- Write Cert Reason #335 in the first Cert Reason on the Encounter form if a prenatal is pregnant with multiple fetuses,
- Write a “2” in the Outcome field (for multiple births) on the Encounter Form for a “Partially BF Mother of Multiples”.

The PHOA should:

- Leave the “Next FP” field blank on the WICV screen if “STD” has been entered on the Encounter Form by the CPA. The system will look at the WIC status and other fields to determine which food package and FI/CVV’s to give.
 - For example, when a WIC Status 4 (Fully Formula Fed Infant) is entered, the system will look at the age in months to determine the correct amount of formula, and whether or not to give cereal and infant fruits and vegetables.
 - Similarly, when a WIC Status 9 (Partially Breastfed Infant) is entered, the system will look at the age in months to determine the correct number of cans of formula and whether or not to issue cereal and infant fruits and vegetables.
- Key #335 in the first “Cert Reason” field on the WICQ screen if it has been entered in the first field of Cert Reasons. The system will pick up this information and issue the correct food package (which is the same as the Fully BF Woman). The system will also issue the Fully BF package to the “Partially BF Mother of Multiples” when a “2” is entered in the Outcome field.

Leaving the “Next FP” on the WICV screen blank will allow the system to work for you.

These are the WIC Statuses to use on the Encounter Form and the WICQ screen:

WIC Status 1 (Prenatal)

WIC Status 2 (Non-Breastfeeding Woman)

WIC Status 3 (Partially Breastfeeding Woman)

WIC Status B (Postpartum Woman who is breastfeeding at least once per day, but whose baby is receiving the maximum amount of formula allowed)

WIC Status 4 (Fully Formula Fed Infant 0 to 12 months receiving the powdered contract formula)

WIC Status 5 (Child age 1 to 5)

WIC Status 6 (Fully Breastfeeding Woman)

WIC Status 7 (Fully Breastfeeding Infant)

WIC Status 9 (Partially Breastfeeding Infant)

Review the screen display to confirm that the FI/CVV’s about to be printed are correct.

No more than three (3) months of FI/CVV’s should be issued, except at initial certification. Initial certification after the 15th may be issued for 3 1/2 months. (Initial certification has been defined in Chapter 1.)

If a returning patient has FI/CVV’s for the current month that need to be replaced (changed formula, etc.), these may be replaced at the same time as a new three (3) month supply is being issued. That is not perceived to exceed the limitation of three (3) months.

Some food packages will require several voucher codes. The WICV screen allows for 28 voucher codes to be populated/entered on one screen. Once printed, additional codes may be added on the same day if needed.

If an infant under six (6) months of age is fully breastfeeding, the system will issue Food Package Code 7XSTD which will print an “XBI” FI. This FI is not given to the participant, but should be filed with the voids. It should not be voided on the TVH

screen, because its purpose is to count the fully breastfeeding infant (who does not get any FIs until six months of age when he/she gets infant fruits and vegetables and cereal) in participation. The system counts active participation each month as persons who have been issued a FI/ CVV for that month. There is no need to have a participant sign a receipt on which **only** XBI or DSF food instruments were printed.

For infants receiving immunizations at the health department, issue two months of FI at one time, (up to six months of age) to coincide with the infant's immunization schedule.

Check the printed FI for correctness.

Participant/guardian must sign each FI/ CVV receipt.

If a participant/guardian fails to sign the FI/ CVV receipt: contact the participant/parent/guardian, ask them to return to the clinic to sign the receipt. **Enter the actual date the receipt is signed.**

A person who cannot write must have a witness sign "witnessed by (witness's name)" beside the X of the person making the mark.

Proof of identity for the person receiving FI/ CVVs is required at the time of FI/ CVV pickup. The proof provided must be documented on the FI/ CVV receipt using the same two digit codes as defined for participant proof of identity. Receipts of FI/ CVVs issued are filed in chronological order, maintained at the clinic site for at least one year and available on CD thereafter. Name and number on the receipt identify the participant. The receipt date corresponds to visit in the patient file and on the WICQ/ WICV screens. If the FI/ CVV folder is used for this proof, then more than one signature (i.e. parent and alternate signer) may be on the same folder as long as both are authorized to sign FI/ CVVs for the participant.

Quality of FI/ CVVs Printed

The following items should be checked for quality control of all FI/ CVVs printed. If each FI/ CVV does not meet these standards, they should be voided and adjustments made for correct printing.

1. Toner on FI/ CVV should be sufficiently dark without gaps in numbers or letters, (especially the MICR line at the bottom of the FI/ CVV).
2. FI/ CVV print should be aligned straight and not printed uphill. This will cause the MICR line to be unreadable by the bank equipment. Observe if the MICR line prints in the box at the bottom of the FI/ CVV to check alignment if it is in question.
3. Perforations should be smooth, not jagged or torn. Always tear the FI/ CVVs apart before giving them to the participant. Fold and crease twice to assist in smooth tearing.

Issuing FI/CVV to a Proxy

A parent/caregiver may authorize a proxy to receive her/his FI/CVVs in clinic. (Proxy procedure in Chapter 1 and nutrition education proxy instructions in Chapter 3.) This proxy may also shop for the WIC foods.

Once the participant/parent/caregiver signs the Informed Consent Form, proxies may be issued FI/CVVs. Proxies must provide proof of his/her identity before receiving FI/CVVs. Whoever shops for the food must sign the FI/CVVs at the store.

Explain the food package and how, where, and when to spend the FI/CVVs. Provide list of authorized foods, stores, and the local resource agencies as required. Emphasize that FI/CVV folder must be presented at the store when the FI/CVVs are being transacted. Also emphasize that they must have knowledge of the procedures for transacting FI/CVVs which are described inside the FI/CVV folder. Confirm the next appointment and the action due in writing for the participant.

Issuing FI/CVVs to Alternate Shoppers

The participant/parent/caregiver or proxy may authorize an alternate shopper(s) to transact FI/CVVs at an authorized store on behalf of the participant. It is not required for an alternate shopper to be declared during the clinic visit and the name entered on the FI/CVV folder by the clinic staff. The name(s) can be added at a later time by the participant/parent/caregiver.

If the alternate shopper is not present in clinic when the food package is explained (information given on how, where and when to spend the FI/CVVs), it is the responsibility of the participant/parent/caregiver or proxy to do so. This includes the current WIC food list and the procedures for transacting the FI/CVVs which are described inside the FI/CVV folder. It is also the responsibility of the participant/parent/caregiver or proxy to assure the alternate shopper has signed the FI/CVV folder prior to it being given to the alternate shopper to use.

Replacement of FI/CVVs

Replacing FI/CVVs for Formula

FIs or purchased formula must be returned before replacement FIs are issued. The quantity of formula issued on a current month replacement FI will normally be limited to the amount returned, or the prorated amount, whichever is smaller.

Once returned FIs have been voided, replacements can be issued for a different food package. The system will allow you to issue an additional FI(s) to replace the returned formula as long as you find a different food package code to issue which represents the same formula or food.

Never void a FI/CVV that has been redeemed. If FIs for the same formula code need to be printed and there is not an equivalent FPC, you may use a different voucher code for the same formula to get a prorated amount. .

When formula is returned and replaced with a new FI, the formula must be logged into the clinic's formula inventory.

Replacing FI/CVV's for Cessation of Fully Breastfeeding

When a fully breastfeeding woman (WIC Status 6) reports that she either has ceased breastfeeding and needs formula, or she has cut back and needs formula to supplement:

On the Woman's Record:

Change her status from a 6 (Fully BF) to a 3 (Partially BF Woman) or a B (Barely BF Woman) or 2 (Postpartum Woman), whichever applies.

Issue any future FI/CVV's for the appropriate food packages, but do not try to recover the G and G2 FI/CVV's she may already have been given. When a woman miscarries, the food instruments she has should not be recovered. Issue any future food instruments as a WIC status 2 (Postpartum) through six months postpartum.

If it is beneficial to the woman to reissue the food instruments it should be done, e.g. a prenatal who delivers early and begins to fully breastfeed. She could be reissued food instruments for a WIC Status 6 (Fully Breastfeeding Woman) instead of the prenatal food instruments she might still have.

The exception to this is if she has been given FI/CVV's past her six month postpartum period and she goes from exclusively breastfeeding (WIC Status 6) to a Barely BF Woman (WIC Status B) or a Postpartum Woman (WIC Status 2.) In this instance FI/CVV's given past 6 months postpartum must be recovered. (This would also apply to a WIC Status 3 who quit breastfeeding after the six month postpartum record.)

On the Infant's Record:

Change the infant's status from a 7 to a 9 (Partially BF infant) or a 4 (Fully Formula Fed Infant).

Access the TVH for that infant and void the "non negotiable" FI/CVV's issued for current and any future months. If you will write "XBI" on the comment line of the TVH screen, it will show on the Void Report. There is no need to pull the actual FI/CVV (filed with the voids) and void it.

Reissue a FI/CVV for the designated formula for the current month for the appropriate number of cans as defined by the Nutritionist and for appropriate future months.

Other Replacements:

In general, replacements should provide the same or equivalent quantity of food as the FI/CVV being replaced. For example, when child FI/CVV's are returned or reported stolen, replace them with the same type, E or E2.

When a full month's FI/CVV(s) is replaced on or after the 15th, the normal replace-

ment quantity would be the prorated amount. For example, when both E and E2 are returned on the 20th, only one replacement FI would be issued and that would be a “P” (prorated) FI and one CVV.

Replacing FI/CVVs to Foster Parents

If a foster parent visits the clinic to pick up FI/CVVs for a foster child in his/her custody and FI/CVVs have been issued to a parent/caregiver, the following options are available:

- Call and ask the parent/caregiver to bring in the FI/CVVs (unless it is known that the FI/CVVs have been exposed to a situation that would make them a health hazard). If they cannot be reached or refuse to comply with the request to return the FI/CVVs,
- Send a letter to the parent explaining that the FI/CVVs have been voided and should not be cashed since the child is no longer in his/her custody. Ask for them to return the FI/CVVs to the clinic. Issue replacement FI/CVVs to the foster parent. If the voided FI/CVVs show up on the error listing report as having been redeemed **after** the letter was received by the parent/caregiver, send another letter requesting they repay the amount of the redeemed voucher(s).

In either of the above cases, check the WIC on line banking system to determine if the FI/CVVs were redeemed. Depending upon the urgency of the situation and the foster parent’s need, the seven day waiting period for replacing FI/CVVs considered to be “lost” may be waived.

Sending the correspondence by regular mail or certified mail is left to the judgment of the WIC Director. In making this decision he/she should consider the number of outstanding FI/CVVs and the total cost of the food packages.

PROCEDURE TO ISSUE WIC FI/CVVS WHEN SYSTEM IS DOWN

When the system is down and FI/CVVs cannot be printed on site for the participants who are in clinic, the participant should be given two options to receive FI/CVVs.

REAPPOINTMENTS - May be given at any time after system is down. No minimum timeframe for this option to be offered.

If the patient chooses to return to the clinic to pick up FI/CVVs, the clinic must work these persons into the clinic schedule. Appointments should be given and patients encouraged to return while they still have FI/CVVs.

MAILING - Should be offered to the participant when the system has been down for four hours. Should be offered immediately if it is advised by the System Administrator that the system will be down longer than four hours.

If it is five days from the end of the month and the parent/guardian chooses mailing, it must be pointed out that they might not receive current month FI/CVV's in time to spend before the month is over. She/he may choose to call the clinic later in the day or on subsequent days to ask if the system is up and return in person.

- Fill out the *Agreement to Mail WIC Vouchers* form (**Appendix 4-1**).
 - Have them sign the “Agreement to Mail WIC Vouchers” form.
 - Give them a copy of the signed form.
 - Place original in a holding folder until the system is back up and FI/CVV's can be printed.
 - Update the mailing address from the “Agreement to Mail WIC Voucher” form to the registration screen
 - Keep Agreement with Receipt Report for the day FI/CVV's were printed.
 - When the system is back up, follow these procedures for mailing:
1. Clerk will print the FI/CVV's for all persons in the family who were due to receive FI/CVV's when the system is down. The participant may not have FI/CVV's for the current month. If it is five days from the end of the month, and the participant has chosen the mailing option, the clerk must determine if the FI/CVV's have the possibility of arriving before the end of the month. If not, she/he should not print FI/CVV's for the current month.
 2. If the patient was in clinic for “voucher pick up,” three months may be mailed. If the patient was due a certification, only one month should be mailed.
 3. Clerk will print address labels with the Parent/Guardian Name. Be sure the address label is the same address that was written on the Agreement to Mail WIC Vouchers Form. A label for the envelope and one label for every set of FI/CVV's should be printed. The command PAL (Participant Address Label) is used to print address labels from inside the PTBMIS record. (Parent/Guardian may need to be registered, but should be registered for the A2 screen).
 4. The parent/guardian address label will be placed on the envelope for mailing. The envelope must be marked “Do Not Forward.”
 5. The additional labels will be placed on each receipt for the FI/CVV's that were sent to that address.
 6. A clerk (or other Health Department staff member), other than the one who printed FI/CVV's should place the FI/CVV's in the envelope. “DO NOT FORWARD” should be written on the envelope. She/he should then mail the FI/CVV's.
 7. The person (who mailed the FI/CVV's) should initial and date the receipt with the date the FI/CVV's were mailed and file the receipts as usual.
 8. The method to use to mail (regular first class, certified, etc) is an option of the clinic; however, the envelope must be marked “Do Not Forward.”
 9. If FI/CVV's are returned as undeliverable through the U.S. mail, an attempt should

be made to telephone the parent/guardian to come in to receive FI/CVVs. If unable to locate the parent/guardian, an employee other than the one who printed the FI/CVVs must handle the envelopes. Employee opens the envelope, marks void on the FI/CVVs. The issuing clerk should then void the FI/CVVs on the system and place with void FI/CVVs for that day. The signed agreement should also be noted that FI/CVVs were returned as undeliverable and voided, initialed and dated by employee.

10. If parent/guardian calls to say FI/CVVs have not been received, allow three business days from date mailed to check to see if the FI/CVVs have cleared the bank. If not, place a "stop payment" on them and have parent/guardian come in for a reissue. If they have been redeemed, turn over to the Regional WIC Director for investigation.

NOTE: The Agreement to Mail Voucher Form, PH-3683, is not available through Central Stores because of the required volume necessary to store there. A supply was issued to each region for distribution to the clinics. Regional offices should notify the WIC Central Office-Data System Section when the supply is running low.

POSTAGE OPTIONS FOR MAILING WIC FI/CVVS

FIRST CLASS MAIL

If patient claims not received, would have to wait until redeemed and bank can send copy.

CERTIFIED MAIL

The USPS will get a signature of the person who signed for the Certified Mail. Anyone at the address can sign for it. If no one is home when delivery is attempted, the Postman leaves a notice. The person has the option of calling the number and scheduling a redelivery or going to the Post Office to pick it up.

There are two options for finding out who signed for the Certified Mail:

- **RETURN RECEIPT** = by mail or receive electronically. This proof of who signed for the certified mail is automatically sent to the sender of Certified Mail. Will show the signature of person who signed receipt, but it could take 4 - 21 days to arrive.
- **REQUEST COPY OF RECEIPT FROM USPS** = Would request after mailing only if needed, e.g. if participant states has not received in a reasonable time period

To request a copy of who signed for the Certified Mail. Must wait 21 days to request. (21 days allows for 3 days of delivery; holding for 15 days; 3 days to return to sender)

PRIORITY MAIL

May be the fastest method, but most expensive

VOIDING FI/CVVS / VOID VOUCHER REPORT

Voiding FI/CVVs

When a FI/CVV needs to be voided, it is necessary to do the following:

Void the FI/CVV on the TVH screen with either:

Void code 01 - Voided in clinic (have actual FI/CVV in hand).

Void code 02 - L/S/D/ (do not have FI/CVV[s] to void).

Void code 03 - Printer Problems.

Void code 04 - Replacement of Vendor transacted FI/CVV.

If the wrong FI/CVV(s) is voided on the TVH accidentally, call the Regional WIC Director (or the person designated by the WIC Director) to “unvoid” the FI/CVV.

Void FI/CVVs by writing or stamping “void” on front of FI/CVVs.

Voided FI/CVVs may be kept in an accessible box on a daily basis, then for storage, should be transferred to the box provided for storage and shipping.

Vouchers may also be voided on the WICV screen. Put a “V” in the small box underneath the voucher code where there is an “I” or “R”. Press Enter and a box will “pop-up” that allows entry of all of the items shown above.

After voiding on the WICV screen, it will show the “V” and all of the information on the TVH.

Voiding on Receipt

When FI/CVVs are voided before they ever leave the clinic, indicate on the receipt that all or part were voided. If all were voided, write or stamp “void” on the receipt. No date or initials are required if entire set was voided instead of issued. If part were voided, clearly indicate on the receipt which FI/CVVs were voided. Date and initial this alteration on the receipt.

LOST/STOLEN/DESTROYED FI/CVVS

Lost FI/CVVs

The policy on lost FI/CVVs is that they are not replaced. Exceptions are allowed only when the CPA documents and signs in the participant’s record the determination that the individual’s nutritional and economic status would be at risk. In those cases, it will take at least seven days to replace the lost FI/CVVs. This will involve the clinic contacting the WIC Director or Vendor Management Staff to search CSC WIC Banking to see if the FI/CVVs have been transacted. (Specific procedures follow “Destroyed FI/CVVs”.)

In order for lost FI/CVV to be replaced, the CPA must determine need and document such in the patient file.

Staff may implement one of the three following options:

- limit FI/CVV issuance to one month at a time; or
- restrict replacement of lost FI/CVVs to one loss per family per year, or
- provide formula from inventory on hand.

If replacement FI/CVVs are issued, the participant should be warned that if the FI/CVVs reported lost are transacted, he/she may be responsible for reimbursing the WIC Program. (Refer to “Participant Abuse” in Chapter 7.)

Stolen FI/CVVs

A police report is required before stolen FI/CVVs may be replaced. Once a participant brings in a police report for stolen FI/CVVs, the clinic may replace the FI/CVVs with no delay using the current proration quantities that apply.

Every effort should be made to ascertain which FI/CVVs, if any, were transacted before the theft so that the correct serial numbers are reported stolen. The clinic staff should contact the WIC Director or Vendor Management Staff for a search to be conducted on CSC WIC Banking. The police report and the original LSD Report are filed in the patient’s record.

Destroyed FI/CVVs

Destroyed FI/CVVs may be replaced in the following situations:

- When there is an adequate remnant to recognize a specific FI/CVV.
- In natural disasters, staff’s general knowledge and media coverage of the disaster and the patient’s statement that the FI/CVVs were destroyed may be documented in the record in lieu of an official report.
- A house or car fire that was identified in the media as the patient’s property may constitute proof of the incident.
- In other circumstances, the patient must provide a police or fire report before FI/CVVs can be replaced. The clinic should contact the WIC Director or Vendor Management Staff for a search of CSC WIC Banking to see if the FI/CVVs have been transacted.

Special note: In cases of natural disaster when the food purchased with the WIC FI/CVV has been destroyed, it can be replaced. Document the loss as above, but do not void the FI/CVV.

Procedures for Documenting Lost, Stolen or Destroyed FI/CVVs

All criteria must be met in the above sections before FI/CVVs should be replaced. If the criteria are met, follow these steps:

1. Staff completes the *Lost/Stolen/Destroyed Report* (**Appendix 4-2**) and obtains signatures. (Or the TVH may be printed showing the FI/CVV numbers and that they are L, S or D, attach it to the report, note in the area where you would normally write the FI/CVV numbers that they are attached, and obtain the signatures.) There is no need to void the FI/CVV on the TVH until it is determined whether or not it is to be replaced. If it is not replaced, it may be found and spent.
2. For lost FI/CVVs, contact the Regional Office immediately after first being notified and then seven (7) days later for them to check the CSC WIC Banking to see if the lost FI/CVV(s) have been transacted.

Please Note: Regional Offices must maintain a log of clinic contacts and documentation of the results from the search on CSC WIC Banking as to whether the FI/CVVs have been transacted.

3. Clerk voids FI/CVVs on the TVH screen using void code “02”, enters “L, S, or D” and issues replacements.
4. It is also useful to document what happened in the “Comment” area.

UNVOIDING/REPLACING FI/CVVS (WICUR)

The “unvoid” and “replace” functions should both have security measures attached so that this command is not available to all users. They are to be performed by the WIC Director or her/his designee(s). Such a designee for the “replace” function must be a WIC Vendor Representative. A Vendor Representative will almost never issue FI/CVVs to participants directly. However if she/he does, they should never replace (or validate) a FI/CVV she/he issued. It is recommended that the number of persons performing these functions is kept to a minimum number for security reasons.

The “unvoid” feature is to be used only when a FI/CVV has been accidentally voided and must be unvoided. The clinic should notify the appropriate person(s) at the Regional Office when the wrong FI/CVV number has been voided and the Regional Office staff will correct the problem with this feature.

If a voided FI/CVV shows up on an error listing indicating that it has been redeemed, do not unvoid the FI/CVV. This feature only works if the FI/CVV is “unvoided” **before** the FI/CVV is redeemed. **Therefore, do not “unvoid” a FI/CVV that prints on the error listing** as it will overwrite the original void information on the TVH screen.

The “replace” feature is for use only on FI/CVVs the WIC Vendor Representative is replacing for a grocery store. This feature will print a FI/CVV exactly like the one it is to replace, i.e. same valid month, food package code, etc. It is not for replacing FI/CVVs in clinic to participants.

NOTE: These “unvoid” and “replace” features are not used simultaneously and certainly never on the same FI/CVV.

Before using the “replace” feature, the active cosite should be the Regional Office cosite. By replacing a FI/CVV from this Regional Office cosite, the WIC Receipt Report will print at the Regional Office location.

When using either of these two features:

Type the command WICUR and press {Enter}. The screen is divided into halves, the upper portion for the “unvoid” feature and the lower portion for the “replace” feature.

With a <Tab>, the cursor will go to the prompt for the voucher number to “unvoid.” If this is the feature to use, simply enter the FI/CVV number to unvoid and press {Enter}. The message “Function Complete” will show on the top right of the screen. The FI/CVV has now been unvoided and a “U” will show in the status column of the TVH screen.

If the feature needed is to “replace” a voucher (WIC Director or Vendor Representative use only), then <Tab> twice and the cursor will be at the “replace damaged voucher” prompt. Enter the voucher number to be replaced and press {Enter}. The message “Function Complete” will show on the top right of the screen. A FI/CVV will print with the receipt attached. A “P” should show in the status column of the TVH screen.

VOID VOUCHER REPORT

The Void Voucher Report:

The command to run this report is Report TWVOID (unless your System Administrator has given you different instructions to run this report).

Should be run daily for the previous clinic day, OR

Should include in the Report Date Parameters all days of the week which are in the past, not the current day, including Saturday and Sunday. The reason for this is that FI/CVVs can be voided whether WIC clinic is operating or not. The Time Lock Table will not affect access to the TVH screen and voiding FI/CVVs; therefore, in order to accurately reflect all “voiding” activity, the report needs to cover every day of the week.

Void FI/CVVs on file should match daily void voucher report except in cases of mechanical failure, LSD, or an exclusively breastfeeding voucher (XBI).

When you have no paper FI/CVV to void (lost, stolen or destroyed FI/CVVs, etc.), void the FI/CVV # on the TVH, use type 02 and explain what happened in the “comments” section. This will show on the void report.

Void voucher reports are initialed and dated by the clerk to indicate voided FI/CVVs have been checked and are present. Reports should be kept unfolded in a file or notebook.

Void voucher reports are filed daily by chronological and user ID order.

For FI/CVVs voided the same day they are printed, the void documentation on the receipts and the voided FI/CVVs match.

Void FI/CVVs are kept on file for one year for audit, and submitted to the WIC contract bank for imaging according to WIC Manual schedule in this chapter.

FI/CVV receipts and voids are monitored and documented monthly on a review form, showing beginning and ending dates, by someone other than the person who issued FI/CVVs.

Report should be maintained for two (2) years. Reports may be recreated if needed.

WIC RECEIPTS / RECEIPT REPORT

Receipts

Have the participant sign the receipt indicating they have received the FI/CVVs. (More detailed instructions previously this Chapter under “Issuing FI/CVVs”.)

FI/CVV receipts are to be kept on file in receipt number order and by user ID and match the daily Voucher Receipt Report. They should be kept until the assigned time to ship to the Bank for filming/imaging.

Receipt Report

WIC Receipt Report should be run:

The command to run this report is Report TWREC (unless your System Administrator has given you different instructions to run this report).

The following day of every day that FI/CVVs have potential to be issued OR

With date parameters that include every day that FI/CVVs have the potential to be issued. The date parameter should be in the past and not include the current day.

Unless a day of the week, including Saturday/ Sunday, is prohibited from printing FI/CVVs through the Time Lock (TWICTIM), the Receipt Report needs to be run for that day to verify that no activity occurred.

Receipts are checked against report to verify:

All receipts are present and signed in ink.

FI/CVVs marked “void” on the receipt are present and appear on the Void Report.

Receipt Report is initialed and dated by personnel who checked the report to indicate receipts have been checked and are present. These should be kept unfolded in a file or

notebook.

Receipt Reports are to be kept on file by chronological (by receipt number for a given date) and user ID order.

FI/CVV receipts and voids are monitored and documented monthly on a review form, showing beginning and ending dates, by someone other than the person who issued the FI/CVVs.

Report should be maintained for two (2) years. Reports may be recreated if needed by using date parameters to run the report.

DISPOSITION OF VOIDS AND RECEIPTS

The voided FI/CVVs and the receipts must be kept at least one year in the clinic for audit purposes. They will then be sent to the Regional WIC Offices, for destruction.

The Regional WIC Office will destroy the voids using RDA-1550 and the approved method of destruction. (Future instructions will be sent out on the destruction of the receipts.)

The schedule for archiving both voids and receipts from the clinics to the Regional Offices is on a quarterly basis. Within 30 days after the end of each quarter, the voids and receipts should be sent to the Regional Office (by staff traveling to and from clinics to the Regional Office in order to save shipping costs).

The schedule will be as follows:

Date to send to RO:	Send Voids and Receipts Processed During:
October 2016	July 2015 - September 2015
January 2017	October 2015 - December 2015
April 2017	January 2016 - March 2016
July 2017	April 2016 - June 2016

Continue a quarterly schedule in a like manner.

Receipts and Voids From Clinics to Regions

- Each clinic should send their year old receipts and voided FI/CVVs quarterly to the Regional WIC Office.

Voids

- The Regional WIC Office will destroy the voids using RDA-1550 and the approved method of destruction.

Voids Received from Clinics by Regions (to be destroyed)

Between the 1st and 7th days of the second month after the end of the quarter, the Regional Offices should destroy voided FI/CVV's received from clinics.

The Records Destruction Authority for the Voided FI/CVV's is RDA-1550.

The rural Regional Offices should use the shredding services on State contract and a "Certificate of Records Destruction" (GS-0989) should be completed and sent to the address on the form.

The metro Regional Offices should use the services available to them and complete the GS-0989 as completely as possible and keep in a file with other paperwork or description of the destruction.

Access this form by the link below. Then go to Records Management and click on "Certificate of Records Destruction".

<http://www.tn.gov/sos/rmd/index.htm>

DUAL PARTICIPATION REPORT

A report that identifies potential dual participants across the State within the WIC sites will be generated at the WIC Central Office and mailed to the Regional WIC Director for investigation. You should no longer see matches between WIC and CSFP because the CSFP only serves the Elderly population. However, if this report shows a match between WIC and CSFP, action must be taken to be sure the CSFP site does not continue to serve Women and Children.

This report will be run at least semi-annually as required by federal regulations. It will be printed and mailed during the month following the match month for which the Dual Participation Report is reporting e.g. a report showing persons who had duplicate FI/CVV's for the month of May will be mailed in June.

The purpose of the report is to identify participants that may be participating in more than one WIC program within the state of Tennessee.

The match will show up on the report of the site where the person was enrolled last. That region is responsible for initiating the investigation and reporting the results. The report must be investigated and the results of the investigation returned to the WIC Central Office within (30) days of the receipt or date requested on of the report.

If it is determined that there is no dual participation, documentation should be sent to the WIC Central Office on the results of the investigation (e.g. "SSN in error in cosite XXX. Was corrected").

If it is determined that dual participation has occurred (a duplicate set of WIC FI/CVV's issued to the same person for the same month), service in all but one site should be discontinued immediately. A phone call should be made to the issuing clinic or regional office to verify FI/CVV's were issued. The second set of FI/CVV's should be recovered, if

possible, from the participant and voided. If both sets of FI/CVV's have been redeemed, and it is determined that dual participation was intentional, efforts should be made to collect money for one set. It is not permissible to withhold FI/CVV's that would be issued for future eligible months in lieu of dual benefits previously received. Additional information pertaining to dual participation is provided in Chapter 7 under Participant Abuse.

Additionally, Tennessee WIC has agreements with bordering states for the prevention and detection of dual participation. When dual participation is identified, the local agency WIC Director will be contacted and will investigate. Action will be taken according to the dual participation agreement once the investigation is complete.

NOTE: A match will occur when the threshold score equals 50 points or more. An exact match of Social Security Numbers will equal 50 points. A match of last name, first name, date of birth, sex and race will also equal 50 points.

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Agreement to Mail WIC Vouchers



DEPARTMENT OF HEALTH AGREEMENT TO MAIL WIC VOUCHERS

Mail vouchers to these participants:

Participant Name	DOB	Month	# of Months?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Approximate date to be mailed: _____

When I receive the vouchers, I will check them against the list above. If they do not match, I will call the clinic immediately.

If I have not received them by _____ I will notify the clinic. I understand that if I do not notify the clinic promptly, vouchers not received cannot be replaced.

Mail to: Name _____
 Address _____
 City/St/Zip _____
 Phone No (_____) _____

Responsible Party Signature

(_____) _____
Clinic Telephone Number

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SYSTEMS INTRODUCTION

The WIC Data System is a module of the Patient Tracking Billing Management Information System (PTBMIS) which is the Tennessee Department of Health's (TDH) integrated computer system. All participants who use services in the TDH clinics are registered and income is reported through the PTBMIS. It is an online, real-time system that runs on IBM AS/400 mid-range computers located in the seven rural regions of the State and six metropolitan areas. The thirteen regional AS/400s upload participant data to a central AS/400 located in the Office of Information Resources (OIR). Only participant data requested by State Office personnel for statistical and reporting purposes is uploaded. The active participant database for each location is kept on the AS/400 at each region and maintained by the regional systems staff.

The WIC module eliminates much of the clerical time that would otherwise be required to operate the WIC Program. It is designed to assist, document and expedite the following key participant activities:

- Enrollment in WIC
- Certification
- Voucher-FI/ CVV Issuance
- Reconciliation of Voucher Redemption
- Reporting

When WIC services are given, the WICQ screen is accessed and on this one screen is captured all of the data necessary to track participant certification, nutrition education, pregnancy outcome data and breastfeeding data. The data fields are edited for logical edits and some cross-field edits. Once all the fields have been completed as necessary, a command is issued to go to the WICV screen so that FI/ CVVs can be printed on-demand for that participant.

Clinics are supplied routinely with secure voucher paper that is used in laser printers to create a WIC FI/ CVV when requested on the WICV screen by the PHOA/ WIC Clerk. These laser printers have been modified with programming and a toner cartridge to print the check image, the specific participant information and food package, and the Magnetic Ink Character Recognition (MICR) line for bank equipment to read as it travels through the banking system. A shaded piece of blank check stock is transformed in a matter of seconds into a WIC FI/ CVV by the program software and the laser printer. These printers are also equipped with a flash memory card that contains the form (check image), and the software to print the form for the check. The software downloads the food package and prints it on the FI/ CVV according to the food package code that was requested for this individual person.

Participants redeem their FI/ CVVs for the prescribed foods at grocery stores that have been authorized. Once the FI/ CVV has been properly negotiated, the grocery store imprints its store stamp on it and deposits it in the store bank account. It travels through the banking system arriving finally at the WIC contract bank. The bank performs some automated and visual edits to be sure it was redeemed properly. They then send an electronic file to the central office AS/400 for reconciliation.

Reconciliation of the system occurs when the file of the FI/ CVVs numbers which were

“redeemed” is compared to the FI/CVV numbers sent to the central office AS/400 as “issued”. From this comparison process, matches occur. Those FI/CVV numbers redeemed without a record of issuance or redeemed but have been voided are put on an exception report called an “Error Listing” for further investigation and follow-up.

Additional reports that are generated as a result of information from the system are participation counts, neonatal summaries, certification summaries, possible dual participation, breastfeeding duration, redemption analysis, etc.

WIC participants should be allowed to self-identify race and ethnicity and to also declare more than one race. Although PTBMIS allows “other” as an allowable code for Race, WIC does not recognize it and cannot report on it. Therefore, all persons registered for WIC should have one or more of the five race codes and not “other”.

PTBMIS REGISTRATION SCREEN

(Refer To PTBMIS Manual)

All patients must be registered in PTBMIS on the Registration Screen which contains much

demographic data. A “patient number” is automatically assigned.

Once the required fields of the Registration Screen are completed/updated, the system will move to the 2nd Registration Screen which is called the A2 Screen.

PTBMIS REGISTRATION PAGE 2 (A2) SCREEN

(Refer To PTBMIS Manual)

The A2 screen collects information about citizenship; origin of birth; participation in the SNAP program and TANF (previously called Food Stamps and AFDC Programs). A critical piece of information on the A2 screen is the Birth Mother or Care-Giver/Guardian's (Grandmother, Aunt, Foster Parent, etc.) Patient # or Social Security #. A long registration must be completed for the Mother/Care-Giver if she/he is not registered. Then once the A2 has been completed, there are commands that may be used to find the connections.

PTBMIS ENCOUNTER (ENL) SCREEN

(Refer To PTBMIS Manual)

PTBMIS requires that an Encounter be established for services to be entered.

PTBMIS FINANCIAL INFORMATION (FI) SCREEN

(Refer To PTBMIS Manual)

NOTE: When a participant is “adjunctively eligible” (eligible by enrollment in the Supplemental Nutrition Assistance Program (SNAP); TANF or Medicaid) for WIC and is not interested in declaring income for other program eligibility or for fee for service sliding scale, the income does not need to be taken or verified. In this case, put a “Y” in the sliding scale field, and enter in the Verification Source the two digit code to reflect the adjunctive eligibility (FS, GL or the correct Medicaid code form the TNCare system); and no income will show on the screen.

The field **TN WIC Eligible?** in the upper right corner of the FI is system generated and must show a Y for Yes in order for FI/CVV's to be printed. To have a Y generated, the Residency; Proof ID and Verification Source of Income fields must be WIC eligible codes (e.g. NP for Not Provided or VD for Verbal Declaration are not allowed for WIC). Additionally, the total income must be within the allowable income guidelines for the family size, unless the participant is adjunctively eligible. An FI date with a “Y” in the “WIC Eligible field must match a cert date for vouchers to print.

PTBMIS WICQ SCREEN

In order to print FI/CVVs on-site on-demand, all fields on this screen must be properly keyed. The following information about each section will give instructions for each field.

Visit Identification Information

(Protected Fields from Other Data Sources)

Patient Number – Assigned by computer

EN – The encounter number initiated and assigned to this particular participant on the particular visit

Entered – Date of Encounter

Site – County Site

Chart Name – Clinic assigned number entered on the CHX screen that matches participant record

DOB

Next Appointment – Shows any appointment that a participant has in the Health Department in any Clinic within the regional AS/400

Time – Time of next appointment

Clinic – Which clinic appointment

Visit Type – What action participant is due for on the next appointment

More Appts. – If more than one appointment has been given in the Appointment Scheduling System, a “Y” will show in the MORE APPTS field. To see the additional appointments, type PA on the command line.

Next Action Due on - Date next action is due. This information is calculated from such

information as certification date, infants turning 1 year old, 5 years old, etc.

Immunization Due – Date on which next immunizations are due

Last Visit – Date of previous WIC visit record

Vouchers Thru - The last month for which this participant was issued FI/CVV's

FP – Food Package received on the last month FI/CVV's were issued

Add(itional) FP – Any additional food packages issued.

Certification & Eligibility Data

This Visit – Date of encounter (The encounter date regulates the date of the WIC visit. If this visit is not the same as the encounter date, it is wrong. Go back and check to see that a new encounter number has been established.)

(Begin Data Entry Fields)

Approved for Online Nutrition Ed? – Y(es) or N(o)

(Last ED was (Type) on (Date)) Date will be displayed if participant received nutrition education on prior visit.

WIC Status – Status 1-9 (refer to WIC Manual Chapter 1)

Cert Date – Date of Certification of this participant

Cert Reasons – There are 3 certification reason fields. Only 1 must be keyed in order to update the screen. Enter up to 3 if applicable.

Priority – This field is automatically calculated based on WIC Status and the Cert Reasons. The Cert Reasons can be entered in any order in the three fields and the system will use the highest priority of the three.

DOM – This is the date the measures were taken. (Date of Measures cannot be more than 60 days before the cert date and not less than date of birth.

Old DOM – The last date of measures entered on the participant's visit record

Ht In ___ ___/8 – Height in inches in fractions of 1/8 (to be completed with the appropriate data)

Weight Lb ___ **Oz** - Weight in pounds and ounces (to be completed with appropriate data.)

Cent – Height in Centimeters (to be completed with appropriate data.)

Kilo – Weight in Kilograms (to be completed with appropriate data from certification visit if weight lb. oz. not input.)

HGB Date – The date the HGB or HCT was taken.

Old HGB Date – The date of the previous HGB/HCT.

HGB – Hemoglobin (to be completed with appropriate data.)

HCT - Hematocrit (to be completed with appropriate data if HGB not input.)

Ever BF? – To be completed once on all statuses except a Prenatal (Status 1). For WIC Status 2, 3, 6 or B, complete regarding her most recent delivery.

Termination Date – Enter the date the participant was or is to be terminated from the WIC Program. Terminations with future dates are allowed, but should be the end of the month in which the eligibility period ends and not the beginning of the month of ineligibility.

Termination Reason – A termination reason must be entered if a termination date is entered.

Special Data

Woman

Smoke – Enter “Y” or “N”

EDD – Estimated Date of Delivery

Del – Actual Delivery Date

Gain During Preg – Total weight gained during her pregnancy once she has delivered

Outcome – This is birth outcome (Press the Help key for the codes to key)

Birth 1,2,3 Sex Wt lb___Oz__- Enter “M” for male and “F” for female and birth weights of each. The third field has been added for triplets.

Infant Data on WICQ SCREEN

Additional Fields that only show on Infant and Children (under two yrs) records:

Measures:

Hd Cir (in and /8 in) – Head Circumference is required for infants under 2 years of age.

Or Hd Cir (Centimeters)

Infant Data:

EDD – Enter the Expected Date of Delivery of this infant

Or

Gest. Age at Del.- the gestational age at birth of this infant (either of these fields will be used to calculate prematurity.

Birth: Length – Enter Inches and /8 of an inch of this infant’s birth length

Weight Lb Oz - Enter pounds and ounces of this infant’s birth weight.

WICV SCREEN

Voucher Issuance

The first five lines are brought forward with information from previous visits.

Issue Thru – The last month for which FI/CVV's are to be issued. (A maximum of 3 ½ months of FI/CVV's can be issued here and only for an "initial" visit.)

ED today? – Enter the type of Nutrition Education given today (I=Individual; G=Group or O=Online).

Next FP – There are 4 blank fields that can be keyed with Food Package Codes. If they are left blank when screen is updated, they will automatically be filled with the Standard Food Package Codes for the Participant Status and vouchers thru month. To issue other Food Packages, type the Food Package Code desired for each month of FI/CVV's to be issued. (To see a list of Food Package Codes, tab to a blank FP field and press the Help key)

Add. FP – Additional Food Packages may be issued here, e.g. Phenex 2 in addition to the standard package for a woman/

Voucher Print Details:

Month/Yr – This is the month and year for each FI/CVV being issued based upon the Issue Thru month and the Food Package Code.

Vo Code– The Voucher Codes are generated from the Food Package Codes that were filled in the "Next FP" field. The Voucher Codes may be changed as needed (Use the Help Key)

Qty/Stat– Enter the quantity for infant formula only if not standard amount. Defaults to standard quantity otherwise. Quantity is only usable with formulas. To the right of the Qty shows the "status" of the individual voucher. A voucher may be voided using this field.

User ID – The system will fill in this field with the logged on user ID.

Proxy – Enter the name of a “Proxy” if one is designated to receive vouchers.

Exp. Date – The date the Proxy designation expires. If left blank, system will fill in the Certification Date.

Infant Screen:

Shown above is an Infant screen which with the field “BF now?” This field will only be shown on Infant and Children statuses (4, 5, 7 and 9).

BF now? – This field is used for all infant statuses (4, 7 and 9) and a Child status (status 5) if they are still breastfeeding after the 1st birthday. Use “Y” if the infant/child is currently breastfeeding. The number of weeks breastfed will be calculated from the infant’s date of birth and will show in the field “# Weeks”. If the mother ceases breastfeeding, tab to this field and enter “N” and enter the actual “# wks” the mother breastfed the infant/child or the date she “Stopped BF”. Only one of these two fields must be completed and the system will calculate the other field.

DISPLAY WICQ (DWICQ) SCREENS

This command is used to view a WICQ screen by the date of the visit. To use:

- Type DWICQ on the command line
- All of the WIC visits for that participant will list in order of the most recent visit.
- If the last visit is the one the user is wanting to view, simply press {Enter} and the most recent WICQ screen will appear.
- If any other than the most recent is the one to be viewed, <Tab> to the left of the participant name on the line of that visit and place an X, then press {Enter} and that visit will appear.

(NOTE: New information should not be added to the old WICQ screens when viewing these records.)

DISPLAY WICV (Voucher Issuance) SCREEN

Each WICV screen is associated with a WICQ screen. To view the WICV screen and vouchers issued, use the command DWICQ and instead of putting an “X” to access the historical WICQ screen, put a “V” beside the “Visit Date” you want to access and press {Enter} to view the historical WICV screen.

This is the WICV screen displayed after vouchers have printed. The “Stat” of a voucher shows here as an “I” for Issued. Vouchers may be voided from this screen and a pop-up box allows the same information to be completed as when voiding on the TVH screen. (See TVH in this Chapter)

TENNESSEE VOUCHER HISTORY (TVH)

The Tennessee Voucher History or TVH screen is the mechanism to use for researching the status of a particular FI/CVV or to void a FI/CVV. The command “TVH” will produce a menu selection screen as shown above. From this menu the user may select to find the FI/CVV by using one of the following sorts:

- Voucher Number
- Issue Date
- Participant Name
- Chart #
- Participant #

Tab and place an “X” to the left of the chosen sort method. The user must then define the specific of the sort chosen, such as the eight digit voucher number if using that sort.

NOTE: If in a current participant, TAB to the “Participant Name” option, place an “X” to its left and press enter. (Do not need to enter Participant Name.) It will take the user to the most recent FI/CVV of all of the FI/CVVs issued to that participant. If not in a current participant’s record and are searching by Name, enter Last Name, then TAB to the second part of the Participant Name to enter the First Name.

Once the sort has been selected, the Voucher History screen will appear. Every FI/CVV has a two line entry. The top line lists the Voucher Number, Last Name, First Name, WIC ID (Chart #), Issue Date, Valid Month, Status and the User ID of the person who issued.

Viewing Voucher Details

To view the details of a specific FI/CVV:

- Go to the Voucher History Screen (TVH command then select a sort).
- Put an * where the “Stat” (Status) of the voucher shows (it should be an I, R, V, U or P).
 - I - represents “Issued” FI/CVVs
 - R -represents FI/CVVs which were “Reissued or Replaced” in Clinic
 - V -represents “Voided” FI/CVVs
 - U -represents FI/CVVs which have been “Unvoided” if voided in error.
 - P -represents “Replacements to merchants” authorized and printed by Merchant Field Representatives.

Press {Enter} and see a screen with all the details about this FI/CVV number.

To return to the Voucher History listing, just press {Enter} again.

The only data field that can be changed is the “Status” of the FI/CVV. If it is to be voided, this can be done by the following:

- Change the voucher status to a “V”.
- The Tab will then go to the first character of the second line, which is “VC” for Void Code. Put either of the following:
 - 01 = Voided in clinic (Have actual FI/CVV)
 - 02 = L/S/D (Do not have actual FI/CVV)
 - 03 = Printer “perceives” it printed, but no FI/CVV resulted
 - 04 = Replacement of vendor redeemed FI/CVV

(For policy instructions on L/S/D, refer to Chapter 4.)

- The cursor will then move to the one character field for L/S/D. Key L to represent a lost FI/CVV, S for a stolen or D for one that was destroyed. Leave blank unless the void code was 02.
- The cursor will then move to the beginning of the “Comment” field. Here the user may document any information that may be of use later in investigating or recalling this situation. A comment may be changed (or added) once the screen is updated, but not totally deleted.
- Once all FI/CVVs on a page have been voided, (U)pdate the screen before moving to a second page to make more changes. If the user pages down before updating, the data keyed will be lost.

WIC UNVOID/REPLACE (WICUR)

The “unvoid” and “replace” functions should both have security measures attached so that this command is not available to all users. They are to be performed by the WIC Director or their designee(s). Such a designee for the “replace” function must be a WIC Vendor Representative. It is recommended that the number of persons performing these functions is kept to a minimum for security reasons.

The “unvoid” feature is to be used only when an FI/CVV has been voided by mistake and must be unvoided. The co-site should notify the appropriate person(s) at the Regional Office when the wrong FI/CVV number has been voided and the Regional Office staff will correct the problem with this feature.

The “replace” feature is for use only when the WIC Vendor Representative is replacing a FI/CVV for a grocery store. This feature will print a FI/CVV exactly like the voided one it is to replace, i.e. same valid month, food package code, etc. **It is not for replacing FI/CVVs in clinic to participants.**

NOTE: These features are not used simultaneously and certainly never on the same FI/CVV.

When using either of these two features:

- Type the command WICUR and press {Enter}.
(The screen is divided into the two halves, the upper portion for the feature to “unvoid” and the lower portion for the “replace” feature.)

- With one <Tab> the cursor will go to the prompt for the voucher number to “unvoid”. If this is the feature to use, simply enter the voucher number to unvoid. Press {Enter}.
- If the feature needed is to “replace” a FI/CVV (Field Representative use only), then <Tab> twice and the cursor will be at the “Replace damaged FI/CVV” prompt. Enter the voucher number to be replaced.
- The message “Function complete” will show on the top right of the screen.
- If unvoiding, the FI/CVV has now been unvoided. If replacing, a FI/CVV will print with the receipt attached.

WIC CAREGIVER (WICCGP)

The WICCGP (or WICCG if connected by the SSN) command is used to identify all of the infants or children for whom a Caregiver is responsible for in the WIC Program. To use this command:

- Go to the Caregivers PTBMIS record.
(**NOTE:** In order for this command to execute, the Caregiver must have a Registration record. Her/his Patient # or SSN must be on her Registration and on the A2 record of the infants/children she/he is responsible for in WIC.)
- When in the Caregivers record, at the command line, type WICCG (SSN) or WICCGP (Pat #).
- The names, DOB, Participant #, Cert Date, Term Date, Next Act Code and Next Act Date for all infants and children for whom this Caregiver is listed will show on the screen.

This feature is especially useful for assisting the clerk in seeing that appointments are scheduled together for a Caregiver with more than one person receiving WIC services.

WIC BIRTH MOTHER (WICBMP)

The WICBMP (or WICBM if connected by the SSN) command is used to identify all of the infants or children of a particular Birth Mother in the WIC Program. To use this command:

- Go to the Birth Mother's PTBMIS record.
(NOTE: In order for this command to execute, the Birth Mother must have a Registration record. Her/his Patient # or SSN must be on the Registration and on the A2 record of the infants/children for whom she is the Birth Mother.)
- When in the Birth Mother's record, at the command line, type WICBMP (Pat #) or WICBM (SSN).
- The names, DOB, Participant #, Cert Date, Term Date, Next Act Code and Next Act Date for all infants and children for whom this mother is the Birth Mother will show on the screen.

This feature will be most useful in compiling information relative to the birth outcome of WIC participants relative to time on the WIC Program.

VERIFICATION OF CERTIFICATION (VOC)

To assist a WIC participant who is moving to another area while still within the certification period, a Verification of Certification (VOC) is issued. Refer to Chapter 1. This can be automatically generated by the system through the following steps:

- Go to the participant's WICQ screen.
- Terminate the participant for Termination Reason #4 (Transfer/Other).
- On the Command line, type VOC and press {Enter}.
- The VOC will print on regular 8 1/2" X 11" paper. It will contain all of the necessary information for the new site to use.
- Obtain signatures of the Participant, Parent, or Guardian and the Issuing Clerk.

NOTE: A VOC is most often given to the participant at their last visit before moving. It can also be printed to mail or fax to another clinic in response to a release of information request. In that case, use the previous WICQ screen to terminate on the current date. In place of the participant signature, document phone, mail, or fax request.

DISPLAY ENCOUNTER RECENT (DENR)

When wanting to view a particular Encounter of a WIC participant the DENR command may be used:

- At the command line, type DENR and press {Enter}.
- <Tab> to the Encounter wanting to view, place an X and press {Enter}.
- The Encounter screen will appear and that Encounter will be current.
- To access the WICQ screen completed at that Encounter (if one was), type WICQ and press {Enter}

(NOTE: This command requires selecting even the first record to view with an X, unlike the DWICQ command which will default to the first record if another is not selected with an X.)

DISASTER RECOVERY PLAN

The WIC Program registers and tracks participants and issues FI/ CVVs on the PTBMIS. The voucher history is kept on the Central Office AS 400 and updated daily from the thirteen regional AS 400s.

In the event of a disaster in one of the regions, the Central Office AS 400 could reconstruct the FI/ CVV data for that region. In the event of a disaster in the Nashville area only, the data would still be on the AS 400 where the participant is served. In the event of both a regional and the Central Office AS 400 succumbing to a disaster, we would revert to the latest back up tape maintained by the Information Technology System Division (ITSD) and/or the affected Region.

The WIC Central Office maintains manual FIs for issuing in emergency disaster situations. They have been printed by the WIC Contract bank and would provide WIC food to the participants until the onsite, on demand computer FI/ CVV issuance could be restored.

The WIC Central Office and Division of Nutrition Services are very dependent upon the desktop computers for daily operations. We keep many important files on the shared network drive. Each employee should follow the instructions given by their Systems Administrator staff to back up important documents on a regular basis.

Off-site storage is available for files or software that cannot be backed up. Consult your System Administrator staff.

Breastfeeding

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USDA BREASTFEEDING STANDARDS AND REGULATIONS

Breastfeeding Promotion and Support

“Establish standards for breastfeeding promotion and support which include, at a minimum, the following:

- A policy that creates a positive clinic environment which endorses breastfeeding as the preferred method of infant feeding;
- A requirement that each local agency designate a staff person to coordinate breastfeeding promotion and support activities;
- A requirement that each local agency incorporate task-appropriate breastfeeding promotion and support training into orientation programs for new staff involved in direct contact with WIC clients; and
- A plan to ensure that women have access to breastfeeding promotion and support activities during the prenatal and postpartum periods.”

USDA-FNS Policy Guidance

“Because the food packages for the breastfeeding mother/infant dyad are by design closely tied, it is important to ensure each breastfeeding pair receives a complete breastfeeding assessment. Value Enhanced Nutrition Assessment (VENA) encompasses and supports the breastfeeding assessment.

A WIC nutrition assessment is the process of obtaining and synthesizing relevant and accurate information in order to assess nutrition status and risk, tailor the food package to address nutrition needs, design appropriate nutrition education, and make appropriate referrals.

VENA guidance describes essential staff competencies and knowledge required to assess the breastfeeding dyad and includes evidence-based recommendations published by the American Academy of Pediatrics, the American Dietetic Association, the American College of Obstetrics and Gynecology, the Academy of Breastfeeding Medicine, and the International Lactation Consultant Association. The document includes guidance to be addressed during the assessment of pregnant and breastfeeding women or breastfed infants, such as beliefs and knowledge about breastfeeding, potential complications, the mother’s medical providers’ recommendations and the mother’s support network for successful breastfeeding.”

Food Packages of the Breastfeeding Dyad

The breastfeeding assessment and the mother’s plans for breastfeeding serve as the basis for determining the food package issuance and the counseling and support provided to the mother. WIC’s goal is to encourage mothers to breastfeed exclusively without supplementing with formula. A mother who intends to breastfeed should be provided counseling and support to help her feed only breast milk to her baby. Efforts should be made to schedule mothers who

1 United States Department of Agriculture, Food and Nutrition Services, CFR 246.11 (c) (7)

2 <http://www.nal.usda.gov/wicworks>

intend to breastfeed for subsequent certification as soon after delivery as possible in order to provide timely breastfeeding support.

If the mother was on WIC prenatally, she should be provided the fully breastfeeding food package in the first week after birth or as soon as possible so that she may benefit from the additional foods.

TENNESSEE BREASTFEEDING POLICY AND STANDARDS

Summary of Enacted Tennessee Breastfeeding Legislation

Tennessee has laws in place to support and protect breastfeeding families:

- A mother may breastfeed in any public or private place she is authorized to be ³
- Breastfeeding shall not be considered public indecency or nudity, obscene, or sexual conduct ⁴
- Local governments shall not prohibit breastfeeding in public by local ordinance ⁵
- Employers must accommodate breastfeeding mothers at work ⁶

Department of Health Policy Guidance⁷

“All local health departments must establish and maintain an environment which supports and encourages women in the initiation and continuation of breastfeeding.

APPLICABILITY

This policy applies to Local Health Department and Regional Office personnel.

PURPOSE

To promote breastfeeding as the preferred method of infant feeding and to optimize the health of all Tennessee children by increasing the percentage of women who breastfeed.

PROCEDURE

Regional Directors and County Directors are responsible for ensuring that a positive clinic environment is created which clearly endorses and supports breastfeeding for health department patients.

Educational materials are to be made available to patients which portray breastfeeding as the preferred infant feeding method in a manner that is culturally and aesthetically appropriate

3 TENNESSEE CODE ANNOTATED 68-58-101

4 TENNESSEE CODE ANNOTATED 68-58-102

5 TENNESSEE CODE ANNOTATED 68-58-103

6 TENNESSEE CODE ANNOTATED 50-1-305

7 Tennessee Department of Health, Policy Memorandum #2006-5

for the population group. For example, all print material, audio-visual materials, and office supplies, such as cups, pens and note-pads, should be free of formula product names. Health department personnel should exhibit a positive attitude toward breastfeeding and should incorporate positive breastfeeding messages in all relevant educational material, outreach efforts and education activities for program participants, professional groups and potential patients.

The visibility of infant formula should be minimized by insuring that cans of formula are stored out of the view of patients. Every effort should be made to provide an area for women to breastfeed their infants which is away from entrances and has chairs with arms available when possible.”

Standards for Breastfeeding Support

Regional Breastfeeding Coordinator

“Each region should designate a staff person to coordinate the region’s breastfeeding promotion and support activities.

The qualifications for the Regional Breastfeeding Coordinator include:

- Meets the qualifications for a Competent Professional Authority (CPA).
- Has experience in program management.
- Has, at minimum, 1 year of experience in counseling breastfeeding women.
- Has successfully completed specialized training in lactation management and care (International Board Certified Lactation Consultant (IBCLC) is preferred, but individual may be exam-eligible or have successfully completed other State-approved specialized training).

The roles and responsibilities include:

- Oversees the planning, implementation and evaluation of the region’s breastfeeding activities.
- Ensures that the regional staff is properly trained on breastfeeding education and support.
- Provides ongoing supervision of regional breastfeeding staff.
- Keeps current with up-to-date breastfeeding information and disseminates this as well as FNS-provided information to regional staff.
- Identifies, coordinates and collaborates with community breastfeeding stakeholders.
- Monitors the region’s breastfeeding rates.
- Ensures that breast pump issuance, inventory, and maintenance are logged and monitored.
- Performs the roles and responsibilities of a CPA.”⁸

8 United States Department of Agriculture, Food and Nutrition Services, WIC Nutrition Service Standards, December, 2013

Regional Breastfeeding Access Plan

The Regional Breastfeeding (BF) Access Plan documents compliance and evaluation of the State breastfeeding access goal to effectively encourage and support WIC women participants to breastfeed. See *Breastfeeding Access Plan* (**Appendix 6-1**)

The Regional BF Coordinator will prepare and evaluate the BF Access Plan based on the Federal Fiscal year beginning on October 1 and ending on September 30. At a time specified by the State BF Coordinator, the Regional BF Coordinator should submit the region's BF Access Plan for the next year and submit the region's implementation of the BF Access Plan.

Breastfeeding Support Team

The breastfeeding support team members have the responsibility to encourage, educate, and support women in their breastfeeding decisions. All staff members in contact with WIC participants should have a basic knowledge of breastfeeding and understand their unique role in order to effectively support breastfeeding as the optimal method of infant feeding. See *Staff Roles in Breastfeeding Promotion and Support* (**Appendix 6-5**)

The breastfeeding support team should develop program goals, philosophy, policies and procedures on breastfeeding education promotion and support that are consistent with Federal regulations as well as other guidelines and publications, including, but not limited to the *Loving Support Makes Breastfeeding Work* Campaign, Using Loving Support to Grow and Glow curriculum, *Healthy People 2020* goals and objectives, American Academy of Pediatrics policy statement on breastfeeding, and the *Surgeon General's Call to Action to Support Breastfeeding*.⁹

“*Loving Support*© to Grow and Glow in WIC” is a standardized competency-based curriculum developed to ensure that all staff attain a level of proficiency in the skills required to promote and support breastfeeding in the WIC setting. These competencies in breastfeeding promotion and support continue to be essential for WIC staff, and participants.

9 <http://www.nal.usda.gov/wicworks>

Breastfeeding Peer Counseling Program

Peer Counseling: Making a Difference for WIC Families

Healthy People 2020 outline specific national objectives for breastfeeding initiation and duration in recognition of the significant contribution breastfeeding makes to infant health.¹⁰ WIC mothers continue breastfeeding at a rate of 33.7% at 6 months and 17.5% at 12 months, compared to 54.2% and 27.6% among mothers ineligible for WIC¹¹. The 2011 Surgeon General's "Call to Action to Support Breastfeeding" describes strengthening programs that include peer counseling as an evidence-based strategy:

- "Create and maintain a sustainable infrastructure for mother-to-mother support programs and for peer counseling programs in hospitals and community health care settings.
- Establish peer counseling as a core service available to all women in WIC"¹²

A systematic review of peer support programs shows that peer counselors have a significant effect on increasing rates of breastfeeding initiation, duration, and exclusivity. This effect is especially noticeable among low-income populations served by WIC.¹³ The U.S. Preventative Task Force provided a meta-analysis of 38 randomized control trails that met their study criteria of breastfeeding interventions. They concluded that lay support interventions that include peer support significantly increase the rate of any breastfeeding by 22%, and exclusive breastfeeding by 65%. Peer counseling programs are a key strategy to enhance WIC and community breastfeeding promotion interventions to increase breastfeeding support for WIC mothers.¹⁴

There are several factors that contribute to the success of breastfeeding peer counseling

10 United States of Health and Human Services. (2010). *Healthy People 2020*. Washington, D.C.: United Department of Health and Human Services, Centers for Disease Control.

11 Centers for Disease Control and Prevention. (2011). National Immunization Registry, 2007 data.

12 United States Surgeon General. (2011). *Surgeon General's Call to Action to Support Breastfeeding*. Washington, D.C.: Office of the U.S. Surgeon General.

13 Chapman D, Morel K, Anderson AK, Damio G, & Perez-Escamilla R. (2010). Breastfeeding peer counseling: from efficacy through scale-up. *Journal of Human Lactation*, 26(3):314-326.

14 Chung M, Raman G, Trikalinos T, Lau J & IP S. (2008). Interventions in primary care to promote breastfeeding: an evidence review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, 149(8): 565-582.

programs. Some of the factors are:

- Program leadership and support from management and local WIC staff
- Dedicated supervisors and program managers
- Continuous mentoring
- Standardized training programs that include the local WIC staff
- Familiarizing peer counselors with WIC issues and policies, and educating WIC staff on breastfeeding support
- Clear guidance on scope of practice and referral networks
- Access to designated breastfeeding experts
- Adequate funding to maintain the program
- Methods to retain peer counselors for program stability

Breastfeeding Peer Counselors (BFPCs)

BFPCs are women who have successfully breastfed or expressed milk for at least one baby and are a valuable source of support and encouragement to mothers. They are peers who are selected from the community to be served. They form important links to health services in the community and can help overcome societal influences that encourage formula use.¹⁵

The goal of the BFPC is to serve as a role model for breastfeeding mothers. For breastfeeding concerns and problems beyond their scope of practice, they must yield to health care professionals including Breastfeeding Coordinators, Designated Breastfeeding Experts, and CPAs. All BFPCs must comply with Program standards set forth in the Loving Support curriculum and Peer Counselor Handbook. See Scope of Practice/Yielding (**Appendix 6-19**).

All BFPCs are trained using USDA's Loving Support through Peer Counseling: A Journey Together for WIC Peer Counselors. This competency-based curriculum is designed to help introduce peer counselors to their role as part of the WIC team to support new mothers and to equip them with specific skills in counseling and breastfeeding management. It also teaches peer counselors that each new mother will be impacted by a variety of people who form a "Circle of Care" to surround her with support.

The BFPCs receive ongoing mentoring from the DBE and supervision from the Regional Breastfeeding Coordinator, DBE or CPA, County Director, or Nursing Supervisor. See Overview of Tennessee WIC Breastfeeding Peer Counselor Program (**Appendix 6-7**). Each peer counselor will complete activity reports that are reviewed by their clinic supervisor and/or the Regional BF Coordinator. See Monthly BFPC Activity Report. (**Appendix 6-18**)

Regional Breastfeeding Coordinators and any clinic staff supervising a peer counselor must complete USDA's Loving Support through Peer Counseling: A Journey Together for WIC Managers curriculum. The State Breastfeeding Coordinator and/or the State Breastfeeding

¹⁵ Loving Support© Through Peer Counseling: A Journey Together-For WIC Managers

Peer Counselor Coordinator can be contacted to schedule training or refreshers.

Regional Breastfeeding Coordinators and any clinic staff supervising a peer counselor must complete USDA's *Loving Support through Peer Counseling: A Journey Together for WIC Managers* curriculum. The State Breastfeeding Coordinator and/or the State Breastfeeding Peer Counselor Coordinator can be contacted to schedule training or refreshers.

IMPLEMENTATION OF BREASTFEEDING SUPPORT

Prenatal Counseling/Education

Healthcare providers strongly influence the outcome of prenatal educational efforts. Health professionals who convey an enthusiastic attitude when talking about breastfeeding can have a positive impact on the mother's desire to breastfeed. The Breastfeeding Counseling Points outline anticipatory breastfeeding guidance to prenatal and breastfeeding mothers. See *3 Step Counseling Process and Loving Support Counseling Points for BF Mother* ([Appendix 6-27](#))

To allow for an informed choice of infant feeding, certain actions should take place:

- Assess attitudes and concerns toward breastfeeding at certification
- Dispel common misconceptions
- Provide accurate, positive information on the benefits of breastfeeding for the mother and baby
- Discuss services provided by WIC for the breastfeeding mother

It is important to provide a relaxed, informal discussion on breastfeeding to adequately allow the prenatal patient to express her attitudes toward breastfeeding. Few women will choose to breastfeed if their inhibitions and misconceptions are not successfully resolved. Many women make the decision about how to feed their babies early in pregnancy; therefore, the most effective time to discuss breastfeeding is in the first trimester.

The most common concerns women have about breastfeeding are:

- Lack of confidence in the ability to nourish their infants adequately
- Embarrassed about breastfeeding in public
- Fear that breastfeeding is incompatible with a busy lifestyle
- Concern their eating/health habits will harm the baby
- Lack of social support from family and friends
- Belief that breastfeeding is painful

Repeated conversations throughout the pregnancy help uncover and address the WIC client's concerns as they arise. Pregnant women should be made aware that WIC does not routinely provide infant formula to partially breastfed infants less than one month of age.

BFPCs can assist the CPA with gathering information using the *Breastfeeding Assessment, Promotion, Counseling and Support* portion of the Prenatal and Postpartum WIC Records during the certification visit. However, if the BFPC encounters a Prenatal or Postpartum woman that has a concern outside of her scope of practice during the screening, she must yield to a DBE or CPA. See Scope of Practice/Yielding ([Appendix 6-19](#)) pregnant women

should be counseled on the importance of contacting her WIC clinic soon after delivery so breastfeeding support and counseling can be scheduled to assure successful initiation of breastfeeding. Fully breastfeeding women and infants should be certified and enrolled in WIC soon after birth.

Frequency of Contacts

Nutrition education for women shall be made available at a quarterly rate during their certification period. The two required contacts cannot occur on the same day.

Prenatal: If the prenatal has received two nutrition education contacts, then she may receive breastfeeding (BF) information and support by a Breastfeeding Peer Counselor (BFPC). The BFPC documents the contact on the BFPC contact log. (See *BFPC Documentation and BFPC Contact Log* ([Appendix 6-23](#)))

Postpartum: After certification a postpartum woman is eligible for breastfeeding /nutrition education contacts. All postpartum women can receive breastfeeding/nutrition education up to 6 months postpartum. If the postpartum woman receives breastfeeding information and support from the BFPC, then the BFPC must document the contact on the BFPC contact log. See *BFPC Documentation and BFPC Contact Log* ([Appendix 6-23](#)) However, if a woman has BF status (3, 9, or B) she can continue to receive breastfeeding/nutrition education contacts through 12 months postpartum, as long as she reports that she is still breastfeeding. Remember, all BFPC contact must be documented on the BFPC log. (See *BFPC Documentation and BFPC Contact Log* ([Appendix 6-23](#)) Barely (B) BF women beyond 6 months postpartum do not receive a food package but are counted in WIC participation.

If Group Contact (Subsequent visit):

Make it interesting, informal, and use facilitative discussion. If groups are mixed statuses, make sure the topic is general so that it will cover all families. Some examples might be the benefits of breastfeeding or breastfeeding resources. Topics or questions that may only be of interest to one person in the group should be discussed individually with the participant after the group.

BFPCs can assist CPAs in their presentation of groups. If the group contact will be used as a nutrition education contact, the CPA provides education during the group and must be present during the portion of the class presented by the BFPC. Please indicate on the Master file which group session was assisted by the BFPC. If the CPA does not provide education and is not present during BFPC provision of breastfeeding information and support, the contact is not a nutrition education contact. This group contact is only a BFPC group contact. All BFPC contact is reported on the Peer Counselor Contact Log. See *BFPC Documentation and BFPC Contact Log* ([Appendix 6-25](#))

If High Risk participants are provided group education, individual nutrition concerns in relation to their previous care plan should be briefly addressed and documented after the session.

Maintain a master file of lists of attendees, dates of the group sessions, and descriptions or outline of what has been discussed, OR document the contact on the WIC records in each

participant's chart. Maintain the files for four years.

Reference should be made at the certification or previous contact to attending a group session by marking on the WIC record "Attend group at the next visit". Enter Y (yes) on the WIC screen for received education today and the PTBMIS code according to state instructions.

If On-line (Subsequent visit):

The CPA will determine if on-line nutrition is an option to offer the participant. On-line nutrition education must NOT be offered to High risk participants or those receiving therapeutic products. Participants can access nutrition education on-line at the following website: <http://health.tn.gov/wicedu>.

The participant will present a printed certificate or paper with name of session, certificate number, date and time completed at the subsequent visit (voucher pick up visit). The date completed should be within the last three months. Certificates or paper documentation must be kept on file in clinic by month/year. Retention period is four years.

Breastfeeding Documentation

WIC Prenatal Record and Questionnaire

The WIC Prenatal Records and Participant Questionnaires are designed for recording any information pertinent to WIC certification and nutrition counseling, including nutrition information and assessment, care plans, and follow-up. Documentation that is found in one part of the record need not be repeated elsewhere.

The focus of *Breastfeeding Assessment, Promotion, Counseling, and Support* is to identify each woman's personal breastfeeding barriers and information gaps with her current pregnancy and help her make an informed infant feeding decision. She may be facing new barriers and challenges in her life, changes that she did not have when she breastfed her other child. Conversely, a woman may not have breastfed or may have had complications with breastfeeding her previous children that can now be resolved through WIC or WIC referrals.

By completing a thorough breastfeeding assessment and counseling at certification, the CPA can develop a plan for breastfeeding education at each subsequent WIC visit. This will provide every prenatal with the tools to make an informed decision on the infant feeding choice best for her baby. For example, both the CPA and BFPC can use Sections A and B of the WIC Prenatal Record to document the conversation(s) for current and return nutrition education visits. The BFPC can assist in data gathering and begin basic breastfeeding education. However, if the BFPC encounters a prenatal that has a concern outside of her scope of practice she must yield to a DBE or CPA. See *BFPC Scope of Practice/Yielding (Appendix 6-19)* The BFPCs must use their Contact Log for return visit documentation (See *BFPC Documentation and BFPC Contact Log (Appendix 6-23)*)

In the WIC Prenatal Record, Section A: Ask Open-Ended Questions (Required at Certification,) the CPA or the BFPC can continue obtaining subjective information by asking open-ended questions during the **Breastfeeding Interview**. See *3 Step Counseling Process and Loving Support Counseling Points for BF Mother (Appendix 6-27)*. Each of the

probing questions allows the CPA or BFPC to explore the participant's knowledge, attitudes, support access, barriers, and concerns for choosing to breastfeed her baby. It is important that a mother is fully informed before asking her to make a decision about how she will feed her baby. While she may express feelings today that she will not breastfeed, mothers often make the decision to breastfeed after delivery, especially when infants are born prematurely or are at medical risk.

It's important that all mothers know WIC is here to help prepare her should she decide to breastfeed. Record findings that will assist in the development of a breastfeeding education plan to be used throughout the pregnancy and immediately following delivery. For example, if a woman breastfed her other children, probing questions should include asking how long the infant(s) were breastfed, what challenges or barriers she faced, and if life circumstances now might provide new challenges that could influence her infant feeding decision.

Review the comments to the questions recorded at certification and develop a plan to provide anticipatory breastfeeding education at every nutrition education contact opportunity. For example, effective breastfeeding promotion should convey that providing formula to breastfed infants, especially in the early months challenge the mother's will to breastfeed and affect her ability to sustain or increase her supply of milk. To prevent weaning in the first few weeks after birth, WIC staff should help mothers anticipate the various issues they may experience postpartum in the hospital, as well as when they bring their new baby home, and offer practical strategies to combat these potential obstacles. See *3 Step Counseling Process and Loving Support Counseling Points for BF Mother* ([Appendix 6-27](#))

In the WIC Prenatal Record, Section B: Affirm and Educate, the CPA and/or BFPC can discuss the breastfeeding topics listed. Each provider must put the date/initials in the appropriate box. The same provider can use downward arrows to indicate the discussion of more than one topic. "Yielding" must take place if the BFPC identifies a situation outside of her scope of practice. See *BFPC Scope of Practice/Yielding* ([Appendix 6-19](#)).

The CPA and/or BFPC can identify breastfeeding materials given by providing date/initials in the appropriate box. If additional conversation occurs with the prenatal mother other than questions from Section A, it must be documented. BFPC must use their BFPC Contact log form. See *BFPC Documentation and BFPC Contact Log* ([Appendix 6-23](#)), and the CPA may document on the back of the Prenatal Questionnaire or WIC Prenatal Record.

Discussion on all topics with an **asterisk (*)** must be conducted at the initial certification.

WIC Postpartum Record

The focus of the *Breastfeeding Assessment, Promotion, Counseling, and Support* is to determine if the mother has initiated breastfeeding and to address her concerns or any barriers to breastfeeding. Documentation that is found in one part of the record need not be repeated elsewhere.

Effective breastfeeding promotion should convey that providing formula to breastfed infants, especially in the early months can be a challenge to a mother's breastfeeding plan. To prevent weaning in the first few weeks after birth, WIC staff should help mothers anticipate the various issues they may experience postpartum in the hospital, as well as when they bring their new baby home. The CPA or BFPC can offer practical strategies to combat these potential obstacles. See *3 Step Counseling Process and Loving Support Counseling Points for BF mother* ([Appendix 6-27](#))

The CPA or the BFPC will complete the *Breastfeeding and Breast Pump Information Assessment, Promotion, and Support* Section A when assessing the mother's breastfeeding plan. However, Section B must be completed by the DBE or CPA conducting a need for a breast pump. It is important for BFPCs to remember if they encounter a breastfeeding woman that has a concern outside of her scope of practice she must yield to a DBE or CPA. See *Scope of Practice/Yielding* ([Appendix 6-19](#)). Once the need for the pump has been completed and approved by the DBE or CPA, the BFPC, if available, can issue the pump and provide other pertinent information. See *Breast Pump Guidelines/Inventory* ([Appendix 6-48](#))

This page is also used for WIC mothers who have delivered and are not yet certified as postpartum. For example, if the mother is a WIC Prenatal and has requested a breast pump for her premature or hospitalized infant prior to her postpartum certification, then the VENA breastfeeding pump assessment information on this page is gathered by the CPA using Sections A through C on the WIC Postpartum Record. The CPA should follow these steps:

- Assess both the woman and infant dyad, then using the Additional Notes/Comments Section on the last page of the form
- Document the assessed nutrition status 6 (fully breastfeeding) and risk(s)
- Design appropriate breastfeeding education. See *3 Step Counseling Process and Loving Support Counseling Points for BF Mother* ([Appendix 6-27](#))
- Tailor the fully breastfeeding food package for the mother

While status in PTBMIS cannot be changed until the postpartum certification, the system will allow issuance of the fully breastfeeding food package and the CPA must document in the chart the change of status prior to pump issuance. If the mother does not have her prenatal vouchers in hand to make the exchange the day of pump issuance, the CPA can issue the pump, and PBF voucher to upgrade the mother to 'FBF' status.

Remember, the CPA must document the assessment and status change on the day of pump issuance. Pumps cannot be loaned beyond the 6 week post deliver extension of prenatal certification. At the postpartum certification, if the mother is still fully breastfeeding, the need for loaner pump is reassessed and issuance can be extended unless there is a change in her status. Please follow the procedure for completing the Breastfeeding Assessment, Promotion, and Support for WIC Postpartum women in the next section.

In the WIC Postpartum Record, Section A-Ask Each Visit Breastfeeding Plan: The CPA or BFPC will use this information to help determine food package issues at this visit. However, if the postpartum woman is having concerns outside the BFPC scope of practice she must yield to a DBE or CPA. See *BFPC Scope of Practice/Yielding* (**Appendix 6-19**) **Every** Postpartum woman must be asked if she **initiated** breastfeeding. By using the 3-step counseling process when asking a woman each visit about how long she plans to breastfeed, the CPA can help the mother achieve her infant feeding plans and help the mother uncover solutions to perceived barriers leading to weaning from the breast. These steps should be followed:

- Record the number of weeks the mother plans to breastfeed at each WIC visit
- Use the 3-Step counseling process from Loving Support to help mom with breastfeeding solutions at each visit (See *3 Step Counseling Process and Loving Support Counseling Points for BF Mother* (**Appendix 6-27**))
- Reassure the mother that WIC will provide continued breastfeeding support
- Record the number of weeks breastfed, if breastfeeding has stopped (This should be the same number of weeks found on the Encounter form- WIC Special Data box under infant)
- See BF Concerns (**Appendix 6-65**)

Breast Pump Information

It is important to ask every breastfeeding mother if she is using a breast pump and to review her knowledge on using the pump to assure its safe use. Unless a breast pump is a hospital grade, the pump will not be adequate for initiating breastfeeding and can lead to an unsuccessful breastfeeding experience. If a woman owns her pump, WIC can help make sure she is operating the pump correctly to prevent breast trauma or milk contamination.

Mothers of healthy babies are to be encouraged to first establish feeding at the breast exclusively until her milk supply is fully established to assure adequate milk supply. If she is using an older pump from a previous breastfeeding experience the pump may now lack adequate suction and disappointing breast milk expression volume.

It is outside of the scope of practice for BFPCs to issue a breast pump to mothers who are ill (for example: separation from infant) or to mothers of infants with nutrition medical needs or with feeding problems unless the CPA has first assessed or reassessed the mother/infant dyad.

Pump screening information should be documented on page 2 of the postpartum record:

- Check **YES** or **NO** if mom has a pump
- If YES, check **Manual** or **Electric**
- Write in the **brand** name
- Write in where mom got the pump
- The CPA will use this information to assess if the mother has a pump and what type of pump. (If she has a pump, then see *Breast Pump Guidelines/Inventory* (**Appendix 6-48**))
- Check **YES** or **NO** if mom knows how to hand express her milk. All breastfeeding mothers are to be taught hand expression. Research shows hand expressing milk after pumping results in additional extraction of one to two ounces of breast milk. See *Hand Expression* (**Appendix 6-92**)

Section B: Only for Women who are Requesting a Pump

The DBE or CPA must complete this section for a breastfeeding woman who is using a pump of her own or would like a pump issued by WIC See *Breast Pump Guidelines/Inventory* (**Appendix 6-48**). The DBE or CPA completes this section for breastfeeding mothers who will be separated from their infants for a period of time due to work or school. However, if the mother has an infant with BF problems or concerns the DBE or CPA can use this section to conduct a BF assessment to address the needs of the mother. See *3 Step Counseling Process and Loving Support Counseling Points for BF Mother* (**Appendix 6-27**)

Please mark all boxes that apply and fill in blanks accordingly in Section B. Please complete date of pump assessment. Please mark the reason(s) the participant desires a pump. The DBE or CPA makes the final decision for a breastfeeding mother to receive a breast pump or aids based on the information gathered in Sections A-B. It is important to mark all boxes that apply to the mother requesting the breast pump. This will justify the need for the breast pump. Lastly, the DBE or CPA must sign and check off the breast pump issued to the participant.

Section C- Affirm and Educate (Completed by CPA or BFPC)

Discussion on all topics with an **asterisk (*)** must be conducted at the initial certification. The CPA or BFPC must educate her on the breast pump use, cleaning, and storage of breast milk. Counseling must be supportive and emphasize breastfeeding as the normal method of feeding for infants. If the mother wants to request formula, discover the reason and ensure she receives support from a staff member who has received advanced breastfeeding training such as CLC or DBE. BFPC must remain in her **scope of practice**, and remember to **yield** to CPA or DBE if a situation occurs outside of her practice. Additional counseling may be needed regarding breastfeeding concerns. See *BF Concerns* (**Appendix 6-65**)

If additional conversation occurs with the breastfeeding mother other than Sections A-C it must be documented. BFPC must use their BFPC contact log form See *BFPC Documentation and BFPC Contact Log* (**Appendix 6-23**), and the CPA may document on the back of the Postpartum Questionnaire or WIC Postpartum Record.

Each provider must put the date and initials in the appropriate box for the topic discussed. The same provider can use downward arrows to indicate discussion on more than one topic.

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REGIONAL BREASTFEEDING ACCESS PLAN

The Regional Breastfeeding Access Plan documents compliance and evaluation of State breastfeeding access goal to effectively encourage and support WIC women to breastfeed. Regions should use the Goal and Objectives below to document the Breastfeeding access plan annually.

GOAL: Implementation and continuance of a breastfeeding plan to assure that WIC women during their prenatal and postpartum have access to breastfeeding education promotion and support services.

Quality Improvement Measure:

Increase the state's number of WIC infants who receive fully and partially breastfeeding food packages from the yearly monthly average of 16 percent of the total infants served (measured using Participation Reports from July 2014 through June 2015) to 18 percent a yearly monthly average (measured using Participation Reports from July 2015 through June 2016).

Objective 1. Since a major goal of WIC is to improve the nutritional status of infants, WIC staff must provide educational and anticipatory guidance to pregnant and postpartum women about breastfeeding, encourage women to breastfeed for as long as possible, and provide appropriate support for the breastfeeding dyad, especially at time periods critical to breastfeeding success. Clinic action activities are:

1.1 All pregnant WIC participants must be encouraged to breastfeed unless contra indicated for health reasons, i.e., human t-lymphotropic virus type 1(HTLV-1), HIV+, cancer, radioactive treatment, chemotherapy, or known substance abuser.

1.2. CPAs assess all pregnant WIC participants on their knowledge, concerns, attitudes, and personal support systems related to breastfeeding and implement an education plan to help these women make an informed infant feeding decision by:

- Completing WIC breastfeeding assessment at prenatal certification using VENA principles and techniques including the 3-step counseling process.
- integrating breastfeeding promotion in prenatal nutrition education using
- strategies provided in Grow and Glow staff breastfeeding competency
- training and in USDA's Counseling Points.
- using every nutrition contact (whether communication is one-on-one, within a group, over the phone, or even electronically) as an opportunity to provide breastfeeding education as an interactive exchange between WIC staff and the participant.

1.3 All postpartum breastfeeding participants will receive timely support, education, and referral services to help them achieve their personal breastfeeding intent by:

- Scheduling mothers who intend to breastfeed for a subsequent certification as soon after delivery as possible in order to provide timely breastfeeding support.
- Assuring the breastfeeding mother/infant dyad are assessed by the CPA as a pair
- CPA completion of the WIC postpartum breastfeeding assessment soon after delivery using VENA principles and techniques including the 3-Step Counseling

process.

- CPAs use the assessment information gathered to determine nutritional status and risk, tailor the food package to address nutritional needs, design appropriate postpartum breastfeeding education and make appropriate referrals.
- Integrating breastfeeding support in postpartum nutrition education using strategies provided in Grow and Glow staff competency training and in USDA's Counseling Points.

1.4 Counseling will include helping prepare the mother to communicate effectively with hospital staff her decision to breastfeed.

1.5 The participant's family and friends should be included in all breastfeeding education and support sessions, whenever possible.

1.6 All clinic staff is to incorporate in the prenatal and postpartum period positive peer influence, e.g., bulletin board of successful breastfeeding WIC participants, peer testimonials in classes, breastfeeding peer support counselors, etc.

Objective 2. Identify and train Designated Breastfeeding Experts. Action activities include:

Note: A Designated Breastfeeding Expert (DBE) is a CPA with advanced breastfeeding training who can provide both basic and clinical breastfeeding management within TN Department of Health and WIC guidelines. TN WIC is working toward a process which will provide all DBEs advanced training such as the Certified Lactation Counselor (CLC) course. All DBEs are encouraged to become an International Board Certified Lactation Consultant (IBCLCs).

2.1 The DBEs will serve as the clinic's breastfeeding expert on breastfeeding to which other clinic CPAs and Peer Counselors can yield breastfeeding concerns.

2.2 Each region identifies one or more WIC DBEs for staff to call upon when facing breastfeeding counseling situations outside of their scope of practice.

2.3 Each region identifies procedures detailing how clinic staff refers breastfeeding concerns out of their scope of practice to the DBE present at the clinic site.

2.4 In clinics where DBEs are not available on site daily, each clinic identifies a clinic CPA who reviews the chart and can consult with the DBE by phone to determine the best plan of action for assisting the WIC mother with her breastfeeding concern. Every effort is made to provide the breastfeeding mother at the time of her expressed need with appropriate breastfeeding advice and if needed, referral outside of WIC, to assure breastfeeding success.

2.5 DBEs have been trained on breastfeeding using the complete Grow and Glow Staff competency training, the Tennessee WIC Manual, the VENA online training both on infant feeding and on breastfeeding, and assigned evidence based practice reading materials.

2.6 DBEs who work with Peer Counselors have been trained on breastfeeding using training material found in the curriculum from the Loving Support: A Journey Together Peer Counseling Training Manual.

Objective 3.0 Create a positive clinic environment which clearly endorses breastfeeding as the preferred infant feeding method. Action activities include:

3.1 Educational materials portray breastfeeding as the preferred infant feeding method in a way that is culturally and aesthetically appropriate for the population group.

- All print and audio-visual materials should be free of formula product names.
- All office supplies such as cups, pens and note pads should be free of formula product names.

3.2 The relay of positive breastfeeding messages in all educational activities, materials and outreach efforts where infant feeding is addressed, including:

- participant orientation programs and/or materials.
- materials, including printed and audio-visual for professional audiences.
- materials, including printed, audio-visual, and display for potential clients.

3.3 The visibility of infant formula is be minimized.

- Cans of formula are stored out of the view of participants.
- Staff should not accept formula from formula manufacturer representatives for personal use.

3.4 The VENA breastfeeding assessments of the breastfeeding mother/infant dyad are used to serve as the basis for determining food package issuance.

- When a WIC breastfeeding mother requests infant formula, CPAs assess and troubleshoot the reason mother is requesting formula and steps are taken to ensure the mother receives breastfeeding support to address her concerns and help her to continue to breastfeed.
- The use of supplemental formula for the breastfeeding infant is tailored by providing only the amount of supplemental formula that the infant is consuming at the time of mother's request.
- All breastfeeding women receive information from the CPA about the potential impact of formula on lactation and breastfeeding before formula FIs are given.
- Regional policies are established and implemented to provide fully breast-feeding mothers a fully breastfeeding food package in the first week after birth or as soon as possible so she may benefit from the additional foods.

3.5 A supportive environment where women feel comfortable breastfeeding their infants (e.g., an area away from the entrance and chairs with arms; when possible) is provided.

3.6 All staff should exhibit a positive attitude toward breastfeeding.

Objective 4. Train all health department staff on breastfeeding promotion and support.

Action activities include:

4.1 All employees are oriented to the clinic environment policies regarding breastfeeding, the Bureau of Health Services Breastfeeding Policy, the Regional Breastfeeding Access Plan and the roles of each staff member in the promotion of breastfeeding.

4.2 All employees who have contact with WIC participants have completed all 10 Modules included in the Using Loving Support to Grow and Glow in WIC: Breastfeeding Competency Training for Local Staff. Each region develops a Regional training plan with attendance documentation to assure all new employees complete all 10 Grow and Glow training Modules during the first year of employment. Each region should offer breastfeeding updates at least biannually during the Federal Fiscal Year. Provide staff training updates regarding the Grow and Glow refresher courses Central Office will provide assistance regarding these courses.

4.3 Every WIC health professional should be familiar with:

- Culturally appropriate breastfeeding promotion strategies.
- Current breastfeeding management techniques to encourage and support the breastfeeding mother and infant.
- Provision of Anticipatory Breastfeeding Counseling using the Counseling Points found in the TN WIC Manual Chapter 6: [Appendix 6-28](#).
- Appropriate use of breastfeeding education materials.

The Regional BF Coordinator will prepare and evaluate the BF Access Plan based on the Federal Fiscal year beginning on October 1 and ending on September 30. Each region's Breastfeeding Access Plan for the next year and evaluation previous year is due at a time specified by the State Breastfeeding Coordinator.

STAFF ROLES IN BREASTFEEDING PROMOTION AND SUPPORT

Staff Roles in Breastfeeding Promotion and Support

WIC directors and managers at both the State and local level set the tone for breastfeeding promotion and support, maintain breastfeeding friendly clinics, and allocate adequate funding and resources for staff training. All staff has a responsibility to encourage, educate, and support women in their breastfeeding decisions, and all staff should have a basic knowledge of breastfeeding and understand their unique role in order to effectively support breastfeeding as the optimal method of infant feeding (see details on Staff Roles below).

WIC Staff Roles in Breastfeeding Promotion and Support

The State WIC Director - Articulates the Vision

- Articulates vision of breastfeeding in WIC to staff at all levels
- Empowers staff through training and policies and procedures that support vision
- Allocates funding and resources for breastfeeding promotion and support

The State WIC Breastfeeding Coordinator – Implements the Vision

- Coordinates State breastfeeding efforts
- Provides breastfeeding training and support, technical assistance and consultation to State and local staff and participants as necessary
- Identifies breastfeeding promotion methods for local agencies
- Develops State breastfeeding standards
- Monitors State breastfeeding rates and local agency activities
- Evaluates State breastfeeding activities
- Coordinates with other agencies for breastfeeding promotion and support

The State WIC Breastfeeding Peer Counselor Coordinator – Manages the Vision

- Establishes peer counseling program goals
- Develops peer counseling program policies and procedures consistent with the *Loving Support Model*
- Monitors State and local agency peer counseling budgets and activities
- Provides peer counseling guidance, training, technical assistance, and consultation to State and local staff as needed or upon request
- Provides assistance to the State WIC Breastfeeding Coordinator

The Regional Director and County Health Department Directors – Sets the tone

- Supports breastfeeding activities
- Maintains a breastfeeding-friendly clinic
- Allocates funding and resources for breastfeeding promotion and support

The Regional Breastfeeding Coordinator and Regional Nutrition Director – Mentors Staff and Coordinates Activities

- Oversees planning, implementation, evaluation and training of breastfeeding activities
- Keeps current with breastfeeding knowledge
- Identifies, coordinates and collaborates with community breastfeeding resources
- Monitors local breastfeeding rates

The Competent Professional Authority (CPA) including nutritionists, nutrition educators, and nurses – Gives Appropriate Advice

- Conducts a complete WIC breastfeeding assessment using VENA principles and techniques
- Provides appropriate education/assistance/referrals
- Provides appropriate food package to mother and infant to encourage breastfeeding with minimal supplementation

The Breastfeeding Peer Counselor – Gives Mother-to-Mother Support

- Serves as model for breastfeeding behaviors
- Supplements the WIC breastfeeding team
- Available to mothers outside of the usual clinic hours and environment
- Fills the gap in services after hospital discharge for seamless continuity of care

The Clinic Clerks and Public Health Office Assistants (PHOAs) – Provides Front Line Support

- Uses breastfeeding-friendly language
- Knows agency's breastfeeding policies
- Makes appropriate appointments for breastfeeding mothers for support and follow-up

OVERVIEW OF TENNESSEE WIC PEER COUNSELOR PROGRAM

The Tennessee WIC Breastfeeding Peer Counselor Program is a federal funded grant by the USDA to support peer counseling in the WIC clinics. With research showing how beneficial peer counselors are in improving breastfeeding outcomes, TN WIC is dedicated in providing WIC clinics with adequate BF support through peer counseling. Peer Counselors have a tremendous impact on helping mothers decide the healthiest way to feed their baby and giving the support they need during their pregnancy and after delivery.

Placement of Peer Counselors

- Based on prenatal and breastfeeding caseload
- Caseload determines the number of full time equivalents (FTEs)
- Not all clinics qualify
- Regions **must** contact the State BFPC Coordinator for assistance

Purpose of a BFPC

- Increase breastfeeding rates
- Improve the initiation, duration and exclusivity of breastfeeding

TN Peer Counselor Job Description

Qualifications

- Has breastfed at least one child¹
- Is passionate about breastfeeding and supporting mothers and babies with their journey
- Is able to work the budgeted hours scheduled at the time of hire

Responsibilities

- Counsels WIC pregnant and breastfeeding mothers present in the WIC clinic for WIC services.
- Counsels WIC pregnant and breastfeeding mothers by telephone, home visits, and/or hospital visits at scheduled intervals determined by the regional WIC offices.²
- Provides mother-to-mother support to prenatal and postpartum WIC mothers by providing basic breastfeeding information and encouragement.³
- Is available to participants outside of usual clinic hours and the WIC clinic environment.⁴

1 United States Department of Agriculture, Food and Nutrition Services, WIC Nutrition Service Standards, June, 2013

2 WIC Nutrition Service Standards, June, 2013

3 WIC Nutrition Service Standards, June, 2013

4 WIC Nutrition Service Standards, June, 2013

- Refers participants to appropriate WIC, health or social service providers that include the WIC Designated Breastfeeding Expert (DBE), local IBCLC, TN BF Hotline, nutritionist, Obstetrician, and Pediatrician for situations outside the PC's scope of practice.
- Completes activity reports accurately on a daily basis and submits to their supervisor by the day designated.
- Documents all conversational contacts in the BFPC Contact Log form.
- Documents all attempted contacts either in the mother's medical chart or logged in a manual or electronic master file.
- Completes all necessary trainings required by the State and Region.
- Completes encounter forms correctly and timely. See ([Appendix 6-14](#))
- See *Sample Peer Counselor Job Description* ([Appendix 6-7](#))

Guidelines

Cell phones

- The BFPCs that will have a cell phone must sign the guidance document before they start using it.
- The Regional BF Coordinator, County Director, and BFPC should have a copy of the signed document.
- Phone calls are a continuous challenge, which allows texting as an option to make contact.
- Text friendly phones need to be purchased using the PC grant funds.
- Texting can be implemented for appointment reminders, positive messages, and to see how mother and baby are doing.
- Counseling is not encouraged and needs to be conducted either over the phone or face to face.
- An encounter can be generated with using the phone visit setting code when a conversation has taken place via text, but not for appointment reminders.
- Contact the State BFPC Coordinator for assistance.
- Sample Cell Phone Policy ([Appendix 6-11](#)) is provided in the *Loving Support A Journey Together For Manager's* curriculum.

Home visits

- A county or regional policy is required before the BFPC can make a home visit.
- This policy should be a separate policy from the Regions HUGS policy.
- The BFPCs that will be making home visits must sign the policy before their first visit.
- The Regional BF Coordinator, County Director, and BFPC should keep a copy of the signed policy for their records.
- Home visits should be based on emergency cases.
- E.g. Lack of transportation or mother or baby with medical issues.
- Contact the State BFPC Coordinator for assistance.

Hospital visits

- A Memo of Understanding (MOU) is required before the BFPC is allowed to go into the hospital. See *MOU with Hospitals* ([Appendix 6-12](#))
- The BFPCs that will be making hospital visits must sign the MOU before their first visit.

- The Regional BF Coordinator, County Director, and BFPC should have a copy of the signed MOU for their records.
- Contact the State BFPC Coordinator for assistance

Primary Preventive Initiative (PPI)

- Only full time BFPCs may participate in BF PPI projects. Par-time BFPCs are not approved for PPI projects.

Allowable Cost Items Funded Through the PC Grant

- Furniture and office equipment
- Cell phones (smartphones or iPhones)
- BF aids and pumps for demonstration purposes by PCs
- Salaries and benefits
- Recruiting Peer Counselors
- Travel
- Training
- Promotional items for the PC Program

***IMPORTANT – The PC Grant funds are ONLY for items that are Peer Counselor related. Contact the State BFPC Coordinator for assistance.**

Encounter Time

- Clinic visits (group and individual), phone calls, text messaging and home and hospital visits
- Coding and documentation required
- Encounter goal is 60-70% of their time

Mentoring and Supervising

- Supervisor/mentor should be knowledgeable in breastfeeding and the BFPC Program
- Supervisor is in charge of the BFPC's admin, includes their time, leave request, IPP, disciplinary actions
- Mentor needs to be the DBE or CPA and maintains frequent contact to discuss contacts being made, referrals, and challenges and give feedback for BFPC's IPP
- Mentoring needs to be continuous for adequate guidance and support
- BFPCs need continuous feedback
- Training on the "Loving Support: A Journey Together" for managers' curriculum is strongly recommended.

Strongly Recommended

- The BFPCs complete the 3 question BF assessment in the WIC Prenatal Record
- The BFPCs meet with all prenatal and post-partum breastfeeding mothers regardless of their feelings towards BF or BF issues
- The BFPC's services are to be included into the WIC services that pregnant women and breastfeeding mothers receive
- BFPCs participate in World Breastfeeding Week, National Breastfeeding Month, or Latch-On events (Contact the State BFPC Coordinator for assistance)

POLICIES

Sample Peer Counselor Job Description

Job Description 3: WIC Breastfeeding Peer Counselor

General Description:

- A WIC Breastfeeding Peer Counselor is a paraprofessional support person who gives basic breastfeeding information and encouragement to WIC pregnant and breastfeeding mothers.
- Qualifications:
 - Has breastfed at least one baby (does not have to be currently breastfeeding).
 - Is enthusiastic about breastfeeding and wants to help other mothers enjoy a positive experience.
 - Can work about 10 hours a week.
 - Has a telephone and is willing to make phone calls from home.
 - Has reliable transportation.

Training:

- Attends a series of breastfeeding classes. Nursing babies are welcomed.
- Observes other peer counselors or breastfeeding experts helping mothers breastfeed.
- Reads assigned books or materials about breastfeeding.

Supervision: The peer counselor is supervised by the _____

Specific Duties of the WIC Peer Counselor:

1. Attends breastfeeding training classes to become a peer counselor.
2. Receives a caseload of WIC mothers and makes routine periodic contacts with all mothers assigned.
3. Gives basic breastfeeding information and support to new mothers, including telling them about the benefits of breastfeeding, overcoming common barriers, and getting a good start with breastfeeding. She also helps mothers prevent and handle common breastfeeding concerns.
4. Counsels WIC pregnant and breastfeeding mothers by telephone, home visits, and/or hospital visits at scheduled intervals determined by the local WIC Program.
5. May counsel women in the WIC clinic.
6. Is available outside the WIC clinic and the usual 8 to 5 working schedule to new mothers who are having breastfeeding problems.
7. Respects each mother by keeping her information strictly confidential.
8. Keeps accurate records of all contacts made with WIC mothers.
9. Refers mothers, according to clinic-established protocols, to:
 - WIC nutritionist or breastfeeding coordinator.
 - Lactation consultant.
 - Mother's physician or nurse.
 - Public health programs in the community.
 - Social service agencies.
10. Attends and assists with prenatal classes and breastfeeding support groups.
11. Attends monthly staff meetings and breastfeeding conferences/workshops as appropriate.
12. Reads assigned books and materials on breastfeeding that are provided by the supervisor.
13. May assist WIC staff in promoting breastfeeding peer counseling through special projects and duties as assigned.

I understand the above job responsibilities, and agree to perform these duties as assigned.

WIC Breastfeeding Peer Counselor

Date

Sample Cell Phone Policy

Policies 1: Sample Cell Phone Policy

1. Peer counselors are issued a cell phone for all peer counseling related business when not in the WIC clinic.
2. Cell phone plan includes:
 - *Free incoming calls*
 - *Free outgoing calls after 7 p.m. until 6 a.m.*
 - *Free outgoing calls on weekends*
 - *Free incoming text messages*
 - *Free outgoing text messages*
 - *Free Mobile to Mobile*
3. Phone calls made or taken are to be documented in the client log and weekly activity report and time sheets. Text messages should also be documented.
4. Text messages that are more involved than simple checks require telephone follow-up.
5. The cell phone may be turned off when the peer counselor is not available to take calls due to personal obligations and family time. Voicemail messages and missed calls should be returned the same day, if possible, or within 24 hours.
6. When the peer counselor is unavailable for an extended time, calls should be forwarded to another peer counselor. This should be arranged through the supervisor or peer counselor coordinator.
7. Report loss or damage to the supervisor or peer counselor coordinator immediately so that a replacement mobile phone can be issued.
8. If the peer counselor discontinues providing services for the WIC Program, the cell phone shall be promptly returned to the supervisor or peer counselor coordinator.
9. Use of the cell phone for personal business may be grounds for dismissal. If it must be used for an emergency, notify the supervisor or peer counselor coordinator immediately.

My security plan to keep the phone secure and client information locked up for confidentiality is the following:

⇒

I have reviewed the cell phone policy with my WIC supervisor or peer counselor coordinator and agree to the above terms:

Print Peer Counselor Name

Date

Peer Counselor Signature

Date

Peer Counselor Coordinator Signature

Date

WIC Coordinator Signature

Date

Adapted from Scott County, Iowa "Breastfeeding Peer Counselor Cell Phone Policy"

Sample MOU with Hospitals

Policies 3: Sample Memorandum of Understanding with Hospitals

Goal

The purpose of this Memorandum of Understanding (MOU) is to begin a partnership between the _____ WIC Agency (hereafter “WIC Agency”) and the _____ Hospital (hereafter “Hospital”) in _____ (City/State). The goal is to improve breastfeeding initiation and duration rates among WIC participants and WIC eligible mothers who deliver their infants at the Hospital through providing WIC Breastfeeding Peer Counselors (BPC).

Terms of Agreement

WIC Agency agrees to provide the following personnel and services for WIC participants and WIC eligible clients at the Hospital.

1. A Breastfeeding Peer Counselor (BPC) who has been trained through the WIC Breastfeeding Peer Counseling Program will provide basic breastfeeding education, support, and referrals for WIC participants and WIC eligible mothers during rounds at _____ the Hospital.
2. The BPC will be screened by the Hospital volunteer office to ensure that she meets all the requirements necessary to provide patient care in the Hospital, and will comply with all the guidelines provided by the volunteer office.
3. An International Board Certified Lactation Consultant (IBCLC) or breastfeeding expert from the WIC Agency or Hospital will provide additional training on working in the Hospital, and will mentor the BPC until she is competent to conduct rounds independently.
4. The WIC Agency will designate a liaison to provide technical assistance and to mediate any concerns that may arise.
5. Scope of work for the WIC BPC in the Hospital includes providing encouragement and support, and basic education on:
 - Reasons to breastfeed.
 - Overcoming barriers to breastfeeding.
 - Colostrum quantity and benefits.
 - Normal course of breastfeeding.
 - Positioning and latch.
 - Skin-to-skin and its benefits.
 - Maintaining adequate milk production.
 - Normal infant output.
 - Preventing common problems.
 - Anticipatory guidance to prepare for post-discharge needs.
 - Resources for breastfeeding support.
6. Duties of the WIC BPC are to:
 - Check in with the hospital nurse or lactation consultant.

- Make rounds with all WIC and WIC-eligible mothers to assess their interest in breastfeeding and to provide basic assistance.
- Observe a feeding within accordance with hospital policy to check positioning and latch.
- Report any breastfeeding concerns that are beyond the BPC scope of practice to the patient’s assigned nurse or lactation consultant, and the WIC designated breastfeeding expert.
- Keep accurate records for all contacts and submit them in a timely manner to the WIC supervisor and to the hospital nurse following agreed upon procedures.
- Give breastfeeding literature provided by the WIC Program.
- Refer to the WIC office for follow-up with the WIC designated breastfeeding expert to arrange for an electric breast pump, if necessary.
- Arrange for follow-up contacts after discharge if agreeable to the mother.
- Assist patients with accessing WIC services.

7. Role of the Hospital:

- Designate a contact person to whom the WIC BPC will report.
- Facilitate rounds in conjunction the WIC Agency.
- Provide the WIC BPC with referrals of breastfeeding mothers under their care who demonstrate a need for breastfeeding support.
- Provide the WIC BPC with space to store breastfeeding education materials.
- Work with the WIC Agency liaison to report any concerns, and to regularly communicate progress of the services being provided.
- May require a Hospital orientation for the WIC BPC through the volunteer program.

Acknowledgement of Agreement

The term of this MOU is from _____[date] to _____[date], unless sooner terminated pursuant to the terms of this agreement. This MOU is of no force or effect until signed by both the Hospital and WIC Agency.

(Name of Hospital)
(Hospital Address)

(Name of WIC Agency)
(WIC Agency Address)

Signature

Signature

Print name

Print Name

Title

Title

Date

Date

Adapted from Texas WIC and Alameda County WIC Program

INSTRUCTIONS FOR COMPLETING THE MONTHLY BFPC ACTIVITY REPORT

Objective:

To ensure WIC Breastfeeding Peer Counselors (BFPC) participate in and report on Breastfeeding Peer Counseling activities funded through USDAs BFPC Federal Grant.

Goal:

BFPCs will use 60-70% of their time participating in encounter activities to ensure WIC mothers are being provided sufficient breastfeeding (BF) support.

Explanation of Process:

BFPCs will keep track of all their BF contacts with mothers and other breastfeeding activities on a daily basis using the *Monthly BFPC Activity Report*. See ([Appendix 6-14](#)) If needed, the BFPC can send her activity report to her clinic supervisor or BF Coordinator for review at the end of every week. At the end of the month, their clinic supervisor will send the completed report for a final review to the Regional BF Coordinator. After her review, she will send the report to the BFPC Coordinator at CO by the 8th day of every month (notice the due date is located at the top of each week in the report).

The BFPC will need to discuss with their clinic supervisor the date the report is due to her for the end of the month submission. Under special circumstances, CO will accept a partially completed month with a written explanation of when the full report can be expected. Should DOH or USDA request an immediate report for that month, it reflects better on the region to show some activity report data rather than no data for the month.

USDA specifies that grant funds cannot be used to pay the BFPC to perform clinic activities that are not breastfeeding peer counseling related. For example, BFPCs cannot be used to perform PHOAs activities while charging work hours to the BFPC grant. The BFPC cannot perform activities for other health department programs like HUGS while charging work hours to the PC grant.

Saving Excel Report

- Save a blank template with BFPC's name
- For every monthly report, "save as" from the template to create a new file renaming it with BFPC's name, month and year.

Top Portion of the Spreadsheet

- At the top of week 1, BFPCs **must** enter their county and region, week beginning date and year, name, and the number of scheduled hours budgeted to work per month.
- **The number of scheduled hours budgeted needs to include holidays and sick and annual leave and might differ from month to month based on the number of days in the month.**
- For BF Coordinators/PC Program Managers, this number should correlate to charges to the PC Grant Funds unless the PC had unpaid leave.

Entering Data on the Spreadsheet

Make sure you always record activity using the appropriate tabbed week located at the bottom of the report.

Date, Participant and/or Activity

- Under “date”, enter the day and month only for the activity.
- Enter the participant’s name or ID# or BF activity. Examples: Prenatal classes (QUICK WIC), BF Support Groups, cleaned pumps, mass mailing of BF letters or mass texts, reminders via text, class prep time, pulling charts, inventory, documentation, or reports.

Blue - # Clients Counseled Section

- **ONLY** enter a number in the Prenatal, Postpartum-BF, or Postpartum-Non BF columns for activities that required the completion of an Encounter (activities in the green columns).
- Examples: for an individual contact the number “1” is put in the appropriate blue column or for a group class the number of WIC women participants attending the class is entered.

Do not enter a number for something mailed or for an unanswered phone call since encounters are not completed for these activities.

Green – Encounter Form Counseling (In Person or Phone Counseling and Texting) Section

- Amount of time spent with a mother(s) as listed in the columns.
- Enter only the decimal break down found in the box at the top right of the page. For example, if a participant is counseled for 5, 10, 15 minutes, enter “.25” rather than “.1, .15, or .2”.
- Include the entire time for counseling and documenting, even if documenting after the consult.
- If additional documentation is taken after the counseling ends, put the extra time in the clerical column.

Purple – Non-Encounter Activities Section

- Record time spent in BF related activities ONLY, except for staff meetings.
- **“Other Activities” column:**
 - Related to BF or non-BF activities.
 - Examples: travel time to and from base clinic, local or regional staff meetings – monthly or quarterly basis (travel included), World Breastfeeding Week activities (baby fair/shower), outreach, time spent cleaning pumps, or a pump return that does not require counseling. **Answering phones and helping clerical staff is NOT allowed.**
- **“Self-Study, Staff Meeting, Training, In-Service”:**
 - Related to only BF or WIC program policies.
 - Examples: Grow and Glow, A Journey Together PC training, annual BF training for all local staff, WIC only meetings, E-learning courses, or research **ONLY** on basic BF topics.
- **“Consultations (WIC Staff/BF Experts)”:**
 - When yielding to other WIC staff or BF experts for BF issues outside scope of practice.
 - Examples: In-person, phone, or email conversations.
- **“Clerical/Admin, Unanswered Calls”:**
 - Since unanswered calls do not require an Encounter, the number of calls is not added to the Blue column and individual participant names are not needed.
 - Total time spent that day with unanswered calls is placed in this column.
 - Examples: Pulling BF charts, completing record keeping activities such as the Activity reports, class Encounters that could not be completed during class time, making copies of handouts, extra time needed for documentation, time spent doing inventory, etc.
- **“Mail”:**
 - Describe the type of mail in the black second column and note the number of letters and additional comments in the “remarks” column.
 - Examples: email, post office mail or texting appointment reminders.
 -

Orange Section – OUT

- Only log amount of time not worked
- Required for both full-time and part-time BFPCs *
- Sick leave
- Annual leave (vacation)
- Holidays
- 15 minute breaks
- Lunch – NOT required by CO since it is unpaid time
- *** If part-time BFPCs are able to make up any missed time that has been approved on a county level, then missed time does not have to be logged in this column.**

Red – Total Number of Hours Section

- Changes do not need to be made
- This column will automatically tally based on the time entered in the green through the purple columns.

Remarks Section

Some examples of notes that **MUST** be made in this section:

- Number of letters or text messages sent out for reminders
- Number of attempted calls made (unanswered)
- Topics researched on the internet (**ONLY on BF training topics within BFPC scope at approved websites**)
- Location and name of trainings
- Name of BF activities or events, e.g. Baby Shower, World Breastfeeding Week, Latch On, etc.
- Name of DBE or BF expert and issue for when yielding is needed
- Sites traveling to and from
- Number of charts being pulled and documented
-

Monthly Data Worksheet

- The number of leave hours (OUT) column and total number of hours column must equal the number of hours scheduled per month.

BFPC SCOPE OF PRACTICE & YIELDING¹

Tennessee WIC BFPC –Scope of Practice

BFPCs provide an important adjunct to the usual WIC program services. The WIC local agency CPA conducts a complete WIC breastfeeding assessment using VENA principles and techniques. The CPA provides appropriate education and referrals to lactation professionals as necessary. The BFPCs **supplement**, but do not replace, the work of CPAs and lactation professionals. BFPCs can help fill the gaps since they are available outside the usual clinic hours. Their scope of practice is to provide basic information and support to new moms, and to make referrals when they are experiencing problems beyond their training.

Research shows higher breastfeeding rates with high intensity peer support initiatives which include making contacts early in pregnancy, with more frequent contacts as the due date approaches. Research shows most women make their infant feeding decisions before or during the first trimester of pregnancy. However, women who initially decide to formula feed often change their mind with information and support from a peer counselor. Establishing a relationship with the mother before her baby is born can help prepare for the early days of breastfeeding. It is not uncommon for BFPCs to experience many disconnected phones, wrong numbers, or unreturned messages. BFPCs should be realistic in realizing that difficulty reaching clients is normal. The fact that WIC mothers often do not return calls is a primary reason BFPCs should always be the ones to initiate contact.

BFPCs fill in the gaps:

- Provide prenatal breastfeeding promotion and support messages timed to mothers when they need it most
- Connect mothers to other health programs and services that can help during pregnancy and beyond
- Call or visit mothers in the hospital to troubleshoot early concerns
- Contact mothers in the early days home from the hospital
- Make referrals as needed
- Provide ongoing support as baby grows to help mom's confidence

BFPCs can help during pregnancy:

- Help explore a mother's barriers to breastfeeding that may change as her pregnancy unfolds
- Help mothers explore options for maximizing the benefits of breastfeeding and lowering the mother's barriers
- Educate mothers about basic breastfeeding techniques, how to get a good start with breastfeeding in the hospital, and tips for good milk production

1

Loving Support through Peer Counseling: A Journey Together—For WIC Managers

- Make referrals to CPA or DBE if problems continue or are beyond her scope

BFPCs can help during the early days of postpartum:

- Link and support for new mothers
- Make phone calls and visits to the hospital to address early concerns
- Assist mothers with positioning and latch
- Home visits to assess breastfeeding if applicable

BFPCs can help during the first month of postpartum:

- Offer ongoing help and support throughout the critical first month when milk production is being established and mothers are adjusting to the demands of mother and breastfeeding
- Promote the WIC food packages for fully breastfeeding mothers and to answer their many questions
- Help mothers gain confidence in their milk production, and encourage them if they do not have friends or family members who support them
- Make weekly phone calls after breastfeeding is going smoothly
- Contact within 24 hours if mothers experience problems (yield to DBE if situation occurs outside of her scope of practice)

BFPCs can help beyond the first month:

- Help answer questions concerning baby's growth
- Assist with pre-baby routines such as returning to work or school
- Continue to offer ongoing help and support
- Offer breast pumps and strategies for combining work or school with breastfeeding
- Contact the mother around 1-2 weeks before she plans to return to work/school and a day or two after she returns
- Help mothers deal with common challenges (ex: breastfeeding in public)
- Promote the WIC food packages
- Make referrals
- Connect mothers to other mothers in the community
- Contact monthly as long as things are going well

Tennessee WIC BFPC - When to Yield

When BFPCs identify any of the following problems or situations, they must immediately consult their WIC DBE (such as the Regional Breastfeeding Coordinator, Clinic CPA with CLC, WIC IBCLC, Regional Nutrition Director, or CPA) to discuss the best plan for supporting the mother and infant. This plan includes any referrals that are appropriate.

The BFPC will continue to provide **basic** support while the DBE or HCP is addressing the issue, unless the DBE, CPA, or BFPC determines that it is best to discontinue peer support.

Pregnancy Issues

1. Spotting or bleeding
2. Excessive vomiting or nausea
3. Swelling
4. Contractions, suggesting premature labor
5. Baby stops moving
6. Other troublesome medical situations

Baby Concerns

1. Baby is born preterm or low birth weight
2. Baby is sick
3. Baby has fewer than 6 wet diapers and 3 stools per 24 hours in the first month after the baby is 4 days old
4. Baby fails to gain weight or gains weight slowly:
 - Baby loses more than 7% of birth weight
 - Birth weight is not regained by 2 weeks postpartum
 - Weight gain is less than 4.5 ounces per week
5. Baby has difficulty latching or remaining latched after several attempts
6. Baby appears unhappy at the breast or refuses to breastfeed
7. Baby is still hungry after feedings despite 24 hours of increased frequency and duration of breastfeeding
8. Breastfeeding typically last more than 45 minutes
9. Baby is jaundiced
10. Baby has a congenital defect such as cleft lip/palate or Down Syndrome
11. Baby has restricted tongue movement from a tight frenulum

Mother Concerns

1. Mother has engorgement or plugged ducts that are not resolved after 24 hours
2. Mother has fever (suggesting possible mastitis)
3. Mother has nipple discomfort that does not improve after 24 hours
4. Mother is supplementing with formula before the baby is 1 month old and wants to increase her milk production or reduce/eliminate formula supplements
5. Mother has been formula feeding the baby since birth and now wants to breastfeed
6. Mother is exclusively pumping her milk and now wants to put her baby to breast
7. Mother wants to breastfeed an adopted baby
8. Mother is breastfeeding more than one baby
9. Mother wants to breastfeed but has been advised NOT to by her HCP
10. Mother finds lump in her breast

Illness in Mother or Baby

1. Mother or baby has symptoms of thrush/yeast infection
2. Mother or baby or vomiting or have diarrhea
3. Mother or baby are hospitalized
4. Mother has symptoms of mastitis
5. Mother has a physical handicap
6. Mother or baby has a chronic or acute illness; Hepatitis B or C, tuberculosis, CMV, or chicken pox; renal, liver, intestinal, or heart problems; cystic fibrosis; metabolic disorder such as diabetes mellitus
7. Mother has been diagnosed with AIDS/HIV

Other Medical Situations

1. Mother has been prescribed medications that have not been approved for breastfeeding by current established authorities such as the AAP or Lactmed
2. Mother has prior breast surgery (breast implants, breast reduction, biopsy, breast cancer), chest surgery, or trauma
3. Mother has had gastric bypass surgery
4. Mother has history or PCOS, hypothyroidism, or other hormonal conditions that could affect breastfeeding

Nutrition

1. Mother has nutrition questions
2. Mother is nutritionally at risk for underweight, has bulimia, or anorexia
3. Mother has no food

Social

1. Mother appears depressed
2. Physical abuse of the mother or another family member is suspected
3. Mother is abusing or suspected of abusing alcohol or street drugs (such as heroin, marijuana, meth, cocaine, etc.)

Other

1. Mother or baby have any other medical problems that are outside the peer counselor scope of practice
2. Mother feels there is a problem that needs a referral
3. Peer counselor feels there is a situation that needs to be addressed by a lactation expert
4. Mother is not following suggestions given by the peer counselor

BFPC DOCUMENTATION

INSTRUCTIONS FOR COMPLETING THE BREASTFEEDING PEER COUNSELOR CONTACT LOG

Policy:

Breastfeeding Peer Counselors in TN WIC must use the Breastfeeding Peer Counselor Contact Log (Edison # 10000135381) to document all contact and attempted contact with all WIC prenatal and BF women assigned to their caseload. TN Department of Health requires all counseling documentation be entered into the participant's medical record at the time of service. The original of the PC Contact Log is kept permanently in the participant's medical record at all times.

Implementation Procedures for Completion of the Contact Log form:

[When to Initiate the Contact Log](#)

The evidenced-based successful BFPC Program model in TN has demonstrated the effectiveness of face-to-face counseling as the first BFPC contact with a WIC prenatal. The Contact Log is initiated at the time of the first visit. See a copy of the Breastfeeding Peer Counselor Contact Log in ([Appendix 6-25](#))

See instructions in Chapter 6 of the WIC Manual on completing the Prenatal and Postpartum WIC Record's page 2 "Breastfeeding Assessment, Promotion, Counseling and Support" for BFPC documentation on this form.

The Contact Log cannot be removed from the chart when making home visits. Make notes related to the visit on separate paper while in the home then transfer the notes to the original Contact Log upon return to the clinic. Medical records, including the Contact Log must be handled securely at all times to avoid breach in participant confidentiality.

While the BFPC documents only in the mom's chart, always pull both the mom's and infant charts as a dyad to review all notes written by CPA staff concerning breastfeeding. It can be helpful to review the infant growth chart when counseling moms.

Attach the participant label to the front of the Contact log in the area indicated. In the data section below the label, it is not necessary to record any information already on the label or in the chart elsewhere. BFPC should record the infant's name since it is not always elsewhere in the mom's chart.

Type of Contact: Use these numbers in the check boxes below as appropriate for the contact .

Prenatal and Postpartum Contact Content (check areas discussed): On the Date line, enter the month, day and year of the contact in the appropriate box. The BFPC needs to initial inside each box next to the topic(s) discussed or can have one initial and mark line through topics as appropriate. Remember Loving Support training: Teach the smallest amount possible at each contact to avoid losing the big message!

Narrative Documentation of Contacts: It is not necessary to write a narrative with each contact. Use this area to document anything additional you want to remember, that you want other providers to see or that was discussed that is not listed on the front. The BFPCs need to put their signature (first initial, last name and BFPC) after every contact note. BFPCs will not need to sign the bottom on the back of the form.

See the complete listing of approved abbreviations found in Chapter 7 of the WIC Manual.

Date Client Exited from the Program: Enter the date the participant stopped breastfeeding. This can also be found under section “A” page 2 of the WIC Postpartum WIC Record. The dates should match.

PTBMIS Codes for Breastfeeding Peer Counselors

Breastfeeding Peer Counselors (BFPCs) hired by the BFPC Grant need to use procedure code 1009 and diagnosis code Z02.9. BFPCs must document all encounter contacts in the patient’s medical record. Encounter contacts can be face to face, group, phone calls or text messaging. If phone contact was made, change the visit setting to 04.

The disposition code should be recorded on the encounter and entered into the disposition field on the PTBMIS encounter screen. The disposition codes are listed below:

- FS – Breastfeeding Survey
- IC – Individual Counseling
- BP – Breast Pump Issuance
- HV – Home or Hospital Visit
- GC – Group Counseling

BFPC CONTACT LOG



Tennessee Department of Health Breastfeeding Peer Counselor Contact Log

Mother's Name: _____
Mother's PT/Chart # _____
Phone # _____

Due date: _____ Breastfed ever? Yes No Baby's name: _____

Baby's date of birth: _____ Baby's birth wt.: _____ Discharge wt.: _____ Two week wt.: _____

Type of contact: 1= clinic visit 2= phone call 3= text 4= group class 5= home visit 6=hospital visit 7=other (describe on back)

Prenatal Contacts Content (check areas discussed)										
MM/DD/YY and Initial										
Type of Contact (see above numbers)										
Breastfeeding Assessment										
Breastfeeding benefits										
Breastfeeding management										
Breastfeeding technique										
Class or group invitation										
Overcoming BF barriers										
Refer to DBE/CPA/MD/other expert										
Separation from baby/work/school										
Support critical to BF success/ schedule WIC visit soon after delivery										

Postpartum Contacts Content (check areas discussed)										
MM/DD/YY and Initial										
Type of Contact (see above numbers)										
Breastfeeding Status: 6, 3, B, 2										
Baby fussy/colicky										
Baby's bowel movements/wet diapers										
Baby sick										
Basic BF technique (position/latch)										
BF & contraception use										
BF with medical issues/medications										
Breast refusal										
Breastfeeding going well										
Class or support group invitation										
Engorgement/plugged duct										
Growth spurt										
Infant hunger cues										
Milk supply issues										
Nursing schedule										
Nutrition referral										
Overcoming BF barriers										
Premature infant &/or twins (circle)										
Pumping/hand expression/pump follow-up										
Refer to DBE/CPA/MD/other expert										
Relactation										
Separation from baby/work/school										
Signs of Breast infection/referral										
Sore nipples										
Teething										
Weaning										

BEST START 3 STEP COUNSELING STRATEGY

Table 2

Best Start Three-Step Counseling Strategy*

Step 1. Ask an open-ended question.

This will elicit a mother's particular barriers to choosing breastfeeding and allow you to hone in on her personal issues. It is an efficient way to direct your educational efforts toward her concerns.

"What have you heard about breastfeeding?"

"What concerns do you have about breastfeeding?"

Step 2. Affirm her concerns.

This step is critical for several reasons: It helps her realize that you are in fact listening to her; it normalizes her concern; it lets her know you don't consider her concerns silly or stupid; and importantly, this helps her develop a relationship with you.

"You know, I hear that worry from lots of women ... good for you to mention that."

"Many women wonder if their diet has to be really good to breastfeed."

Step 3. Provide targeted education directed to her specific concerns.

"Did you know that your breast works to make quality milk even when your diet is not great?"

"There are lots of ways to feed your baby when you are separated — here's a pamphlet about breastfeeding after returning to work."

The Three-Part Counseling Strategy in Action

I. NP: "What have you heard about breastfeeding?"

Mother-to-be: "I hear it's best for my baby, but all my friends say that it really hurts!"

NP: "You know, most women worry about whether it will hurt. Did you know that it is not supposed to be painful, and that if you are having discomfort, there are people who can help you make it better?"

II. NP: "What questions do you have about breastfeeding?"

Mother-to-be: "My diet is so terrible, it would be better for the baby to get formula."

NP: "I hear that comment from lots of women. Although eating a wide variety of foods helps you stay healthy and feel better, your breasts will make wonderful milk for your baby, even when your diet's not great."

*See Bryant C, Roy M. *Best Start's Three-Step Counseling Strategy*. Tampa, Fla.: Best Start Inc.; 1997.

†Adapted from: McCamman S, Page-Goertz S. Breast-feeding success: you can make the difference. *The Perinatal Nutrition Report*. 1998;4(4):2.

Counseling Points for the Breastfeeding Mother

VENA philosophy connects nutrition and breastfeeding assessment to effective and appropriate counseling and support that best meet the needs of the breastfeeding mother and infant. Effective counseling approaches are participant-centered and include active listening using open-ended questions to build rapport, identify and reflect concerns, and help women set realistic goals. The following key concepts may be used as a guide when developing targeted messages about breastfeeding during pregnancy and after delivery.

The Counseling Points for the Breastfeeding Mother may be used by the **Breastfeeding Peer Counselor (BFPC)**, however she must remain in her scope of practice and yield to the CPA or DBE if mothers are experiencing problems beyond her training.

Initial PRENATAL Visit: Refer to BFPC (Counsel throughout the pregnancy)

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

****Breastfeeding is a priority for the WIC Program***

- A major goal of the WIC Program is to improve the nutritional status of infants; therefore, WIC mothers are encouraged to breastfeed their infants unless medically contraindicated. Breastfeeding women are at a higher level in the priority system to receive services
- Encourage pregnant mother to initiate and continue the breastfeeding relationship at least through the first 12 months of age
- Assess a pregnant mother's intention to breastfeed and identify factors that affect breastfeeding success
- Address any concerns or questions mother may have about breastfeeding.
- Discuss with mother how breastfeeding is an important relationship that takes patience and practice in order for mother and infant to learn and recognize each other's signals
- Advise pregnant mother about the enhanced services breastfeeding mothers receive in the WIC Program:
 - information through counseling and breastfeeding educational materials
 - follow-up support through WIC counselors and referrals
 - eligibility to participate in WIC longer than non-breastfeeding mothers
 - breast pumps, breast shells or nursing supplementals to help support the initiation and continuation of breastfeeding
- Emphasize to pregnant mother the incentives provided in the food packages for breastfeeding mothers and their infants
- Advise mother that breastfeeding women who do not accept formula from WIC receive the largest quantity and variety of foods

PRENATAL : Next nutrition education visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

*Breastfeeding is the optimal infant feeding method

- The **American Academy of Pediatrics (AAP)** recommends breastfeeding as the preferred feeding for all infants, including preterm infants
- Breastfeeding has various **health, emotional, and economical** benefits for a mother and her infant
- A mother's breast milk has the **perfect** combination of nutrients needed for her infant's growth and development
- **Fully breastfeeding** for the first 6 months of life confers the greatest benefit
- Discuss the various benefits of breastfeeding with mother for her infant as well as herself
- Discuss the advantages of breastfeeding versus feeding infant formula

*Support is critical to breastfeeding success

- **Family, friends, and HCPs** are **influential** in a mother's decision to breastfeed and the duration of the breastfeeding relationship
- Mothers should surround themselves with **supportive** family and friends when adjusting to new motherhood and breastfeeding her infant
- Encourage mother to develop a support plan which may include family, friends, a WIC counselor, lactation professional or WIC **BFPC**
- Encourage mother to talk with family and friends about breastfeeding and to invite them to attend prenatal breastfeeding classes
- Encourage mother to call WIC with questions or for advice
- Provide referrals and contact information if additional support is necessary, especially in the first few weeks after birth when mothers are most likely to wean (e.g., WIC counselors, lactation professionals, peer counselors, HCPs)
- Provide follow-up to address mother's concerns as appropriate

*Hospital practices/protocol and their impact on the breastfeeding relationship

- Some hospital practices act as barriers to successful initiation and continuation of the breastfeeding relationship
- Familiarize yourself with your local hospitals' delivery and postpartum practices

PRENATAL: Next Nutrition Education visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Encourage mother to discuss her plans to breastfeed with her health care provider before birth and state her requests on the hospital preadmission forms
- Encourage mother to talk to the pediatrician and hospital nursing staff about her plans to breastfeed her infant
- Counsel mother on postpartum practices supporting breastfeeding:
 - Breastfeed as soon as possible after birth
 -
 - Breastfeed on cue
 - Delay offering a pacifier until breastfeeding is established
 - “Room in” or keep the infant in the room as much as possible
 - Do not offer supplemental bottles of formula or water unless medically indicated
 - Ask to see a lactation professional or nurse knowledgeable about breastfeeding
- **Provide** mother with tools that will help her assert her choice to breastfeed during her hospital stay (e.g., birthing plan, crib card)

****Supplementation interferes with a mother’s milk supply and her breastfeeding success***

- **Supplemental feedings** of water or infant formula are **unnecessary** as breast milk provides ideal nourishment for the infant
- Supplemental feedings, especially in the early days after birth, **interfere** with a mother’s milk supply (the amount of milk she produces)
- The amount of milk a mother produces depends on the frequency and effectiveness of milk removal from the breast (“**supply and demand**”)
- Artificial nipples on bottles and pacifiers require different movements of the infant’s tongue, lips, and jaw that may make it difficult for infants to easily go back to the mother’s nipple and breast
- Discuss with mother why supplemental feedings are unnecessary and how they interfere with the success of the breastfeeding relationship
- Discuss fears mother may have about her ability to breastfeed and her milk supply

****Maternal nutrition supports breastfeeding***

- Breastfeeding mothers need to maintain a balanced diet; however, her breast milk will provide all the nutrients her infant needs if her diet is not perfect

PRENATAL (Especially 3rd Trimester) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Discuss recommendations for pregnant moms on making healthy food choices with regular physical activity. Refer to: <http://www.nal.usda.gov/wicworks/Topics/PregnancyFactSheet.pdf>
- Emphasize that the additional foods provided in WIC food packages for breastfeeding mothers supplement their special nutritional needs
- Advise the mother that breastfeeding women who do not accept formula from WIC receive the largest quantity and variety of foods
- If the mother was on WIC prenatally, provide her the fully breastfeeding food package (Food Package 6STD) in the first week after birth or issue **Voucher PBF** as soon as possible so she may benefit from the additional foods

***Breastfeeding can continue when returning back to work or school**

- Many mothers need or want to return to work or school outside their home shortly after their infant's birth
- Mothers who are temporarily separated from their infants can continue to breastfeed successfully
- Discuss strategies mother can use that may improve her ability to continue breastfeeding when she returns to work or school and must be separated from her infant such as:
 - Breastfeed the infant when home and express breast milk by hand or by using a breast pump
 - Make arrangements for safely storing expressed breast milk while away from home
 - Choose a babysitter or day care center that is supportive of breastfeeding
 - Introduce infant to drinking from a bottle and to being fed by someone else
 - Breastfeed regularly on weekends and evenings.
- State agency policy should be followed regarding appropriate protocols for providing breast pumps, i.e., TN's guidelines for issuing breast pumps ([Appendix 6-48](#))

Initial POSTPARTUM Visit or BFPC contact (Birth – 2 WEEKS)

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

**Breastfeeding is the optimal infant feeding method*

- **AAP recommends** breastfeeding as the preferred feeding for all infants, including preterm infants
- **Breastfeeding** has various health, **emotional, and economical benefits** for a mother and her infant
- A mother's breast milk has the **perfect** combination of nutrients needed for her infant's growth and development
- **Fully breastfeeding** for the first 6 months of life confers the greatest benefit
- Discuss the various benefits of breastfeeding with mother for her infant and herself
- Discuss the advantages of breastfeeding versus feeding infant formula
- Encourage mother to initiate and continue the breastfeeding relationship at least through the first 12 months of age

**Breastfeed as soon as possible after birth*

- Infants are alert and ready to breastfeed **immediately** after birth. After the first few hours of life, newborn infants become very sleepy
- If possible, infant should be put **skin-to-skin** in delivery room and offered the breast, fostering the breastfeeding relationship

**Importance of Colostrum*

- **Colostrum** is a thick, yellowish fluid that provides antibodies to resist infection
- Colostrum is small in quantity (teaspoons)
- **Frequent feeding** is important even when only colostrum is present. It helps establish a good milk supply once milk comes in and provides various health benefits
- Discuss the importance of the first "milk" or colostrum, which provides antibodies that help infants resist illness and disease
- Discuss the transition from colostrum to mature milk
- Encourage mother to breastfeed her infant as soon as possible after birth to provide this important substance to her infant

POSTPARTUM (Birth – 2 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

**Comfort and Proper Positioning*

- There are **three** commonly used positions that allow an infant and mother to breastfeed comfortably:
 - **Lying down or side lying (Older infants)**
 - **Across the lap or cradle hold**
 - **Football hold or clutch hold**

- Positioning the infant properly at breast is essential for successful latch-on and avoidance of sore nipples
- Some mothers may experience some **initial** discomfort, but breastfeeding should not be painful
- Discuss correct positioning, essential for proper “latch-on”
- Address any issues related to pain and discomfort during breastfeeding
- Encourage mother to see her health care provider for assessment if pain or discomfort persists

*Recognize hunger and satiety cues and feed often and on cue

- Infants should breastfeed **8 to 12 times** in 24 hours (or about every 1½ to 3 hours), usually 10 to 15 minutes per breast or until both breasts are **emptied**.
- Signs of hunger/feeding cues:
 - Rooting reflex
 - Small fussing sounds
 - Hand-to-mouth activity
 - Smacking lips
 - Pre-cry facial grimaces – (Crying is a late signal)
- Signs of fullness:
 - Coming off the breast
 - Slows or stops suckling
 - Hands relax
 - Falls asleep
- Frequent feeding helps build milk supply
- A newborn infant should not go longer than 2 to 3 hours during the day or 3- 4 hours at night without feeding

POSTPARTUM (Birth – 2 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Discuss infant feeding patterns with mother. Although 1½ to 3 hours is the average breastfed infant feeding pattern, this varies from infant to infant and day to day
- Discuss with mother that breast milk empties from the stomach faster than infant formula does. New mothers may compare their infants to formula-fed infants and misinterpret the normal frequency of breastfeeding to mean that they have insufficient milk
- Encourage mother to breastfeed often and on demand and avoid scheduling feedings
- Discuss the importance of recognizing feeding cues. Emphasize that crying is a late sign of hunger and can result in an infant who is difficult to calm and latch to the breast

*Signs that infant is getting enough

- Breastfeeds frequently and is satisfied after each feeding
- Plenty of wet and soiled diapers, with pale yellow or nearly colorless urine
 - At least 5-6 wet and 3 soiled diapers per day in the first 3-5 days of life
 - 6 or more wet and 3-4 soiled diapers per day by 5-7 days of age
- Audible swallowing consistently while breastfeeding
- Wakes to feed
- Gains weight consistently
- Ask mother about specific indicators to ensure that infant is getting enough milk such as elimination patterns for breastfed infants, appropriate weight gain, etc
- Advise mother to contact her health care provider if she believes her infant is not getting enough milk

*Appropriate weight gain/loss for infants

- Nearly all infants lose a few ounces of weight the first few days after birth. During this period, infants pass their first stools and eliminate extra fluids
- As the mother's milk production increases, an infant who is breastfeeding effectively should begin gaining weight
- AAP recommends that newborn infants be seen by their pediatrician or other knowledgeable and experienced health care provider at 3 to 5 days of age
- By two weeks of age, infants should be at or over their birth weight

POSTPARTUM (Birth – 2 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Encourage mother to arrange a follow-up visit for her infant with her health care provider or WIC clinic within the first week after birth (3 to 5 days of age). An early weight check gives a new mother confidence in her ability to produce enough milk and the opportunity to ask questions
- If there are concerns about an infant's weight or weight loss is $> 7\%$ of birth weight, encourage the mother to consult her health care provider

*Breast Fullness/Engorgement

- During the first week after birth, milk supply steadily increases and breasts may feel full and heavy
- **Frequent feedings** will relieve the fullness, but engorgement (swollen, hard and painful breasts) may occur if breastfeeding is not frequent and effective
- Discuss normal fullness of breasts and encourage mother to breastfeed frequently and on cue to avoid engorgement
- Discuss symptoms of engorgement. If mother experiences very full, hard, painful breasts, this may be an indication of engorgement and may require that she contact her health care provider for assistance

****Maternal nutrition supports breastfeeding***

- Breastfeeding mothers need to maintain a balanced diet; however, her milk will provide all the nutrients her infant needs if her diet is not perfect
- Discuss recommendations for breastfeeding moms on making healthy food choices with regular physical activity. Refer to: <http://www.nal.usda.gov/wicworks/Topics/BreastfeedingFactSheet.pdf>
- Emphasize that the additional foods provided in WIC food packages for breastfeeding mothers supplement their special nutritional needs
- Advise mother that breastfeeding women who do not accept formula from WIC receive the largest quantity and variety of foods
- If the mother was on WIC prenatally, provide her the fully breastfeeding food package (Food Package 6STD) in the first week after birth or as soon as possible so she may benefit from the additional foods

POSTPARTUM (Birth – 2 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

****Supplemental feedings interfere with a mother's milk supply and her breastfeeding success***

- Supplemental feedings of water or infant formula are unnecessary as breast milk provides ideal nourishment for the infant
- Supplemental feedings, especially in the early days after birth, interfere with a mother's milk supply (the amount of milk she produces)
- The amount of milk a mother produces depends on the frequency and effectiveness of milk removal from the breast ("supply and demand")
- Artificial nipples on bottles and pacifiers require different movements of the tongue, lips, and jaw and may make it difficult for infants to go back to the mother's nipple and breast
- Discuss with mother why supplemental feedings are unnecessary and how it interferes with the success of the breastfeeding relationship
- Discuss fears mother may have about her milk supply. She may perceive a decrease in her milk supply when the initial fullness of her breasts subside or question her ability to produce enough milk to nourish her infant adequately
- Advise mother that WIC does not routinely provide infant formula to partially breastfed infants less than one month of age to help the mother and infant get off to a good start with breastfeeding
- If mother requests formula, troubleshoot the reason to the **DBE** and ensure she receives support and referrals as appropriate to continue to breastfeed
- State agency policy should be followed regarding provision of formula in the first month postpartum

*Basic Breast Care

- There are simple steps mothers can take to care for their breasts to minimize the development of common breastfeeding-related breast and nipple problems
- Discuss recommended breast care practices with mother such as:
 - Keep nipple dry between feedings
 - Avoid using harsh soaps and detergents on nipples and areola
 - Do not use creams, ointments or oils on the nipples or areola on a routine basis to heal sore nipples, abrasions or cracks.

POSTPARTUM (Birth – 2 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

*Appetite/Growth Spurts

- Appetite or growth spurts are short periods of time when the infant breastfeeds more frequently than normal
- Usually occurs around 2 to 3 weeks of age; however, the time period an infant goes through an appetite spurt may vary
- During this time mother's breast fullness may have subsided
- **Reassure** mother about their milk supply. A mother may feel that she has an insufficient milk supply, but during these periods of frequent feeding the infant is signaling the mother's body to produce more milk to meet his growing needs
- Encourage the mother to keep the infant at the breast as often as the infant demands to feed during this period
- Assure mother that her milk supply will quickly increase with her infant's demand and soon her infant's feeding routine will return to normal
- **Praise** mother for her breastfeeding efforts and **encourage** her to continue breastfeeding her infant
- If a mother expresses concern that an appetite spurt lasts longer than a few days, refer her to a DBE, lactation professional or her health care provider

*Vitamin D Supplementation

- AAP states that breastfed infants who do not receive supplemental vitamin D or adequate sunlight exposure are at increased risk of developing vitamin D deficiency or rickets
- **AAP recommends** that all healthy infants have a minimum daily intake of 400 IU of vitamin D per day beginning within the first few days of life to prevent rickets and vitamin D deficiency
- Discuss vitamin supplementation. A daily supplement of 400 IU of vitamin D is recommended by AAP beginning within the first few days of life. Encourage mother to discuss vitamin D supplementation with her infant's pediatrician

****Support is critical to breastfeeding success***

- **Family, friends, and HCPs are influential in a mother's decision to breastfeed and the duration of the breastfeeding relationship**

POSTPARTUM (2 – 4 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- **Mothers should surround themselves with supportive family and friends when adjusting to new motherhood and breastfeeding her infant**
- Encourage and praise mother for her breastfeeding efforts. Encourage mother to call DBE or BFPC with questions or for advice
- Provide referrals and contact information if additional support is necessary, especially in the first few weeks after birth (e.g., DBE, BFPC, lactation professional, health care provider)
- Provide follow-up to address mother's concerns as appropriate

****Breastfeeding is the optimal infant feeding method***

- AAP recommends breastfeeding as the preferred feeding for all infants, including preterm infants
- Breastfeeding has various health, emotional, and economical benefits for a mother and her infant
- A mother's breast milk has the perfect combination of nutrients needed for her infant's growth and development
- **Fully breastfeeding** for the first 6 months of life confers the greatest benefit
- Discuss the various benefits of breastfeeding with mother for her infant and herself
- Discuss the advantages of breastfeeding versus feeding infant formula
- Encourage mother to continue the breastfeeding relationship at least through the first 12 months of age

****Maternal nutrition supports breastfeeding***

- Breastfeeding mothers need to maintain a balanced diet; however, her milk will provide all the nutrients her infant needs if her diet is not perfect
- Discuss recommendations for breastfeeding moms on making healthy food choices with regular physical activity. Refer to: <http://www.nal.usda.gov/wicworks/Topics/BreastfeedingFactSheet.pdf>
- Emphasize that the additional foods provided in WIC food packages for breastfeeding mothers supplement their special nutritional needs
- Advise mother that breastfeeding women who do not accept formula from WIC receive the largest quantity and variety of foods

POSTPARTUM (2 – 4 WEEKS) Follow up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

***Appetite/Growth Spurts**

- Appetite or growth spurts are short periods of time when the infant breastfeeds more frequently than normal
- Usually occurs around **6 weeks** of age; however, the time period an infant goes through an appetite spurt may vary
- Reassure mother about her milk supply. A mother may feel that she has an insufficient milk supply, but during these periods of frequent feeding the infant is signaling the mother's body to produce more milk to meet his growing needs
- Encourage the mother to keep the infant at the breast as often as the infant demands to feed during this period
- Assure mother that her milk supply will quickly increase with her infant's demand and soon her infant's feeding routine will return to normal
- Praise mother for her breastfeeding efforts and encourage her to continue breastfeeding her infant
- If a mother expresses concern that an appetite spurt lasts longer than a few days, refer her to a DBE, lactation professional or her HCP

***Basic Breast Care**

- **There are simple steps mothers should take to care for their breasts to minimize the development of common breastfeeding-related breast and nipple problems**
- Discuss recommended breast care practices with mother such as:
 - Keep nipple dry between feedings
 - Avoid using harsh soaps and detergents on nipples and areola
 - Do not use creams, ointments or oils on the nipples or areola on a routine basis to heal sore nipples, abrasions or cracks

****Recognize hunger and satiety cues and feed often and on cue***

- Infants should breastfeed 8 to 12 times in 24 hours (or about every 1½ to 3 hours), usually 10 to 15 minutes per breast or until both breasts are emptied
- Signs of hunger:
 - Rooting reflex
 - Small fussing sounds
 - Hand-to-mouth activity
 - Smacking lips
 - Pre-cry facial grimaces – (**Crying** is a late signal)

POSTPARTUM (2 – 4 WEEKS) Follow-up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Signs of fullness:
 - Coming off the breast
 - Slows or stops suckling
 - Hands relax
 - Fall asleep
- **Frequent feeding** helps build milk supply
- A newborn infant should not go longer than 2 to 3 hours during the day or 4 hours at night without feeding
- Discuss infant feeding patterns with mother. Although 1½ to 3 hours is the average breastfed infant feeding pattern, this pattern varies from infant to infant and day to day
- Discuss with mother that breast milk empties from the stomach faster than infant formula does. New mothers may compare their infants to formula-fed infants and misinterpret the normal frequency of breastfeeding to mean that they have insufficient milk
- Encourage mother to breastfeed often and on demand and avoid scheduling feedings
- Discuss the importance of recognizing feeding cues. Emphasize that crying is a late sign of hunger and can result in an infant who is difficult to calm and latch to the breast

*Signs that infant is getting enough

- Breastfeeds frequently and is satisfied after each feeding
- Plenty of wet and soiled diapers, with pale yellow or nearly colorless urine
- Audible swallowing consistently while breastfeeding
- Wakes to feed
- Gains weight consistently
 - By 2 weeks of age, infants should be **at or above** birth weight
 - **AAP recommends** that infants have a second follow-up visit with the pediatrician or other knowledgeable and experienced health care provider at 2 to 3 weeks of age to **monitor** weight gain
 -
 - Encourage the mother to arrange a follow-up visit for her infant with her health care provider or WIC clinic (2 to 3 weeks of age)
 - Early weight check gives a new mother confidence in her ability to produce adequate milk
 - Discuss infant's weight gain with the mother

POSTPARTUM (2 – 4 WEEKS) Follow-up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- If there are concerns about an infant's weight, encourage the mother to consult her health care provider
- Discuss elimination patterns. Stools of breastfed infants should be non-formed, yellowish and seedy in appearance, with no foul odor. Reassure mother that this is normal versus the firm brown stools typical of formula-fed infants

***Supplemental feedings interfere with a mother's milk supply and her breastfeeding success**

- Supplemental feedings of water or infant formula are unnecessary as breast milk provides ideal nourishment for the infant
- Supplemental feedings, especially in the early days after birth, interfere with a mother's milk supply (the amount of milk she produces)
- The amount of milk a mother produces depends on the frequency and effectiveness of milk removal from the breast ("Supply and demand")
- Artificial nipples on bottles and pacifiers require different movements of the infant's tongue, lips, and jaw that may make it difficult for the infant to go back to the mother's nipple and breast
- Emphasize to mother that exclusive breastfeeding confers the greatest benefit for her infant and for herself
- Discuss with mother why supplemental feedings are unnecessary and how it interferes with the success of the breastfeeding relationship
- Advise mother that WIC does not routinely provide infant formula to partially breastfed infants less than one month of age to help the mother and infant get off to a good start with breastfeeding
- Discuss fears mother may have about her milk supply. She may perceive a decrease in her milk supply when the initial fullness of her breasts subsides or question her ability to produce enough milk to nourish her infant adequately
- If mother requests formula, troubleshoot the reason and ensure she receives support and referrals as appropriate to continue to breastfeed
- State agency policy should be followed regarding provision of formula in the first month postpartum

POSTPARTUM (1-5 months) Follow- up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

****Breastfeeding is the optimal infant feeding method***

- **AAP recommends** breastfeeding as the preferred feeding for all infants, including preterm infants
- Breastfeeding has various health, emotional, and economical benefits for a mother and her infant
- A mother's breast milk has the perfect combination of nutrients needed for her infant's growth and development
- Fully breastfeeding for the first 6 months of life confers the greatest benefit
- Discuss the various benefits of breastfeeding with mother for her infant as well as herself
- Discuss the advantages of breastfeeding versus feeding infant formula
- Determine mother's plan for breastfeeding. Encourage mothers to continue the breastfeeding relationship at least through the first 12 months of age

***Maternal nutrition supports breastfeeding**

- Breastfeeding mothers need to maintain a balanced diet; however, her milk will provide all the nutrients her infant needs if her diet is not perfect
- Discuss recommendations for breastfeeding moms on making healthy food choices with regular physical activity. Refer to: <http://www.nal.usda.gov/wicworks/Topics/BreastfeedingFactSheet.pdf>
- Emphasize that the additional foods provided in WIC food packages for breastfeeding mothers supplement their special nutritional needs
- Advise mothers that breastfeeding women who do not accept formula from WIC receive the largest quantity and variety of foods

***Appetite/Growth Spurts**

- **Appetite or growth spurts** are short periods of time when the infant breastfeed more frequently than normal. Usually occurs around 3 and 6 months of age; however, the time period an infant goes through an appetite spurt may vary
- Reassure mother about her milk supply. A mother may feel that she has an insufficient milk supply, but during these periods of frequent feeding the infant is signaling the mother's body to produce more milk to meet his growing needs

POSTPARTUM (1-5 months) Follow-up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Encourage the mother to keep the infant at the breast as often as the infant demands to feed during this period
- Assure mother that her milk supply will quickly increase with her infant's demand and soon her infant's feeding routine will return to normal
- Praise mother for her breastfeeding efforts and encourage her to continue breastfeeding her infant
- If a mother expresses concern that an appetite spurt lasts longer than a few days, refer her to a DBE, lactation professional, or her HCP

***Recognize hunger and satiety cues and feed often and on infant cues**

- Infants should breastfeed 8 to 12 times in 24 hours (or about every 1½ to 3 hours), usually 10 to 15 minutes per breast.
- Signs of hunger:
 - Rooting reflex
 - Small fussing sounds
 - Hand-to-mouth activity
 - Smacking lips
 - Pre-cry facial grimaces – (Crying is a late signal)
- Signs of fullness:
 - Coming off the breast
 - Slows or stops suckling
 - Hands relax
 - Fall asleep
- Discuss infant feeding patterns with mother. Although 1½ to 3 hours is the average breastfed infant feeding pattern, this pattern varies from infant to infant and day to day
- Discuss with mother that breast milk empties from the stomach faster than infant formula does. New mothers may compare their infants to formula-fed infants and misinterpret the normal frequency of breastfeeding to mean that they have insufficient milk
- Encourage mother to breastfeed often and using infant cues and avoid scheduling feedings
- Discuss the importance of recognizing feeding cues

****Teething***

- It is not necessary to wean an infant from the breast when an infant's teeth began to erupt

POSTPARTUM (1-5 months) Follow- up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Mother can soothe the infant and make breastfeeding more comfortable
- Provide anticipatory guidance to mother about teething and discourage early weaning
- Discuss the importance of oral health for all infants, including breastfed infants. Advise mother to cleanse infant's gums and teeth after feedings

***Breastfeeding can continue when returning back to work or school**

- Many mothers need or want to return to work or school outside their home shortly after their infant's birth.
- Mothers who are temporarily separated from their infants can continue to breastfeed successfully.
- Discuss strategies mother can use which may improve her ability to continue breastfeeding when she returns to work or school and must be separated from her infant such as:
 - Breastfeed the infant when home and express breast milk by hand or by using a breast pump
 - Make arrangements for safely storing expressed breast milk while away from home
 - Choose a babysitter or day care center that is supportive of breastfeeding
 - Introduce infant to drinking from a bottle and to being fed by someone else
 - Breastfeed regularly on weekends and evenings

***Supplemental feedings interfere with a mother's milk supply and her breastfeeding success**

- Supplemental feedings of water or infant formula are unnecessary as breast milk provides ideal nourishment for the infant
- Supplemental feedings, especially in the early days after birth, interfere with a mother's milk supply (the amount of milk she produces)
- The amount of milk a mother produces depends on the frequency and effectiveness of milk removal from the breast ("supply and demand")
- Emphasize to mother that fully breastfeeding confers the greatest benefit for her infant and for herself
- Discuss with mother why supplemental feedings are unnecessary and how it interferes with the success of the breastfeeding relationship

POSTPARTUM (1-5 months) Follow- up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Discuss fears mother may have about her milk supply. She may perceive a decrease in her milk supply when the initial fullness of her breasts subside or question her ability to produce enough milk to nourish her infant adequately
- If mother requests formula, troubleshoot the reason and ensure she receives support and referrals as appropriate to continue to breastfeed
- If careful breastfeeding assessment indicates some formula is indicated, encourage mother to work with the DBE so she can provide as much breast milk as possible to her infant
- **Tailor** the amount of infant formula based on the assessed needs of the infant
- Provide the minimal amount of formula that meets but does not exceed the infant's nutritional needs
- Convey to mother it is possible to resume exclusive breastfeeding after using supplemental formula

***Introducing solids/complementary foods**

- Complementary foods should not be introduced to infants before they are developmentally ready for them; this readiness occurs in most infants between 4 and 6 months of age
- Infants fed complementary food before they are developmentally ready for them may:
 - Choke on the food
 - Consume less than the appropriate amount of breast milk
 - Develop food allergies
- Developmental signs an infant is ready to consume complementary foods include:
 - Sits up, alone or with support
 - Holds his head steady and straight
 - Opens his mouth when he sees food coming
 - Keeps food in his mouth and swallows it rather than pushing it back out
- Discuss introducing complementary foods with mother
- Discuss with mother the developmental signs indicating an infant's readiness for complementary foods
- Discuss reasons mother should not introduce complementary foods to her infant before he is developmentally ready for them
- Discuss the importance of oral health for all infants, including breastfed infants. Advise mother to cleanse infant's gums and teeth after feedings

POSTPARTUM (6-12 months) Follow-up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

*Breastfeeding is the optimal infant feeding method

- **AAP recommends** breastfeeding as the preferred feeding for all infants
- Breastfeeding has various health, emotional, and economical benefits for a mother and her infant
- A mother's breast milk has the perfect combination of nutrients needed for her infant's growth and development
- Discuss the various benefits of breastfeeding with mother for her infant as well as herself
- Discuss the advantages of breastfeeding versus feeding infant formula
- Encourage mother to continue the breastfeeding relationship at least through the first 12 months of age

*Breastfeeding can continue when returning back to work or school

- Many mothers need or want to return to work or school outside their home shortly after their infant's birth
- Mothers who are temporarily separated from their infants can continue to breastfeed successfully
- Discuss strategies mother can use which may improve her ability to continue breastfeeding when she returns to work or school and must be separated from her infant such as:
 - Breastfeed the infant when home and express breast milk by hand or by using a breast pump
 - Make arrangements for safely storing expressed breast milk while away from home
 - Choose a babysitter or day care center that is supportive of breastfeeding
 - Introduce infant to drinking from a bottle and to being fed by someone else
 - Breastfeed regularly on weekends and evenings

****Maternal nutrition supports breastfeeding***

- Breastfeeding mothers need to maintain a balanced diet; however, her milk will provide all the nutrients her infant needs if her diet is not perfect.
- Discuss recommendations for breastfeeding moms on making healthy food choices with regular physical activity. Refer to: <http://www.nal.usda.gov/wicworks/Topics/BreastfeedingFactSheet.pdf>

POSTPARTUM (6-12 months) Follow- up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Emphasize that the additional foods provided in WIC food packages for breastfeeding mothers supplement their special nutritional needs
- Advise mother that breastfeeding women who do not accept formula from WIC receive the largest quantity and variety of foods

*Recognize hunger and satiety cues and feed often and on demand

- **As an infant grows older, they breastfeed more efficiently, and the frequency and duration of feedings may decrease**
- Discuss infant feeding patterns with mother
- Encourage mother to breastfeed often and using infant feeding cues and avoid scheduling feedings
- Discuss the importance of recognizing feeding cues

*Introducing solids/complementary foods

- Developmental signs an infant is ready to consume complementary foods include:
 - Sits up, alone or with support
 - Holds his head steady and straight
 - Opens his mouth when he sees food coming
 - Keeps food in his mouth and swallows it rather than pushing it back out
- When introducing infants to complementary foods, caregivers should follow these guidelines:
 - Introduce one “single-ingredient” new food at a time
 - Allow at least 3-5 days between introducing each new food
 - Introduce a small amount (e.g., about 1 to 2 teaspoons) of a new food at first
 - observe the infant closely for adverse reactions
- Discuss introducing complementary foods with mother
- Discuss with mother the developmental signs indicating an infant’s readiness for complementary foods
- Discuss the importance of oral health for all infants, including breastfed infants. Advise mother to cleanse the gums and teeth after feedings
- Recommend that mother continue gradually introducing of a greater variety of complementary foods

POSTPARTUM (6-12 months) Follow- up visit or BFPC contact

What Mothers Should Know: Counseling Points/Action Steps for WIC Staff

- Advise mother that WIC provides infant cereal and infant (baby) food fruits and vegetables to infants at 6 months of age. Fully breastfed infants receive the greatest quantity and variety of infant fruits and vegetables
- Advise mother that in addition to infant (baby) food fruits and vegetables, fully breastfed infants also receive infant (baby) food meats at 6 months of age. Infant (baby) food meats provide iron and zinc, essential nutrients for all healthy infants, and are special nutrients of concern for exclusively breastfed infants

*Appetite/Growth Spurts and Adequate milk supply

- Appetite or growth spurts are short periods of time when the infant breastfeed more frequently than normal
- Usually occurs around 6 months of age; however, the time period an infant goes through an appetite spurt may vary
- Reassure mother about their milk supply. A mother may feel that she has an insufficient milk supply, but during these periods of frequent feeding the infant is signaling the mother's body to produce more milk to meet his growing needs
- Encourage the mother to keep the infant at the breast as often as the infant demands to feed during this period
- Assure mother that her milk supply will quickly increase with her infant's demand and soon her infant's feeding routine will return to normal
- Praise mother for her breastfeeding efforts and encourage her to continue breastfeeding her infant
- If a mother expresses concern that an appetite spurt lasts longer than a few days, refer her to a DBE, lactation professional, or her HCP

*Weaning

- The AAP recommends that breastfeeding be continued through at least through the first 12 months of age and for as long after as is mutually desired by the mother and child
- The weaning process begins in part when complementary foods are introduced and the infant begins breastfeeding less frequently
- If a mother is beginning to wean, she should be encouraged to do so slowly. A mother can partially wean by continuing to breastfeed several times during the day
- Infants less than one year of age who are no longer breastfeeding need to receive iron-fortified infant formula

GUIDELINES FOR ISSUING PUMPS AND BREASTFEEDING SUPPLIES

Policy:

Since a major goal of the WIC Program is to improve the nutritional status of infants, WIC mothers are encouraged to breastfeed their infants, unless medically contraindicated. Breastfeeding mothers may receive breast pumps and other aides to help support the initiation and continuation of breastfeeding.

Implementation Procedures for Pumps:

How to Assess the Need for a WIC Breastfeeding Aid and Where to Document

CPAs determine through a VENA breastfeeding assessment the appropriateness of any pump or breastfeeding aid based on individualized need of the mother and infant breastfeeding dyad. Manual and electric pumps are FDA regulated medical devices. Improper use of a pump can cause physical trauma to the breast. The CPA considers the participant's level of understanding and ability to follow both oral and written instructions on pump operation as part of the overall breastfeeding assessment. If she is using an older breast pump from a previous breastfeeding experience the pump may now lack adequate suction and disappointing breastmilk expression volume. The CPA will need to assess the pump using the Breastfeeding Assessment, Promotion, Counseling and Support in the WIC Postpartum Record.

Assessing previously used pump:

- Encourage the mother to contact the breast pump manufacture regarding replacing worn pump parts-tubing, filters, valves, and to determine if it is a single or multi user pump
- Encourage the mother to inspect the pump looking for moisture and possible mold
- Evaluate the suction using the breast pump pressure gauge

For each breastfeeding aid issued, CPA should clearly state in the certification BF assessment (page 2 on the WIC Postpartum Record) the participant's BF problem or concern. (Any information gathered by the CPA while reviewing the Questionnaire can be briefly documented there too if needed.) Through the CPA's VENA assessment, recommending and providing a breastfeeding aid to a participant becomes part of the individualized education plan to resolve that nutrition/breastfeeding problem identified.

BFPCs can assist the CPA in information gathering for both manual and electric pump issuance. The BFPC can complete Sections A and C in the WIC Postpartum Record-Breastfeeding Assessment, Promotion, Counseling and Support. However, the CPA/DBE must complete Section B. The CPAs can record any additional written information on page 3 or 4 of the WIC record. BFPCs record any additional written information concerning the need for a pump or aid on the Peer Counselor Contact Log.

The CPA reviews this documentation before completing the assessment for the pump or aid. Once the CPA approves appropriateness, if a BFPC is present in the clinic on the day of the

pump or aid assessment, the CPA can ask the BFPC to instruct the mother on the use of the pump or aid and to issue the device. The BFPC can also provide phone follow-up in the days immediately after issuance to assure mom is using the device correctly and the device is solving the issue or concern prompting the device need. If a BFPC is not assigned to the clinic, the CPA should make every effort to contact the mom by phone within a few days to assure that the mother has no questions or concerns about using the device.

Documentation for reassessments to extend electric pump loan (or for a new assessment when a different type of pump is needed) is made by the CPA on the back page of the Postpartum WIC Record under Additional Notes/Comments. If a BFPC is gathering information for pump reassessment, her notes are recorded on the Peer Counselor Contact Log for review by the CPA.

Who Can Issue Pumps to Participants

All CPAs must have pump competency training and be able to issue a pump at the time and the day the pump assessment takes place. Mechanical operation of both manual and electric pumps varies with each manufacturer. It is the responsibility of the Regional BF Coordinator to assure CPAs receive timely pump competency training for all models of pumps used by TN WIC. As appropriate for the clinic, if a BFPC is assigned to the clinic, she can be trained on pump issuance.

Time Table for Issuing Pumps to Participants

Postponing pump issuance until another CPA returns to the clinic or until the BFPC's next working day at that clinic only serves to undermine the mother's breastfeeding efforts. When a mother contacts the clinic to request a pump or breastfeeding aid, every effort should be made to work her into the clinic's schedule as quickly as possible for assessment. All clinics must maintain an on-site clinic inventory of at least one or more manual and electric pumps and the corresponding kits based on the clinic's size and pump usage pattern.

Non-returnable and Loaned Breast Pumps

All manual breast pumps are single-user only and must never be shared, given away or sold by the participant. If a mother has been issued a WIC manual pump or a single-user electric pump within 2 years of current request, document why a new pump is needed.

As of October 1, 2012 all electric pumps for WIC clinic issuance are loaner pumps. All electric pumps are loaned to match the anticipated time frame based assessed pump use. For example, if the need is based on an acute short term medical issue with infant or mother, issuance may be needed for only a couple weeks or one month. For premature hospitalized infants, pumping may be necessary only for the duration of the hospitalization and with anticipation the infant will acquire the physical skills to feed at the breast before released as an inpatient.

Inform participants at electric pump issuance that pumps are loaned for no longer than **3 months** at a time, before pump need is reassessed and the loan extended if qualifying need still exists. With rare exception (requiring Regional BF Coordinator to contact Central Office for approval), all electric loaner pumps are issued only to a fully breastfeeding mother/infant dyad and must be returned to WIC when infant is changed to a partially BF status or the infant certification status ends. Central Office strongly encourages WIC staff to inform participant's to bring their loaned pump with them at all returned visits. This allows staff

opportunity to check pump operation should there be a question during the visit. It also allows for return of the pump should the circumstances for issuance no longer exist. Always issue the corresponding personal use pump kit with electric pump issuance.

Participants Failure to return Loaner Pumps

If there are unsuccessful loaner breast pump follow ups such as BF mothers returning into clinic without the loaner breast pump, the following steps may occur:

1. Make a telephone call to all the contact numbers on file.
2. Put a message on the WICQ screen to flag the account.
3. Mail out a follow up letter (please see below)
4. If the pump is lost or stolen, the participant can pay for the pump at contract cost of \$115.00 (make payment arrangements if necessary).

If the pump cannot be found note it on the inventory log, inform the Regional BF Coordinator, and notify Central Office.

Sample participant letter requesting return of loaner pump

(use clinic or Region letterhead)

Date_____

Dear_____:

You were issued an electric loaner pump to assist you with breastfeeding your infant on (date). You signed the release form and are responsible for the return of the breast pump in good condition. If you do not return the pump, you are abusing the WIC Program. You/ your child are also in danger of being disqualified from participating in the Tennessee WIC Program for up to one year.

Please contact (name of staff you want contacted) at (phone number) immediately to arrange the return of the pump or to arrange payment for the breast pump. If we do not hear from you within 30 days of this letter, we will begin the disqualification process for (participant and infant's names).

Sincerely,

(Name and title of staff)

Issuance of WIC Pumps to WIC Mothers of Hospitalized Newborns

If a premature infant of a mother who was a WIC prenatal requires a loaner pump before her recertification as a postpartum mother, the pump can only be issued through the end of her prenatal certification. At the time of the postpartum certification, pump need is reassessed and if qualifying needs still exist, pump issuance can be extended as described above.

If a mother was on WIC prenatally and a breast pump is requested by a mother of a premature or hospitalized infant prior to her postpartum certification, the CPA uses Sections A-C on the WIC Postpartum Record to record VENA breastfeeding pump assessment data. The CPA assesses both the woman and infant dyad, then using the Additional Notes/Comments Section on the last page of the form, documents the assessed nutritional status (fully breastfeeding) and risk; designs appropriate breastfeeding education; and tailors the fully breastfeeding food package for the mother. The BFPC can issue the breast pump, however, she must record any necessary additional notes on the Breastfeeding Peer Counselor Contact Log for the CPA to review. BFPCs cannot deliver a pump to a mother during a home visit or hospital visit unless the CPA is present to complete the VENA pump Assessment during the home or hospital visit.”

While status in PTBMIS for a WIC prenatal cannot be changed until postpartum certification, the system will allow issuance of the fully breastfeeding food package and the CPA must document in the chart the change of status prior to pump issuance. If the mother does not have her prenatal vouchers in hand to make the exchange the day of pump issuance, the CPA can issue the pump and PBF voucher to upgrade the mother to FBF status. Remember the CPA must document the assessment and status change on the day of pump issuance. Pumps cannot be loaned beyond the 6 week post deliver extension of prenatal certification. At the postpartum certification, if the mother is still fully breastfeeding, the need for loaner pump is reassessed and issuance can be extended unless there is a change in her status.

The BFPC must record any necessary additional notes on the Peer Counselor Contact Log for CPA review. BFPCs cannot deliver a pump to a mother during a home visit or hospital visit unless the CPA is present to complete the VENA Pump Assessment during the home or hospital visit.

Participant Instructions on the Operation of Manual and Electric Pumps

Since breast pumps are FDA regulated medical devices, participant understanding of the operation of the device is essential to assure product effectiveness and to prevent participant injury.

Instructing a participant on the operation of a breast pumps must include demonstration of an assembly and disassembly of the pump itself and the milk collection kit. A breast model or photos for proper use of the pump at the breast is also reviewed. All participants are asked to demonstrate assembly and disassembly of the pump at the end of the instruction to assure participant understanding and mastery of the skills. This provides opportunities for participants to ask questions and for staff to affirm the participant on their newly learned skills. Tips for successful pumping, including stimulating let-down and for pumping away from home can be discussed.

Participant Instructions for Cleaning Pumps at Home

Each pump manufacturer has guidelines for sanitizing and cleaning pump and milk collection parts that are unique to their pump. Participant training must include both verbal and written instructions for cleaning the pump at home.

Participant Instruction for Safe Handling and Storage of Human Milk

There are several readily available resources that can be used by staff to instruct participants on proper handling and storage of pumped breast milk. USDA's *Infant Nutrition and Feeding Guide* offer guidelines, and the CDC also provide a downloadable handling and storage handout See *BF Concerns* ([Appendix 6-65](#)).

Each of these resources offers slightly different time frames for safely holding breast milk at room temperature, refrigerated, or frozen. Staff should assess the living conditions and life style of the participant and provide them guidelines best suited for their situation See *BF Concerns* ([Appendix 6-65](#)).

Completing the WIC Breast Pump Release (see below)

The "WIC Breast Pump Release (Rev 3/11)" form must be completed for issuance of manual, pedal, and electric multi-user loaner pumps. The Release form is a legal consent document which verifies the participant understands usage and care of the pump as a medical device and the proper collection and storage of breast milk. Participants must read (or be read to) the 5 statements on the Release, sign and date the form. The canary copy must be issued to the participant and the white copy must be placed permanently in the mom's chart. The pink copy is placed in the BF Aids Logbook behind the Log page for that pump. When the CPA completes the monthly inventory of all BF supplies, a list is made of all Pump Release pink copies indicating the pump is overdue so participants can be contacted. Once the pump has been returned, the pink copy is removed from the Logbook.

Planning Participant Follow-up Pump Assistance

It's human nature for a person to be able to repeat a newly learned skill immediately following the instructor's observation and guidance, yet forget essential steps and hints hours later when practicing the skill alone. When a pump is needed to resolve a breastfeeding concern, mom's ability to implement pump operation skills at home is essential to breastfeeding success. Follow-up phone call should be made by the CPA or BFPC to the mother within a week of issuance to answer any questions.

Completing an Encounter for Pump Services Provided

An Encounter is completed by the CPA for the visit using the Breastfeeding PTBMIS Codes for CPA chart found below. If the BFPC assisted the CPA with information gathering and after assessment issued the pump to the participant, she uses the Peer Counselor assigned PTBMIS codes to complete the Encounter.



**WIC BREAST PUMP RELEASE
TENNESSEE DEPARTMENT OF HEALTH-WIC Program**

Check Type of Pump Issued

- Hand Pump/Extractor de leche manual**
Pumping Kit Only
Electric Loaner Pump and Kit _____
 Extractor Electrico y el equipo para extraer
 *Serial Number/Numero de Serie _____
 *Date Due/Fecha para Devolver el Equipo: _____
 *Date Returned/Fecha de Devolucion: _____
 *Date Due Extended: _____

Additional Loaner Pump Info:

Infant's name _____
 Hospital _____
 DOB _____ Wks gestation _____
 Relative or friend (name & phone #)

Participant to read and sign below/Leer y firmar abajo por el participante

- I have been given the breast pump marked above.**
 Acepto que me han dado la pompa electrica para extraer la leche materna marcada arriba.
- The assembly, use and cleaning of the pump have been explained to me and I fully understand how to use and clean it and how to store the breastmilk.**
 He recibido instrucciones para ensamblar, el uso y la impieza de la pompa electrica y entiendo completamente como usaria y limpiarla y como almacenar de manera correcta la lecha materna.
- I understand that this pump is for my use only. I will not give or sell this pump to anyone else or let anyone else use it. Violation constitutes fraud.**
 Entiendo que esta pompa es solamente para mi uso. Yo no dare o vendere esta pompa a nadie y no dejare que nadie mas la use.
- If I have problems with this pump or need help with pumping, I will call the local WIC clinic:** _____
 Si tengo problemas con esta pompa o si necesito ayuda para extraer la lecha materna, llamare a la clinica local de WIC: _____
- If I have been issued an electric loaner pump, I understand that I am responsible for returning the pump clean and in good condition and authorize any agency, institution, organization, place of employment or individual having knowledge of my whereabouts to release this information, including current address and phone number, to the Health Department. Violating the return constitutes fraud.**
 Si me han prestado un extractor de leche tipo EnJoye, entiendo que soy responsable en regresar la pompa limpia y en buenas condiciones y autorizo a cualquier agencia, institucion, organizacion, lugar de empleo o individuo que sepa donde me encuentro de dar o divulgar esta informacion incluyendo mi direccion y telefono actuales al Departamento de Salud.

Affix patient label or complete information below:

_____ Date _____
WIC participant signature/Date: Firma del participante de WIC/Fecha

WIC participant name (woman's name)

Street Address/Direccion

Participant Date of Birth/chart number

Phone number(s): Home and Work/ Telefono(s): Casa y Trabajo

Issued by (Employee signature) Date

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 USDA es un proveedor con igualdad de oportunidades.*

White-Patient Record

Canary-WIC Participant

Pink- Local Clinic

PH-3817 (Rev. 10/14) ED# 1000052112

RDA-150

Breastfeeding PTBMIS Codes for CPAs

Procedure	Code	Comments	Pro-gram	RE	Diagnosis	Code	Qty
Breastfeeding Survey	99401 99402	15 minutes 30 minutes	BF	6	Pregnancy	V222	1
Counseling * Used when the participant has a medical chart and the provider has their chart in front of them	99401 99402 99403 99404	15 minutes 30 minutes 45 minutes 60 minutes	BF	6	Dietary Counseling	V653	1
Electric Pump Issuance	10708	Need to add one of the counseling codes listed above with this code	BF	6	Postpartum	V242	1
Manual Pump Issuance	10708M	Need to add one of the counseling codes listed above with this code	BF	6	Postpartum	V242	1
Group Counseling Establish individual encounters for each participant and code group education	99411 99412	Use for up to 30 minutes Use for up to 60 minutes	BF	6	Prenatal	V222	1
					Postpartum	V242	1
Community Service Used when a participant has no medical chart	78059	Use code 78059 in 30 minute increments in the QTY column. Write # of participants in the disposition column of the WIC encounter. Person keying in the encounter will key number of participants in the column on the EN screen.	BF	6	Dietary Counseling -or-	V653	# 30 min Incs
Home Visit-initial	99350H	Change site code to reflect off-site location of visit. Home visits to non-WIC patients should be provided under the HUGS program	BF	6	Dietary Counseling	Z71.3	1
Home Visit-f/up	99349H						
Home Visit-attempted	99348A						

***If the participant has a chart, but the provider does not have the chart available then code 3560 needs to be used on the encounter. Central Office strongly advises to exercise caution when using this code.**

Documenting the Return of a Loaned Pump

When a loaned pump is returned, the CPA documents why the pump is returned in the WIC Record. The white copy of the WIC Pump Release form is updated to show the pump has been returned. An entry is made on the Logbook page for the pump with the date returned and the CPA's signature. The pink copy of the WIC Pump Release form is removed from the Logbook. .

Sanitizing Loaner Pumps

All Electric Loaner breast pumps will be sanitized before being issued to clients. Each time a pump is returned, the employee is responsible for cleaning, sanitizing and proper storage of the pump. Clean your pumps at your earliest convenience so they are clean and ready. Pumps may be spattered with human milk, and also may be contaminated with other personal and environmental microbes and substances.

- Gloves, lab coat and protective glasses or face shield are recommended. Disposable lab coats are very useful.
- Fresh chlorine bleach solution is made daily, as needed. The solution is a 1: 10 ratio, or one part of bleach to nine parts of water. A plastic spray bottle with ounce or millimeter demarcation would be ideal. Label container with contents and date.
- Use a clean laboratory or clinic area and sanitize surfaces when pump care is completed.
- Remove the pump and any other items from the case. Spray the case and pump with the chlorine solution and wipe clean with paper towels to remove debris from surfaces and crevices.
- When clean and air-dried, store the pump in a location away from dust and contamination. Pack the pump case with pamphlets and blank loaner agreement for next use.
- Cavicide wipes may also be used for cleaning pumps.

Safety Concerns about Condition of a Returned Loaner Pump

If you have serious concerns about the electric loaner pump's condition upon return from a participant (example – pump appears to be contaminated on exterior with substance you suspect to be harmful and could have migrated to interior parts), seal the pump in a plastic bag and consult with your Health Department's Environmentalist. If there is any concern that loaning the pump again could expose a participant to harm, contact your Regional BF Coordinator and properly destroy the pump.

Note on the clinic's pump Inventory Log that the pump was destroyed and why. The Regional BF Coordinator will contact Central Office so a replacement pump can be ordered.

Mechanical Failure of Loaned Hygeia Pumps

See Hygeia's Pump Troubleshooting Guide (below). Every Region has one or more pump pressure gauges. If a pump has been checked using the Troubleshooting Guide and you are not sure if pump suction pressure is adequate, contact the Regional BF Coordinator to have the pump checked by the pressure gauge. *USE TROUBLESHOOTING GUIDE BEFORE SHIPPING PUMP BACK TO HYGIEA FOR REPAIR.*

All Hygeia electric multi-user pumps are under warranty for 3 years after date of purchase, which is typically the date the pump arrived at the Regional Office directly from the manufacturer. This date must be recorded on the individual clinic pump Inventory Log page used to sign pumps in or out to participants.

Prior to returning the pump back to Hygeia (see Customer Services contact number on Troubleshooting Guide), do a physical check on the overall condition of the pump. If you suspect pump failure may be due to any on the following conditions, chances are the pump warranty is voided:

- Mishandling by participant dropping it
- Accidentally breaking parts off
- Exposure to liquids that may have leaked into the mechanics or
- Extreme heat that may have melted interior mechanisms

Customer Service will provide you with all additional information on how to ship pumps back for repair. Pumps with a manufacturer defect are repaired free of charge under the warranty. However, should a pump be returned to Hygeia and the technicians find the needed repair is due to mishandling of the pump rather than a manufacturer defect, there is a \$25 charge to return the pump.

Hygeia EnJoye/EnRiche Troubleshooting Guide

The pump will not turn on:

5. Make sure the pump is plugged into a working electrical outlet.
6. Make sure that if the pump has an internal rechargeable battery (EnJoye-LBI), the battery has been charged. If in doubt, plug pump into a working electrical outlet to use.
7. Make sure when using the pump with an external battery pack, that eight (8) AA batteries have been placed inside the battery pack and that they are charged or new batteries. Make sure the batteries are correctly inserted in the battery pack with + and -. **Note:** The external battery pack is NOT rechargeable and only holds standard AA batteries.
8. Make sure if using a car adapter to check your automobile's owner's manual. Some newer car models need to have the ignition turned on or the car may even need to be running in order for the car outlet to be functional.
9. If you are still having trouble please contact Hygeia Customer Care at: (888) 786-7466 extension 1.

There is no/low suction:

10. Make sure the bacteriostatic pump filter is screwed tightly onto the pump and has not gotten wet or damaged in any way. If the filter has gotten wet or damaged, replace with a new filter.
11. If single pumping, make sure the other tubing port on the bacteriostatic pump filter is covered by the attached port cover.
12. Make sure the tubing is not damaged in any way. If tubing is damaged replace with new tubing.
13. Make sure the tubing does not have moisture in it. If moisture is present in the tubing, detach from flange and turn on pump with just the tubing attached, let run for several minutes until moisture is completely gone. Or drip a couple of drops of Iso-propyl Alcohol in each tube to help remove the moisture.
14. Make sure the tubing is securely attached to the bacteriostatic pump filter, as well as the breast flange.
15. Make sure the duckbill valves are placed inside the flange.
16. Make sure the duckbill valves will open by squeezing them. If the duckbill valve does not open it has to be replaced.
17. Make sure there is no visible damage to the duckbill valves like small tears or holes. If they are damaged they have to be replaced.

18. Make sure there is no air leaking out between the breast flange and the breast.
Note: The flange being used may be too large or too small for your breast size. If so, please purchase flanges that fit your breast.
19. Make sure the strength regulator has been slowly increased clock wise to a higher, comfortable setting.
20. Make sure the speed regulator has been slowly increased clock wise to a higher, comfortable setting.
21. Try single pumping, if the suction is strong enough to single pump but not to double pump there might be a problem with one of the Personal Accessory Set pieces. To determine which piece may need to be replaced do the following:
 - Unscrew bacteriostatic filter from pump by turning it counter clock wise.
 - Set the strength regulator to the highest setting.
 - Turn on pump by turning the speed regulator to the highest setting.
 - Place finger lightly over filter port on pump, if the pump has suction the motor will slow down and sound labored or may even shut off completely. This indicates the pump is working properly, remove your fingers from the filter port, and continue to next step. If the pump does not slow down or sound labored please contact Hygeia Customer Care at (888) 786-7466 extension 1.
 - Turn off pump and replace the bacteriostatic filter only by screwing it on clock wise and leaving both ports uncovered.
 - Turn on pump and turn the speed and strength regulators to the highest settings. Place fingers tightly over both filter ports; if the pump slows down and sounds labored remove fingers and continue to next step. If the pump does not slow down or sound labored please contact Hygeia Customer Care at (888) 786-7466 extension 1.
 - Cover one of the ports with the attached cover while the pump is still turned on and the strength and speed are at the highest settings, place finger tightly over open port; if pump slows down and sounds labored the filter is working properly. Turn off pump and continue to next step. If the pump does not slow down or sound labored please contact Hygeia Customer Care at (888) 786-7466 extension 1.
 - Attach 1 tube, 1 flange with duckbill valve and 1 bottle as if single pumping making sure all the connections are secure and tight. **DO NOT PLACE ON BREAST TO TROUBLESHOOT!**
 - Turn on pump and turn the speed and strength regulators to the highest settings. **DO NOT PLACE ON BREAST TO TROUBLESHOOT!** Place the Flange either on your cheek, upper arm, stomach or thigh tightly so that a vacuum can be created. If suction can be noticeably felt and the flesh is visibly pulled into the flange, turn off pump and continue to next step.
 - Detach the working single pumping accessories and attach the remaining 1 tube, 1 flange with duckbill valve and 1 bottle, repeat above step with the speed and the strength set to highest setting. **DO NOT PLACE ON BREAST TO TROUBLESHOOT!** If suction is not noticeable, remove the most recently used accessories from the filter and reattach the previously used accessories determined to be in working order. First change the duckbill valve only, repeat single pumping step. If suction is noticeable continue to next step, if suction is not noticeable please exchange duckbill valve for a new valve.

- Exchange the flange, repeat single pumping test with the speed and the strength set to highest setting. **DO NOT PLACE ON BREAST TO TROUBLESHOOT!** If this does not show adequate suction replace flange with a new flange. If it works continue to next step.
- Exchange tubing and repeat single pumping test with the speed and the strength set to highest setting. **DO NOT PLACE ON BREAST TO TROUBLESHOOT!** If suction is not noticeable, replace tubing with new tubing. If it is found to be working properly after having checked everything separately but the suction is still inadequate when double pumping, please contact
- Hygeia Customer Care at (888) 786-7466 extension 1.
- If you are still having trouble please contact Hygeia Customer Care at (888) 786-7466 extension 1.

Guidelines for Issuing a Supplemental Nursing System

A supplemental nursing system is a feeding device with tubing that attaches to the breast and used to provide the infant supplemental nourishment while breastfeeding. The SNS provides additional nourishment to the infant at the breast and is useful for infants with a weak or inadequate suck and as an aide in building a mother's milk supply.

Policy: Supplemental nursing systems are used under the consultation of the infant's health care provider. In TN WIC, only a nurse, RD, or IBCLC who have been trained on the device are authorized to issue a SNS. When a SNS is needed, immediately contact the State WIC BF Coordinator to order a reusable or for daily-use-only SNS.

Instructions for Completing the Breastfeeding Aids Log Purpose:

The **Breastfeeding Aids Log** records breastfeeding aids (manual pumps, pump kits, breast shells, breast pads, etc. **non-returnable items**) received in the clinic and distributed to WIC breastfeeding women. The form should be used whenever a breastfeeding aid is received or issued. Use a separate sheet for each type of breastfeeding aid.

Maintain a separate log page for each loaner pump by model number. Please refer to **Electric Loaner Breast Pump Inventory Log**. This will help track how frequently the pump has been used. The log sheets should be reviewed monthly by the DBE or clinic CPA to assure pumps that are no longer in use by a mother has been returned to the clinic. A monthly physical count of each breastfeeding aid item is completed monthly by a clinic CPA. The quantity on hand on of each aid the last day of the month is recorded by the CPA on the electronic (this is optional for the Regional Breastfeeding Coordinator to create) County Monthly Breastfeeding Aids Inventory Excel Spreadsheet. However, the Regional Breastfeeding Coordinator must create a form to tally up the inventory for the region. County Monthly Breastfeeding Aids Inventory Excel Spreadsheet. In counties with more than one clinic site, the spreadsheet must be named for the individual clinic site within the county. The need for any particular breastfeeding aid can vary from month to month at clinic sites. Sometimes excess aids at one clinic site will need to be moved within a month to another clinic location within the region or within the state. It is essential for the state management of breastfeeding aids for the Region and Central Office to know the location of breastfeeding aids on any given day/month.

The hand-counted monthly tally of each item must match the number recorded on the item's Breastfeeding Aid Log page. If the count does not match the number recorded on the Log page, both the clinic nursing supervisor and office manager must be notified. An explanation must be recorded on the Log page, signed by the CPA who counted the inventory and initialed by the nursing supervisor. If the nursing supervisor is the CPA counting the inventory, the explanation is initialed by the office manager or county director.

Inventory Management of Breastfeeding Aids

(Regional Breastfeeding Coordinator)

Policy:

1. Accountability of each breastfeeding aid item must be continuously maintained by the Regional Office to accurately reflect the date and number of each item delivered to the Regional Office and inventoried prior to distribution; the date and number of each item distributed to a named clinic. Any breastfeeding aids retained on inventory at the Regional Office must be manually counted each month by the BF Coordinator to verify supply accuracy.
2. Accountability of each breastfeeding aid item must be continuously maintain by each clinic site in the Region to accurately reflect the date and number of each item delivered from the Regional Office or transferred from another clinic and inventoried prior to distribution; the date and number of each item issued to a named participant. An inventory of each breastfeeding aid item is manually counted by a CPA at the end each month and recorded on the County Monthly Breastfeeding Aid Inventory which is created by the Regional Breastfeeding Coordinator. The Clinic CPA sends the updated County Monthly Breastfeeding Aid Inventory to the Regional BF Coordinator by the 8th day of the following month. If the CPA is unable to complete and the BFPC has free time, then BFPCs can assist with inventory.
3. The Regional Breastfeeding Coordinator tallies each of the County Monthly Breastfeeding Aid Inventory and reports the monthly tallies on the electronic Regional Monthly Breastfeeding Aid Inventory Spreadsheet which is created by Regional Breastfeeding Coordinator. The electronic Regional Monthly Breastfeeding Aid Inventory Excel Spreadsheet is forwarded to Central Office on the following days: January 15th, April 15th, July 15th and October 15th. Central Office determines supply order quantity for the state based on these Excel Inventory Spreadsheets. Orders for new supplies will only be place for regions that submit the electronic Regional Monthly Breastfeeding Aid Inventory on the required dates.

Overview of Breastfeeding Aid Inventory Management

USDA does not assign Breastfeeding Aid inventory management as a role for BFPCs; inventory management is not an approved Activity for BFPCs. As inventory of any supply diminishes report the need to restock to the Regional Breastfeeding Coordinator.

As inventory of any supply diminishes report the need to restock to the Regional Breastfeeding Coordinator.

Breastfeeding aid supplies represent federal dollars (Food Cost dollars for pumps and Breastfeeding WIC dollars for kits and accessory parts) for items issued to WIC mothers to help them feed breastmilk to their WIC infants. Accountability records are maintained by Central Office for all purchase requests, purchases, invoices, and payments for delivered supplies. Every Region is responsible for maintaining a paper trail for each supply item from the time it is delivered to the Region, to the clinic and finally issued to the WIC participant. This paper trail will allow auditors to follow the breastfeeding aids from Purchase Request to participant issuance for compliance accountability throughout the process.

Breastfeeding Aids Log should include (please refer to template):

Region code

County number code

Clinic number code

Item (examples: manual pump, pumping kit)

Brand/Model (example: Hygeia Enjoye pump #)

Date of transaction

Received units- number of units received by health department or returned by participant

Issued- number of units issued to patient

On hand- number of units on hand

Record Participant number

Participant signature for issued

Staff signature for received and issued by

Inventory Date/Initials (Note any discrepancies)

Regional Office and Clinic Mechanics and Filing:

Retain original Log form for 4 years. Regional Offices should log in the total number of each aid received and how many units were distributed to each clinic. The Regional Office records can be maintained electronically.

Types of Breast Pumps and Their Use

Type of Pump	Reason for Request	Examples of Use (Document use in WIC record)
Hand Expression Manual Pump	Convenience	Occasional separation from baby Hand expression is often more effective than manual pump – consider if separation is 1 to 5 times per week Manual is considered if used no more than 8 times per week
Multi-user electric Pump	Twins or multiples	Frequent daily use; reassess need every 3 months Consider if mother needs others to help bottle feed breast milk to one infant at the same time the other is at the breast
Hand expression Manual pump	Minor BF issue or concern	Temporary use to relieve engorgement – consider both methods Inverted or flat nipples
Multi-user electric pump	Medical Need	Mother is fully breastfeeding with medical need or self or infant Frequent daily use Short or longer term medical need To bring in or increase milk supply for premature, sick, hospitalized infants or infant unable to nurse at breast due to muscle weakness To maintain milk supply during medical need Severe feeding problems (cleft lip or palate) Short term to detox newborn Short term for Mother with extremely sore nipples requiring medical treatment/intervention Short term for Mother with severe, recurrent engorgement Mother with feeding difficulties due to breast surgery Mother that is relactating and plans to fully breastfeed long term Issue/reissue every 3 months for long term use, reassess Maintain milk supply during medical treatment

Multi-user electric pump	Work or School	<p>Mother is fully breastfeeding; plans to BF for a few months</p> <p>Mother has established milk supply; baby is 4 weeks old</p> <p>Used 9 or more times per week</p> <p>Separated 30 hours per week including travel time to and from work or school</p> <p>Anticipated separation from baby is 6 or more hours per day.</p> <p>Issue no more than 2 weeks before mother intends to return to work or school once BF is well established</p> <p>Issue/reissue every 3 months for long term use, reassess</p>
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BREASTFEEDING CONCERNS

Information for breastfeeding families

Selecting a Breast Pump



Walk into a baby store and look at the wall of breast pumps. It is hard to make a decision about which one will be effective and comfortable for you! The basic parts of a breast pump will vary from manufacturer to manufacturer. But these are typical.



Flange goes over the breast



Connector



Tubing attaches to a motor on an electric breast pump. In the case of a manually operated pump, a handle would be located here.



Bottle

Breast pumps can remove milk from one breast at a time or both breasts simultaneously. Of course, bilateral pumping cuts the time in half. In addition, it stimulates the hormones of lactation better.

Pumps fall into 4 basic categories:

- Hospital grade - Generally rental pumps used while establishing a milk supply if your infant is premature or ill
- Personal use pumps - Generally used by employed mothers at work
- Battery or small electric pumps - Generally used by employed mothers or for occasional use
- Manually operated breast pumps - Best used for occasional use

Selection criteria

- Purpose
- Age and health of infant
- Comfort
- Availability
- Cost
- Ease of use
- Adjustable suction and frequency
- Adjustable breast flange
- Ease of cleaning
- Universal collection container
- Durability
- Versatile power source
- Portability
- Safety

Resources

FDA Breast Pump Website – Basic information on breast pumps

<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BreastPumps/default.htm>

Breast Pumps Direct – User review of various breast pumps

http://www.breastpumpsdirect.com/breast-pump-reviews_a/183.htm

Breast Pump Comparisons – User reviews of various breast pumps

<http://www.breastpumpcomparisons.com/category/first-years-breast-pump-reviews>

Are Used Breast Pumps a Good Option? Issues to Consider.

<http://www.llli.org/llleaderweb/lv/lvjunjul04p54.html>

Purpose: Is your infant premature, ill or do you need to be separated from your infant for any reason? Select a Hospital grade pump. If you will be working and away from your baby for 8 or more hours, select a personal use pump. If you will be using your pump occasionally, a battery, small electric or manually operated pump will be fine.

Age and health of infant: If your infant is a newborn and your milk supply is not well established, choose a hospital grade or personal use pump.

Comfort: Select a pump that has adjustable suction levels and flanges so you can adjust them to your comfort.

Availability: Breast pumps may be available at your hospital, from your lactation consultant or at your local baby store.

Cost: Pumps range in price from about \$35 to over \$300. Rental pumps range from \$1 to \$5 per day depending on the length of the rental agreement. Purchase or rent the best pump you can afford, it will make a difference!

Ease of use: The pump should come with clear instructions and be easy to figure out. If it is very complicated, you won't end up using it.

Adjustable suction and cycle frequency: You want your pump to mimic the typical suction patterns of a baby at the breast. Therefore the suction range should be adjustable up to about 240 mm Hg and cycle about 48-50 times per minute. Breast pump packages are not labeled with this information at this time.

Durability: What kind of a guarantee does the pump have? Is it likely that you can use it for this baby and for another baby or two?

Adjustable breast flange: Many pumps come with a standard size flange that fits most women. However, if you have very small or very large nipples, you will need a flange that fits you. You can tell the you flange fits you if it completely supports the areola and does not pull any areola into the flange indicating it would be too large. You can tell if the flange is too tight if the nipple is tight in the nipple tunnel, hurts or does not empty the breast completely.

Ease of cleaning: Check the small parts. Is it likely that small, but essential, parts could slip down the sink and be lost? Is the pump easy to reassemble? The pump should be washed with soap and water after each use.

Universal collection container: Most pumps will accept any standard baby bottle and it is convenient to be able to mix and match with any bottles you have handy. Others require their own particular size.

Versatile power source: It is useful that an electric pump can be plugged in, but also could be operated on batteries at other times. In the case of a power outage, you should be able to operate it manually.

Portability: Where will you use your pump? Will there be times you will need to quickly put it in your purse or wear it as a backpack? Or will you always be sitting in a designated pumping room?

Safety: If it is operated by electricity, the pump should be rated by the Underwriters Laboratory as safe. Check to assure it will automatically cut off at suction levels above 240 mm Hg which could damage the breast tissue.

Selected Major Pump Manufacturers

Medela <http://www.medela.us/>

Ameda <http://www.ameda.com/>

Hygeia <http://www.hygeiababy.com/>

Bailey <http://www.baileymed.com/>

Simplisse <http://www.simplisse.com/>

Limerick PJ's Comfort http://www.limerickinc.com/pjs_comfort_breast_pump.php

Information for breastfeeding families



Your Newborn is Crying, Now What?

Try these quick solutions to calm him down

➤ **Hold the baby skin to skin**

Skin to skin contact reduces stress levels for both mother and baby. When the baby is calm, then offer the breast

➤ **Let the baby suck**

Offer a finger (or pacifier) for the baby to suck on for a minute or two. Sucking is a way babies sooth themselves.

➤ **Give a taste**

Hand express milk from the nipple for the baby to taste. Or dribble milk over the nipple to entice him to the breast.

➤ **Provide motion**

Pick the baby up, rock, walk, bounce or dance. Babies are used to constant motion while in the uterus. Providing motion reminds them of “home”.

➤ **Offer swaddling**

Wrap the baby snugly for a few minutes

➤ **Check his skin temperature**

Feel your baby’s tummy and make sure he is not too hot or too cool.

➤ **Stay Calm**

Babies are sensitive to your stress level. Remain calm and your baby may follow suit.

➤ **Reduce the stimulation**

Too much stimulation, for too long, can be over-whelming for babies. Dim the lights, make no sounds and give the baby a break. Sometimes white noise like the sound of a hair dryer helps.

➤ **Burp your baby or bicycle his legs**

Maybe there is a burp that needs to come up or gas that needs to go down.

➤ **Do something different**

If none of these solutions work, distract your baby with something different. Blow in his face, sing or hum, hold him up over your head or give a bath.

Watch for feeding cues for the next feeding:

- Waking up
- Licking lips & sticking tongue out
- Sucking sounds
- Rooting
- Hand to mouth activity
- Generalized body movements

Feed the baby before the last feeding cue

- Crying

You won’t spoil your baby by attending to his needs

Information for breastfeeding families



Sore Nipples

Tender and sensitive nipples are normal as you begin breastfeeding your new baby. However, very sore, cracked or bleeding nipples are not. Usually this problem is related to the way your baby latches-on to the breast. It is important that your baby get a big "mouthful" of the nipple and areola.

Positioning

1. Hold your baby's head behind his ears



2. Align him "nose to nipple"



3. Roll him "belly to belly"



Laid back breastfeeding

Recline with your baby "on top". Use pillows to support you and your baby as needed.



This is an excellent position for feeding and may just be the trick to remedy sore nipples.

Cross-cradle hold

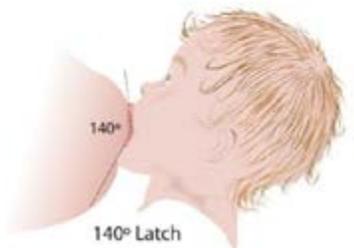
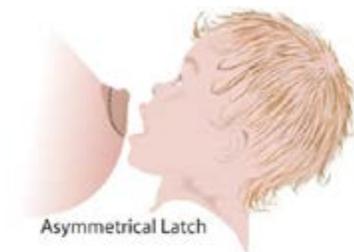


Latch-on

Use a “sandwich hold” to achieve a better latch-on. Gently squeeze the breast to shape it like an oval that fits deeply in your baby’s mouth.



Look for a wide mouth on the breast



If breastfeeding hurts, break the suction and try the latch-on again. Do not continue with a feeding if you experience pain.

Treatment

- ✓ Correct position and latch-on
- ✓ Check wide open 140° wide mouth
- ✓ Apply your expressed breastmilk or purified lanolin to nipples after feeds
- ✓ Use breast shells to protect the nipple



- ✓ Look for a wide mouth on the breast
- ✓ Use hydrogen dressings to speed healing



- ✓ Feed for short, frequent feedings
- ✓ Start on the least sore side
- ✓ Rotate the position of your baby at each feeding
- ✓ If your breasts are very full, hand express some milk, use reverse pressure softening (see handout on engorgement) or use a breast pump

These measures may help you resolve uncomplicated problems with sore nipples. There are circumstances where sore nipples indicate a more severe problem. Please seek help if your problem does not resolve quickly.

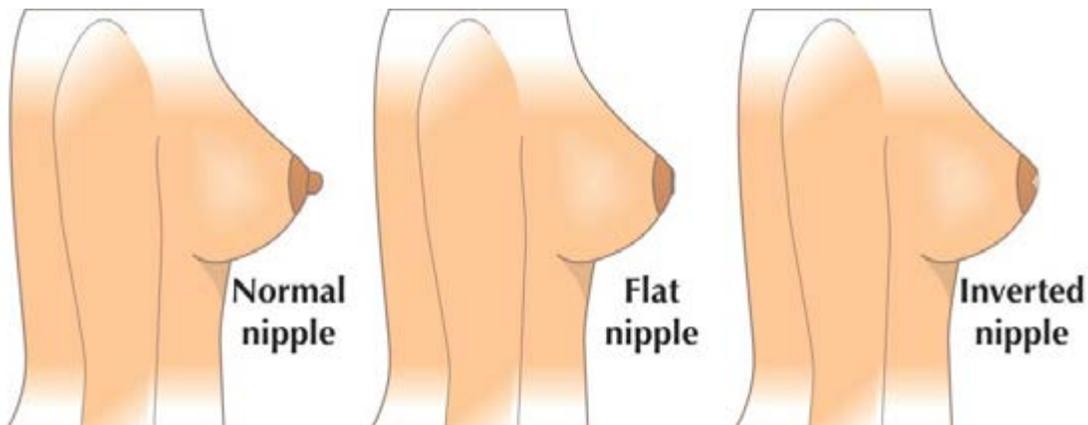
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Information for breastfeeding families

Do I Have Flat or Inverted Nipples?



Flat or inverted nipples can sometimes be problems when starting to breastfeed. It is a good idea to know your nipple shape before starting to breastfeed. Compare yourself to these examples. Gently squeeze at the edge of the areola to see how your nipples react. There are three basic shapes.



Normal Nipples

These normally shaped nipples are easy for most babies to latch-on to. The nipple is erect at rest or becomes erect when it is stimulated or the mother is chilled. If you gently squeeze at the edge of this nipple it remains everted.



Flat nipples

These nipples can be difficult for an infant to attach to. They are flat and remains flat even when stimulated.

Occasionally lactation consultants recommend the use of breast shells prior to the baby's birth. Regularly gently rolling and pulling the nipple it may help it become more erect. Do not wear breast shells or pull your nipples if you are at risk for preterm delivery.

The use of a breast pump just before feedings will help the nipples become more erect.

Check with your lactation consultant or knowledgeable health care provider to determine solutions that will work best for your situation.



Inverted Nipples

These nipples actually retract at rest or when stimulated. Try gently squeezing at the edge of the areola. Usually these nipples remain inverted.

Occasionally lactation consultants recommend the use of breast shells prior to the baby's birth.

They may suggest a breast pump just before feeding the baby to pull these nipples out for the baby. Check with your lactation consultant or knowledgeable health care provider to determine which solution will be best for your situation.



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Information for breastfeeding families



Plugged Ducts & Mastitis

Plugged Ducts

If you notice a small lump the size of a pea in your breasts, it may be a plugged duct. This occurs when a portion of the breast does not get emptied completely during feedings.

Remedy:

- ✓ Apply a warm compress to the area before feeding
- ✓ Massage the lump towards the nipple during a feeding
- ✓ It may take 2 or 3 feedings for it to completely empty. Position your baby's chin towards the area of the lump. This is where the greatest emptying will occur.
- ✓ If you find a persistent lump that does not respond to these measures, please see your physician. It could be a different problem.

Plugged Nipple Pore

This appears as a small white dot on the tip of the nipple and is usually very painful. It is one milk duct that has become plugged.



Remedy:

- ✓ Soften the plug with a warm compress
- ✓ Massage the nipple beginning near the plug and gradually work your way back following the duct, if you can feel it.
- ✓ In persistent cases, soak the nipple with olive oil on a cotton ball for several hours, then massage the nipple and gently scrape the skin surface while in the shower

Mastitis

This occurs most frequently in mothers who have had a cracked or blistered nipple or who are undergoing a period of stress such as returning to work, participating in holiday activities or experiencing a change in normal daily routine.

Symptoms may include:

- High fever, starting suddenly
- Hot, reddened area
- Red streaks
- Pain and a lump in the breast
- Hard wedge shaped area
- Flu like symptoms chills
- Extreme tiredness



Remedy

- ✓ Apply warm compresses before feedings
- ✓ Gently massage the area
- ✓ Keep your breast empty by frequent nursing
- ✓ Continue to breastfeed, even on the affected side
- ✓ If your baby does not empty that side well, use a good quality breast pump after feedings
- ✓ Apply ice after feedings for 10 - 15 minutes for the first day or two.
- ✓ Rest in bed as much as you can
- ✓ Drink plenty of fluids.

Your physician, usually your obstetrician or family doctor, will prescribe an antibiotic. You must take a full 7 -10 day course of medication. Do not stop taking it until the prescription is gone even though you start to feel better. Inadequately treated mastitis is more likely to return.

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Information for breastfeeding families

Is My Baby Getting Enough?



Often, a new parent's biggest concern is about how much and how often the baby breastfeeds.

Here are some guidelines to help you know if your baby is getting enough:

- ✓ Your newborn baby should nurse 8 - 12 times in 24 hours during the first 2 - 3 weeks. As your baby gets older he will become more efficient and feedings may be less frequent.
- ✓ Some feedings may be close together, even an hour or so apart. Other feedings will be less frequent. Feedings do not need to be evenly spaced and are often irregular in the newborn baby. Wake your baby if he doesn't awaken to feed within 3 hours during the day. Night time feedings can be less frequent.

Typical patterns for wet diapers is

- 1 wet diaper on day one
- 2 wet diapers on day two
- 3 wet diapers on day three
- 4 wet diapers on day four
- 5 wet diapers on day five
- 6 wet diapers on day six and from then on.

Look for light yellow to clear urine.

Typical patterns for stools is several per day

- Day 1 Meconium (dark & tarry)
 - Day 2 Brownish
 - Day 3 Brownish yellow
 - Day 4 Dark yellow, soft
 - Day 5 Yellow, semi-liquid
- Some newborns stool after every feeding. Stools taper off and may not even occur every day as your baby gets older.

Babies generally lose a little weight in the first few days after birth and then begin to gain. This is a normal pattern. Ten percent is considered the maximum acceptable weight loss. Have your baby's weight checked a couple of times during the first 2 weeks, especially if you are concerned that your baby is not eating enough. A check of his weight is the only sure way to determine adequate intake. Once your baby has regained his birth weight, at about 2 weeks, you can relax and let your baby set the pace for the feedings.

Sometimes, babies seem to take a good feeding at the breast but wake within a few minutes wanting more. Offer the breast again. It will likely be a short feed "top off" feeding and your baby will drop off to sleep.

Is My Baby Getting Enough?

<p>Signs of hunger</p> <ul style="list-style-type: none"> Rooting Mouthing movements Tense appearance Grunting, other sounds Hand-to-mouth activity Kicking, waving arms Crying 	<p>Signs of a good latch-on</p> <ul style="list-style-type: none"> Relatively comfortable, latch-on pain subsides quickly Lips at the breast at least 140° angle or greater All or most of the areola in the baby's mouth with more areola covered from the area near his chin (asymmetrical latch-on) Lips flanged (rolled out)
<p>Signs the Baby is Full</p> <ul style="list-style-type: none"> Drowsiness, sleepiness Baby comes off the breast spontaneously Relaxed appearance Hands and shoulders are relaxed Sleeps for a period of time before arousing to feed again 	<p>Signs of a good feeding</p> <ul style="list-style-type: none"> Easy latch-on, stays latched-on Swallowing you can hear Noticing that the breasts are softer after feedings Feeling strong, deep, "pulling", sucking Seeing milk in your baby's mouth Leaking from the other breast or feeling of a "let-down" reflex 15 - 20 minutes vigorous sucking on each breast or 20 – 30 minutes on one side Wide jaw movements and consistent sucking

Please see the advice of a Lactation Consultant or a physician if:

1. Your baby has not begun to gain weight by his fifth day after birth or has not regained his birth weight by 2 weeks
2. Your baby is not voiding at least 6 - 8 times per day
3. Your baby is not having several stools per day

These signs can indicate inadequate feedings and can become a serious concern if not corrected quickly. You may wish to keep a written record of when your baby voids, stools and feeds for a few days so you can accurately report this to your health care provider. Please seek help if your problem does not resolve quickly.

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It's only natural

mother's love. mother's milk.



Cross Cradle Hold



Breastfeeding takes patience and practice at first. With the right support and information you can make it work.

Simple steps to breastfeeding success

Position yourself comfortably

- Sit up in bed, in a comfortable chair, or in a rocking chair (unless you are side-lying).
- You can use pillows to support your back and arms while you hold your baby.
- Relax your muscles and get comfortable.

Football Hold



Position your baby

- Hold your baby lying on his/her side with his/her body facing you.
- Hold your baby at the level of your nipple so that you're not leaning forward. Using the pillow on your lap will help.
- Use your hand to form a "U" around the darker part of your breast (areola) and offer your breast to the baby. Your thumb should be in line with the baby's nose, with the rest of your fingers on the other side of your breast.
- Your baby's head should be tilted back slightly to make it easy to suck and swallow.
- As shown here, there are several types of holding positions you can try to find the one that is right for you.
- Remember that making sure both you and your baby are comfortable is important to breastfeeding success.
- You can find more information about positioning and feeding your baby at www.womenshealth.gov/ItsOnlyNatural

Side-lying



Cradle Hold



Help your baby to latch properly

- Tickle the lips so your baby opens wide. Some women feel a pinch at first. However, if it lasts longer, your baby may not be latched correctly.
- Pull your baby close so the chin and lower jaw move into your breast first.
- Put the lower lip as far from the base of the nipple as possible, so your baby takes a large mouthful of breast.
- Remember your baby can breathe while at your breast because nostrils open wider to let air in.
- Some babies latch on right away, and some take more time.

Signs of a good latch

- The latch feels comfortable to you.
- Your baby's chest is against your body so the head doesn't need to turn.
- Your baby's mouth is filled with breast.
- You hear or see your baby swallow. For some babies the only sign of swallowing may be a pause in breathing.
- Your baby's ears "wiggle" slightly.
- Your baby's lips turn out, not in.



About It's Only Natural

Breastfeeding provides mothers and their babies with a healthy start. The U.S. Department of Health and Human Services created *It's Only Natural* to offer African American moms the knowledge, help, and support they need to breastfeed. You'll find all this at www.womenshealth.gov/ItsOnlyNatural. Breastfeeding. It's only natural with mother's love, mother's milk.



U.S. Department of Health and Human Services

How to know if your baby is getting enough milk

You may be concerned that you're not making enough milk. But your baby is likely getting more than you think at each feeding. Regardless of your baby's weight, a newborn's stomach is only the size of an almond.



Many babies lose a small amount of weight after birth, so don't be alarmed. Your baby's doctor will check weight at the first visit after you leave the hospital, which should be scheduled 2 to 3 days after birth. After the first few days, typical weight gain is a little less than 1 ounce per day. If he/she is getting enough milk, your baby will:

- Pass enough clear or pale yellow urine. It should not be deep yellow or orange. In the early days, your baby should have at least 1 wet diaper for each day of life (1 on day 1, 2 on day 2, etc.). Once the amount of milk you are making increases (24-72 hours), expect at least, 5-6 wet diapers every 24 hours.
- Have enough bowel movements. In the early days, your baby should have at least 1 dirty diaper for each day of life (1 on day 1, 2 on day 2, etc.). After day 4, expect at least 3-4 stools daily.
- Switch between short sleeping periods and wakeful, alert periods.
- Be satisfied and content right after feedings. (Keep in mind that breast milk digests quickly so babies must eat frequently.)
- Also, your breasts may feel less full after feeding your baby.

Talk to your baby's doctor or a breastfeeding expert if you are concerned that your baby is not getting enough milk before you stop breastfeeding or begin using formula.



Information for breastfeeding families

If your baby refuses your breast



If your newborn has had some bottle or uses a pacifier a lot, he may seem confused, or even refuse to go to the breast. Sometimes babies have difficulty latching-on if your nipples are soft and flat.

Skin to skin holding

Try this several times each day for an hour or two. Not only is skin-to-skin contact great for promoting breastfeeding, it helps enhance your baby's nervous system and is fun to do.

Laid-back breastfeeding

If your baby needs more assistance, try laying back for the feeding. Babies seem to feed better when their tummy is in full contact with the mom.

All you have to do is lean back, find a comfortable position and lay the baby near the breast. When he is ready he will find the breast with little help from you. Watch the video of this "Laid Back Breastfeeding" at <http://www.biologicalnurturing.com/video/bn3clip.html>



Give him a taste

Express a few drops on milk on your nipple or drip some milk over your nipple for your baby to taste. Stroke your baby's lips with your nipple (from nose towards chin) until his mouth opens wide and pull him quickly onto the breast. Encourage your baby softly and calmly.

Sandwich hold

If your nipple is difficult to grasp, roll it gently between your fingers to make it stand out. Make your breast into a "nipple sandwich" by gently compressing behind the edge of the areola. Keep your thumb in line with your baby's nose and your fingers on the opposite side.



Temporary feeding measures

Sometimes lactation consultants recommend additional feedings given in a way that will not compromise breastfeeding, in addition to trying at the breast. It is best not to persist beyond about 10 minutes if your baby is resisting. You want the breast to be a pleasant place for your baby to be, not a battleground. Get advice on alternative feeding methods.

Persistence and patience will remedy this situation. Don't confuse your baby with bottle nipples or pacifiers at this time. After breastfeeding is going well, they can be used. If using these hints doesn't help resolve these problems, make an appointment to see a Lactation Consultant. While you are working on transitioning the baby to the breast, be sure to use a hospital grade breast pump at least 8 times per day to maintain your milk supply. Returning the baby to the breast is always easier if there is an abundant flow of milk available.

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Information for breastfeeding families

Positioning & Latch-on: Baby-led Latching



The way you hold your baby and how he latches-on to the breast, are the keys to comfortable feeding for you and full feedings for your baby. Correct positioning and latch-on can prevent many of the common problems mother's encounter when starting to breastfeed.

Baby-led latching is good for the first feeding and for all feedings after that when the baby is awake and willing to participate.

Getting comfortable

Choose a bed or sofa where you can lean back about half way or more, whatever is comfortable for you.

Positioning your baby

Position the baby between your breasts and allow your baby to wake skin-to-skin. Holding your newborn skin-to-skin is one of the best ways to make breastfeeding easy!

Be Patient

Your baby will gradually realize where he is and that food is nearby! He will slowly begin to move towards the breast. Provide support and assist a bit if it seems necessary, but avoid directing the baby. Your baby will locate the nipple and latch-on with minimal assistance from you. Let your baby lead the way.



This baby located the breast and latched on independently



Importance of Skin to Skin contact

Babies tend to feed best when they have direct contact with mother, in skin-to-skin contact. Not only does it keep baby warm, the smells and feel of the breast encourage locating the breast and feeding

Mix & Match Techniques

You may find that the sandwich hold would help your baby get a deeper latch-on the breast. Place thumb near the baby's nose and fingers on the opposite side of the breast, and gently compress the breast into a "sandwich". Listen for swallows to assure that your baby is drinking milk.

Feel free to use any of the Mother-led Latching techniques from the handout "Mother-led Latching" if they seem to work better at the time.

If you find breastfeeding painful or your baby is not gaining weight (3/4 to 1 oz per day), please seek the help of a lactation consultant to give you personalized guidance.

Although breastfeeding is natural, it is a learning process for both you and your baby. Allow yourself several weeks to perfect these techniques.

At any time that you are unsure that you are feeding correctly, seek the help of a lactation consultant or other knowledgeable health care provider. Once breastfeeding is fully established, it can be one of the most rewarding experiences of new motherhood.

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Sandwich hold

Information for breastfeeding families

Positioning & Latch-on: Mother-led Latching



The way you hold your baby and how he latches-on to the breast, are the keys to comfortable feeding for you and full feedings for your baby. Correct positioning and latch-on can prevent many of the common problems mother's encounter when starting to breastfeed.

Mother-led latching is good for any time the baby needs additional assistance, is too sleepy to latch spontaneously or you have sore nipples.

Getting comfortable

Choose a comfortable chair or sofa with good support for your back. Use a footstool to bring your knees up so your lap is slightly inclined and the pressure is off the small of your back. Position pillows where ever needed to support your arms and relax your shoulders.



Look for a straight line from the baby's ear to the shoulder to the hips. His head should not be tipped back or on his chest.

Positioning your baby

With any position you choose to hold your baby, turn your baby completely onto his side, "tummy to tummy", so his mouth is directly in front of the breast and he does not need to turn his head at all to get to the nipple.

Position your baby with his nose to your nipple so he has to "reach up" slightly to grasp the nipple. His chin should touch the breast first, then grasp the nipple.



Place your baby's lower arm around your waist. This will draw him close to you. Look for a straight line from your baby's ears, to shoulders, to hips. His legs should curl around your waist.

Basic positions for breastfeeding

Beginner's Positions
(first few days or weeks)
Cross Cradle Hold
Football Hold

Advanced Positions
(after the latch-on is easy and quick)
Cradle Hold
Side Lying

The cross-cradle hold is one of the preferred positions for the early days of breastfeeding. You will have good control of the position of your baby's head when you place your hand behind your baby's ears. Roll the baby to face you "belly to belly".



The football hold (clutch hold) is good for mothers who have had a cesarean delivery because the weight of the baby is not on the abdomen. Tuck the baby under your arm with pillow support to place the baby at breast height. Tuck a pillow or rolled receiving blanket under your wrist for support.

Place your baby's head in the bend of your arm or on your forearm and support his body with your arm in the **cradle hold**. Roll the baby towards you "belly to belly".



Side lying is great for getting a bit of rest while your baby nurses or if you want to avoid sitting because of soreness. Notice the pillow support and your back and the baby's back, and between your legs. Roll the baby towards you "belly to belly".



The Cradle hold is great for after the baby is nursing easily and the latch-on is easy. It is the most common position and you will often see this in pictures of breastfeeding mothers. Please wait to use this position until your baby latches easily.



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Latch-on

Compress your areola slightly to make a "nipple sandwich" for the baby. This will allow the baby to get a deeper latch-on. Make sure your fingers are well behind the edges of the areola (1 to 1 ½ " from the base of the nipple). Allow your baby's head to lean back slightly so his chin touches the breast first.



An easy way to remember how to hold your hand is to keep your thumb by your baby's nose and your fingers by the baby's chin. That way you will automatically rotate your hand to match the baby's positioning.

Touch your nipple to the philtrum (the skin between his nose and lips). Your baby will open wide and you can bring him on to the breast. If he doesn't, tickle the philtrum and wait until he opens WIDE (like a yawn) and his tongue comes forward. He should get the nipple and a "big mouthful" of the areola (the dark brown part of the breast) in his mouth. Bring the baby to the breast, not the breast to the baby!

Listen for swallowing every 3 to 5 sucks (May not be apparent until your milk comes in). Once your milk is in you will notice swallowing with every suck.

Let the baby nurse for 15-20 minutes on each breast or 20-30 on one breast. 8 - 12 feedings each 24 hours is normal for a newborn. Refer to the handout "How do I know my baby is getting enough?" for details.

Check your latch-on

Your baby's *chin* should touch the breast, his nose should be free.

Worried that your baby can't breathe while at the breast? Don't! If the baby truly can't breathe, he will let go. Usually, babies can breathe easily even when pressed close to the breast because they can breathe around the "corners" of their noses. Do not press on the breast to make a breathing passage for the baby to breathe. This can distort the shape of the nipple in the baby's mouth and contribute to soreness as well as limit the drainage from the area of the breast above your fingers. If necessary, pull the baby's hips in closer to you. This should free up his nose.

Some mothers describe pain as their baby latches-on that eases as the milk begins to flow. This will subside over time, as your body adapts to breastfeeding. If it persists, remove your baby from the breast and re-attach him. The angle of your baby's lips at the breast is greater than 140 degrees or greater.



Most of the areola is in your baby's mouth and both upper and lower lips are flanged (rolled out). You feel deep pulling sensation as the baby nurses. It should not be sharp pain or last more than a moment during the latch-on.

If you need to remove your baby from the breast, slip your finger between his lips and gums to break the suction. Wait for the suction to release, and remove him.

Information for breastfeeding families



Check List for Essentials of Positioning And Catch-on

Positioning

- ✓ Hold head behind ears
- ✓ Nose to nipple
- ✓ Belly to belly



Offer the breast

- ✓ Sandwich hold
- ✓ Stroke nipple from nose to chin rolling out lower lip
- ✓ Bring baby to breast, not breast to baby



Check the latch-on

- ✓ Flanged lips, open mouth to 140o
- ✓ No pain, no wedged or creased nipple
- ✓ Chin touching breast, asymmetrical latch-on



Assess milk transfer

- ✓ Wide jaw excursion
- ✓ Consistent sucking
- ✓ Audible swallowing (after milk comes in)

Information for breastfeeding families

Signs of a Good Feeding



A good latch-on is the key to a good feeding. Regardless of the position you hold your baby, the latch-on remains the same.

Signs of a good latch-on

The baby has a deep latch with an angle where the lips meet the breast of at least 140°

Both upper and lower lips are flanged (rolled out)

All or most of your areola is in the baby's mouth (at least 1" from the base of the nipple). More from the bottom of the areola than the top (asymmetrical latch-on).



You are comfortable through the feeding. There may be some "latch-on" pain that subsides quickly.

There is movement in the baby's temples with sucking and the jaw moves up and down an inch or more.

There is slight movement of your breast near the baby's lips.

Signs of a good feeding

Hearing swallowing at least every third suck once the milk comes-in. Seeing milk in the baby's mouth

Consistent sucking with only brief pauses

The breasts are softer after feedings

Appropriate output for age. (1 wet diaper on day 1, 2 wet diapers on day 2, 3 wet diapers on day 3, 6 wet diapers on day 4 and on, and several stools each day)

Feeling strong, deep, "pulling", sucking, no sharp pain

Leaking from the other breast or feeling of a "let-down" reflex or noticing a change in the baby's sucking rhythm from faster to slower

15 - 20 minutes vigorous sucking on each breast or 20 - 30 minutes on one side for a newborn. 5-10 minutes for an older baby

Your baby nurses 8 -12 times per day (24 hour day). Less than 8 or more than 12 is a concern

Your baby latches-on easily with minimal attempts and stays latched-on.

Minimal weight loss during the first few days (<10% of birth weight) and return to birth weight by 2 weeks Lactation Education

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Information for breastfeeding families

Infant Hunger Cues



Babies show several cues in readiness for breastfeeding. Tuning into your baby's cues will make your feeding more successful and satisfying for both your baby and for you.

Your baby does not have to cry to let you know he is hungry. ***Crying is the last hunger cue!***

Awakening
Soft sounds
Mouthing (licking lips, sticking tongue out, licking lips)
Rooting towards the breast (turning the head and opening the mouth)
Hand to mouth activity
Crying beginning softly and gradually growing in intensity



Try to catch your baby's feeding cues early in the cycle – avoid crying – and begin breastfeeding!

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Human Milk Storage Guidelines for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

These guidelines are for healthy full term babies¹

Guidelines are for home use only and not for hospital use.

	Counter top or table	Refrigerator	Freezer with separate door	Deep Freezer
Storage Temperatures *	Up to 77°F ² (25°C)	At or below 40°F ^{2,3,4} (4°C)	0°F ² (-18°C)	At or below -4°F ⁵ (-20°C)
Freshly Pumped / Expressed Human milk	Up to 4 hours ²	Up to 4 days ^{2,3}	Up to 6 months ^{2,3}	Up to 12 months ⁵
Thawed Human Milk	1-2 hours ⁴	Up to 1 day (24 hours) ^{2,4}	Never re-freeze thawed human milk ²⁻⁵	Never re-freeze thawed human milk ²⁻⁵

* Storage times and temperatures may vary for premature or sick babies. Check with your health care provider.

1. Adapted from 7th Edition American Academy of Pediatrics (AAP) Pediatric Nutrition Handbook (2014); 2nd Edition AAP/American College of Obstetricians and Gynecologists (ACOG) Breastfeeding Handbook for Physicians (2014); and Academy of Breastfeeding Medicine (ABM) Clinical Protocol #8 Human Milk Storage Guidelines (2010).
2. 2nd Edition AAP/ACOG Breastfeeding Handbook for Physicians (2014).
3. 7th Edition AAP Pediatric Nutrition Handbook (2014).
4. ABM Clinical Protocol #8 Human Milk Storage Guidelines (2010).
5. CDC Human Milk Storage Guidelines accessed at:
www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm.

Human Milk Storage Guidelines Tips

Collection and Storage

- Wash your hands. Wash bottles and pumping supplies in hot soapy water or in the dishwasher.*
- Human milk can be stored in clean glass or BPA-free** plastic bottles with tight fitting lids. Put the collection date on the container.
- If you are giving the milk to your childcare provider, put your child's name on the container and talk to your childcare provider about storage guidelines for human milk.
- When traveling short periods of time, such as to and from work or school, store your pumped/expressed milk in an insulated cooler bag with frozen ice packs.
- Refer to the Human Milk Storage Guidelines chart for storage time and temperatures of human milk.

-
- *Don't use disposable bottle liners or other plastic bags to store your human milk.*
 - *Don't store milk on the shelves in the door of the refrigerator because the temperature varies due to the frequency of opening and closing the door.*

* Check the manufacture information on whether pump parts can be washed in the dishwasher.

** Bottles with the recycle symbol number 7 indicates that the container may be made of BPA-containing plastic.

Freezing Milk

- Freeze milk in small batches of 2 to 4 ounces.
- Leave an inch or so of space at the top of the container because milk will expand as it freezes.
- Store milk in the back of the freezer. Don't store milk on the shelves of the freezer door.
- Chill freshly pumped milk before adding it to frozen milk.

Thawing and Warming Milk

- Use the oldest stored milk first. Practice FIFO (first in, first out).
- Human milk does not need to be warmed. It can be served room temperature or cold.
- Gently swirl the milk (don't shake it) to mix it, as it is normal for human milk to separate.
Note – If you do warm your milk, test the milk temperature by dropping some on your wrist. It should be comfortably warm.
- Milk may be thawed in several ways, (1) in the refrigerator overnight, (2) under running warm water or (3) in a container of warm water.
- Milk thawed should be used within one hour after it is thawed or placed in the refrigerator. Milk thawed in the refrigerator should be used within one day (24 hours) after it is thawed.
- Discard unused milk left in the bottle within 1-2 hours after the baby is finished feeding.

-
- *Do not microwave human milk. Microwaving breaks down nutrients and creates hot spots, which can burn your baby's mouth.*
 - *Never refreeze thawed human milk even if it had been refrigerated.*

Information for breastfeeding families

Waking a Sleepy Baby



Babies are often sleepy during the first week or so. They may not awaken often enough to feed: remember newborns need to eat 8-12 times per 24 hours. Or once the feeding has begun, they may fall asleep again. Here are a few suggestions for waking your baby. Some work better on certain babies than others. When one quits working, try another.

Stimulate all of your baby's senses

- Hold baby skin-to-skin for 15-30 minutes
- Undress the baby to his diaper to cool him off slightly
- Rub and massage the baby in various places
 - Top of the head
 - Bottom of the feet
 - Up and down the spine
 - Across the belly
 - Up and down the arm
 - The spot right above the belly button
- Change the position of the baby, from cradle hold to football hold and back again
- Do "baby sit-ups". Rock the baby from a sitting to lying position and back again. Rock gently back and forth until the baby's eyes open. *Do not* "jack-knife" the baby (force him forward)
- Talk to the baby. Babies respond to mom's voice
- Try adjusting room lights up for stimulation or down so the baby can comfortably open his eyes

➤ Start to pull the nipple from the baby's mouth (Make sure that this does not result in the baby sucking on just the tip of the nipple. If it does break the suction and re-attach the baby to the breast.)

➤ Change the baby's diaper

➤ Apply a cool washcloth to the baby's head, stomach or back. (Do not let the baby become chilled. Premature infants become chilled more easily than term infants.)

➤ Allow your baby to suck on your finger for a few minutes

➤ Express some breastmilk and place just under your baby's nose. Dribble milk over the nipple while latching-on.

Signs of concern

If your baby is un-arousable after a reasonable amount of time and the use of several techniques, contact your physician.

Feel free to duplicate Lactation Education Resources 2011.

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Information for breastfeeding families

Breastfeeding in the Hospital



Getting the best start, right in the hospital in the first few days of your baby's life, is key to long-term breastfeeding.

Talk to your obstetrician during your pregnancy so he/she is aware of your wishes. Talk to your labor nurse when you arrive at the hospital to assure that she knows your wishes and can help you when the time arrives. Talk to your pediatrician in a prenatal consultation so he/she can follow-up with your ideal plan.

First, ask that your baby be put on your tummy right after delivery

- Hold your baby skin to skin and watch him crawl up to the breast for his first feeding. This may happen from 10 to 40 minutes after birth.
- Keep your baby skin-to-skin until he has fed for the first time.
- Delay the eye treatment, first weight, newborn injections and other procedures that are common right after delivery until the first feeding is finished.

➤ If you give birth by cesarean-section, your partner can hold your baby skin-to-skin until you are able to hold him and breastfeed.

Second, keep your baby right with you at all times (rooming-in)

- If you are moved from the delivery area to the maternity area after the birth is over, hold your baby skin-to-skin during this transfer. Cover you both with blankets.

- Your baby can't breastfeed in the hospital nursery. Keep your baby with you so you can respond easily and quickly every time he shows feeding cues.
- Feed your baby 8-14 times each 24 hour day. It seems like a lot, allow your baby to tell you how hungry he is.
- Look for feeding cues:
 - Waking up, becoming agitated
 - Rooting (turning his head and opening his mouth)
 - Licking, smacking, mouthing movements
 - Sucking on fingers or fist
 - Crying is the last cue, don't wait for that!
- Continue holding your baby skin-to-skin, before feedings, after feedings, whenever your baby is upset.

Avoid unnecessary supplementation

- Feeding right after birth assures that your baby gets a nice big feeding right away. Then offer the breast often.
- If you are unsure your baby is breastfeeding properly, ask for help! Your nurse can give you pointers and if you need more assistance, ask to see the Lactation Consultant.

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Newborn Feeding Log



<p>Day 1</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1</p> <p>Black tarry stools 1</p> <p>Notes:</p>	<p>Day 4</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4</p> <p>Yellow stools 1 2 3</p> <p>Notes:</p>
<p>Day 2</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2</p> <p>Black/brown stools 1 2</p> <p>Notes:</p>	<p>Day 5</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>
<p>Day 3</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3</p> <p>Brown stools 1 2</p> <p>Notes:</p>	<p>Day 6</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>



Newborn Feeding Log

<p>Day 7</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>	<p>Day 10</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>
<p>Day 8</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>	<p>Day 11</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>
<p>Day 9</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>	<p>Day 12</p> <p><i>Circle the hours</i></p> <p>12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11</p> <p>Wet diapers 1 2 3 4 5 6</p> <p>Yellow seedy stools 1 2 3</p> <p>Notes:</p>

HAND EXPRESSION

Information for breastfeeding families

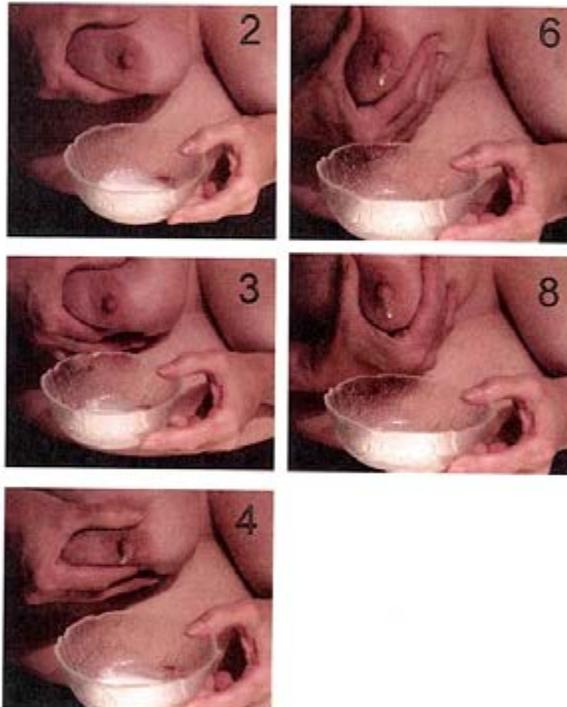
Hand Expression



Hand expression is a handy skill to have whenever you need to empty your breasts and you are not with your baby or your baby is temporarily unable to breastfeed. In the first few days after birth hand expression can be more effective at removing colostrum than using a breast pump. If your baby needs a supplement in the first few, use hand expression to provide the milk he needs!

Hand expression routine:

1. Apply heat, massage, stroke
2. Position fingers behind areola
3. Press back towards chest
4. Roll fingers forward behind areola
5. Express for 5-7 minutes
6. Move fingers around the breast
7. Massage, stoke, shake
8. Express milk for 3-5 minutes
9. Massage, stoke, shake
10. Express milk for 1-2 minutes
11. Complete cycle takes 20-30 minutes



Marmet Technique

***Watch this video while you are hand expressing
to see the technique in action!***

<http://newborns.stanford.edu/Breastfeeding/HandExpression.html>

Provided for you by Lactation Education Resources. May be freely copied and distributed. Please be aware that the information provided is intended solely for general educational and informational purposes only. It is neither intended nor implied to be a substitute for professional medical advice. Always seek the advice of your physician for any questions you may have regarding your or your infant's medical condition. Never disregard professional medical advice or delay in seeking it because of something you have received in this information.

FOOD PACKAGE 6STD

Food Package 6STD is issued to:

Infants of fully **breastfeeding women** do not receive infant formula from WIC. Their infants receive the XBI food instrument through age 5 months; at 6 months their infants receive the fully breastfed infant food package. Women fully breastfeeding *multiple infants from the same pregnancy* receive 1.5 times the supplemental foods provided in Food Package 6STD when food package code **6FBM** is used.

(NOTE: Fully breastfeeding infants should be certified soon after delivery to be counted as WIC participants).

Partially (mostly) **breastfeeding women** who are breastfeeding *multiple infants from the same pregnancy* and whose infants receive formula from WIC in amounts that *do not exceed* the maximum formula allowances for partially breastfed infants. After the first month postpartum, their infants receive the partially breastfed infant food package appropriate to the age of the infant.

(NOTE: women pregnant with two or more fetuses also receive Food Package 6STD)

Food Package 3STD is issued to:

Partially (mostly) **breastfeeding women** who are breastfeeding *singleton* infants up to 12 months of age and whose infants receive formula in amounts that *do not exceed* the maximum formula allowances for partially breastfed infants. After the first month postpartum, their infants receive the partially breastfed infant food package appropriate to the age of the infant.

Food Package 2STD is issued to:

Barely **breastfeeding women** who are breastfeeding at least one time per day singleton infants or multiple infants *who are less than 6 months of age* and their infant(s) receive formula from WIC in amounts that *exceed* the maximum formula allowance for partially breastfed infants. These infants receive the fully formula fed package appropriate to the age of the infant, with the amount of formula tailored to the needs of the infant(s). Barely breastfeeding women receive the same food package as non-breastfeeding women; however, status B counts these women in our overall breastfeeding rate as required by USDA.

No Food Package (BSTD) is issued to:

Barely **breastfeeding women** are breastfeeding at least one time per day singleton infants or multiple infants from same pregnancy *who are greater than 6 months of age* and the infant(s) receive formula from WIC in amounts that *exceed* the maximum formula allowance for partially breastfed infants. Their infants receive the fully formula fed infant food package appropriate to the age of the infant. Status B barely breastfeeding women who are more than 6 months postpartum are counted in our overall breastfeeding and participation rates as required by USDA and continue to receive nutrition counseling services.

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CIVIL RIGHTS

Public Notification

The following nondiscrimination statement must appear on all state or local printed materials for public distribution:

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, religious creed, disability, age, political beliefs, 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

The FNS Instruction 113-1 allows for the use of a shorter version of the statement, in print size no smaller than the text, if the material is too small to permit the full statement. The use of the short statement should be the exception and not the rule.

The full statement must be included on all vital documents such as:

- applications
- notices of eligibility or ineligibility
- expiration of certification notifications
- discontinuance of notifications

All materials and websites that contain the nondiscrimination statement should be updated as soon as possible with the current statement (bolded language above). State and local agencies may deplete their printed supplies of anything that contains the earlier statement; however when materials are reprinted the current statement should be included.¹

For Tennessee participants, the Tennessee Relay Service (TNRS) provides free, statewide assisted telephone service to those with speech, hearing and visual impairments. Dial (800) 848-0298 or for TTY or TB device (800) 848-0299; or (866) 503-0263 (Spanish.)

A civil rights statement is not required to be imprinted on items such as cups, buttons, magnets, and pens that identify the WIC Program, when the size or the configuration make it impractical. In addition, recognizing that radio and television public service announcements are generally short in duration, the nondiscrimination statement does not have to be read in its entirety. Rather, the short version of the statement is sufficient to meet the nondiscrimination requirement. Finally, nutrition education and breastfeeding promotion and support materials that strictly provide a nutrition message with no mention of the WIC Program are not required to contain the nondiscrimination statement.

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

Notice of Public Meetings

Access to each state service, program or activity is required by the Americans with Disabilities Act of 1990. Announcements of WIC Program public meetings and activities should include a statement explaining that, “all reasonable efforts to accommodate persons with disabilities (at the meeting) will be made. Please contact (telephone number) with your request.”

Procedures for Handling Complaints Regarding Discrimination

Any person alleging discrimination on the basis of race, color, national origin, sex, age, or disability, has a right to file a complaint which must be processed within 180 days of the alleged discriminatory action. Under special circumstances the time limit may be extended by the Office of Minority Affairs (OMA), Washington, D.C.

Complaint forms can be found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and either e-mailed or mailed immediately to USDA, Office of the Assistant Secretary for Civil Rights, Washington, D.C. (see page 7-1 for e-mail and mailing address).

¹ Tihesha Jenkins-Salley, FNS, February 21, 2014.

A copy of the complaint should be filed with the State and can be mailed to:

Luvenia Harrison
Title VI Compliance Officer
Tennessee Department of Health
Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

If any applicant or participant should complain of discrimination, written or verbal, the complaint shall be accepted by any health department staff member and forwarded to the Washington office within 5 business days after receipt. Additionally, forward the complaint to the state office listed above. The state will maintain a copy of any correspondence regarding the complaint for at least four years after the date Tennessee Department of Health is notified that the complaint is closed.

It is necessary that the information be sufficient to determine the identity of the agency or individual towards which the complaint is directed and to indicate the possibility of a violation. Anonymous complaints shall be handled as any other complaint. Only the OMA can reject a complaint when the allegation is not covered by the requirements of the Department Regulations.

If the complaint is verbal, the person accepting the complaint must get as much information as possible. Every effort shall be made to have the complainant provide at a minimum the following information:

- Name, address, and telephone number of the complainant or other means of contacting the complainant
- The specific location and name of the entity delivering the service or benefit
- The nature of the incident or action that led the complainant to feel discrimination was a factor, or an example of the method of administration which is alleged to have a discriminatory effect on the public or potential and actual participants
- The basis on which the complainant feels discrimination exists (race, color, national origin, age, sex, or disability)
- The names, titles, and business addresses of persons who may have knowledge of the discriminatory action
- The date(s) during which the alleged discriminatory actions occurred, or if continuing, the duration of such actions

Civil Rights Training

Civil Rights Training must be provided annually for all staff members who have contact with WIC applicants and /or participants. The training must be provided to all new employees during orientation and prior to working in clinics. The training may be face-to-face or electronically. Specific subject areas for training include, but are not limited to:

- Collection and use of race/ethnic data
- Effective public notification systems
- Complaint procedures
- Compliance reviews techniques
- Resolution of non-compliance
- Requirements for ADA
- Language assistance
- Conflict Resolution and Customer service²

Civil Rights Reviews

Compliance reviews are made annually in conjunction with monitoring visits to regions. The state has the responsibility to ensure that the regions review all clinics for Civil Rights compliance annually. These reviews should include:

- Checking that regions have conducted civil rights training for employees annually.
- Making sure the “And Justice for All” poster is displayed in plain view where participants can see it.
- Checking to see if state or local printed written materials that are handed out contain the nondiscrimination statement or have an attachment with the statement.
- Observing staff responsible for collecting racial/ethnic data to ensure that appropriate assessment procedures are being used like allowing self-declaration or offering up to five (5) combinations of race/ethnicity
- Checking to see if materials for non-English speaking people are available in clinics where these minority groups are served.
- Checking to see that there are adequate notifications addressing the availability of free service to those who are limited English proficient (LEP) or disabled.
- Checking to see that Fair Hearing procedures are posted in clinics in plain view where participants can see them and any other items required for Civil Rights are available.

² United States Department of Agriculture, Food and Nutrition Service, Instruction 113-1, p.2

Fair Hearings

A Fair Hearing Procedure is required by Federal Regulations so that pregnant and breastfeeding women, parents, or caregivers can appeal decisions made by the clinic regarding their participation in the WIC Program.

Explanation to Applicant or Participant

If a person is determined to be ineligible, a clinic staff member is required to explain why to that person and tell them they have a right to a Fair Hearing (right to appeal the decision).

If a non-English speaking or disabled participant is determined to be ineligible, an explanation must be provided and the right to a Fair Hearing explained to that person in their language or with the use of an auxiliary aid to ensure that she/he can understand.

Confirmation of Fair Hearing Rights

The Fair Hearing Procedure for the WIC Program **must be posted** in English and Spanish in each WIC clinic.³ A copy of the complete Fair Hearing Procedure for the WIC Program must be on file with the WIC Director in each Regional Office (see State Plan) and also on file in each County Health Department Director's Office. The "And Justice for All" poster must be posted in plain view in each clinic waiting room. Requests by participants for a Fair Hearing should be referred to the WIC Director for appropriate action.

The WIC Director should contact complainant to explore details of problem and seek resolution. If unresolved, WIC Central Office should be informed of the situation immediately. Participant will be notified of time and place of fair hearing. A copy of the notice will be sent to the Regional WIC Director.

Service Rights

Participants have a right to expect courteous and caring service when receiving or applying for program benefits. WIC clinic staff must assist participants in referring service complaints to the appropriate person in accordance with Regional policy.

³ Memo: Bernadette Lorenzo, Program Specialist, SE Region, USDA-FNS to Sharon Morrow, May 9, 2014.

ABUSE OF PROGRAM BY PARTICIPANT(S)

Dual Participation^{4 5}(See Chapter 4)

A participant may not intentionally receive WIC benefits from two (2) separate locations or from two (2) food programs, i.e., WIC and CSFP. If it is determined that a participant has intentionally participated in two (2) locations or programs, collection will be made of the total value of improperly obtained benefits. There may also be a one (1) year disqualification. The Notification of Ineligibility (NOI) (*Notification of Ineligibility*, (**Appendix 1-8**)) must contain notice of the participant's right to a fair hearing. It is not permissible to withhold WIC benefits that would be issued for future eligible months in lieu of dual benefits previously received.

Intentionally Providing False or Misleading Information

A warning letter may be sent if there is an indication that false information was intentionally provided during the certification procedures (refer to *Participant Sample Warning Letters*, (**Appendix 7-1**)).

When there is definite proof, collection will be made of the total value of improperly obtained benefits. There may also be a one (1) year disqualification if the value of the benefits is \$100 or more for the first violation and for any dollar amount if there was a previous violation of the types described in this section. Document the findings and file in the participant chart. If the participant is ineligible for program benefits following the investigation, complete the NOI which notifies the participant of their right to a fair hearing.

Sale or Exchange of WIC Foods or WIC Food Instruments or Vouchers

A warning letter may be sent if there is suspicion that WIC vouchers have been sold or exchanged for other than eligible WIC foods (refer to *Participant Sample Warning Letters*, (**Appendix 7-1**)).

When there is definite proof, collection will be made of the total value of improperly obtained benefits. There may also be a one (1) year disqualification if the value of the benefits is \$100 or more for the first violation and for any dollar amount if there was a previous violation of the types described in this section. Document the findings and file in the participant chart. If the participant is ineligible for program benefits following the investigation, complete the NOI which notifies the participant of their right to a fair hearing.

4 United States Department of Agriculture, Food and Nutrition Services, 7 CFR 246.7.,12 &.23

5 State of Tennessee Rules 1200-15-2-.06 Hearing.

Verbally and/or Physically Abusive to Clinic Program Staff and/or Authorized Vendor Staff and/or Other Staff

A warning letter may be sent if there is an accusation of verbal or physical abuse to clinic program staff and/or authorized vendor staff and/or other staff (refer to *Participant Sample Warning Letters*, ([Appendix 7-1](#))).

When there is definite proof, collection will be made of the total value of benefits obtained during such a situation. There may also be a one (1) year disqualification if the value of benefits is \$100 or more for the first violation and for any dollar amount if there was a previous violation of the types described in this section. Document the findings and file in the participant chart. If the participant is ineligible for program benefits following the investigation, complete the NOI which also notifies the participant of their right to a fair hearing.

Local law enforcement authorities may be contacted in such a situation if determined appropriate.

OUTREACH AND REFERRALS

The WIC Program has a broad mandate to conduct outreach, make referrals, and coordinate with other agencies that serve the WIC eligible population. The WIC Program seeks to target benefits to all eligible pregnant and breastfeeding women, infants, and children in the highest risk categories.

Outreach

Maintain an outreach file which is kept current and updated annually.

Inform potentially eligible persons about the WIC Program and how to apply. Document all outreach activities. Clip/copy articles for the outreach file. Also, use public service announcements (PSAs) to inform the public. Articles, PSA's, and other media must be approved by the Department's Public Information Office prior to distribution.

Mail any notice of changes in the WIC Program operation to agencies that serve the potentially eligible WIC population. Document these notices in the outreach file.

Distribute printed materials describing the WIC Program to various medical/community offices, schools, day care centers, and service agencies.

Referrals and Coordination

Prepare a referral resource list for each county including local agencies that help the eligible population. Update this list annually. A sample list is found in *Local Resource Referral List*, ([Appendix 7-6](#)). The most current nondiscrimination statement must be on the list.

Distribute information on TennCare at each certification visit as appropriate.

When needed, set up agreements (located in Regional Offices), with local hospitals and homeless shelters that serve mothers and children.

MONITORING AND AUDITS⁶

State Local Agency Review

The monitoring review schedule and monitoring tracking spreadsheet is completed prior to each fiscal year. Each Local Agency is reviewed on-site by state WIC staff every 2 years, which includes 20% of their clinics and the regional office.

- The Local Regional Director, Nutrition Director, and WIC Director are notified with a letter on state letterhead (electronically) 30 days in advance of the review.
- The letter notifying the Local Agency of the monitoring visit must have a verification of the email saved with the letter for monitoring purposes.
- Email the Data System Specialist 30 days before monitoring the Local Agency to obtain the Participant Record Review and the Therapeutic Formula Reports.
- The following programs are reviewed in the Local Agency, the clinic, or Regional Office:
 -
 - Administrative/Outreach/Targeting of Benefits/Fair Hearing
 - Certification/Health Services/Referrals/Civil Rights
 - Nutrition Services/Breastfeeding
 - Record Keeping and Accountability
 - Vendor Management
 - Farmers Market Nutrition Programs
- At the end of the review an exit conference is provided with the Regional/Local WIC staff to discuss the findings. A summary of all the findings is also provided with the monitoring report.
- A written (electronic) report is provided by the State WIC staff 45 days after the month of the review.
- The Local Agency must provide a written (electronic) response with the Corrective Action Plan within 60 days of receiving the response.
- If all agree, a written (electronic) notification of the closure of the review is sent to the Regional Director, Nutrition Director, and WIC Director.
- If the Local Agency disagrees with the findings, supporting documentation must be submitted on the review forms (electronically).
- Local Agencies will be revisited in 6 months if the findings are of such a nature that it is necessary.

⁶ United States Department of Agriculture, Food and Nutrition Services, 7 CFR 246.19

Local Agency Review

The WIC staff (which may consist of the WIC Director, Nutrition Director, and other assigned administrative staff) reviews WIC Food Instruments receipts/voids and at least 10 participant records in each clinic annually for compliance with WIC program standards. WIC staff can review WIC services as long as the reviewer does not provide WIC services in the clinics reviewed. The State WIC monitoring tools or the monitoring tools developed by the Regional WIC and Nutrition Directors may be used as long as they include all items listed on the State WIC Review Form. The state monitors whether or not the Local Agencies have completed these reviews (refer to state monitoring forms that are sent out annually).

State Audit

All non-Federal entities that expend \$750,000 or more in Federal awards in a year are required to obtain an annual audit⁷. A single audit is intended to provide a cost-effective audit for non-Federal entities in that one audit is conducted in lieu of multiple audits of individual programs. It establishes consistency and uniformity among State Departments in the management of grants and cooperative agreements with State, local, and federally-recognized Indian tribal governments. The Tennessee Comptroller of the Treasury, Division of Audits, conducts the single audit annually.

ORDERING WIC FORMS AND PAMPHLETS

Forms and pamphlets are available through Central Stores. To assist with the ordering process, a list of available materials is provided in *Ordering WIC Forms and Pamphlets*, ([Appendix 7-8](#)).

Metros use *Requisition Form GS-0943*, ([Appendix 7-7](#)) for Central Stores orders and send to WIC Central Office. After completion of the form, attach the form to an email or fax to 615-532-7189. Rural counties should send all requests to the person assigned to submit orders to Central Stores from their county or region.

ABBREVIATIONS

Refer to *WIC Abbreviations*, ([Appendix 7-11](#))

CONTACTS

Regional Health Offices

Refer to *Regional Health Offices*, ([Appendix 7-15](#))

⁷ In accordance with the Single Audit Act Amendments of 1996 , OMB Super Circular Support F.

Regional Health Offices (WIC Contact Information)

Refer to Regional Health Offices *WIC Contact Information*, ([Appendix 7-15](#))

Tennessee WIC Clinics

Refer to *Tennessee WIC Clinics*, ([Appendix 7-20](#))

Tennessee County Health Directors

Refer to *Tennessee County Health Directors*, ([Appendix 7-28](#))

Nutrition Education Centers

Refer to *Nutrition Education Centers*, ([Appendix 7-29](#))

Central Office Personnel

WIC Central Office Staff and their areas of assignment and direct phone numbers are listed. Refer to *Central Office Personnel*, ([Appendix 7-31](#))

Central Office Email Addresses

The e-mail addresses of the WIC Central Office Staff are listed. Refer to *Central Office Email Addresses*, ([Appendix 7-33](#))

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SAMPLE WARNING LETTERS

For Dual Participation

(Sent Certified Mail with Return Receipt)

Date _____

Dear _____:

The Dual Participation Report for_ (MONTH)_____ indicates that you received food instruments and/or cash value vouchers for __ (MONTH VALID) at two WIC clinics _____ on _____ and _____.

Receiving program benefits from more than one clinic during the certification period could result in being disqualified from the WIC Program for one (1) year and/or repayment of the total value of the WIC foods that were improperly obtained. Your signature on the Informed Consent/Signature Sheet (attachment 1) indicates that you read/or had read to you the information on the back of the form and understand its contents.

If you are disqualified from the WIC Program for one (1) year and/or requested to repay the state, you have a right to request a fair hearing.

If you think this is an error and have the food instruments and cash value vouchers, please contact me at this telephone number _____.

Sincerely,

WIC Director

Cc: (other program involved)

For Intentionally Providing False or Misleading Information

(Sent Certified Mail with Return Receipt)

Date _____

Dear _____:

It has come to our attention that you may have provided false or misleading information at the time of certification for the WIC Program. If this is true, this is program abuse and is against program regulations.

If we are able to determine that you did provide and/or have continued to provide such false or misleading information, you will be required to pay back the value of the WIC foods that have been received. Also, all eligible WIC participants in your household may be disqualified from program participation for one (1) year.

Sincerely,

WIC Director

For Program Abuse

(Sent Certified Mail with Return Receipt)

Date: _____

Dear _____:

It has come to our attention that you have received and spent food instruments and/or cash value vouchers that were reported as “destroyed due to _____/lost/stolen” for (participant name). Replacements were issued on (date/s) for (\$ amount/s).

On (date), the original food instrument(s)/cash value voucher(s) issued on (date) was/were also spent for (\$ amount/s). The spending of both sets of these for the same person for the same month is program abuse. Since you have received and spent both sets of food instruments/cash value vouchers for the same person for the same month, you are expected to repay (\$ amount) for one set of these. If you do not repay the (\$ amount), you may be disqualified from participating in the Tennessee WIC Program for up to one year.

Please contact (Regional WIC Director’s name) at (WIC Director’s phone number) **immediately** to arrange your repayment. If we do not hear from you within 30 days of receiving this letter, we will begin the disqualification process for (participant name).

Sincerely,

WIC Director

**For Selling WIC Food or
Exchanging Food Instruments or
Cash Value Vouchers for Cash or Credit**

(Sent Certified Mail with Return Receipt)

Date _____
Dear _____:

It has come to our attention that you may have sold food that was purchased with your WIC food instruments or cash value vouchers or you exchanged them for cash or credit. If this is true, this is program abuse and is against program regulations. WIC food instruments and cash value vouchers are to be used to obtain WIC foods that are to be eaten by the participant for whom they were issued.

If we are able to determine that you are continuing to sell or exchange your WIC food instruments or cash value vouchers following this warning, you will be required to pay back the value of the WIC foods. Also, all eligible WIC participants in your household may be disqualified from program participation for one (1) year.

Sincerely,

WIC Director

For Verbal or Physical Abuse

(Sent Certified Mail with Return Receipt)

Date _____

Dear _____:

It has come to our attention that you may have committed an act of verbal or physical abuse toward an employee of your WIC clinic or of a WIC authorized grocery or pharmacy. If this is true, this is program abuse and is against program regulations. Activities involving receiving and using WIC food instruments and/or cash value vouchers are to be conducted in a respectful manner.

If we are able to determine that you are continuing to commit such abuse, you will be required to pay back the value of the WIC foods received. Also, the eligible WIC participants in your household may be disqualified from program participation for one (1) year.

Sincerely,

WIC Director

LOCAL RESOURCE REFERRAL LIST

The following is a suggested format for this information, which will provide an easy to use reference sheet. This list is not intended to be complete. Include Agencies/Programs which are located in your health services area which provide services to low income persons. The list must be given to each participant at initial certification.

HOTLINES	Telephone Number	Days/Hours Svc.
Available		
TENNCARE	1-800-342-3145	M-F 8 AM-4:30 PM CT
AIDS	1-800-525-2437	M-F 8 AM-4:30 PM CT
BABYLINE	1-800-428-2229	M-F 8 AM-4:30 PM CT
NATIONAL BREASTFEEDING	1-800-994-9662	
WIC	1-800-DIALWIC(342-5942)	M-F 8 AM-4:30 PM CT
text4baby	text BABY (BEBE en Espanol) to 511411	
SMOKING QUIT LINE	1-800-Quit Now	
Local 2-1-1 Service	211	

Items with asterisks are mandatory.

- *Drug Treatment Centers
- *Alcohol/Drug Abuse Center
- *Families First
- *Child Support Enforcement Agency
- *Supplemental Nutrition Assistance Program (formerly Food Stamps)

Others:

Community Services/Programs	Expand Food & Nutrition Program	Handicapped Services
Health Department	Food Bank	Hearing Impaired Center
Well Child Clinic	Emergency Food Resources	Visually Impaired Center
Prenatal Clinic	Department of Mental Health	Crisis Intervention
Family Planning Clinic	Alcoholics Anonymous	Homeless Shelters
Children's Special Services	Narcotics Anonymous	Shelters for Abused Women
Immunization	Department of Human Services	Other Community Services
WIC Clinic	Day Care Centers	Head Start Centers
Private Health Care Provider	Handicapped Children's	Transportation Services
Hospital Prenatal Clinic	Association	Civic Clubs
Hospital Pediatric Clinic	Juvenile Court Contact	Churches
Breastfeeding Support	Foster Care	Social Security
Migrant Health Centers	Child Abuse	
Food/Nutrition	Protective Services	

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, religious creed, disability, age, political beliefs, 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, audiotope, 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) e-mail: program.intake@usda.gov |
|--|-----------------------------|--|

This institution is an equal opportunity provider.

REQUISITION FORM GS-0943

CENTRAL STORES USE ONLY

Order Type Reg. Emer.
 Date shipped _____
 No. of packages _____
 Messenger Truck
 Other **No. 093655**

Tennessee Department of General Services
 Central Stores
 831-A Cowan Street
 Nashville, TN 37207
 615-741-3886 Fax: 615-741-9780
FORMS AND SUPPLIES ORDER

Fund _____ Alloc. _____
 Cost Center _____ Agency Obj. Code _____
 Grant/Sub-Grant _____
 Project/Sub-Project _____
 Location No. _____

Department & Division _____ Authorized by _____ Date _____

No.	Brief Description	Agv. Obj. Code	Catalog Number	I	Amount or Units	A	Attention	Brief Description	Agv. Obj. Code	Catalog Number	I	Amount or Units	A
1							1. All departments should use current form numbers assigned to them when ordering forms. 2. All departments should use current stores catalog numbers when ordering supplies.						
2													
3													
4													
5													
6													
7													
8													
9							Central Stores use only.						
10							Forms filled by _____						
11							Checked _____						
12							Supplies filled by _____						
13							Checked _____						
14													

Ship to Address _____
 Remarks: _____

ORDERING WIC FORMS AND PAMPHLETS

Metros use Requisition Form GS-0943 for Central Stores orders and send to WIC Central Office. After completion of the form, attach the form to an email or fax to 615-532-7189.

Rural counties should send all requests to the person assigned to submit orders to Central Stores from their county or region.

Nutrition Counseling Pamphlets

	<u>EDISON#</u>
10 WAYS TO GET YOUR KIDS TO EAT FRUITS AND VEGETABLES (Bilingual), PK/200	1000080544
TEACHING YOUR BABY TO USE A CUP, PK/100	1000050364
TEACHING YOUR BABY TO USE A CUP, PKG/100, (Spanish)	1000080273
BE SNACK WISE, PK/100	1000050371
BE SNACK WISE, PKG/100, (Spanish)	1000080523
BREASTFED BABIES ARE WELCOME HERE POSTER, PKG/50 (Bilingual)	1000166180
BREASTFEEDING HOTLINE MAGNETS, BOX/500 (Bilingual)	1000166050
BREASTFEEDING HOTLINE PALM CARDS, BOX/500 (Bilingual)	1000164856
BREASTFEEDING IS THE BEST, PKG/100 (Bilingual)	1000162183
PATRICK PLATE AND THE GOOD FOODS BAND, (Coloring Book) PKG/50	1000080308
DRUGS, ALCOHOL, TOBACCO NO FRIEND, (Bilingual) PK/200	1000050301
EXERCISE DURING PREGNANCY, PD/100 (Bilingual)	1000080389
FEEDING YOUR BABY 4 MO.-1 YR., PKG/100	1000080289
FEEDING YOUR BABY 4 MO. – 1 YR., (Spanish) PKG/100	1000080409
FEEDING YOUR BABY BIRTH-4 MO., PKG/200	1000080290
FEEDING YOUR BABY BIRTH – 4 MO., (Spanish) PKG/200	1000080408
FOOD FOR A HEALTHY MOTHER AND BABY, (Spanish) PKG/100	1000080576
FOOD FOR A HEALTHY MOTHER AND BABY, PKG/200	1000100008
FOODS FOR AFTER YOU DELIVER, PKG/100	1000080495
FOODS FOR AFTER YOU DELIVER, (Spanish) PK/100	1000050361
FOODS FOR YOUR CHILD 1 - 3 YEARS, PKG/100	1000080496
FOODS FOR YOUR CHILD 1 - 3 YEARS, (Spanish) PK/100	1000080370
FOODS FOR YOUR CHILD 4 - 8 YEARS, PKG/100	1000080498

	<u>EDISON#</u>
FOODS FOR YOUR CHILD 4 - 8 YEARS, (Spanish) PK/100	1000080272
FRUITS AND VEGGIES-MORE MATTERS, (Bilingual) PK/200	1000080282
HELP YOUR CHILD GAIN WEIGHT, PKG/100	1000050425
HELP YOUR PICKY EATER, PK/100	1000080601
PHYSICAL ACTIVITY AFTER YOU DELIVER, (Bilingual) PD/100	1000080569
RELIEF FOR COMMON PREGNANCY DISCOMFORT, (Bilingual) PKG/200	1000100010
SHOP AND SAVE, PKG/100, (Bilingual)	1000050296
TENNESSEE BREASTFEEDING LAW, BOX/500 (Bilingual)	1000170108
THE STRENGTH OF IRON, PKG/200	1000080305
THE STRENGTH OF IRON, PKG/100, (Spanish)	1000050322
WATCHING YOUR CHILD'S WEIGHT, PKG/200	1000080526
WATCHING YOUR CHILD'S WEIGHT, PKG/200, (Spanish)	1000050295
WHY EVERY WOMAN NEEDS FOLIC ACID, PKG/100	1000080542
WHY EVERY WOMAN NEEDS FOLIC ACID (Spanish) PKG/100	1000080585
WHOLE GRAINS (English/Spanish) PKG/200	1000114947
TENNESSEE WIC PROGRAM (Eng), PKG/200	1000162315
TENNESSEE WIC PROGRAM (Spanish), PKG/200	1000166618
YOUR GUIDE TO HEALTHY EATING AND PHYSICAL ACTIVITY WHILE YOU ARE PREGNANT AND BREASTFEEDING, PKG/100	1000080414
ABC's OF SPOON FEEDING, PKG/200	1000170104
ABC's OF SPOON FEEDING, (Spanish) PKG/200	1000171390

Forms for WIC Clinics

	<u>EDISON#</u>
AGENCY APPLICATION FOR VOTER REGISTRATION, PK/250	000-00-00SS3066
BREASTFEEDING PEER COUNSELOR CONTACT LOG, PD/100	1000135381
GROWTH CHART BOYS 2-20 YRS., PKG/200	1000051618
GROWTH CHART BOYS BIRTH-24 MO., PKG/200	1000051617
GROWTH CHART GIRLS 2-20 YRS., PKG/200	1000051616
GROWTH CHART GIRLS BIRTH-24 MO., PKG/200	1000051615

	<u>EDISON#</u>
LOST/STOLEN/DESTROYED VOUCHER REP, PD/100	1000051614
NOTIFICATION OF INELIGIBILITY, (Bilingual) PD/100	1000051951
PROXY PERMISSION SHEET, PKG/100 (Bilingual)	1000051866
WIC BREAST PUMP RELEASE, PD/50 (Bilingual)	1000052112
WIC CHILD NUTRITION QUESTIONNAIRE, PKG/500	1000052245
WIC CHILD NUTRITION QUESTIONNAIRE, (Spanish) PKG/500	1000080366
WIC CHILD RECORD, PK/500	1000051901
WIC INFANT NUTRITION QUESTIONNAIRE, PKG/500	1000052243
WIC INFANT NUTRITION QUESTIONNAIRE, (Spanish) PKG/500	1000080365
WIC INFANT RECORD, PK/500	1000051998
WIC INFORMED CONSENT SIGNATURE, PD/100	1000051613
WIC INFORMED CONSENT SIGNATURE, (Spanish) PD/100	1000051804
WIC POSTPARTUM RECORD, PKG/500	1000052244
WIC PRENATAL RECORD, PKG/200	1000051785
WIC FI/ CVV SIGNATURE CARD (FOLDER), PKG/100 (English)	1000051704
WIC FI/ CVV SIGNATURE CARD (FOLDER), PKG/100 (Spanish)	1000051860
WIC WEIGHT GAIN GRID PRE PREGNANCY NORMAL WEIGHT BMI 18.5-24.9 PKG/500	1000139938
WIC WEIGHT GAIN GRID PREPREGNANCY OBESE BMI > 30.0	1000139937
WIC WEIGHT GAIN GRID PRE PREGNANCY OVERWEIGHT BMI 25.0-29.9	1000139936
WIC WEIGHT GAIN GRID PRE PREGNANCY UNDERWEIGHT BMI <18.5	1000139935
WIC WOMAN NUTRITION QUESTIONNAIRE, PKG/500	1000052246
WIC WOMAN NUTRITION QUESTIONNAIRE, (Spanish) PKG/500	1000080396
VOTER DECLINATION FORM, PD/100	000-00-00GS0979
YOUR APPT. NOTICE REMINDER CARD, PKG/500	1000051823

ABBREVIATION LIST

A

amt
amount
Abx
antibiotics
appt
appointment
AGC
Automated Growth Chart

B

Ba
Baby
bac
bacon
BLT
bacon, lettuce, tomato sandwich
BK
baked
bis
biscuit
BG
Blood Glucose
B/P or BP
Blood Pressure
BMI
Body Mass Index
BoF
Bottle Feeding
BM
bowel movement
brd
bread
BF
Breastfeeding
BFPC or PC
Breastfeeding Peer Counselor

C

Cal
calorie
Carb
carbohydrate

CVV
cer
CLC
C-Section
Δ
ch
CB
chix
choc
Chol
cigs
CPA
conc
cont
crax
crm
c
Cash Value Vouchers
cereal
Certified Lactation Counselor
Cesarean Section
change
cheese
cheeseburger
chicken
chocolate
cholesterol
cigarettes
Competent Professional Authority
concentrate
continue
crackers
creamed
cup

D

DOB
d
DCS
DHS
DBE
dev
Dx
DTR
D/C
Date of Birth
day or daily
Department of Children Services
Department of Human Services
Designated Breastfeeding Expert
development
diagnosis
Dietetic Technician, Registered
discharge

E

ed
EoE
EG
esp
EDD
q
EBF
EBM
education
Eosinophilic Esophagitis
Eosinophilic Gastroenteritis
especially
Estimated Date of Delivery
every
Exclusive Breastfeeding
Expressed Breast Milk

F

FTT
F, Fa or Dad
fdg
Failure to Thrive
Father
feeding

FeSo4	Ferrous Sulfate	HMF	Human Milk Fortifier
FN	Flat Nipple	HTN	Hypertension
FA	Folic Acid		
f/u	Follow Up	I	
fd	food		
FNS	Food and Nutrition Service	icecrm	ice cream
FI	Food Instruments	IBW	Ideal Body Weight
FF	formula-fed	INP	Inappropriate Nutrition Practices
FPIES	Food Protein-induced Enterocolitis Syndrome	IEM	Inborn Errors of Metabolism
		IVL	Income Verification Label
FPIP	Food Protein-induced Proctocolitis	IBCLC	International Board Certified
FF	french fries		Lactation Consultant
fr	fried	IN	Inverted Nipple
frt	fruit	Fe	Iron
FBF	Fully Breastfeeding		
		J	
G			
		jc	juice
GERD	Gastroesophageal Reflux Disease		
GI	gastrointestinal	K	
G-tube	Gastrostomy tube		
G. Ade	Gatorade	Kcal	Kilo calorie
GDM	Gestational diabetes mellitus	Kaid	Kool-Aid
GTT	Glucose tolerance test		
GS Gentle	Good Start Gentle	L	
GS Nourish	Good Start Nourish		
GS Protect	Good Start Protect	LC	Lactation Consultant
GS Soothe	Good Start Soothe	las	lasagna
GS Soy	Good Start Soy	L/O	Latch On
GF	grandfather	LES	Leave & Earnings Statement
GM	grandmother	LPN	Licensed Practical Nurse
gr beans	green beans	LEP	Limited English Proficiency
grd	ground	liq	liquid
grp/grps	group or groups	LBW	low birth weight
		M	
H			
hamb/wbun	hamburger with bun	mac	macaroni
HCP	Health Care Provider	mac/ch	macaroni & cheese
HIPAA	Health Insurance Portability & Accountability Act	m	mashed
		MA	Master of Art
ht	height	m. loaf	meat loaf
Hct	Hematocrit	Med	Medication
Hgb	Hemoglobin	MER	Milk Ejection Reflex
Hx	history	M, Mo or Mom	Mother
h/o	history of	MVI	Multivitamin
hr	hour		
HIV	Human Immunodeficiency Virus		
HM	Human milk		

N

N & V Nausea and Vomiting
 NAS Neonatal Abstinence Syndrome
 NICU Neonatal Intensive Care Unit
 NKA No Known Allergies
 NKFA No Known Food Allergies
 NSVD Normal Single Vaginal Delivery
 N/A Not Applicable
 NOI Notification of Ineligibility
 nutr or nutri nutrition

O

occ occasional
 OT occupational therapy
 oj orange juice
 oz ounce

P

pk pack
 pkg package
 ppd packs per day
 Pt patient
 PTBMIS Patient Tracking &
 Billing Management
 Information System
 PBJ peanut butter & jelly
 PT physical therapy
 PCOS polycystic ovarian syndrome
 p. chop pork chop
 PP Postpartum
 pot potatoes
 lb pound
 pwd powder
 preg pregnant
 PN Prenatal
 PBF Prenatal Breastfeeding
 PNV Prenatal Vitamin
 prep preparation
 Rx prescription
 PCP Primary Care Physician / Provider
 prob problem

Q

qt quart
 qrtpdr quarter pounder

R

REM rapid eye movement
 RTF Ready to Feed
 rec recommend, recommended
 RDA recommended dietary allowance
 ref referral, referred, referring
 RD Registered Dietitian
 RDN Registered Dietitian Nutritionist
 RN Registered Nurse
 r/t related to
 R. Beef roast beef

S

sand sandwich
 sc sauce
 saus sausage
 scr scrambled
 svg serving
 SBS short bowel syndrome
 Sim Adv Similac Advance
 Sim Soy Similac Soy
 SS Similac Sensitive
 Sim TC Similac Total Comfort
 sk skim
 STS Skin-to-skin
 sl slice
 SGA small for gestational age
 SN Sore Nipple
 spag spaghetti
 SAHM Stay At Home Mom
 SOAP Subjective, Objective,
 Assessment Plan
 SNS Supplemental Nursing System
 SNAP Supplemental Nutrition Assistance
 Program
 sw. acid sweet acidophilus
 sw pot sweet potatoes
 Sx symptoms

T			V	
Tbsp		tablespoon	VENA Value Enhanced Nutrition Assessment	
tsp		teaspoon	veg	vegetable
TNCare		TennCare	VOC	Verification of Certification
X		times	VLBW	very low birth weight
tom		tomato		
Tx		Treatment	W	
TB		tuberculosis		
t. grns		turnip greens	H2O	water
T1DM	Type 1 Diabetes Mellitus		wk	week
T2DM	Type 2 Diabetes Mellitus		wt	weight
			wh	whole
U			ww	whole wheat
			w/ or	with
USDA	United States		WNL	within normal limits
	Department of Agriculture		WHO	World Health Organization
			Y	
			yr	year
			y/o	year old

ABBREVIATIONS FROM THE PHN PROTOCOL MANUAL (see below link) AND PTBMIS CAN ALSO BE USED

<http://hsaintranet.health.tn.gov/PhnProtocols/2013-04-10-PhnProtocols-OneFile.pdf>

REGIONAL HEALTH OFFICES

Rural & Metro Regional Office staff can be reached through State Outlook or the county email systems. All regional staff email addresses are included at the end of this section.

NORTHEAST TENNESSEE REGION (1)

185 Treasure Lane
Johnson City, TN 37604-6150
(423) 979-3200
FAX (423) 979-3261

EAST TENNESSEE REGION (2)

2101 Medical Center Way
P. O. Box 59019
Knoxville, TN 37920
(865) 549-5335
FAX (865) 594-6291

SOUTHEAST REGION (3)

Tennessee Department of Health
1301 Riverfront Parkway, Suite 209
Chattanooga, TN 37402
(423) 634-3124
FAX (423) 634-1003

UPPER CUMBERLAND REG (4)

1100 England Drive
Cookeville, TN. 38501
(931) 528-7531
FAX (931) 372-2756

MID-CUMBERLAND REGION (5)

710 Hart Lane
Nashville, TN 37243 Mailing Address
Nashville, TN 37216 Shipping Address
(615) 650-7000
FAX (615) 262-6139

SOUTH CENTRAL REGION (6)

1216 Trotwood Avenue
Columbia, TN 38401
(931) 380-2532
FAX (931) 380-3364

WEST TENNESSEE REGION (7)

1010 Mt. Zion Road
P.O. Box 190 (P.O. Box ZIP Code 38281)
Union City, TN 38261
(731) 884-2645
FAX (731) 884-2650

WEST TENNESSEE REGION (8)

295 Summar Drive
Jackson, TN 38301
(731) 423-6600
FAX (731) 421-5148

SHELBY COUNTY (9)

Shelby Co Health Dept.
757 Galloway
Memphis TN 38105
(901) 222-9750
FAX (901) 222-9772

DAVIDSON COUNTY (10)

Davidson Co Health Dept.
2500 Charlotte Ave.
Nashville, TN 37209
(615) 340-5368
FAX (615) 340-2110

KNOX COUNTY (11)

Knox County Health Dept.
140 Dameron Avenue
Knoxville, TN 37917-6413
(865)215-5050
FAX (865) 215-5064 or (865) 215-5066

HAMILTON COUNTY (12)

Chattanooga-Hamilton Reg Office
921 East Third Street
Chattanooga, TN 37403
(423) 209-8220
FAX (423) 209-8314

SULLIVAN COUNTY (13)

Sullivan County Health Dept
154 Blountville By-Pass
P.O. Box 630
Blountville, TN 37617
423-279-2777
FAX (423) 279-7556

MADISON COUNTY (14)

Jackson-Madison Co Health Dept.
589 East College Street
Jackson, TN 38301
(731) 423-3020
FAX (731) 927-8601

Regional Health Offices Contact Information

Name/Title	E-mail Address	Phone Number
Northeast Tennessee Region		
Shannon Roark, MS, RDN, CLC Nutrition Director/Breastfeeding Coordinator	Shannon.Roark@tn.gov	(423) 979-4597
Gail Layne, BS WIC Director	Gail.Layne@tn.gov	(423) 979-4600
Stephanie Edwards Vendor Coordinator	Stephanie.Edwards@tn.gov	(423) 979-4598
East Tennessee Region		
Joni Coker, RD, LDN, CLC Director of Nutrition Services	Joni.Coker@tn.gov	(865) 549-5342
Leigh Ann Bolton, NE, CLC Breastfeeding Coordinator	LeighAnn.Bolton@tn.gov	(865)-549-5314
JoAnne Kirkland WIC Director	JoAnn.Kirkland@tn.gov	(865) 549-5316
Lisa Pitner Vendor Coordinator	Lisa.Pitner@tn.gov	(865) 549-5270
Southeast Region		
Vacant Director of Nutrition Services		
Shelby Stansell, BS, LC Breastfeeding Coordinator	Shelby.Stansell@tn.gov	(423) 745-7431
Susan Yates WIC Director	Susan.Yates@tn.gov	(423) 634-1949
Robin Mackey Vendor Coordinator	Robin.Mackey@tn.gov	(423) 634-5818
Upper Cumberland Region		
Geetha Natarajan, MS, RD, LDN, CLC Director of Nutrition Services/Breastfeeding Coordinator	Geetha.Natarajan@tn.gov	(931) 646-7512
Miranda Ford WIC Director	Miranda.Ford@tn.gov	(931) 520-4220
Karen Maxwell Vendor Coordinator	Karen.Maxwell@tn.gov	(931) 520-4218

Shelby County

Vacant Nutrition Director	Vacant	Vacant
Cynthia Tharp, BS WIC Director Galloway	cynthia.tharp@shelbycountyttn.gov	(901) 222-9754
Kathleen Baroff, RD, CLC Breastfeeding Coordinator	Kathleen.Baroff@shelbycountyttn.gov	(901) 222-9827
Acqua Banks-Woods Vendor Coordinator	acqua.banks@shelbycountyttn.gov	(901) 222-9756

Davidson County

Teresa Thomas, MS, RD WIC/Nutrition Director	Teresa.Thomas@nashville.gov	(615) 340-5368
Kelly Whipker, RD, CLC Breastfeeding Coordinator	Kelly.Whipker@nashville.gov	(615) 340-8606
Maggie Morales Vendor Coordinator	Blanca.Morales@nashville.gov	(615) 880-2212

Knox County

Lori Emond, NE WIC Director	Lorna.Emond@knoxcounty.org	(865)215-5048
Sarah Griswold, MS, MPH, RD, LDN Nutrition Director	Sarah.Griswold@knoxcounty.org	(865)215-5052
Robin Penegar, IBCLC Breastfeeding Coordinator	Robin.Penegar@knoxcounty.org	(865) 215-5060
Terry Brooks Vendor Coordinator	Terry.Brooks@knoxcounty.org	(865) 215-5055

Hamilton County

Amanda Kirkpatrick, RD, LDN, CNSC, CLC Nutrition Director	AmandaKirk@HamiltonTN.gov	(423) 209-8313
Angie Gross, RD, CLC WIC Director	AngieG@HamiltonTN.gov	(423) 209-8318
Jolene Hare, RN Breastfeeding Coordinator	JoleneH@HamiltonTN.gov	(423) 209-8321
Marian Clay Vendor Coordinator	MarianC@HamiltonTn.gov	(423) 209-8312

Sullivan County

Becky Burris, BS, IBCLC
Nutrition Director
WIC Director/Breastfeeding Coordinator

rburris@sullivanhealth.org

(423)279-2782

Lou Taylor
Vendor Coordinator

ltaylor@sullivanhealth.org

(423) 297-2779

Madison County

Amy Clanton, RD, LDN, MBA, CLC
Nutrition Director

Amy.Clanton@tn.gov

(731) 423-3020 ext. 2111

Brenda Bowles
WIC Director

bbowles@jmchd.com

(731) 927-8539

Chris Ellis – Administrator of WIC Center
Vendor Coordinator

cellis@jmchd.com

(731) 927-8569

Leanne Montgomery, CLC
Breastfeeding Coordinator

leanne.montgomery@tn.gov

(731) 423-3020 ext. 62108

TENNESSEE WIC CLINICS BY COUNTY

Rural & Metro Regional Office staff can be reached through State Outlook or the county email systems. All regional staff email addresses are included at the end of this section.

ANDERSON REGION 2 CLINIC 0101
ANDERSON COUNTY HEALTH DEPT.

710 N. MAIN ST. SUITE A
CLINTON 37716

Tel: 865-425-8804
Fax: 865-457-4850

Tel: 423-562-8351 or 423-562-8352
Fax: 423-562-1593

CANNON REGION 4 CLINIC 0801
CANNON COUNTY HEALTH DEPT.

301 W MAIN STREET SUITE 200
WOODBURY 37190-1100

Tel: 615-563-4243 or 615-563-4202
Fax: 615-563-6212

BEDFORD REGION 6 CLINIC 0201
BEDFORD COUNTY HEALTH DEPARTMENT
140 DOVER STREET

SHELBYVILLE 37160-2776
Tel: 931-684-3426 or 931-684-0000
Fax: 931-684-5860

CARROLL REGION 7 CLINIC 0901
CARROLL COUNTY HEALTH DEPARTMENT
633 HIGH STREET

HUNTINGDON 38344
Tel: 731-986-1990 or 731-986-1993
Fax: 731-986-1995

BENTON REGION 7 CLINIC 0301
BENTON COUNTY HEALTH DEPARTMENT
225 HOSPITAL DRIVE

CAMDEN 38320
Tel: 731-584-4944
Fax: 731-584-8831

CARTER REGION 1 CLINIC 1001
CARTER COUNTY HEALTH DEPARTMENT
403 EAST G. STREET

ELIZABETHTON 37643
Tel: 423-543-2521
Fax: 423-543-7348

BLEDSON REGION 3 CLINIC 0401
BLEDSON COUNTY HEALTH DEPARTMENT
1185 OLD ALVIN YORK BX 277

PIKEVILLE 37367
Tel: 423-447-2149
Fax: 423-447-6777

CHEATHAM REGION 5 CLINIC 1101
CHEATHAM COUNTY HEALTH DEPT.
162 COUNTY SERVICES DRIVE STE 200
ASHLAND CITY 37015-1787

Tel: 615-792-4318
Fax: 615-792-6794

BLOUNT REGION 2 CLINIC 0501
BLOUNT COUNTY HEALTH DEPT
301 MCGHEE ST.

MARYVILLE 37801
Tel: 865-983-4582
Fax: 865-983-4574

CHESTER REGION 8 CLINIC 1201
CHESTER COUNTY HEALTH DEPARTMENT
301 QUINCO DRIVE, P.O. BOX 323

HENDERSON 38340
Tel: 731-989-7108
Fax: 731-989-9686

BRADLEY REGION 3 CLINIC 0601
BRADLEY COUNTY HEALTH DEPT
201 DOOLEY STREET S.E.

CLEVELAND 37311
Tel: 423-728-7020
Fax: 423-479-6130

CLAIBORNE REGION 2 CLINIC 1301
CLAIBORNE COUNTY HEALTH DEPARTMENT
620 DAVIS DR., PO BOX 183

TAZEWELL, 37825
Tel: 423-626-4291
Fax: 423-626-2525

BRADLEY REGION 3 CLINIC 0603
BRADLEY COUNTY HEALTH HOSP
201 DOOLEY STREET S.E. PO BOX 1398

CLEVELAND 37311
Tel: 423-476-0568
Fax: 423-479-6130

CLAY REGION 4 CLINIC 1401
CLAY COUNTY HEALTH DEPARTMENT
115 GUFFEY STREET

CELINA 38551-4089
Tel: 931-243-2651
Fax: 931-243-3132

CAMPBELL REGION 2 CLINIC 0701
CAMPBELL COUNTY HEALTH DEPARTMENT
162 SHARP PERKINS RD, PO BOX 418
JACKSBORO 37757-0418

COCKE REGION 2 CLINIC 1501
COCKE COUNTY HEALTH DEPARTMENT
430 COLLEGE STREET
NEWPORT 37821
Tel: 423-623-8733
Fax: 423-623-0874

COFFEE REGION 6 CLINIC 1601
COFFEE COUNTY HEALTH DEPARTMENT
800 PARK STREET
MANCHESTER 37355
Tel: 931-723-5134
Fax: 931-723-5148

COFFEE REGION 6 CLINIC 1602
TULLAHOMA HEALTH CENTER
615 WILSON AVENUE
TULLAHOMA 37388-3228
Tel: 931-455-9369
Fax: 931-455-4827

CROCKETT REGION 7 CLINIC 1701
CROCKETT COUNTY HEALTH DEPARTMENT
209 N. BELLS STREET
ALAMO 38001
Tel: 731-696-2505 or 731-696-4410
Fax: 731-696-4370

CUMBERLAND REGION 4 CLINIC 1801
CUMBERLAND COUNTY HEALTH DEPT.
1503 SOUTH MAIN ST.
CROSSVILLE 38555-5967
Tel: 931-484-6196
Fax: 931-456-1047

DAVIDSON REGION D
LENTZ WIC CLINIC CLINIC 19LW
2500 CHARLOTTE AVE.
NASHVILLE 37209
Tel: 615-340-5619 or
615-340-8606 (SUPERVISOR)
Fax: 615-340-8530

DAVIDSON REGION D CLINIC 1910
EAST PUBLIC HEALTH CLINIC
1015 E. TRINITY LANE
NASHVILLE 37216
Tel: 615-862-7916(SUPERVISOR)
Fax: 615-862-7938

DAVIDSON REGION D CLINIC 1921
WOODBINE PUBLIC HEALTH CLINIC
224 ORIEL AVENUE
NASHVILLE 37210
Tel: 615-862-7940
Fax: 615-340-2194

DAVIDSON REGION D CLINIC 1979
SOUTH WIC NUTRITION CENTER
3718 NOLENSVILLE PIKE
NASHVILLE 37211
Tel: 615-880-3210
Fax: 615-880-3211

DECATUR REGION 8 CLINIC 2001
DECATUR COUNTY PHD
155 N. PLEASANT ST., P. O. BOX 178
DECATURVILLE 38329
Tel: 731-852-2461
Fax: 731-852-3794

DEKALB REGION 4 CLINIC 2101
DEKALB COUNTY HEALTH DEPT.
254 TIGER DRIVE
SMITHVILLE 37166-6812
Tel: 615-597-7599
Fax: 615-597-1349

DICKSON REGION 5 CLINIC 2201
DICKSON COUNTY HEALTH DEPARTMENT
301 WEST END
DICKSON 37055-1725
Tel: 615-446-2839
Fax: 615-441-1900

DICKSON REGION 5 CLINIC 2203
WHITE BLUFF CLINIC
200 SCHOOL RD.
WHITE BLUFF 37187
Tel: 615-797-5056
Fax: 615-797-5051

DYER REGION 7 CLINIC 2301
SARAH RICE MILLER HEALTH CENTER
1755 PARR AVE.
Dyersburg 38024
Tel: 731-285-7311
Fax: 731-285-2610

FAYETTE REGION 8 CLINIC 2401
FAYETTE COUNTY HEALTH DEPARTMENT
90 YUM YUM ROAD, P. O. BOX 188
SOMERVILLE 38068
Tel: 901-465-5243 or 901-465-5245
Fax: 901-465-5245

FENTRESS REGION 4 CLINIC 2501
FENTRESS COUNTY HEALTH DEPARTMENT
240 COLONIAL CIRCLE, SUITE A
PO BOX 636
JAMESTOWN 38556-3924
Tel: 931-879-9936
Fax: 931-879-9938

FRANKLIN REGION 3 CLINIC 2601
FRANKLIN COUNTY HEALTH DEPT.
338 JOYCE LANE
WINCHESTER 37398
Tel: 931-967-3826
Fax: 931-962-1168

GIBSON REGION 7 CLINIC 2701
GIBSON COUNTY HEALTH DEPARTMENT
1250 MANUFACTURER'S ROW
TRENTON 38382
Tel: 731-855-7601
Fax: 731-855-7603

GIBSON REGION 7 CLINIC 2702
HUMBOLDT CLINIC PO BOX 170-F
149 NORTH 12TH AVE.
HUMBOLDT 38343
Tel: 731-784-5491
Fax: 731-784-1726

GIBSON REGION 7 CLINIC 2703
MILAN CLINIC GIBSON CO. HEALTH DEPT
6501 TELECOM DRIVE P.O. BOX 698
MILAN 38358
Tel: 731-686-9240
Fax: 731-686-0962

GILES REGION 6 CLINIC 2801
GILES COUNTY HEALTH DEPARTMENT
209 S CEDAR LANE
PULASKI 38478-3502
Tel: 931-363-5506
Fax: 931-424-7020

GRAINGER REGION 2 CLINIC 2901
GRAINGER COUNTY HEALTH DEPARTMENT
185 JUSTICE CENTER DRIVE, P.O. BOX 27
RUTLEDGE 37861-0027
Tel: 865-828-5247
Fax: 865-828-3594

GREENE REGION 1 CLINIC 3001
GREENE COUNTY HEALTH DEPARTMENT
810 W. CHURCH ST., PO BOX 159
GREENEVILLE 37745-0159
Tel: 423-798-1749
Fax: 423-798-1755

GRUNDY REGION 3 CLINIC 3101
GRUNDY COUNTY HEALTH DEPARTMENT
PO BOX 65 1372 MAIN STREET
ALTAMONT 37301
Tel: 931-692-3641 or 931-692-3418
Fax: 931-692-2201

HAMBLEN REGION 2 CLINIC 3201
HAMBLEN COUNTY HEALTH DEPARTMENT
331 WEST MAIN STREET
MORRISTOWN 37814
Tel: 423-586-6431
Fax: 423-586-6324

HAMILTON REGION H CLINIC 3359
SOUTHSIDE HEALTH CENTER
100 EAST 37TH STREET
CHATTANOOGA 37410
Tel: 423-209-8220
WIC 423-778-2720
Fax: 423-778-2720

HAMILTON REGION H CLINIC 3314
BIRCHWOOD CLINIC
5623 HWY 60
BIRCHWOOD 37308
Tel: 423-961-0446
Fax: 423-961-2344

HAMILTON REGION H CLINIC 3369
DODSON AVENUE HEALTH CENTER
1200 DODSON AVENUE
CHATTANOOGA 37406
Tel: 423-778-2833
Fax: 423-778-2835

HAMILTON REGION H CLINIC 3350
OOLTEWAH HEALTH CENTER
5520 HIGH STREET
OOLTEWAH 37363
Tel: 423-238-4269
Fax: 423-238-5910

HAMILTON REGION H CLINIC 3360
SEQUOYAH HEALTH CENTER
9527 RIDGE TRAIL RD
SODDY DAISY 37379
Tel: 423-842-3031
Fax: 423-842-5353

HAMILTON REGION H CLINIC 3310
HAMILTON HEALTH DEPT
921 EAST 3RD STREET
CHATTANOOGA 37403
Tel: 423-209-8050
Fax: 423-209-8314

HANCOCK REGION 1 CLINIC 3401
HANCOCK COUNTY HEALTH DEPARTMENT
110 WILLOW ST., PO BOX 267
SNEEDVILLE 37869-0267
Tel: 423-733-2228
Fax: 423-733-2428

HARDEMAN REGION 8 CLINIC 3501
HARDEMAN COUNTY HEALTH DEPT.
10825 OLD HWY 64, PO BOX 670
BOLIVAR 38008
Tel: 731-658-5291 or 731-658-9538
Fax: 731-658-6536

HARDIN REGION 8 CLINIC 3601
HARDIN COUNTY HEALTH DEPARTMENT
1920 PICKWICK ST. P.O. BOX 397
SAVANNAH 38372
Tel: 731-925-2557
Fax: 731-925-3100

HAWKINS REGION 1 CLINIC 3701
HAWKINS CO. HEALTH DEPT.-ROGERSVILLE
201 PARK BLVD., PO BOX 488
ROGERSVILLE 37857-0488
Tel: 423-272-7641
Fax: 423-921-8073

HAWKINS REGION 1 CLINIC 3702
HAWKINS CO. HEALTH DEPT.-CHURCH HILL
247 SILVER LAKE RD., PO BOX 209
CHURCH HILL 37642-0209
Tel: 423-357-5341
Fax: 423-357-2231

HAYWOOD REGION 8 CLINIC 3801
HAYWOOD COUNTY HEALTH DEPARTMENT
950 EAST MAIN
BROWNSVILLE 38012
Tel: 731-772-0463 or 731-772-0464
Fax: 731-772-3377

HENDERSON REGION 8 CLINIC 3901
HENDERSON COUNTY HEALTH DEPARTMENT
90 RUSH STREET PO BOX 1050
LEXINGTON 38351
Tel: 731-968-8148 or 731-968-6398
Fax: 731-968-4777

HENRY REGION 7 CLINIC 4001
HENRY COUNTY HEALTH DEPARTMENT
803 JOY STREET, PO BOX 609
PARIS 38242
Tel: 731-642-4025
Fax: 731-644-0711

HICKMAN REGION 6 CLINIC 4101
HICKMAN COUNTY HEALTH DEPARTMENT
111 MURPHREE AVE.
CENTERVILLE 37033-1418
Tel: 931-729-3516
Fax: 931-729-5029

HOUSTON REGION 5 CLINIC 4201
HOUSTON COUNTY HEALTH DEPARTMENT
60E. COURT SQUARE, PO BOX 370
ERIN 37061-0370
Tel: 931-289-3463
Fax: 931-289-3499

HUMPHREYS REGION 5 CLINIC 4301
HUMPHREYS COUNTY HEALTH DEPARTMENT
725 HOLLY LANE
WAVERLY 37185-0705
Tel: 931-296-2231
Fax: 931-296-4590

JACKSON REGION 4 CLINIC 4401
JACKSON COUNTY HEALTH DEPARTMENT
600 NORTH MURRAY STREET
PO BOX 312
GAINESBORO 38562-9313
Tel: 931-268-0218
Fax: 931-268-0872

JEFFERSON REGION 2 CLINIC 4501
JEFFERSON COUNTY HEALTH DEPARTMENT
931 INDUSTRIAL PARK RD. SUITE 200
PO BOX 130
DANDRIDGE 37725-0130
Tel: 865-397-3930
Fax: 865-397-1246

JOHNSON REGION 1 CLINIC 4601
JOHNSON COUNTY HEALTH DEPARTMENT
715 WEST MAIN STREET
MOUNTAIN CITY 37683
Tel: 423-727-9731
Fax: 423-727-4153

KNOX REGION K CLINIC 4704
KNOX COUNTY HEALTH DEPT.
140 DAMERON AVENUE
KNOXVILLE 37917-6413
Tel: 865-215-5016 or 865-215-5030
Fax: 865-215-5064 or 865-215-5066

LAKE REGION 7 CLINIC 4801
LAKE COUNTY HEALTH DEPARTMENT
400 HIGHWAY 78, SOUTH
TIPTONVILLE 38079
Tel: 731-253-9954
Fax: 731-253-9956

LAUDERDALE REGION 8 CLINIC 4901
LAUDERDALE COUNTY
HEALTH DEPARTMENT
500 HWY. 51 SOUTH
RIPLEY 38063
Tel: 731-635-9711
Fax: 731-635-3630

LAWRENCE REGION 6 CLINIC 5001
LAWRENCE HEALTH DEPARTMENT
2379 BUFFALO ROAD
LAWRENCEBURG 38464-4810
Tel: 931-762-9406
Fax: 931-766-1592

LEWIS REGION 6 CLINIC 5101
LEWIS COUNTY HEALTH DEPARTMENT
51 SMITH AVE.
HOHENWALD 38462-1124
Tel: 931-796-2204
Fax: 931-796-1625

LINCOLN REGION 6 CLINIC 5201
LINCOLN COUNTY HEALTH DEPARTMENT
1000 WASHINGTON STREET, W SUITE A
FAYETTEVILLE 37334-2872
Tel: 931-433-3231
Fax: 931-438-1567

LOUDON REGION 2 CLINIC 5301
LOUDON COUNTY HEALTH DEPT.
600 RAYDER AVE., PO BOX 278
LOUDON 37774-0278
Tel: 865-458-2514
Fax: 865-458-8587

MCMINN REGION 3 CLINIC 5401
MCMINN COUNTY HEALTH DEPT.
393 COUNTY ROAD 554 PO BOX 665
ATHENS 37303
Tel: 423-745-7431
Fax: 423-744-1604

MCNAIRY REGION 8 CLINIC 5501
MCNAIRY COUNTY HEALTH DEPT.
725 E. POPLAR STREET
SELMER 38375
Tel: 731-645-3474
Fax: 731-645-4530

MACON REGION 4 CLINIC 5601
MACON COUNTY HEALTH DEPARTMENT
601 HWY 52 BY PASS EAST
LAFAYETTE 37083-1009
Tel: 615-666-2142
Fax: 615-666-6153

MADISON REGION M CLINIC 5702
MADISON COUNTY HEALTH DEPARTMENT
589 EAST COLLEGE STREET
JACKSON 38301
Tel: 731-423-3020
Fax: 731-927-8602

MARION REGION 3 CLINIC 5801
MARION COUNTY HEALTH DEPT.
24 EAST 7th ST.
JASPER 37347-2110
Tel: 423-942-3737 or 423-942-2238 or 423-942-2237
Fax: 423-942-9186

MARSHALL REGION 6 CLINIC 5901
MARSHALL COUNTY HEALTH DEPARTMENT
206 LEGION STREET
LEWISBURG 37091-2898
Tel: 931-359-1551
Fax: 931-359-0542

MAURY REGION 6 CLINIC 6001
MAURY COUNTY HEALTH DEPARTMENT
1909 HAMPSHIRE PIKE
COLUMBIA 38401-5650
Tel: 931-388-5757
Fax: 931-560-1119

MEIGS REGION 3 CLINIC 6101
MEIGS COUNTY HEALTH DEPARTMENT
400 RIVER ROAD, PO BOX 157
DECATUR 37322
Tel: 423-334-5185
Fax: 423-334-1713

MONROE REGION 2 CLINIC 6201
MONROE COUNTY HEALTH DEPARTMENT
3469 New Highway 68,
P.O. Box 38
MADISONVILLE 37354
Tel: 423-442-3993 or 423-442-5934
Fax: 423-442-9468

MONTGOMERY REGION 5 CLINIC 6303
MONTGOMERY CO. WIC CLINIC-
300 PAGEANT LANE
CLARKSVILLE 37040
Tel: 931-551-8777
Fax: 931-503-0694

MOORE REGION 6 CLINIC 6401
MOORE COUNTY HEALTH DEPARTMENT
251 MAJORS BLVD., RM 1
LYNCHBURG 37352-8325
Tel: 931-759-4251
Fax: 931-759-6380

MORGAN REGION 2 CLINIC 6501
MORGAN COUNTY HEALTH DEPARTMENT
1103 KNOXVILLE HWY., PO BOX 343
WARTBURG 37887-0343
Tel: 423-346-6272
Fax: 423-346-2349

OBION REGION 7 CLINIC 6601
OBION COUNTY HEALTH DEPARTMENT
1008 MT. ZION ROAD, P. O. BOX 248
UNION CITY 38261
Tel: 731-885-8722
Fax: 731-885-4855

OVERTON REGION 4 CLINIC 6701
OVERTON COUNTY HEALTH DEPARTMENT
5880 BRADFORD HICKS DRIVE
LIVINGSTON 38570-2236
Tel: 931-823-6260
Fax: 931-823-5821

PERRY REGION 6 CLINIC 6801
PERRY COUNTY HEALTH DEPARTMENT
31 MEDICAL DR.
LINDEN 37096-3326
Tel: 931-589-2138
Fax: 931-589-5414

PICKETT REGION 4 CLINIC 6901
PICKETT COUNTY HEALTH DEPARTMENT
1013 WOODLAWN DRIVE
BYRDSTOWN 38549-2317
Tel: 931-864-3178
Fax: 931-864-3376

POLK REGION 3 CLINIC 7001
POLK CO. HEALTH DEPARTMENT-BENTON
2279 PARKSVILLE RD.
Rt.1, Box 471H
BENTON 37307
Tel: 423-338-4533
Fax: 423-338-1959

POLK REGION 3 CLINIC 7002
POLK CO. HEALTH DEPT. COPPER HILL
840 CHEROKEE TRAIL
COPPER BASIN CENTER, RT 1, PO BOX 252
COPPER HILL 37317
Tel: 423-496-3275 or 423-496-3276
Fax: 423-496-4442

PUTNAM REGION 4 CLINIC 7101
PUTNAM COUNTY HEALTH DEPARTMENT
701 COUNTY SERVICES DR.
COOKEVILLE 38501-4338
Tel: 931-528-2531
Fax: 931-526-7451

RHEA REGION 3 CLINIC 7201
RHEA COUNTY HEALTH DEPARTMENT
344 EAGLE LANE
EVENSVILLE 37332
Tel: 423-775-7819 or 423-775-7820
Fax: 423-775-8078

ROANE REGION 2 CLINIC 7301
ROANE COUNTY HEALTH DEPARTMENT
1362 N. GATEWAY AVENUE
ROCKWOOD TN 37854
Tel: (865) 354-1220
Fax: (865) 354-0112

ROBERTSON REGION 5 CLINIC 7403
ROBERTSON COUNTY HEALTH DEPT.
900 S BROWN STREET
SPRINGFIELD 37172-2920
Tel: 615-384-0208 or 615-384-4504
Fax: 615-384-2066

RUTHERFORD REGION 5 CLINIC 7501
RUTHERFORD COUNTY HEALTH DEPT.
100 WEST BURTON ST. PO BOX 576
MURFREESBORO 37130
Tel: 615-898-7785
Fax: 615-898-7829

RUTHERFORD REGION 5 CLINIC 7503
NORTH RUTHERFORD COUNTY HEALTH DEPT.
108 DAVID COLLINS DRIVE
SMYRNA 37167
Tel: 615-355-6175
Fax: 615-459-7996

SCOTT REGION 2 CLINIC 7601
SCOTT COUNTY HEALTH DEPARTMENT
344 COURT STREET, PO BOX 88
HUNTSVILLE 37756-0088
Tel: 423-663-2445
Fax: 423-663-9252

SEQUATCHIE REGION 3 CLINIC 7701
SEQUATCHIE CO. HLTH DEPT
16939 RANKIN AVE.
DUNLAP 37327
Tel: 423-949-3619
Fax: 423-949-6507

SEVIER REGION 2 CLINIC 7801
SEVIER COUNTY HEALTH DEPARTMENT
719 MIDDLE CREEK RD.
SEVIERVILLE 37862
Tel: 865-453-1032
Fax: 865-429-2689

SHELBY REGION 9 CLINIC 7903
GUTHRIE PRIMARY HEALTH CLINIC
1064 BREEDLOVE
MEMPHIS 38107
Tel: 901-515-5400
Fax: 901-526-1208

SHELBY REGION 9 CLINIC 7917
CAWTHON PUBLIC HEALTH CLINIC
1000 HAYNES
MEMPHIS 38114
Tel: 901-222-9868
Fax: 901-222-9888 (lab) 901-222-9890 (nurses)

SHELBY REGION 9 CLINIC 7921
HOLLYWOOD CLINIC
2500 PERES
MEMPHIS 38108
Tel: 901-515-5500
Fax: 901-458-5591

SHELBY REGION 9 CLINIC 7923
MEMPHIS HEALTH CENTER-WIC
380 E.H. CRUMP BLVD.
MEMPHIS 38126
Tel: 901-261-2000
Fax: 901-775-2938 (Administration)
or 901-948-9910 (Med)

SHELBY REGION 9 CLINIC 7925
SHELBY CROSSING CLINIC
6170 MACON RD.
BARTLETT 38134
Tel: 901-222-9799
Fax: 901-222-9821

SHELBY REGION 9 CLINIC 7936
CLINIC 7968

THE MED
880 MADISON, 3rd FLOOR SUITE 310E
MEMPHIS 38103
Tel: 901-545-7265
Fax: 901-545-6375

SHELBY REGION 9 CLINIC 7956
SOUTHLAND MALL CLINIC
1287 SOUTHLAND MALL
MEMPHIS 38116
Tel: 901-222-9828
Fax: 901-222-9856

SHELBY REGION 9 CLINIC 7976
MILLINGTON CLINIC
8225 HWY 51 NORTH STE 11&12
MILLINGTON 38053
Tel: 901-222-9940
Fax: 901-222-9950

SHELBY REGION 9 CLINIC 7983
HICKORY HILL CLINIC
6590 KIRBY CENTER COVE
SUITES 101 & 104
MEMPHIS, TN 38115
Tel: 901-222-9906
Fax: 901-222-9936

SHELBY REGION 9 CLINIC 7989
GALLOWAY WIC CLINIC
477 NORTH MANASSAS
MEMPHIS 38105
Tel: 901-222-9790
Fax: 901-222-9796

SMITH REGION 4 CLINIC 8001
SMITH COUNTY HEALTH DEPARTMENT
251 JOY ALFORD WAY
CARTHAGE 37030-3047
Tel: 615-735-0242
Fax: 615-735-8250

STEWART REGION 5 CLINIC 8101
STEWART COUNTY HEALTH DEPARTMENT
1021 SPRING STREET, PO BOX 497
DOVER 37058-0497
Tel: 931-232-5329
Fax: 931-232-7247

SULLIVAN REGION S CLINIC 8201
SULLIVAN CO. HLTH DEPT-BLOUNTVILLE
154 BLOUNTVILLE BYPASS, PO BOX 630
BLOUNTVILLE 37617
Tel: 423-279-2777
Fax: 423-279-2797 or 423-279-7534

SULLIVAN REGION S CLINIC 8202
SULLIVAN CO. HLTH DEPT.-KINGSPORT
1041 EAST SULLIVAN STREET
KINGSPORT 37664
Tel: 423-279-2777
Fax: 423-224-1615

SUMNER REGION 5 CLINIC 8301
SUMNER COUNTY HEALTH DEPARTMENT
1005 UNION SCHOOL RD.
GALLATIN 37066
Tel: 615-206-1100
Fax: 615-206-9742

SUMNER REGION 5 CLINIC 8306
HENDERSONVILLE CLINIC-SUMNER CO.
351 NEW SHACKLE ISLAND
HENDERSONVILLE 37075
Tel: 615-824-0552
Fax: 615-824-9771

SUMNER REGION 5 CLINIC 8303
PORTLAND CLINIC-SUMNER CO.
214 WEST LONGVIEW DR.
PORTLAND 37148
Tel: 615-325-5237
Fax: 615-325-5549

TIPTON REGION 8 CLINIC 8401
TIPTON COUNTY HEALTH DEPT.
4700 MUELLER BRASS RD., PO BOX 685
COVINGTON 38019
Tel: 901-476-0235
Fax: 901-476-0229

TROUSDALE REGION 5 CLINIC 8501
TROUSDALE COUNTY HEALTH DEPT.
P.O. Box 439 541 EAST MAIN STREET
HARTSVILLE 37074-1502
Tel: 615-374-2112
Fax: 615-374-1119

UNICOI REGION 1 CLINIC 8601
UNICOI COUNTY HEALTH DEPARTMENT
101 OKOLONA DRIVE
ERWIN 37650
Tel: 423-743-9103
Fax: 423-743-9105

UNION REGION 2 CLINIC 8701
UNION COUNTY HEALTH DEPARTMENT
4335 MAYNARDVILLE HWY P.O. BOX 460
MAYNARDVILLE 37807-0460
Tel: 865-992-3867
Fax: 865-992-7238

VAN BUREN REGION 4 CLINIC 8801
VAN BUREN COUNTY HEALTH DEPARTMENT
907 OLD MCMINNVILLE STREET, PO BOX 277
SPENCER 38585-0277
Tel: 931-946-2438 or 931-946-2643
Fax: 931-946-7106

WARREN REGION 4 CLINIC 8901
WARREN COUNTY HEALTH DEPARTMENT
1401 SPARTA STREET
MCMINNVILLE 37110-1301
Tel: 931-473-8468 or 931-473-6160
Fax: 931-473-0595

WASHINGTON REGION 1 CLINIC 9001
WASHINGTON CO - JOHNSON CITY PHD
219 PRINCETON RD.
JOHNSON CITY 37601
Tel: 423-975-2200
Fax: 423-975-2210

WAYNE REGION 6 CLINIC 9101
WAYNE COUNTY HEALTH DEPARTMENT P.O.
BOX 175
725 S MAIN ST
WAYNESBORO 38485-2439
Tel: 931-722-3292
Fax: 931-722-7249

WEAKLEY REGION 7 CLINIC 9201
WEAKLEY COUNTY HEALTH DEPT.
9852 HIGHWAY 22
DRESDEN 38225
Tel: 731-364-2258 or 731-364-2250 or 731-364-2210
Fax: 731-364-5846

WHITE REGION 4 CLINIC 9301
WHITE COUNTY HEALTH DEPARTMENT
135 WALKER ST.
SPARTA 38583-1725
Tel: 931-836-2201
Fax: 931-836-3580

WILLIAMSON REGION 5 CLINIC 9401
WILLIAMSON COUNTY HEALTH DEPT.
1324 WEST MAIN ST.
FRANKLIN 37064-3789
Tel: 615-794-1542
Fax: 615-790-5967

WILLIAMSON REGION 5 CLINIC 9403
WILLIAMSON COUNTY HEALTH DEPARTMENT
FAIRVIEW CLINIC
2629 FAIRVIEW BLVD
FAIRVIEW 37062
Tel: 615-799-2389
Fax: 615-799-2260

WILSON REGION 5 CLINIC 9501
WILSON COUNTY HEALTH DEPARTMENT
927 EAST BADDOUR PARKWAY
LEBANON 37087-3685
Tel: 615-444-5325
Fax: 615-444-2750

COUNTY DIRECTORS

Region	County	Director	Region	County	Director
2	Anderson	Art Miller	6	Lawrence	Devin Toms
6	Bedford	Angie Faulkner	6	Lewis	Sarah Russell
7	Benton	Tracy Byrd	6	Lincoln	Debbie Broadway
3	Bledsoe	Vickie Carr	2	Loudon	Teresa Harrill
2	Blount	Robert Schmidt	4	Macon	Michael Railling
3	Bradley	Eloise Waters	3	McMinn	Jeannie Bentley
2	Campbell	Charles Turner	8	McNairy	Pattie Kiddy
4	Cannon	Andrea Fox	3	Meigs	Vickie Carr
7	Carroll	Emily Rushing	M	Madison	Kim Tedford
1	Carter	Caroline Hurt	3	Marion	Charlene Nunley
5	Cheatham	Vanessa Watkins	6	Marshall	Angie Faulkner
8	Chester	Christie Morris	6	Maury	Vacant
2	Claiborne	Charles Turner	3	Meigs	Vicki Carr
4	Clay	Andy Langford	2	Monroe	Teresa Harrill
2	Cocke	Jana Chambers	5	Montgomery	Joey Smith
6	Coffee	Debbie Broadway	6	Moore	Debbie Broadway
7	Crockett	Levarr Boyle	2	Morgan	Laura Conner
4	Cumberland	Karen Roper	7	Obion	Tim James
D	Davidson	William Paul	4	Overton	Andy Langford
8	Decatur	Pattie Kiddy	6	Perry	Sarah Russell
4	DeKalb	Michael Railling	4	Pickett	Andy Langford
5	Dickson	Sherrie Groves	3	Polk	Jeannie Bentley
7	Dyer	Tim James	4	Putnam	Lisa Bumbalough
8	Fayette	Levarr Boyle	3	Rhea	Vickie Carr
4	Fentress	Andy Langford	2	Roane	Laura Conner
3	Franklin	Charlene Nunley	5	Robertson	Vanessa Watkins
7	Gibson	Danna Taylor	5	Rutherford	Dana Garrett
6	Giles	Janet McAlister	2	Scott	Art Miller
2	Grainger	Gail Harmon	3	Sequatchie	Charlene Nunley
1	Greene	Shaun Street	2	Sevier	Jana Chambers
3	Grundy	Charlene Nunley	9	Shelby	Alisa Haushalter
2	Hamblen	Sherrie Montgomery	4	Smith	Michael Railling
H	Hamilton	Becky Barnes	5	Stewart	Karen Anderson
1	Hancock	Susan Venable	S	Sullivan	Gary Mayes
8	Hardeman	Levarr Boyle	5	Sumner	Hal Hendricks
8	Hardin	Pattie Kiddy	8	Tipton	Matt McDaniel
1	Hawkins	Susan Venable	5	Trousdale	Vacant
8	Haywood	Matt McDaniel	1	Unicoi	Cynthia Saylor
8	Henderson	Emily Rushing	2	Union	Charles Turner
7	Henry	Tracy Byrd	4	Van Buren	Karen Roper
6	Hickman	Sarah Russell	4	Warren	Andrea Fox
5	Houston	Karen Anderson	1	Washington	James T. Carson
5	Humphreys	Sherrie Groves	6	Wayne	Devin Toms
4	Jackson	Angie Hassler	7	Weakley	Tracy Byrd
2	Jefferson	Sherrie Montgomery	4	White	Andrea Fox
1	Johnson	Caroline Hurt	5	Williamson	Cathy Montgomery
K	Knox	Martha Buchanan	5	Wilson	Vacant
7	Lake	Tim James			
8	Lauderdale	Matt McDaniel			

NUTRITION EDUCATION CENTERS

Anderson County Health Department
710 N. Main Street
Clinton TN 37716
Coordinator: Vacant
[Vacant](#)
Phone: 865-425-8759 Fax: 865-457-4850

Blount County Health Department
301 McGhee Street
Maryville TN 37801
Coordinator: Susan Messer
Susan.Messer@tn.gov
Phone: 865-983-4582 Fax: 865-983-4574

Bradley County Health Department
201 Dooley Street S.E.
Cleveland TN 37311
Coordinator: Amy Davenport
Amy.Davenport@tn.gov
Phone: 423-728-7020 Fax: 423-479-6130

Carter County Health Department
403 East G. Street
Elizabethton TN 37643
Coordinator: Shannon Hopson
Shannon.Hopson@tn.gov
Phone: 423-543-2521 Fax: 423-543-7348

Franklin County Health Department
338 Joyce Lane
Winchester TN 37398
Coordinator: Haley Colvin
Haley.R.Colvin@tn.gov
Phone: 931-967-3826 Fax: 931-962-1168

Greene County Health Department
810 W. Church Street
Greeneville TN 37743-0159
Coordinator: Beth Tilson
Frances.Tilson@tn.gov
Phone: 423-798-1749 Fax: 423-798-1755

Hamilton County Health Department
921 East Third Street
Chattanooga TN 37403
Coordinator: Renee Giuliani
ReneeG@mail.HamiltonTN.gov
Phone: 423-209-8050 Fax: 423-209-8056

Hancock County Health Department
110 Willow Street
Sneedville TN 37869-0267
Coordinator: Lisa Littleton
Lisa.Littleton@tn.gov
Phone: 423-733-2228 Fax: 423-733-2428

Hawkins County Health Department
247 Silver Lake Road
Churchill TN 37857-0488
Coordinator: Lisa Littleton
Lisa.Littleton@tn.gov
Phone: 423-357-5341 Fax: 423-357-2231

Hawkins County Health Department
201 Park Blvd.
Rogersville TN 37857-0488
Coordinator: Andrea Krauser
Andrea.Krauser@tn.gov
Phone: 423-272-7641 Fax: 423-921-8073

Jackson Madison County Health Department
589 East College Street
Jackson, TN 38301
Coordinator: Anne Harbert
Anne.Harbert@tn.gov
Phone: 731-423-3020 Fax: 731-927-8601

Johnson County Health Department
715 West Main Street
Mountain City TN 37683
Coordinator: Devon Brown
Devon.C.Brown@tn.gov
Phone: 423-727-9731 Fax: 423-727-4153

Knox County Health Department
140 Dameron Ave.
Knoxville TN 37917-6413
Coordinator: Sarah Griswold
Sarah.Griswold@knoxcounty.gov
Phone: 865-215-5052 Fax: 865-215-5066

Lawrence County Health Department
2379 Buffalo Road
Lawrenceburg TN 38464-4810
Coordinator: Katie Winterburn
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Phone: 931-762-9406 Fax: 931-766-1592

Maury County Health Department
1909 Hampshire Pike
Columbia TN 38401
Coordinator: Laura Hill Schmidt
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McMinn County Health Department
393 County Road 554
Athens TN 37303
Coordinator: Shelby Stansell, MS
Shelby.Stansell@tn.gov
Phone: 423-745-7431 Fax: 423-744-1604

Montgomery County WIC Clinic
300 Pageant Lane
Clarksville TN 37040
Coordinator: Ila Avitia
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Phone: 931-551-8777 Fax: 931-503-0694

Roane County Health Department
1362 N. Gateway Ave.
Rockwood TN 37854
Coordinator: Jenny Glenn
Jenny.Glenn@tn.gov
Phone: 865-354-1220 Fax: 865-354-0112

Rutherford County Health Department
100 West Burton Street
Murfreesboro TN 37130
Coordinator: Mary Belle Hunter
MaryBelle.Hunter@tn.gov
Phone: 615-898-7785 Fax: 615-898-7829

Shelby County Southland Mall Clinic
1287 Southland Mall
Memphis TN 38116
Coordinator: Alice Faulkner
Alice.Faulkner@co.shelby.tn.us
Phone: 901-222-9828 Fax: 901-222-9856

Sumner County Health Department
1005 Union School Road
Gallatin TN 37066
Coordinator: Sherrie England
Sherrie.England@tn.gov
Phone: 615-206-1100 Fax: 615-206-9742

Washington County Health Department
219 Princeton Road
Johnson City TN 37601
Coordinator: Janet Hawkins
Janet.Hawkins@tn.gov
Phone: 423-975-2200 Fax: 423-975-2210

Unicoi County Health Department
101 Okalona Drive
Erwin TN 37650
Coordinator: Jennifer Carter
Jennifer.M.Carter@tn.gov
Phone: 423-743-9103 Fax: 423-743-9105

CENTRAL OFFICE PERSONNEL

State WIC Central Office Staff and their areas of assignment and direct phone numbers--**Area code (615).**

Peggy Lewis, MHE, RD, LDN, Supplemental Nutrition Programs Director 741-0227
WIC, CSFP, FMNP and SFMNP State Plans, federal program requirements, caseload management, general policy and budget issues, FNS/USDA correspondence.

Rashika Alwis, CPA, Division Fiscal Director (Consultant) 253-6066
Provides monthly reports of expenditures, consults with program staff related to fiscal issues and serves as liaison to Department's Division of Administrative Services (Fiscal.)

Laura Campbell, MS, LDN, State WIC Breastfeeding Coordinator 741-0266
Coordinates breastfeeding program promotion and support, BF training, and breastfeeding monitoring. Works with BF Hotline staff.

Sabrina Clark, Administrative Services 4 532-8171
Processes WIC and CSFP invoices and contracts, amendments and budget revisions. Places food orders, monitors and reports for CSFP.

Justin Allen, BS, Administrative Services 3 253-2151
Assists with administrative work like travel requests/ reimbursement, nutrition material tracking, annual editing of the WIC Manual and assists with Vendor Management monitoring reviews.

Billy Dodson, Food Administrator Assistant 2 532-8172
Assignment and follow-up for vendor compliance activities, voucher paper and vendor stamp activities. Dual Participation Report and Error Listing Report tracking.

Cynthia Dossett, MS, RD, LDN Nutritionist 4 532-8180
Monitoring visits to regional offices and clinics and review reports, technical assistance to regions and clinics, certification risk codes, therapeutic formula requests, and participant concerns and complaints.

Emily Germer, BS, RD, EBT Coordinator 532-8187
Research, educate, plan, and prepare EBT documents. This position also establishes stakeholder groups.

Tim Gill, BS, Media Director 532-8170
Layout and graphics of media productions, including video and other visual aides, films on location, supports staff in use of audio-visual equipment and PC's, and WIC and BF website maintenance.

Ann Hopton, MA, RD, LDN, Nutritionist 4 532-8184
Coordinator of Farmers' Market Nutrition Programs, training, technical assistance, and special clinic projects.

Kailey Lewis, BS, Public Health Educator 532-6084
Outreach and coordination activities, survey and focus group activities, training on Civil Rights

Sharon Morrow, MPA, RD, State Nutrition Education Coordinator 532-8186
Nutrition education plans and updates, promotion of alternative nutrition education, nutrition education materials development and procurement, staff newsletter editor, staff training, monitoring visits to regional offices and clinics, technical assistance, and participant concerns and complaints.

Sierra Mullen, MPH, Epidemiologist 253-7280
Prepares ad hoc reports and evaluates progress of specific issues within the Supplemental Nutrition Program. Coordinates reporting for the TN BF Hotline and other data analysis requests.

Jerry Orenstein, BS, State Vendor Manager 532-8177
Administration of bank contract, vendor agreements and compliance activities, TIP reporting, regional Vendor Management monitoring, liaison with other State and federal agencies, other WIC programs, and private sources.

Sherrie Patton, Receptionist/Secretary	532-8168
Greets visitors, answers Hotline/section phones, tapes/transcribes meeting minutes, and general secretarial duties.	
Nichoel Ryner, BFA, Media Producer	532-8185
Printing materials management, webinar coordinator, and media designer.	
Kelly Soliman, MS, LD, CLC, Nutritionist 4	532-8173
Building an Approved Product List (APL) for EBT, developing trainings for staff on the current system, MIS/EBT Project, and updating education online modules.	
Kelly Swindell, HR Representative	532-7535
Human resources representative, personnel and out of state travel transactions, and timekeeping specialist.	
Kathy Vaughan, MS, WIC Program System Manager	741-0307
Data System Manager and interface with OIT, CHS, regional and clinic data systems administrators and users.	
These two positions will be filled as soon as possible.	
Vacant, Data Liaison - Position being reclassified	532-2903
Resolving data problems, participate in data system improvements, maximize use of data system extracts and disaster recovery plan.	
Vacant, Nutritionist 3, State BF Peer Counselor Coordinator	532-7987
Coordinates BFPC program, training, tracking expenses, and BFPC program monitoring.	

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Family Health and Wellness Division
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Fax: 615-532-7189
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