

WIC MANUAL
STATE OF TENNESSEE
2012 - 2013



Nutrition and Wellness Section
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Foreword

The Tennessee Special 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 up to date on policies, procedures and changes in the Tennessee WIC Program. Although the WIC Manual provides guidance for doing the business of WIC, it is not all-inclusive.

The purpose of this manual is to guide the Competent Professional Authority (CPA) and the other staff through 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.

This manual has been reviewed, in whole or in part, by a group of WIC staff with expertise in particular areas and we thank them for their efforts to help us remain current.

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.

Chapter 2 Certification/Food Packages

Direction in this section relates to the assessment and documentation of medical and nutritional risk criteria. Food package codes and guidance for the approval of therapeutic formulas and for modifying food packages is contained in this chapter.

Chapter 3 Nutrition Education

Emphasis in this chapter is on the definition of high and low risk participants and how to document and counsel using Value Enhanced Nutrition Assessment (VENA), which includes the SOAP Format, Stages of Change, State of Readiness, and WIC Questionnaires and Records. This chapter also includes guidelines for completing the Regional Nutrition Services Plan, the Bureau's Breastfeeding Policy, the importance of breastfeeding promotion, and support and details for management of problems. The nutrition education curriculum, food abbreviations, and the VENA Counseling Skills Checklist are tools within this chapter. A list of Competent Professional Authorities (CPAs) for nutrition education is also available.

Chapter 4 Vouchers

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

Chapter 5 Systems

The description of the WIC Data System is contained here. The PTBMIS registration, WICQ, and FI/CVV (voucher) issuance screens are included and referenced. The VOC command and its printing and use are outlined.

Chapter 6 Miscellaneous

This chapter gives guidance on WIC participant rights, participant abuse, outreach, referrals, Breastfeeding logs, and monitoring. 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 Regulation—7 CFR 246—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. This manual is not intended to be all-inclusive. Therefore, if there are questions, please contact the Central Office for assistance.

CUSTOMER SATISFACTION

What is it worth? It could be worth increased funding or it could be worth someone's job! High customer satisfaction attracts new customers and helps retain existing ones. Customer dissatisfaction can hit our funding in one way or another. So, show enthusiasm for your work—smile—maintain a professional atmosphere and create a sense of equality. Participants have a right to expect courteous and caring service when receiving or applying for WIC program benefits. 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. Remember, you could be on the other side of the counter/desk!

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 participants (246.26 (d), and FNS Instruction 800-1 located in Regional offices. 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 patient (Bureau of Health Services, Policies and Procedures Manual, Records and Forms Management Section Clinical Records Policy, 1995). HIPAA (Health Insurance Portability and Accountability Act) 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 Informed Consent Form (PH-1530/3290) contains the release of information (#4).

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 Standards [246.7 (f) (2)] 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 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 [246.4 (a) (21) & (22)].

When a new prenatal who is not registered in 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 (246.7 (b) (4) & (5)].

REGISTRATION AND SCREENING

Race/Ethnicity

All WIC applicants/participants will be allowed to self-declare their races. Participants should be allowed to declare up to 5 races. 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 must 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.

Residency

Applicants must be residents of Tennessee and the service area for the health department where they receive WIC benefits. While that area is typically the county of residence, applicants of adjoining counties may be served 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, alien 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 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. Have the participant sign the Informed Consent Form and staff member sign in appropriate place.
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, have the signed Informed Consent Form (PH 1530/3290) faxed to the previous WIC clinic and request a copy of the WIC master record or the VOC.
4. A VOC with name and beginning and ending certification dates will be accepted at the time of transfer.
5. Provide participants with a referral/resource list for the new county.

If a transfer from another state has unused FI/ CVV, write "void" on the FI/ CVV and mail them to your Regional WIC Director. Issue new Tennessee FI/ CVV.

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 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 VOC for Tennessee WIC Participants

Upon request or knowledge that a participant is transferring to another State or another Region within Tennessee, print a Verification of Certification (VOC) for each member of the family/economic unit. The VOC is printed on site through PTBMIS.

VERIFICATION OF CERTIFICATION

Participant No:	0000000522
Participant Name:	Test M. Patient
Address:	N. Main Newport, TN 37821
Date of Birth:	02/10/1997
WIC Status:	EX BF INFANT
Local Agency:	Cocke County Health Dept.
Address:	Pat Honigman Avenue Sandy, TN 37821
Telephone No.:	423-623-8733
Signature: (Participant, Parent or Guardian):	_____

Certification Date:	06/04/1997
Certification Expires:	02/10/1998
Date of Last Income Screening:	06/05/1997
Month Fi/Cvv Issued Through:	07/97
Nutrition Risk Reason(s):	LBW INF/WIC MOM
Height:	29 0/8" 0.0 CM
Weight:	20 LBS 1 OZ. 0.00 KG
Hemoglobin:	12.1 GMS
HCT:	0 gms
Issued By (Signature):	_____
Print Name:	

Interpreters

Based on the Federal requirement for Limited English Proficiency (LEP) and Bureau of Health Service Administration (HSA Policy 7.21), 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". This policy is applicable to the TN WIC program and staff in the local health departments and regional offices. Family members cannot be used as interpreters for participants.

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 caretaker at the certification visit. The infant/child can also be accompanied by another adult/proxy as long as the parent/guardian has signed the Informed Consent 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.

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

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

- living arrangements and relationship of caretaker 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 caretaker status, you may request more proof, issue for one month, or refer to Central Office for further departmental action.

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 the initial date of request for WIC services is captured in PTBMIS.

For applicants/participants who have an unusual circumstance and are unable to provide proofs, i.e. 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, to receive nutrition education or to receive FI/CSV and shop for authorized food. During each certification period, a proxy

must present proof of identity and a written note from the person being represented. This note is filed in the medical record. Proxies are not allowed to sign the Informed Consent Form at certification. Once the participant/parent/caregiver has signed the Informed Consent Form, proxies may complete the certification or nutrition education and receive FI/CVV.

Employee Certification [246.4(a)(26)]

Any health department employee or immediate family member must have his/her application for WIC services reviewed by the Regional WIC Director before FI/CVV can be issued. 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 any other family member who resides in the employee's household. The Regional WIC 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 less than one year of age
- 4 - Infant under one year of age
- 5 - Child one to five years of age
- 6 - Fully breastfeeding woman
- 7 - Fully breastfed infant
- 9 - Partially breastfed infant
- B - Barely breastfeeding woman (BF at least once per day)

Proof of Identity

Document the type of proof on the 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 pres-

ent 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 Health Department employee certifies infant at the hospital and sees the infant, no visit to the health department is required.

Participants with a 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.

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 Folder (WF) (for FI/CVV pickup if the folder 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

Income Criteria

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 provided below.

WIC Income Eligibility Guidelines

July 1, 2012 - June 30, 2013

<u>Family Size</u>	<u>Annual</u>	<u>Monthly</u>	<u>Twice Monthly</u>	<u>Bi-Weekly</u>	<u>Weekly</u>
1	\$20,665	\$1,723	\$862	\$795	\$398
2	\$27,991	\$2,333	\$1,167	\$1,077	\$539
3	\$35,317	\$2,944	\$1,472	\$1,359	\$680
4	\$42,643	\$3,554	\$1,777	\$1,641	\$821
5	\$49,969	\$4,165	\$2,083	\$1,922	\$961
6	\$57,295	\$4,775	\$2,388	\$2,204	\$1,102
7	\$64,621	\$5,386	\$2,693	\$2,486	\$1,243
8	\$71,947	\$5,996	\$2,998	\$2,768	\$1,384
Each Add'l Member Add	+7,326	+611	+306	+282	+141

Note: Do not allow hardship deductions from the above income poverty guidelines. A standard deduction has been included in all of the above income levels.

*At each certification, the gross income is determined and filled in on the Informed Consent Form. The PHOA and the applicant/participant must sign the income form at each certification. English version (PH-1530) and Spanish version (PH-3290).

La elegibilidad por ingreso es uniforme dentro del estado y es determinada localmente por el empleado en la clínica.* El ingreso total doméstico del participante tiene que ser menos que las normas de ingreso de WIC (185% de la guía de la pobreza del USDA).

Guía De La Elegibilidad por Ingreso De WIC

Julio 1, 2012– Junio 30, 2013

<u>Tamaño de familia</u>	<u>Anual</u>	<u>Mensual</u>	<u>Dos veces por Mers</u>	<u>Quincenal</u>	<u>A la semana</u>
1	\$20,665	\$1,723	\$862	\$795	\$398
2	\$27,991	\$2,333	\$1,167	\$1,077	\$539
3	\$35,317	\$2,944	\$1,472	\$1,359	\$680
4	\$42,643	\$3,554	\$1,777	\$1,641	\$821
5	\$49,969	\$4,165	\$2,083	\$1,922	\$961
6	\$57,295	\$4,775	\$2,388	\$2,204	\$1,102
7	\$64,621	\$5,386	\$2,693	\$2,486	\$1,243
8	\$71,947	\$5,996	\$2,998	\$2,768	\$1,384
Por cada Persona adicional añada	+7,326	+611	+306	+282	+141

Nota: No se permiten deducciones, por apuros, de las cantidades en la lista arriba. Una deducción normal se ha incluido en estas cantidades.

*En cada certificación se averigua el ingreso total y se rellena en el papel permiso informado. El empleado y el participante tienen que firmar este papel en cada certificación.

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 family size. If she is expecting twins or triplets, etc., each fetus is counted as one and the family size increases accordingly.

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 level must establish the size of the economic unit of which the applicant/participant is a member to determine WIC income eligibility. The local level 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 expecting or who has a common child/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 family/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 Principles

(Reference: SFP Regional Letter #140-50)

Income means gross cash income before deductions for income taxes, social security taxes, insurance premiums, bonds, etc. It also includes 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. For self-employed individuals, the net income is the basis for income eligibility. Net income= 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 TennCare presumptive eligibility done. 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.

In order to save time, check first for **adjunctive income eligibility** (Medicaid, SNAP, Families First) at the **beginning** of **every** certification. If applicant/participant is adjunctively eligible for any of these services, **no additional income screening is necessary**. Proof of adjunctive eligibility must be confirmed at time of application, except as defined above for the presumptive prenatal. If adjunctively eligible and income is needed for fee-for-service sliding scale, enter the income amount that the applicant/participant tells you.

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 **“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 subsequent WIC appointments for nutrition education/FI/CVV pick-up [246.7 (h)], participants/parents/caregivers should 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.

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 Notice of Ineligibility. (Follow the Notice of Ineligibility 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 1 FI (for the half month) and a CVV. Notify participant that they are over income (>185% of Federal poverty) and remind the participant that if the income changes to come back for re-determination of eligibility.

Special Income Situations

Migrants instream 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.

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 accurately reflects the family 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 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 family (with current notice of disposition)
- Family member of pregnant woman or infant certified eligible for Families First or Medicaid TennCare

For TennCare eligibles, enter the correct Medicaid code from the TennCare system in the spaces provided for 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-time [246.7 (d) (iv)]
- 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 chart below)
- Value of school lunch and SNAP benefits.

Military Income Codes and Guidelines [246.7 (d) (iv)]

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.

A combat zone is any area that the President of the United States designates by Executive Order as an area in which the U.S. Armed Forces are engaging or have engaged in combat. 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

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 (PH-1530)

The Informed Consent/Signature Sheet 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 that needs to be used for the patient to verify 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 Informed Consent/Signature Sheet. A form must be completed for each new patient. The patient should be instructed to read the back of the Informed Consent. 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 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 patient 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.

Notice of Ineligibility (NOI)

If the applicant is ineligible, fill out the most recent version of the Notice of Ineligibility (NOI). 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 (NOI), and at least 15 days worth of benefits.

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.

Procedures

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. 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)

- Infants
- Pregnant Women
- Breastfeeding Women

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 most current version of the Notification of Ineligibility. 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 date applicants are placed on the waiting list.

Selection from Waiting List to Receive Benefits

- Contact the highest priority person(s) from the waiting list with earliest date of screening for certification to inform them they may pick up . 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.

Transfers

Out of state transfers who are within their certification period and have a valid VOC or instate 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.

Certification/Food Package

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ASSESSMENT AND DOCUMENTATION

Certification Assessment

WIC is part of a network of integrated health services available through the Department of Health and various health and social service agencies. To qualify for WIC, participants must be examined and certified to be at nutritional risk by a Competent Professional Authority (CPA). CPAs may be:

Nutritionists,

Nutrition Educators,

Registered Nurses

Physicians.

Licensed Practical Nurses (LPNs) who have been approved by the supervising RN may also certify a participant for WIC but may not provide nutrition education.

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 benefits. Referral measures from a private provider, an outpatient clinic, or hospital birth measures may also be used. If applicants do not bring referral measures, measures must be taken while the applicant is in the clinic for WIC services.

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. (Refer to Chapter 1, “Proof of Identity.”)

EXCEPTION: 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 professional determines the disability of the participant and 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; and/or
- A serious illness that may be exacerbated by coming into the WIC clinic.

The “Local Resource Referral List” in Chapter 6 must be provided on at least one occasion (at initial certification) to each adult participant and individual applying for the WIC Program for themselves or on behalf of others, to comply with Section 246.7(b) (1) of the WIC Program Consolidated Regulations. This list must be updated annually.

Women

The WIC Medical/Nutrition Assessment with results documented in the medical record must include:

As a part of the integrated health services of a local health department of which WIC is a part and according to the Women's Health Manual, Volumes I & II of the Tennessee Department of Health, women shall receive a comprehensive personal history. The initial history should address immunizations (especially rubella and tetanus). The annual exam should address an update to include immunizations (especially rubella). For the initial prenatal visit an obstetric database for the client should include immunizations. The current recommendations from Centers for Disease Control and Prevention (CDC) on immunizations/vaccinations during pregnancy should be the guide for the assessment.

- 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)
- BMI
- Nutrition assessment and postpartum breastfeeding women
- Breastfeeding assessment for prenatals and postpartum breastfeeding women
- EDD (expected date of delivery) (prenatal certification)
- Medical history (as needed for certification)
- Hematocrit or hemoglobin (each certification).

Pregnant Women

If not obvious, pregnancy must be documented by a physician, nurse specialist, or positive pregnancy test performed by a health professional. 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 and followed by written confirmation (by fax or mail). If the physician's office is closed when attempting to confirm pregnancy, may give one (1) month of vouchers 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.

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 for their infant. Partially breastfeeding women (WIC status 3) are issued the partial formula food package for their infant. 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 post delivery but stopped prior to her postpartum certification, the WIC Special Data box on the Encounter form must reflect breastfeeding was initiated and stopped.

As described by USDA in the Breastfeeding Handbook, "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, provide her the fully breastfeeding food package in the first week after delivery or as soon as possible so she may benefit from the additional foods."

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

All breastfeeding women must be screened at certification. 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 are then placed in the priority of the infant's risk. For 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, change her status to postpartum and continue services to 6 months after delivery. A breastfeeding woman who was certified as 601 should be given the option of rescreening or being terminated if she quits breastfeeding before 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.

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. Postpartum certification (non-breastfeeding) covers from 6 weeks up to 6 months past delivery. All postpartum women must be screened at certification. A postpartum woman not served by WIC during her pregnancy may be certified anytime after delivery up to 6 months.

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. The woman should continue to receive prenatal vouchers to the end of the month in which the 6-weeks date occurs. For a woman initially certified as a postpartum, an appointment may be made and a certification exam performed whenever application is made (prior to 6 months).

Infants and Children

The WIC Medical/Nutrition Assessment with results documented in the medical record must include at each certification:

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, Bureau of Health Services, Maternal and Child 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.”

- Length/Height*
 - Weight*
 - Percentiles plotted on weight-for-height, height-for-age, and weight-for-age charts *
 - BMI (2-5 years of age)
 - Medical history *
 - Nutrition assessment *
- *Note: As indicated or at least every three months if on therapeutic formula
- Hematocrit or hemoglobin –
 - Infants - required 9th through 12th month.
 - Children - required 15th through 18th month.
 - Children - after 18 months on annual basis if within normal limits at last certification. This applies only if child has been screened at 12 months and 18 months.
 - Children - must have at least two hemoglobin checks completed prior to 24 months of age.

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

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

Documentation from a physician of the medical condition 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 physician would be required for each subse-

quent certification. If the condition is considered “life long”, such as hemophilia, a new statement from the physician is not required.

In most cases, a person with a serious medical condition will be receiving regular medical care and referral data should be attainable. Therefore, every effort should be made to obtain the data. If attempts to obtain the referral data fail, certify the participant based on an identified risk criteria other than anemia. Document your efforts to obtain the data in the participant’s file.

If after screening for recertification, no other risk is identified, parent/guardian/caretaker should be asked if she/he wants the child’s hematocrit or hemoglobin checked. If response is affirmative, test should be performed. Parent/guardian/caretaker’s response to question should be documented in the participant’s record.

Infants less than 6 months of age are certified to 12 months of age. Infants initially certified at or over 6 months of age must be recertified every six months. With the new WIC Food Packages, the fully formula feeding infant is a WIC Status 4, the partially breastfed infant is a WIC Status 9, and the fully breastfed infant is a WIC status 7.

All breastfed infants should be enrolled immediately after birth. Breastfed infants who have no risk of their own may be certified on the basis of the mother’s risk. (Risk Code 702 for the infant). The Priority is that of the mother’s risk. For example, there are no risk codes that apply to the infant. However, the mother is certified for “Priority 1” risk code 201, low hemoglobin. The infant qualifies for WIC based on the mother’s risk (anemia). The infant is certified for code 702, breastfeeding infant of woman at nutritional risk. Both infant and mother are Priority 1 status. If the infant quits breastfeeding during the certification period, another nutritional risk code must be identified.

Children may be certified from the month of their first birthday through the month of their fifth birthday. Children must be recertified every six months

Mid-Certification Assessment

Infants, children, and breastfeeding women certified for a period longer than six months (i.e., one year certification period) must have a mid-certification assessment. Participants height and weight should be collected and an assessment of growth and/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 occurred. A follow-up blood test is an allowable WIC expense and may be performed by clinic staff.

Documentation in Medical Record

All medical information related to the reason for certification must be recorded in the participant's medical record at each certification. Adequate documentation must be present in the participant's medical record to support all nutrition risks. The signature and title of the Competent Professional Authority (CPA), and date of certification must be written in the medical record. To maintain separation of duties, a CPA that certifies participants to receive WIC benefit cannot issue vouchers.

Identify all nutrition risks by marking the corresponding codes on the risk criteria list on the appropriate WIC record. Note all risks so that they may be addressed in counseling. Enter up to three risk criteria in the "Cert Reason" section of the encounter form. If more than three risks are identified, enter the highest priority risk codes on the encounter.

WIC records and growth chart (plotted) must be started at the initial certification for infants, with information to include the infant's name and address, date of birth, birth weight and length plotted, information on method of feeding, and signature of the person certifying. A proxy may pick up the initial vouchers at the first formula issuance if parent or guardian has signed the Informed Consent Form within the past 30 days. Each infant should be assessed at each visit to receive nutrition counseling and medical follow-up based on individual need.

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.

Referral Measures

Referred anthropometric measures taken within the last 60 days can be used for certification. 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 or prescription pad, or printout from electronic health record may be used to convey data needed for WIC certification. Height, weight, and hematocrit or hemoglobin should be recorded by the provider* and noted with an "REF" or "HOSP" next to the date on the growth chart for WIC certification purposes. 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 and should be plotted on the growth charts.

*Automated growth charts (AGC) are used in many clinics, so plotting is done electronically. User ID is entered into the AGC system.

Correcting Errors

The revised 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

CERTIFICATION IN HOSPITALS

According to 246.6(f) *Outreach / 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 hospital:

1. 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 program services; and
2. 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 letter of 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 and
- 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 at 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 vouchers 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
 - Born to Non-WIC Mom
- Breastfeeding or Postpartum Mothers

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) If not adjunctively eligible, applicant must have proof of income and residency.

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 (PH-1539 or PH-1541)
- WIC Infant Nutrition Questionnaire (PH-3954)
- WIC Infant Record (PH-3669)
- If necessary, Request for Therapeutic WIC Approved Formula (PH-4077)

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 medical 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.

*Automated growth charts (AGC) are used in many clinics, so plotting is done electronically. User ID is entered into the AGC system.

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-County Participants

When infants are directly enrolled into a clinic in their county of residence, the certification forms (see above) should be sent to that clinic site to start the file. When infants are transferred from the hospital clinic into a clinic in their county, the original certification forms may be sent to the new clinic. A list of infants certified at the hospital clinic should be kept in a file at the regional office detailing the clinics where they are transferred.

Out-of-County Participants

When out-of-county infants are enrolled into the hospital clinic, provide a list of clinics in surrounding counties to the new mother with an explanation of how to make an appointment. Issue a VOC to the participant. (Refer to Chapter 5, VOC) The original certification forms may be sent to the home county clinic site. A list of infants certified at the hospital clinic should be kept in a file at the regional office detailing the site(s) where they are transferred.

Staff at the home county site may make follow up calls or send written notices to participants who fail to make their initial visit to the new clinic site.

CERTIFICATION PROCEDURE FOR THE HOMELESS

A homeless individual means:

- An individual who lacks fixed or regular nighttime residence, or
- An individual whose primary nighttime residence is:
 - A supervised publicly or privately operated shelter designed to provide temporary living accommodations, i.e., welfare hotels or congregate shelters or shelters for victims of domestic violence;
 - 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.

Homeless individuals are certified according to program requirements located in risk criteria codes in this chapter. Attention must be directed to the homeless participant's current situation in order to assure that program services can be effectively utilized. If living in a homeless facility, local agency WIC staff members are responsible for determining the status of homeless facilities/shelters in their area as defined in the sample, "Homeless Letter of Agreement" located in Central Office. If it comes to the attention of local agency WIC staff that a facility serving the homeless falls out of compliance with the three required conditions for services (see Homeless Agreement), WIC residents must receive 30 days notice of the need to sever connections with the facility or be disqualified from WIC. Notification must include reasons for the action and participant's right to a fair hearing. Tennessee WIC does not serve applicants who reside in traditional, residential, long term institutions, such as rehabilitative and correctional facilities. Depending upon living conditions, a food package for the homeless (see Chapter 2, "Homeless") and nutrition education (see Chapter 3, "General Information for Completion and Documentation of Nutrition Education") should be issued to meet individuals' needs. It is important to issue VOC to homeless individuals if they are transients or if service at another clinic is expected. CPA's should be alert to needs for referral of this population to health or social services as indicated.

NUTRITION RISK CRITERIA CODES

The following nutrition risk criteria 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.

Identify all risks. Certify for the highest priority reasons and put these codes on the encounter form. Note the risk(s) in the participant's record so that they may be addressed in counseling. If risks appear equal, i.e., same priority, same level of nutrition risk, choice of risk for certification is at the discretion of the certifier.

NUTRITION RISK CRITERIA

Women Pregnant, Breastfeeding & Non-Breastfeeding

Low Weight for Height Pregnant – Priority I, , Breastfeeding – Priority I, Non-breastfeeding – Priority III

101. Underweight

- A. Pregnant Women
pregnancy Body Mass Index (BMI) <18.5
- B. Non-Breastfeeding Women
pregnancy or current Body Mass Index (BMI) <18.5
- C. Breastfeeding Women less than 6 months postpartum
pregnancy or current Body Mass Index (BMI) <18.5
- D. Breastfeeding Women 6 months postpartum or more
current Body Mass Index (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, including pregnant and postpartum adolescents, not the CDC BMI-For-Age charts. More research is needed to determine whether, special categories are needed for adolescents. However, professionals should use all the tools available to them to assess these applicants anthropometric status and tailor nutrition counseling accordingly.

High Weight for Height, Pregnant – Priority I, Breastfeeding – Priority I, Non-breastfeeding – Priority III

111. Overweight

- A. Pregnant Women
prepregnancy Body Mass Index (BMI) ≥ 25
- B. Non-Breastfeeding Women
prepregnancy Body Mass Index (BMI) ≥ 25
- C. Breastfeeding Women less than 6 months postpartum
prepregnancy Body Mass Index (BMI) ≥ 25
- D. Breastfeeding Women 6 months postpartum or more
current Body Mass Index (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. More research is needed to determine whether, special categories are needed for adolescents. However, professionals should use all the tools available to them to assess these applicants anthropometric status and tailor nutrition counseling accordingly.

Inappropriate Growth/Weight Gain Pattern, Pregnant-Priority 1, Breastfeeding-Priority 1, Non-Breastfeeding, Priority III

131. Low Maternal Weight Gain (Pregnant Women)

Low maternal weight gain is defined as:

1. A low rate of weight gain, such that in the 2nd and 3rd trimesters, for singleton pregnancies:
 - Underweight women gain less than 1 pound per week
 - Normal weight women gain less than .8 pounds per week
 - Overweight women gain less than .5 pounds per week
 - Obese women gain less than .4 pounds per week

OR

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

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

**There is insufficient information for the 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.

NOTE: 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.

Nutrition Risk Criteria (Women)

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 of ≥ 2 pounds

133. High Maternal Weight Gain (Singleton Pregnancies)

Pregnant Women (current pregnancy), all trimesters, all weight groups: ≥ 7 lbs/mo.

Breastfeeding or Non-Breastfeeding Women (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the IOM's recommended range based on Body Mass Index (BMI), as follows:

Prepregnancy Weight Groups	Definition (BMI)	Cut-Off Value
Underweight	<18.5	>40 lbs
Normal Weight	18.5 to 24.9	>35 lbs
Overweight	25.0 to 29.9	>25 lbs
Obese	≥ 30.0	>20 lbs

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. More research is needed to determine whether, special categories are needed for adolescents. However, professionals should use all the tools available to them to assess these applicants anthropometric status and tailor nutrition counseling accordingly.

Hematocrit or Hemoglobin Below State Criteria, Pregnant – Priority I, Breastfeeding – Priority I, Non-Breastfeeding – Priority III)

Nutrition Risk Criteria (Women)

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 1st 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
Up to 1pk/day	11.3 34.0	10.8 33.0	11.3 34.0	12.1 36.7	12.3 36.9	12.3 36.7
1-2 packs/day	11.5 34.5	11.0 33.5	11.5 34.5	12.3 37.2	12.5 37.4	12.5 37.2
≥ 2 packs/day	11.7 35.0	11.2 34.0	11.7 35.0	12.5 37.7	12.7 37.9	12.7 37.7

Other Biochemical Test Results Which Indicate Nutritional Abnormality, Pregnant – Priority I, , Breastfeeding – Priority I, Non-Breastfeeding – Priority III

211. Elevated Blood Lead Levels, Blood lead level of (equal to or greater than) 10 micrograms per deciliter, within the past 12 months.

Pregnancy-Induced Conditions, , Pregnant – Priority I, , Breastfeeding – Priority I, Non-breastfeeding – Priority III

301. Hyperemesis Gravidarum (Pregnant Women Only)

Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. Presence of hyperemesis gravidiarum diagnosed by a physician as self-reported by applicant/participant/caregiver, or as reported or documented by a physician, or someone working under the physician's orders.

Nutrition Risk Criteria (Women)

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.

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

303. History of Gestational Diabetes

History of diagnosed gestational diabetes

Pregnant Women: Any history of gestational diabetes

Breastfeeding/Non-Breastfeeding: Most recent pregnancy

Nutrition Risk Criteria (Women)

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.

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

Delivery of Low-Birth Weight/Premature Infant., Pregnant – Priority I, , Breastfeeding – Priority I, Non-Breastfeeding – Priority III)

311. History of Preterm Delivery

Birth of an infant at or less than 37 weeks gestation

Pregnant Women: Any history of preterm delivery

Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy

Nutrition Risk Criteria (Women)

312. History of Low Birth Weight

Birth of an infant weighing 2500 gr. or less or 5 lbs. 8 oz. or less

Pregnant Women: Any history of low birth weight

Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy

Prior Stillbirth, Fetal, or Neonatal Death, , Pregnant – Priority I, , Breastfeeding – Priority I, Non-Breastfeeding – Priority III

321. History of Spontaneous Abortion, Fetal or Neonatal Loss

A Spontaneous Abortion (SAB) is the spontaneous termination of a gestation, <20 weeks gestation or <500 grams. A fetal death (death at, equal to or greater than, 20 weeks gestation) or a neonatal death (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

General Obstetrical Risk, , Pregnant – Priority I, Breastfeeding – Priority I, Non-Breastfeeding – Priority III

331. Pregnancy at a Young Age

Conception 17 years of age or less

Pregnant Women: Current pregnancy

Breastfeeding/Non-Breastfeeding: Most recent pregnancy

Because actual date of conception is difficult to determine, the applicant's age at last menstrual period may be used to determine pregnancy before her 18th birthday.

332. Closely Spaced Pregnancies

Conception before 16 months postpartum

Pregnant Women: Current pregnancy

Breastfeeding/Non-Breastfeeding: Most recent pregnancy.

Nutrition Risk Criteria (Women)

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 based on an Inadequate Prenatal Care Index:

First prenatal visit in the third trimester (7-9 months) or:

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 <10th percentile for gestational age

337. History of birth of an infant weighing equal to or greater than 9 lbs or 4000 g

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

Nutrition Risk Criteria (Women)

338. Pregnant Woman Currently Breastfeeding (Pregnant Only)

Breastfeeding woman now pregnant

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

Nutrition-Related Risk Conditions (e.g., Chronic Disease, Genetic Disorder, Infection), (Pregnant and Breastfeeding Women – Priority I, Non-Breastfeeding Women – Priority III)

Presence of disease, disorder or condition must be 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.

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

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)

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

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.

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

344. Thyroid Disorders

Hypothyroidism (insufficient levels of thyroid hormone produced or defect in receptor) or hyperthyroidism (high levels of thyroid hormone secreted) or postpartum thyroiditis (inflammation of the thyroid occurring in the first year after delivery). Presence of condition diagnosed, documented, or reported by a physician or someone working under physician's orders, or self reported by applicant.

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

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

Nutrition Risk Criteria (Women)

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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 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), and neural tube defects (NTD), such as spina bifida or myelomeningocele, Parkinson's disease and 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 syndrome, thalassemia major/minor and sickle cell anemia (not sickle cell trait) and muscular dystrophy.

351. Inborn Errors of Metabolism

Presence of inborn error(s) of metabolism as diagnosed, documented, or reported by a physician or someone working under physician's orders, or self reported by applicant. Generally refers 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 and Mitochondrial Disorders.

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352. Infectious Diseases

A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to, tuberculosis, pneumonia, meningitis, parasitic infections, hepatitis, bronchiolitis (3 episodes in last 6 months), HIV* (Human Immunodeficiency Virus and AIDS*) (Acquired Immunodeficiency Syndrome). The disease must be present within the past 6 months.

***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

An adverse immune response to a food or a hypersensitivity that causes an adverse immunologic reaction. (Note: Examples of adverse immunologic reactions to food include; atopic dermatitis, anaphylaxis, allergic esophagitis, or gastroenteritis.)

354. Celiac Disease

Also known as celiac sprue, gluten enteropathy or non-tropical sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic makeup.

355. Lactose Intolerance

An insufficient production of the enzyme lactase

356. Hypoglycemia

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

A disturbed sense of body image and morbid fear of becoming fat

Nutrition Risk Criteria (Women)

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 (e.g., Asthma, Lupus)

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.

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, 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, other disabilities.

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.

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

Nutritional Risk Criteria (Women)

Substance Abuse, (Drugs, Alcohol, Tobacco) Pregnant – Priority I, , Breastfeeding – Priority I, Non-Breastfeeding – Priority III)

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.)

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. A serving or standard-sized drink is 1 can of beer (12 fl. oz.), or 5 oz. wine, or 1-1/2 fluid oz.. liquor,
Binge drinking, i.e., drinks 5 or more on the same occasion on at least one day or in the past 30 days, or Heavy Drinking, i.e., drinks 5 or more drinks on the same occasion on 5 or more days in the previous 30 days, or Any illegal drug use.

Other Health Risks, Pregnant – Priority I, Breastfeeding – Priority I, Non-Breastfeeding – Priority III)

381. Dental Problems

Diagnosis of dental problems by a physician 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.

Failure to Meet the Dietary Guidelines for Americans, Pregnant-Priority IV, 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.) Dietary Recall optional.

This risk may be assigned only women for whom a complete nutrition assessment including Inappropriate Nutrition Practices for Women (427) has been performed and for whom no other risk(s) are identified.

Other Dietary Risks Pregnant-Priority IV, Breastfeeding-IV, Non-Breastfeeding-VI

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.

Inappropriate Nutrition Practices for Women	Examples of Inappropriate Nutrition Practices (including but not limited to)
427.1 Consuming dietary supplements with potentially harmful consequences.	Examples of dietary supplements which when ingested in excess of recommended dosages, may be toxic or have harmful consequences: <ul style="list-style-type: none"> <input type="checkbox"/> Single or multiple vitamins; <input type="checkbox"/> Mineral supplements; and <input type="checkbox"/> Herbal or botanical supplements/remedies/teas.
427.2 Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.	<ul style="list-style-type: none"> <input type="checkbox"/> Strict vegan diet; <input type="checkbox"/> Low-carbohydrate, high-protein diet; <input type="checkbox"/> Macrobiotic diet; and <input type="checkbox"/> Any other diet restricting calories and/or essential nutrients.
427.3 Compulsively ingesting non-food items (pica).	Non-food items: <ul style="list-style-type: none"> <input type="checkbox"/> Ashes; <input type="checkbox"/> Baking soda; <input type="checkbox"/> Burnt matches; <input type="checkbox"/> Carpet fibers; <input type="checkbox"/> Chalk; <input type="checkbox"/> Cigarettes; <input type="checkbox"/> Clay; <input type="checkbox"/> Dust; <input type="checkbox"/> Large quantities of ice and/or freezer frost; <input type="checkbox"/> Paint chips; <input type="checkbox"/> Soil; and <input type="checkbox"/> Starch (laundry and cornstarch).

427. Inappropriate Nutrition Practices for Women (continued)

Inappropriate Nutrition Practices for Women	Examples of Inappropriate Nutrition Practices (including but not limited to)
<p>427.4 Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Consumption of less than 27 mg of supplemental iron per day by pregnant woman. <input type="checkbox"/> Consumption of less than 150 µg of supplemental iodine per day by pregnant and breastfeeding women. <input type="checkbox"/> Consumption of less than 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant woman.
<p>427.5 Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.</p>	<p>Potentially harmful foods:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Raw fish or shellfish, including oysters, clams, mussels, and scallops; <input type="checkbox"/> Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole; <input type="checkbox"/> Raw or undercooked meat or poultry; <input type="checkbox"/> Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot; <input type="checkbox"/> Refrigerated pâté or meat spreads; <input type="checkbox"/> Unpasteurized milk or foods containing unpasteurized milk; <input type="checkbox"/> 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; <input type="checkbox"/> 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; <input type="checkbox"/> Raw sprouts (alfalfa, clover, and radish); or <input type="checkbox"/> Unpasteurized fruit or vegetable juices.

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 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

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 Dyad, (Priority I, II, IV)

601. Breastfeeding Women of Infant at Nutritional Risk

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**

602. Breastfeeding Complications or Potential Complications (Priority I)

Any of the following are considered complications or potential complications for breastfeeding:

1. Breastfeeding woman with
 - a) severe breast engorgement
 - b) recurrent plugged ducts
 - c) mastitis
 - d) flat or inverted nipples
 - e) cracked, bleeding or severely sore nipples
 - f) age (equal to or greater than) 40 years
2. Failure of milk to come in by 4 days postpartum
3. Tandem nursing (breastfeeding two siblings who are not twins)

Homelessness/Migrancy, (Pregnant and 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:

1. 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;
2. An institution that provides a temporary residence for individuals intended to be institutionalized;
3. A temporary accommodation of not more than 365 days in the residence of another individual; or
4. A public or private place not designed for, or ordinarily used as, a regular 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.

Other Nutritional Risks, (Pregnant and Breastfeeding – Priority IV, Non-Breastfeeding Priority VI)

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 or Infant/Child of Primary Caregiver 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;
- 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.

Note: 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

Infants And Children

Low Weight for Height, (Infants – Priority I, Children – III)

103. Underweight or At Risk of Becoming Underweight

A. 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).

B. 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).

High Weight for Height, (Infants-Priority 1, Children – Priority III)

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

A. 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.

B. 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.

Short Stature, (Infants – Priority I, Children – Priority III)

121. Short Stature or At Risk of Short Stature

A. 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).

B. 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).

Inappropriate Growth/Weight Gain Pattern, (Infants – Priority I, Children – Priority III)

134. Failure to Thrive

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

Note:

The anthropometric criteria cited by the American Academy of Pediatrics as most commonly used are:

Weight (or weight for height) is less than two percentile lines below the mean for sex and age and/or weight curve has crossed more than two percentile lines on the growth chart after having achieved a previously stable pattern.

135. Inadequate Growth

An inadequate rate of weight gain as defined below:

1. Infants from birth to 1 month of age:
 excessive weight loss after birth
 not back to birth weight by 2 weeks of age
2. 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 following table:

<u>Age</u>		<u>Average Weight Gain</u>	
Birth – 1 mo.	18 gm/day	4½ oz/wk	1 lb 3 oz/mo
1-2 mos	25 gm/day	6¼ oz/wk	1 lb 11 oz/mo
2-3 mos	18 gm/day	4½ oz/wk	1 lb 3 oz/mo
3-4 mos	16 gm/day	4 oz/wk	1 lb 1 oz/mo
4-5 mos	14 gm/day	3½ oz/wk	15 oz/mo
5-6 mos	12 gm/day	3 oz/wk	13 oz/mo

3. 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.

<u>Age</u>		<u>Average Weight Gain</u>	
6-12 mos	9 gm/day	2¼ oz/wk	9½ oz/mo
12-59 mos	2½ gm/day	0.6 oz/wk	2.7 oz/mo
			3 lbs 10 oz/6 mos
			1 lb/6mos

Low Birth Weight/Premature Birth, (Infants – Priority I, Children – Priority III)

141 Low Birth Weight and Very Low Birth Weight

- A. 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).
- B. 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 equal to or less than 37 weeks gestation.

Other Anthropometric Risk, (Infants – Priority I, Children – Priority III)

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.

Nutrition Risk Criteria (Infants/Children)

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Hematocrit or Hemoglobin below State Criteria, (Infants - Priority I, Children - Priority III)

201.- Low Hematocrit or Hemoglobin,

6 months to < 12 months – Hemoglobin < 11.0, Hematocrit <33.0

1 year to <2 years-Hemoglobin < 11.0, Hematocrit < 32.9

2 years to 5 years – Hemoglobin < 11.1, Hematocrit < 33.0

Other Biochemical Test Results which Indicate Nutritional Abnormality, (Infants – Priority I, Children – Priority III)

211. Elevated Blood Lead Levels.

Blood lead levels of 10 micrograms or greater per deciliter, within the past 12 months.

Nutrition-Related Risk Conditions (e.g., Chronic Disease, Genetic Disorder, Infection), (Infants – Priority I, Children – Priority III)

2012 - 2013

Presence of disease, disorder or condition must be 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.

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

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)

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

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.

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

344. Thyroid Disorders

Hypothyroidism (insufficient levels of thyroid hormone produced or defect in receptor) or hyperthyroidism (high levels of thyroid hormone secreted). Presence of condition diagnosed, documented, or reported by a physician or someone working under physician's orders, or self reported by applicant/participant/caregiver.

345. Hypertension and Prehypertension (Chronic)

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

Nutrition Risk Criteria (Infants/Children)

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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 nutritional status.

348. Central Nervous System Disorders

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

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 syndrome, thalassemia major and sickle cell anemia (not sickle cell trait).

351. Inborn Errors of Metabolism

Presence of inborn error(s) of metabolism as diagnosed, documented, or reported by a physician or someone working under physician's orders, or self reported by applicant/participant/caregiver. Generally refers 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 and Mitochondrial Disorders.

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352. Infectious Diseases

A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to, tuberculosis, pneumonia, meningitis, parasitic infections, hepatitis, Bronchiolitis (3 episodes within last 6 months), HIV* (Human Immunodeficiency Virus), AIDS (*Acquired Immunodeficiency Syndrome). The disease must be present within the past 6 months.

***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

An adverse immune response to a food or a hypersensitivity that causes an adverse immunologic reaction. (Note: Examples of adverse immunologic reactions to food include; atopic dermatitis, anaphylaxis, allergic esophagitis, or gastroenteritis.)

354. Celiac Disease

Also known as celiac sprue, gluten enteropathy or non-tropical sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic makeup.

355. Lactose Intolerance

An insufficient production of the enzyme lactase

356. Hypoglycemia

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.

Nutrition Risk Criteria (Infants/Children)

359. Recent Major Surgery, Trauma, Burns

Major surgery, trauma or burns severe enough to compromise nutritional status. Any occurrence within the past two (2) months may be self-reported. 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 (e.g., Asthma, Lupus)

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. Clinical Depression (Children Only)

Presence of clinical depression in children (can be reported or documented by psychologist).

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, 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.

Other Health Risks, (Infant – Priority I, Children – Priority III)

381. Dental Problems

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

- Retarded growth
- Facial abnormalities
- Central Nervous system abnormalities, including mental retardation

Failure to Meet the Dietary Guidelines for Americans, (Children – Priority V)

401. Failure to Meet Dietary Guidelines for Americans (Children ≥ 2)

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 may be assigned only to individuals (≥ 2) for whom a complete nutrition assessment including Inappropriate Nutrition Practices for Children (425) has been performed and for whom no other risk(s) are identified.

Other Dietary Risks, (Infants - Priority IV, Children Priority V)

411. Inappropriate Nutrition Practices for Infants

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

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (including but not limited to)
411.1 Routinely using a substitute(s) for breast milk or for FDA approved iron-fortified formula as the primary nutrient source during the first year of life.	Examples of substitutes: <ul style="list-style-type: none"> <input type="checkbox"/> Low iron formula without iron supplementation; <input type="checkbox"/> Cow's milk, goat's milk, or sheep's milk (whole, reduced fat, low-fat, skim), canned evaporated or sweetened condensed milk; and <input type="checkbox"/> Imitation or substitute milks (such as rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."

411. Inappropriate Nutrition Practices for Infants (continued)

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (including but not limited to)
<p>411.2 Routinely using nursing bottles or cups improperly.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Using a bottle to feed fruit juice. <input type="checkbox"/> Feeding any sugar-containing fluids, such as soda/soft drinks, gelatin water, corn syrup solutions, sweetened tea. <input type="checkbox"/> Allowing the infant to fall asleep or be put to bed with a bottle at naps or bedtime. <input type="checkbox"/> Allowing the infant to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. <input type="checkbox"/> Propping the bottle when feeding. <input type="checkbox"/> Allowing an infant to carry around and drink throughout the day from a covered or training cup. <input type="checkbox"/> Adding any food (cereal or other solid foods) to the infant's bottle.
<p>411.3 Routinely offering complementary foods* or other substances that are inappropriate in type or timing.</p> <p><i>*Complementary foods are any foods or beverages other than breast milk or infant formula.</i></p>	<p>Examples of inappropriate complementary foods:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier; and <input type="checkbox"/> Any food other than breast milk or iron-fortified infant formula before 4 months of age.

411. Inappropriate Nutrition Practices for Infants (continued)

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (including but not limited to)
<p>411.4 Routinely using feeding practices that disregard the developmental needs or stage of the infant.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> 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). <input type="checkbox"/> Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking. <input type="checkbox"/> 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). <input type="checkbox"/> Feeding an infant foods with inappropriate textures based on his/her developmental stage (e.g., feeding primarily pureed or liquid foods when the infant is ready and capable of eating mashed, chopped or appropriate finger foods).
<p>411.5 Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.</p>	<p>Examples of potentially harmful foods:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Unpasteurized fruit or vegetable juice; <input type="checkbox"/> Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese; <input type="checkbox"/> Honey (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.); <input type="checkbox"/> Raw or undercooked meat, fish, poultry, or eggs; <input type="checkbox"/> Raw vegetable sprouts (alfalfa, clover, bean, and radish); and <input type="checkbox"/> Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).
<p>411.6 Routinely feeding inappropriately diluted formula.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Failure to follow manufacturer’s dilution instructions (to include stretching formula for household economic reasons). <input type="checkbox"/> Failure to follow specific instructions accompanying a prescription.

411. Inappropriate Nutrition Practices for Infants (continued)

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (including but not limited to)
411.7 Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source of nutrients.	<ul style="list-style-type: none"> <input type="checkbox"/> Examples of inappropriate frequency of nursings: <input type="checkbox"/> Scheduled feedings instead of demand feedings; <input type="checkbox"/> Less than 8 feedings in 24 hours if less than 2 months of age; and <input type="checkbox"/> Less than 6 feedings in 24 hours if between 2 and 6 months of age.
411.8 Routinely feeding a diet very low in calories and/or essential nutrients.	<p>Examples:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vegan diet; <input type="checkbox"/> Macrobiotic diet; and <input type="checkbox"/> Other diets very low in calories and/or essential nutrients.
411.9 Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breastmilk or formula.	<p>Examples of inappropriate sanitation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Limited or no access to a: <ul style="list-style-type: none"> - Safe water supply (documented by appropriate officials), - Heat source for sterilization, and/or - Refrigerator or freezer for storage. <input type="checkbox"/> Failure to properly prepare, handle, and store bottles or storage containers of expressed breastmilk or formula.

411. Inappropriate Nutrition Practices for Infants (continued)

<p>Inappropriate Nutrition Practices for Infants</p>	<p>Examples of Inappropriate Nutrition Practices (including but not limited to)</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:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Single or multi-vitamins; <input type="checkbox"/> Mineral supplements; and <input type="checkbox"/> Herbal or botanical supplements/remedies/teas.
<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>	<ul style="list-style-type: none"> <input type="checkbox"/> 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. <input type="checkbox"/> 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.

425. Inappropriate Nutrition Practices for Children

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

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (including but not limited to)
425.1 Routinely feeding inappropriate beverages as the primary milk source.	Examples of inappropriate beverages as primary milk source: <ul style="list-style-type: none"> <input type="checkbox"/> Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk; and <input type="checkbox"/> Imitation or substitute milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other “homemade concoctions.”
425.2 Routinely feeding a child any sugar-containing fluids.	Examples of sugar-containing fluids: <ul style="list-style-type: none"> <input type="checkbox"/> Soda/soft drinks; <input type="checkbox"/> Gelatin water; <input type="checkbox"/> Corn syrup solutions; and <input type="checkbox"/> Sweetened tea.
425.3 Routinely using nursing bottles, cups, or pacifiers improperly.	Using a bottle to feed: <ul style="list-style-type: none"> - Fruit juice, or - Diluted cereal or other solid foods. <ul style="list-style-type: none"> <input type="checkbox"/> Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime. <input type="checkbox"/> Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. <input type="checkbox"/> Using a bottle for feeding or drinking beyond 14 months of age. <input type="checkbox"/> Using a pacifier dipped in sweet agents such as sugar, honey, or syrups. <input type="checkbox"/> Allowing a child to carry around and drink throughout the day from a covered or training cup.

425. Inappropriate Nutrition Practices for Children (continued)

<p>Inappropriate Nutrition Practices for Children 425.4 Routinely using feeding practices that disregard the developmental needs or stages of the child.</p>	<p>Examples of Inappropriate Nutrition Practices (including but not limited to)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's requests for appropriate foods). <input type="checkbox"/> Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking. <input type="checkbox"/> 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). <input type="checkbox"/> 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>425.5 Feeding foods to a child that could be contaminated with harmful microorganisms.</p>	<p>Examples of potentially harmful foods for a child:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Unpasteurized fruit or vegetable juice; <input type="checkbox"/> Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese; <input type="checkbox"/> Raw or undercooked meat, fish, poultry, or eggs; <input type="checkbox"/> Raw vegetable sprouts (alfalfa, clover, bean, and radish); <input type="checkbox"/> Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).

425. Inappropriate Nutrition Practices for Children (continued)

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (including but not limited to)
425.6 Routinely feeding a diet very low in calories and/or essential nutrients.	Examples: <input type="checkbox"/> Vegan diet; <input type="checkbox"/> Macrobiotic diet; and <input type="checkbox"/> Other diets very low in calories and/or essential nutrients.
425.7 Feeding dietary supplements with potentially harmful consequences.	Examples of dietary supplements which when fed in excess of recommended dosage may be toxic or have harmful consequences: <input type="checkbox"/> Single or multi-vitamins; <input type="checkbox"/> Mineral supplements; and <input type="checkbox"/> Herbal or botanical supplements/remedies/teas.
425.8 Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.	<input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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.
425.9 Routine ingestion of nonfood items (pica).	Examples of inappropriate nonfood items: <input type="checkbox"/> Ashes; <input type="checkbox"/> Carpet fibers; <input type="checkbox"/> Cigarettes or cigarette butts; <input type="checkbox"/> Clay; <input type="checkbox"/> Dust; <input type="checkbox"/> Foam rubber; <input type="checkbox"/> Paint chips; <input type="checkbox"/> Soil; and <input type="checkbox"/> Starch (laundry and cornstarch).

Nutrition Risk Criteria (Infants/Children)

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)

Eat independently

Weaned from breast milk or infant formula, or

Transition from a diet based on infant/toddler foods to one based on the Dietary Guidelines for Americans

A complete nutrition assessment, including for risk Inappropriate Nutrition Practices for Infants (411) and Children (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 nutritional risk in the next certification period if the competent professional authority determines there is a possibility of regression in nutritional status without the benefits that the WIC Program provides. 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:

1. Jaundice
2. Weak or ineffective suck
3. Difficulty latching onto mother's breast
4. 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 nutritional risk during the pregnancy because of detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally-related medical conditions.

702. Breastfeeding infant of woman at nutritional risk (mother's risk should be documented). (Priority I, II, or IV)

A breastfeeding infant whose mother has been determined to be at nutritional 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 (Infant Only) (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/care-giver; 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

1. 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
2. An institution that provides a temporary residence for individuals intended to be institutionalized
3. A temporary accommodation of not more than 365 days in the residence of another individual

4. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Nutrition Risk Criteria (Infants/Children)

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 Nutritional 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;

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.

Note: 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.

Nutrition Risk Criteria (Infants/Children)

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

FORMULA POLICIES AND PROCEDURES

WIC food packages and nutrition education are the chief means by which WIC affects the dietary quality and habits of participants. WIC was never intended to be a primary source of food (including formulas and medical foods), nor of general food assistance. 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.

Since 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 3.

Standard Formula

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

- is nutritionally complete iron-fortified (contains at least 10 mg. iron per liter of formula at standard dilution),
- supplies 0.67 Kilocalories per milliliter (i.e., 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 Nestlé Infant Nutrition to provide:

- Gerber Good Start Gentle (powder and concentrated),
- Gerber Good Start Protect (powder),
- Gerber Good Start Soothe (powder), and
- Gerber Good Start Soy (powder and concentrated).

Please see the section for **Ready-to-Feed Formulas and Medical Foods** for regulations concerning issuance of ready-to-feed contract Gerber Good Start formulas.

Medical Documentation is not required for an infant to receive the above contract formulas.

Medical documentation is required for the contract formulas when issued to a child or adult who receives Food Package III.

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.

Milk Based Formula

Gerber Good Start Gentle and Gerber Good Start Protect are both cow's milk-based standard formulas. Gerber Good Start milk-based products are made with 100% whey partially hydrolyzed protein, which results in a smaller curd size. Because of this, spit-up may look differently from other cow's milk-based products.

Gerber Good Start Protect is a cow's milk based formula with the probiotic culture *B. lactis* flora added. Probiotics are live cultures and are among the "good" bacteria that aid humans in digestion of foods.

Gerber Good Start Soothe is a cow's milk based formula containing *L. reuteri* probiotics and is lactose reduced (similar to Similac Sensitive and Enfamil Gentlease).

Soy Based Formula

Gerber Good Start Soy products are milk free, lactose free, and contain no animal products (designated on label as kosher pareve).

Ready-To-Feed Formulas and Medical Foods

In accordance with [CFR 246.10(e)(1)(iv) and (3)(iii)], all WIC Good Start formulas must be issued in concentrated liquid or powdered physical forms. Since the maximum monthly allowances for ready-to-feed formula provide fewer ounces per month, families should be counseled and referred to other resources that may be able to with help the purchase of additional product.

Ready-to feed (RTF) WIC formulas may be authorized when the CPA determines and documents that:

- the participant's household has an unsanitary or restricted water supply or poor refrigeration, *
- the participant or person caring for the participant may have difficulty in correctly diluting concentrated forms or reconstituting powdered forms, or
- the WIC formula is only available in ready-to-feed form.

*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 standards for RTF. Using a concentrated formula with cooled water may be a solution. The Regional Nutrition Director should be consulted if there is a question.

In addition to the above requirements, there are two additional conditions which may be used to issue RTF in Food Package III. These will be discussed below in the Food Package III information.

Food Package III

The Code of Federal Regulations [246.10 (e) (3) (i) (ii) (iii) & (v)] state Food Package III is reserved for issuance to women, infants, and child participants who have a documented nutritionally related WIC Qualifying Condition that requires the use of a TN WIC authorized standard infant formula (to a woman or child), therapeutic formulas, and medical foods because use of conventional food is:

- **Precluded (when totally tube feed)**
- **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)**

As mentioned previously, there are two additional conditions that may be used to issue RTF in Food Package III:

- If a ready-to-fed form of a therapeutic formula or medical food better accommodates the participant's conditions; or
- If ready-to-feed form improves the participant's compliance in consuming the prescribed therapeutic product.

Tennessee WIC does not provide for those WIC participants who receive TennCare and have a WIC qualifying condition which involves non tube fed malabsorption syndromes, inborn errors of metabolism or, if the participant is partially or one of the following Gastrointestinal Disorders- Crohn's Disease, Ulcerative Colitis, Short Bowel Syndrome, or Celiac Disease. TennCare is responsible for providing therapeutic formula if the participant is partially or completely tube fed. Please refer to the Therapeutic Handbook for the proper process for referring these patients to TennCare.

Participants who are eligible to receive Food package III must have one or more nutrition related WIC Qualifying Conditions authorized under this food package and determined by a Health Care Provider licensed to write prescriptions under Tennessee state law. The responsibility remains with the participant's Health Care Provider for the medical oversight and instruction concerning all WIC authorized supplemental foods.

Because both therapeutic products and supplemental foods require medical documentation, the Health Care Provider (HCP) must use the TN WIC *Request for WIC Eligible Therapeutic Products and Supplemental Foods* form.

Infants cannot be issued Food Package III for more than three (3) months without a HCP request renewal. Children and women must have HCP request renewal at least every six (6) months.

The new ruling states Food Package III is not authorized for:

- **Any** participant solely for the purpose of enhancing nutrient intake or managing body weight without an underlying WIC Qualifying Condition
- Infants whose only condition is:
 1. a formula intolerance to lactose, sucrose, milk protein or soy allergies that do not qualify as severe (see WIC Qualifying Conditions chart);
 2. 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.

If a participant does not have a Food Package III WIC Qualifying Condition and a therapeutic product cannot be authorized by TN WIC, WIC personnel cannot offer standard formula without the Health Care Provider's medical oversight and instruction.

Likewise, after 6 months of age other supplemental foods cannot be issued without the same medical oversight and instruction. A Food Package III participant cannot receive Food Instruments for conventional WIC foods without HCP authorization to do so.

WIC Qualifying Conditions For Food Package III

WIC Qualifying Conditions Include but not limited to:	Participant category	Examples
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	
Malabsorption Syndromes	Infants, Children & Women	Cystic Fibrosis, Chronic pancreatic, 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 can be issued
Developmental Disabilities with Nutritional Complications	Infants & Children	Such as oral motor feeding problems
Hyperemesis Gravidarum	Women	
Severe Food Allergies disorders as specified:	Infants & Children	Confirmed severe food allergic disorders include gastrointestinal anaphylaxis, allergic eosinophilic esophagitis, allergic eosinophilic gastroenteritis, food protein-induced proctocolitis, food protein-induced enterocolitis, food protein-induced enteropathy/celiac disease; & atopic disease. Excludes suspected food intolerances and allergies. Excludes lactose intolerance.
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	Impair ingestion, digestion, absorption/utilization of nutrients that adversely affect nutrition status.
Immune System Disorders	Women, Infants & Children	HIV/AIDS.

Medical Documentation Forms

Medical documentation is required for infants receiving therapeutic formula, children receiving standard formula, therapeutic formula, or soy beverage and women receiving therapeutic products.

Only the *WIC forms Request for WIC Eligible Therapeutic Products and Supplemental Foods* and *Medical Documentation for Soy Beverage, Tofu, or Additional WIC Cheese* can be accepted as written documentation. All medical documentation must be kept on file at the local clinic in the participant's WIC record.

As stated in the Code of Federal Regulations [246.10 (d) (3) and (4)], for the purposes of the WIC Program, medical documentation means that a Health Care Provider (HCP) licensed to write medical prescriptions in the State of Tennessee has made a determination the participant has a WIC Qualifying Condition as specified under the regulations for Food Packages III or for standard Food Packages for women and children.

Request for WIC Eligible Therapeutic Products and Supplemental Foods

In order to receive a therapeutic product/formula, the Request for WIC Eligible Therapeutic Products and Supplemental Foods must be completed by the participant's HCP.

The Request must include the following:

- Patient's Name and Date of Birth
- The name of the formula/medical food requested (standard infant formula, therapeutic infant formula, WIC-eligible medical food);
- The prescribed amounts, including caloric density if greater than the standard for the product;
- If the product is delivered by feeding tube;
- The length of the time the WIC authorized standard formula, therapeutic product(s) and/or supplemental food is required by the participant (not to exceed three (3) months for infants and six (6) months for children and women without a renewal);
- The WIC Qualifying Condition(s) authorized as appropriate under the regulations for Food Package III;
- The WIC supplemental food(s) that are NOT appropriate for the participant;
- HCP's signature;
- Date of Request; and
- Contact information (phone, fax, address)

The Request for WIC Eligible Therapeutic Products and Supplemental Foods must be reviewed and approved by a Registered Dietitian (RD).

Infants cannot be issued Food Package III for more than three (3) months without a HCP request renewal. Children and women must have HCP request renewal at least every six (6) months.

Medical Documentation for Soy Beverage, Tofu, or Additional WIC Cheese

As the infant becomes a child and can be managed by using soy beverage, tofu or additional cheese, WIC must have medical documentation from the HCP since the soy products are not nutritionally complete. In order for a child to receive Soy beverage or tofu to replace cow's milk, the child's HCP must complete the form *Medical Documentation for Soy Beverage, Tofu, or Additional WIC Cheese*. The form must indicate that the child cannot drink cow's milk due to cow's milk allergy or severe lactose maldigestion or vegan diet preference.

The form must be maintained in the WIC Record. The CPA can tailor the child's food package accordingly without the approval of a registered dietician. At the end of 6 months, new written medical documentation from the HCP must be submitted to WIC.

Soy beverage does not require medical documentation for women. The standard food packages for women can be tailored to issue soy beverage in place of milk. Women always have the option of tofu as part of their standard food package. However, medical documentation is required for women substituting tofu or cheese for more than 3 quarts of cow's milk.

The CPA must direct the PHOA/WIC clerk to prorate soy beverage, additional tofu and WIC cheese on or after the fifteenth day of the month for all participants receiving these substitutions for the maximum monthly allowance of fluid cow's milk in standard Food Packages. The adjustments should meet the participant's assessed nutritional needs for the remaining days of the month.

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 the guideline stated above.

Therapeutic requests must be reviewed and approved by a Registered Dietitian (RD). The Regional Nutrition Director will approve or designate another RD to approve each therapeutic product request in the region for appropriateness. If an RD is not on site, the CPA will need gather the following information and send to the RD for approval or denial of the request:

Current height and weight

WIC Questionnaire

Completed *Request for WIC Eligible Therapeutic Products and Supplemental Foods*

Therapeutic Formula Assessment Tool (in WIC Therapeutic Handbook)

The RD has the option not to do the Therapeutic Formula Assessment Tool if he/she can appropriately assess the patient's needs and provide adequate documentation for the therapeutic formula.

If the medical documentation is not completely filled out, one month can be issued to the participant one time if the diagnosis is a WIC qualifying condition.

Medical documentation may be provided by telephone to a Certified Professional Authority (CPA) who must promptly document the information in the participant's record. Written confirmation of the medical documentation must be received (within one week).

If the woman, infant, or child has documentation that they cannot attend clinic, referral measures taken within the last 30 days must be obtained from the physician to best assess the patient's need for the therapeutic product. The documentation for infants and children to miss clinic needs to be assessed at each visit. If they do not have measures, issue one month FIs/CVVs until measures can be obtained.

The therapeutic product can only be issued for 3 months at a time if ALL the medical documentation and RD approval is complete.

If an RD is not present in the clinic, then the assessment of the patient is sent to the RD for approval. CPA's can only issue one month without RD approval for a therapeutic requests that have WIC qualifying conditions that could be approved by the RD.

The RD has up to 3 weeks to review and approve the therapeutic product. If the RD does not approve or has questions, she or he must work with the CPA and the HCP to obtain the information for needed approval or denial. If the therapeutic product is denied, the infant fruits, vegetables, and cereal FIs may be issued if appropriate.

The approval can be documented in the WIC Record, or on the *Request for WIC Eligible Therapeutic Products and Supplemental Foods*, or on the Therapeutic Formula Assessment Tool.

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 new 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.

Approved requests for therapeutic products and the assessment tool must be kept in a file with the approving RD for review during the monitoring process. They must be kept for 2 years.

Approval for therapeutic products will be for a maximum of three (3) months for infants and six (6) months for Women and Children. If the RD approves the women or child therapeutic request for 6 months, the participant must be assessed at next nutrition visit. The participant needs to have measurements done and WIC questionnaire completed to ensure that they still need and qualify for that therapeutic product.

Women, Infant, and Children using therapeutic products must be nutritionally reassessed and the SOAP plan must be updated at each renewal or formula change. At the end of the therapeutic approval period, continuation of a therapeutic formula must be reevaluated. New written medical documentation from the health care provider must be submitted with a renewal request. Reevaluated means to assess the status of the WIC qualifying condition to determine if the transition to standard formula is appropriate.

Ordering Therapeutic Products through Central Office

Certain therapeutic products are available through TN WIC that do not have voucher codes and must be special ordered by WIC Central Office. When an approved therapeutic product must be delivered by drop shipment, the CPA completes *the Therapeutic Ordering Form located in the Therapeutic Handbook* and e-mails to Glenda.King@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 e-mail confirming the product was ordered. If you do not receive the e-mail 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 we can trace the order.

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 the Central Office to "Attention: Glenda King" at (615) 532-7189.

Log the arrival of the formula in the Formula Logbook. Log the formula out to the participant with their signature and the issuing staff signature or initials. For additional shipments, contact the caregiver/participant at least 3 weeks prior to next pickup to confirm the therapeutic product is still required. Contact Glenda King to order the next delivery.

Formula is shipped in full cases; issue only up to the maximum issuance or calculate the need for each patient for months that are being issued. Should a participant no longer require the ordered product, the CPA needs to contact the Regional WIC Director. The Regional WIC director can determine if other participants in the region are currently using the formula and arrange to move it.

Never issue a WIC voucher for any product that is ordered by Central Office. You may issue FIs/CVVs for foods that are allowed by the HCP. Food package code DSF is used to indicate a drop shipped formula.

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 Health Care Provider should more therapeutic product be required than requested. The HCP can then request additional product from third party payers such as TennCare.

Women, infant, 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 FOR FOOD PACKAGE III

A copy of the current Therapeutic Handbook must be available in the local clinic for guidance when issuing a Food Package III and therapeutic products.

Since WIC must provide the full nutrition benefit for infants, varying amounts of formula must be given at different times during the first year. Leveling is the method for providing participants with the maximum amount of formula when the can size is not equally divisible.

The CPA must direct the PHOA/WIC clerk to prorate the amount of therapeutic products on or after the fifteenth day of the month for Food Packages III. The adjustments should meet the participant's assessed nutritional needs for the remaining days of the month. Also see Chapter 4, *Separation of Duties*. Only CPAs can assign Food Instruments and Cash Value Vouchers. See Chapter 3 for CPA food package documentation requirements as part of the SOAP Plan.

If the Health Care Provider (HCP) indicates on the *Request for WIC Eligible Therapeutic Products and Supplemental Foods* form formula requirements in amounts higher than age time frame, the maximum monthly allowance supplied by WIC or at a dilution higher than 20 calories per ounce, may fall short for the infants requirements. If the infant's assessed formula intake exceeds the age time frame amounts or exceeds the amount indicated by the HCP on the request, the maximum monthly allowances supplied by WIC will fall short.

For each of these circumstances, the CPA must inform both the caregiver and the HCP that additional amounts of product may be obtained through third party payers such as TennCare and Children's Special Services (CSS), referral organizations such as food banks, or purchased by the caregiver.

Medically fragile infants 6 months of age or greater whose medical condition prevent them from consuming complementary foods in Food Package III may receive therapeutic formula at the same rate as infants ages 4 through 5 months of age. These infants will typically be totally tube fed or have feeding issues that prevents them from consuming foods. The HCP must check Do Not Give in both the cereal and the Infant Food Vegetable and Fruits boxes on the *Request for WIC Eligible Therapeutic Products and Supplemental Foods* form for the higher amount of formula to be issued. 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.

Other Substitutions for Cow's Milk Allergies and Lactose Intolerance

Substitutions of "Lactaid," "Enjoy," and "Dairy Ease," is permitted by self declaration of the participant (no written orders required). "Lactaid", "Enjoy", and "Dairy Ease" should never be issued to participants with milk protein allergies or on milk protein avoidance diets.

Women or children (1 through 4 years of age) may be issued 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.

FOOD PACKAGE MODIFICATIONS

Food Packages 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.

For infants, issuance of powdered formula will permit mixing a small amount at a time if refrigeration is lacking. RTF formula may be issued if conditions for mixing powder or concentrate are questionable or if refrigeration is lacking.

Food Instruments and Cash Value Vouchers 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.

Food Package Codes

August 1, 2012				Food Package and Voucher Codes - Sheet 1	
Standard Food Package Codes				Default Voucher Codes	
Status	Default FPC for Standard FP and Contract Formula				
1	1STD Pregnant Woman	A	A2	CVV10	
2	2STD Postpartum Non-BF Woman	B	B2	CVV10	
3	3STD Partially BF Woman	L	L2	CVV10	
B	2STD Barely BF Woman (0-6 mos)	B	B2	CVV10	
B	B5TD Barely BF Woman (7-12 mos)	BBF			
4	C5TD Fully Formula Fed Infant (0 - 3 mo)	9MBP			
4	D5TD Fully Formula Fed Infant (4 - 5 mos)	10MBP			
4	E5TD Fully Formula Fed Infant (6-11 mos)	7MBP	FVC1	FVC2	
5	T5TD 1 Yr old Child	T	T2	CVV6	
5	K5TD 2 Yr old Child	K	K2	CVV6	
5	E5TD 3 & 4 Yr old Child	E	E2	CVV6	
6	G5TD Fully BF Woman	G	G2	CVV10	
7	7X5TD 0 to 6 mo Fully BF Infant (no food)	XBI			
7	75TD 6 through 11 mo Fully BF Infant	FVCM1	FVCM1	FVCM2	
9	F5TD Partially BF Infant (0 to 1 Month)	1MBP			
9	G5TD Partially BF Infant (1-3 Months)	4MBP			
9	I5TD Partially BF Infant (4-5 Months)	5MBP			
9	I5TD Partially BF Infant (6-11 Months)	4MBP	FVC1	FVC2	
FPC	DESCRIPTION	VC	Infant Voucher Codes Description		
*NM	No Milk (has both cheese & eggs) - 3 VC	FVC1	16 Infant Fruits/Vegs and 2 boxes Infant Cereal		
*NC	No Cheese - 3VC	FVC2	16 Infant Fruits/Vegs and 1 box Infant Cereal		
*NMC	No Milk or cheese - 3 VC	FVC21	21 Infant Fruits/Vegs and 1 box Infant Cereal		
*NMCE	No Milk, Cheese or Eggs - 2 VC	FVC22	22 Infant Fruits/Vegs and 1 box Infant Cereal		
*NPB	No Peanut Butter - 3 VC	FVCM1	21 F&V; 1 inf cereal; 10 meats		
*NEP	No eggs or peanut butter - 3 VC	FVCM2	22 F&V; 1 inf cereal; 11 meats		
*NE	No Eggs - 3 VC	IC	1 Infant cereal		
*MA	Multiple Allergies (no milk,cheese,eggs or PB) 3 VC	IC3	3 Infant cereal		
*SB	Soy beverage (no cheese, no milk) - 3 VC	FV16	16 Infant F&V		
*SBC	Soy beverage (cheese, no milk) - 3 VC	FV21	21 Infant F&V		
*VG	Vegan (Soy & Maximum Tofu) - 3 VC	FV22	22 Infant F&V		
*LR	Lactose Reduced or Lactose Free - 3 VC	IM15	15 Infant Meats		
*GM	Goat's Milk - 3 VC	IM16	16 Infant Meats		
*NORE	No Refrigeration (Homeless) - 5 VC				
6FBM	Fully Breastfeeding with Multiples - 5 VC				
FVC	Infant Fruits/Vegs & Cereal (Do not use a prefix) - 2 VC				
DSF	Drop shipped formula (Do not use a prefix) - 1 VC				
The above codes should be preceded by:					
-WIC Status 1, 2, 3, B, 6 if a Woman					
-T for a 1 yr old; K for a 2 yr old; 5 for a 3-4 yr old					
VC	Woman/Child Voucher Codes Description				
M	1 gallon milk (not whole)				
2M	2 gallons milk (not whole)				
WM	1 gallon whole milk (1 yr olds only)				
2WM	2 gallons whole milk (1 yr olds only)				
QTW	1 Qt equiv buttermilk; tofu; evap (women)				
QTC	1 Qt equiv buttermilk; evap (children)				
3QT	3 Qt equiv buttermilk; tofu; evap (women)				
CH	1 lb cheese				
EG	1 doz eggs				
CJ	1 - 64 oz juice (children only)				
2CJ	2 - 64 oz juice (children only)				
AJ	1 - 46 to 48 oz juice (women)				
2AJ	2 - 46 to 48 oz juice (women)				
3AJ	3 - 46 to 48 oz juice (women)				
DB	1 lb. Dried beans/peas				
PB	1 - 16-18 oz Peanut butter				
F	30 oz Fish (Fully BF Women only)				
AC	36 oz of cereal				
WW	12-16 oz whole wheat/whole grain				
1TF	One (1) 14-16 oz package of tofu				
2TF	Two (2) 14-16 oz packages of tofu				
3TF	Three (3) 14-16 oz packages of tofu				
4TF	Four (4) 14-16 oz packages of tofu				
1SB	One (1) Quart Soy Beverage				
2SB	Two (2) Qts or 1/2 gal Soy Beverage				
3SB	Three (3) Quarts Soy Beverage				
4SB	Four (4) Qts or two 1/2 gal Soy Beverage				
MQT	Qt Milk (Lowfat, etc)				
M1/2	Half Gal Milk (Lowfat, etc)				
EVAP	One can Evap Milk				
2EVAP	Two cans Evap Milk				
CVV6	Cash Value Voucher \$6				
CVV8	Cash Value Voucher \$8				
CVV10	Cash Value Voucher \$10				
GRNW	One ww/wh grain and 36 oz cereal				
GRNC	Two ww/wh grain and 36 oz cereal				
2LR	Two (2) half gals Lactose red/free milk				
4LR	Four (4) half gals Lactose red/free milk				
GM	Goat's Milk-Quart or Half Gallons (8GM;10GM;12GM)				
EGM	Goat's Milk-Evaporated (7EGM; 8EGM)				
PGM	Goat's Milk- Powdered (4GM; 5GM; 7GM; 10GM)				
AJWW	Adult Juice & ww/wh grain				
CJWW	Child Juice & ww/wh grain				
CC	16 oz Cabot Cheese (Kosher or Halal needs only)				

* Represents first digit of FPC

VC = Number of Voucher Codes for a full month

Therapeutic Formula Codes

May 1, 2012

FORMULA CODES - SHEET 2

FPC	Description:	VC	CAN MAXIMUMS										Chd	Wom			
			FFF		PBF		PBF		PBF		PBF				C	I	C
			0-3	4-5	6-11	<1	1-3	4-5	6-11	1-3	4-5	6-11					
GSTD	Stat 4 (0-3 mo) STD (default) - 1 VC	9MBP															
DSTD	Stat 4 (4-5 mo) STD (default) - 1 VC	10MBP															
ESTD	Stat 4(6-11 mo) STD (default)- 1VC	7MBP															
*8012	GS Gentle (12.7) - 1 to 3 VC POWDER	MBP															
*8013	GS Gentle (12.1) - 1 to 3 VC CONCENTRATE	MBC															
*8032	GS Gentle (4 pack) - 1 to 3 VC RTF	MBR															
*9013	GS Soy (12.1) - 1 to 3 VC CONCENTRATE	SBC															
*9032	GS Soy (4 pack) - 1 to 3 VC RTF	SBR															
*4512	GS Protect (12.4) - 1 to 3 VC POWDER ONLY	NCP															
*4612	GS Soothe (12.4) - 1 to 3 VC POWDER ONLY	SOP															

All above are prorated by the system.

CONTRACT FORMULAS

FPC	Description:	VC
GSTD	Stat 4 (0-3 mo) STD (default) - 1 VC	9MBP
DSTD	Stat 4 (4-5 mo) STD (default) - 1 VC	10MBP
ESTD	Stat 4(6-11 mo) STD (default)- 1VC	7MBP
*8012	GS Gentle (12.7) - 1 to 3 VC POWDER	MBP
*8013	GS Gentle (12.1) - 1 to 3 VC CONCENTRATE	MBC
*8032	GS Gentle (4 pack) - 1 to 3 VC RTF	MBR
*9013	GS Soy (12.1) - 1 to 3 VC CONCENTRATE	SBC
*9032	GS Soy (4 pack) - 1 to 3 VC RTF	SBR
*4512	GS Protect (12.4) - 1 to 3 VC POWDER ONLY	NCP
*4612	GS Soothe (12.4) - 1 to 3 VC POWDER ONLY	SOP

All above are prorated by the system.

THERAPEUTIC FORMULAS

FPC	Description:	VC	CAN MAXIMUMS										Chd	Wom			
			FFF		PBF		PBF		PBF		PBF				C	I	C
			0-3	4-5	6-11	<1	1-3	4-5	6-11	1-3	4-5	6-11					
*9732	Alimentum (Expert Care) (32) RTF	AMR	26	28	20		12	14	10								
*7132	EnfaCare (32) RTF	ENR	26	28	20		12	14	10								
*9532	NeoSure (Expert Care) (32) RTF	NAR	26	28	20		12	14	10								
*4712	GS Nourish (12.6) Powder ONLY	NOP	10	11	8		5	6	4								
*8513	Nutramigen (13) CONCENTRATE	NUC	31	34	24		14	17	12								
*8532	Nutramigen (32) RTF	NUR	26	28	20		12	14	10								

All above are prorated by the system.

CONTRACT FORMULA	
LEVELING REQUIRED: DETERMINE NUMBER OF CONTAINERS BASED ON AGE & FORMULA OR BREASTFEED	
9012	GS Soy (12.9) POWDER 10SBP
Fully Formula Infant Partially Breastfeeding	
0-1 month = 9 cans	0-1 month = 1 can
1-3 months = 10 cans	1-3 months = 4 cans
4-5 months = 8 cans	4-5 months = 5 cans
6-9 months = 7 cans	6-9 months = 4 cans
10-11 months = 3 cans	10-11 months = 3 cans

Contract Formula Issuance over 1 year of age:	
58012	GS Gentle (12.7) - max 10 POWDER 10MBP
58013	GS Gentle (12.1) - max 37 CONCENTRATE 37MBC
54512	GS Protect (12.4) - max 10 POWDER 10NCP
54612	GS Soothe (12.4) - max 10 cans POWDER 10SOP
54712	GS Nourish (12.6) - max 11 POWDER 11NOP

FFF	PBF	Age in months:
C	F	0 to 1 month (Pwdr only)
D	G	0 through 3 months
E	H	1 through 3 months
	I	4 through 5 months
		6 through 11 months
		W & C formula amounts

When preceded by these letters, the correct adjustments must be made to the qty if the issuance period overlaps with the set ages above. Only default packages will automatically change to the next food package.

Not Allowed for this status

THERAPEUTIC FORMULAS	
LEVELING REQUIRED: DETERMINE NUMBER OF CONTAINERS BASED ON AGE & FORMULA OR BREASTFEED	
ALERT: CORRECT ISSUANCE QUANTITY PER MONTH CAN BEST BE ACHIEVED BY REFERRING TO THE LEVELING GUIDE	
59716	Alimentum(ExpertCare)(16) POWDER 8AMP
58314	EleCare Infant (14.1) POWDER 10ECP
58316	EleCare Jr (14.1) POWDER 9EIP
57112	EnfaCare (12.8) POWDER 11EP
57214	Neocate Infant (14) POWDER 11NP
57514	Neocate Junior (14) POWDER 10NP
59512	NeoSure(ExpertCare)(13.1) POWDER 11NAP
58512	Nutramigen (12.6) Enflora POWDER 11NUP
55808	PediaSure w/Fiber(8) 8 OZ RTF XPDF8
55708	PediaSure(8) 8 OZ RTF XPD8
58814	Phenix-(14.1) POWDER 10PNP
58616	Pregestimil (16) POWDER 8PGP
59814	SimilacPM 60/40(14.1) POWDER 9SPP

le = Leveling is required on these formulas when given to infants either Fully Formula Feeding or Partially Breastfeeding. Precede the FPC only with WIC Status 5 (as shown above). This will default to the maximum amount allowed for age status and you must reduce the quantity accordingly for the age in months of the infant as shown in the GS Soy, Plus & Therapeutic Product Leveling & Maximum Issuance Guide. These are not automatically prorated. On or after the 15th of the current month, reduce quantity to 50% and round up.

FORMULAS ALLOWED ONLY FOR CHILDREN AND WOMEN:	
58408	Boost(8) 8 OZ RTF 6 PACK XBO8
55308	Ensure(8) 8 OZ RTF XES8
56908	Nutren Jr/Nutren Jr with Fiber (8.45) XNTZ8
56308	Peptamen Jr(8.45) 60PJR/47PJR
58914	Phenix-2(14.1) XPN14

When preceded by these letters, the correct adjustments must be made to the qty if the issuance period overlaps with the set ages above. Only default packages will automatically change to the next food package.

BODY MASS INDEX

Height	Inches	Weight (lbs) <i>equal to</i> BMI 30
4' 10"	58	143
4' 11"	59	148
5' 0"	60	153
5' 1"	61	158
5' 2"	62	164
5' 3"	63	169
5' 4"	64	174
5' 5"	65	180
5' 6"	66	186
5' 7"	67	191
5' 8"	68	197
5' 9"	69	203
5' 10"	70	209
5' 11"	71	215
6' 0"	72	221
6' 1"	73	227
6' 2"	74	233
6' 3"	75	240

CALCULATING GESTATION-ADJUSTED AGE

The assignment for nutrition risk criteria #121 (Short Stature) and #152 (Low Head Circumference) for premature infants and children (with a history of prematurity) up to 2 years of age, 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.

Example:

Randy was born prematurely on March 19, 2010. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2010 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

His measurements would be plotted on a growth chart as a 2-week-old infant.

Nutrition Education

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USDA REGULATIONS AND STANDARDS

Federal Regulations For WIC Nutrition Services

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

“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.”

Goals For WIC Nutrition Services [CFR 246.11 (b)]

“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.”

Drug Rule/Substance Abuse [CFR 246.11 (a) (3)]

“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 caretakers 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 caretakers of infants and children participating in local agency services other than the Program.”

Local Agency Nutrition Services Plan [CFR 246.11 (d) (1)(2)]

“Develop an annual local agency nutrition education plan, including breast-feeding 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.”

Associated USDA Standards

Ensuring the Quality of Nutrition Services in the WIC Program

Value Enhanced Nutrition Assessment (VENA) is the latest initiative under the umbrella of Revitalizing the Quality of Nutrition Services (RQNS). 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 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.” (Standard 4: Nutrition Education, page 7, footnote 5)

In Tennessee WIC Clinics, all Nutrition Education is verbal communication and/or interactive between the professional and participant.

Nutrition Contacts [CFR 246.11 (e)] (1-3)

“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 contra indicated for health reasons.

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

Nutrition education contacts shall be made available at a quarterly rate, to parents or caretakers 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.

Completion and Documentation of Nutrition Education – [CFR 246.11 (e)] (4 -6)

“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.

An individual care plan shall be provided for a participant based on the need for such plan as determined by the competent professional authority, except that any participant, parent, or caretaker shall receive such plan upon request. Contacts shall be designed to meet different cultural and language needs of program participants.”

Breastfeeding [CFR 246.11 (c) (7)]

“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

Providing Quality Nutrition Services In Implementing: The Breastfeeding Promotion And Support Requirements Of The New WIC Food Packages.

Breastfeeding Assessment

“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 nutritional status and risk, tailor the food package to address nutritional needs, design appropriate nutrition education, and make

appropriate referrals.”

“The 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 on the information to be addressed during 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 for the Breastfeeding Dyad

“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. 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 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, provide her the fully breastfeeding food package in the first week after birth or as soon as possible so she may benefit from the additional foods.”

TENNESSEE’S PLAN TO IMPLEMENT FEDERAL REGULATIONS

Substance Abuse [CFR 246.11 (a) (3)]

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 (DH0038) 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/CVVs 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.

Appropriate staff in WIC clinics must establish linkages with local substance abuse counseling/treatment programs. An up-to-date 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.

Nutrition Education

Local Agency Nutrition Services Plan

Guidelines For Completion

The Local Agency (LA) Nutrition Services Plan is the guidance the LA 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 Local Agency (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 Education Coordinator and the Breastfeeding Coordinator in the State Special Supplemental Nutrition Programs Office may be contacted for technical assistance.

Content

A. Title Page

1. Title of Plan
2. Time period (fiscal year) covered by plan
3. Name of region
4. Names and titles of those who prepared the plan

B. Section 1: Staff and Resources

This is a current list of all nutrition staff, their credentials, work location, etc. in the region. A “nutrition education resource wish list” for each region is also included.

C. Section 2: Goals, Objectives, and Activities

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

Nutrition Education Curriculum

Nutrition education will be centered around the Value Enhanced Nutrition Assessment (VENA) Process. The focus will be on nutrition assessment in determining 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.

Provide nutrition education that is 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)
- Harmful effects of alcohol, drugs, and smoking
- All pregnant women must be encouraged to breastfeed unless contra indicated for health reasons
- Local Referral/Resource list

Subsequent Certification must include:

- Basic nutrition information as it relates to individual risk(s)
- All prenatals must be encouraged to breastfeed unless contra indicated for health reasons
- Women participating in WIC, especially those ready to "graduate" from the program, must be counseled on folic acid
- Harmful effects of alcohol, drugs, and smoking
- 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.

Frequency of Contacts

Nutrition education, which is federally mandated for the WIC Program, shall be made available to participants or their caretakers 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. If the prenatal has received two nutrition education contacts, then she may receive breastfeeding information and support by a peer counselor on the third clinic visit. The BFPC will document the contact on the Peer Counselor Contact Log and not on the WIC Prenatal or Postpartum record.

Status B barely breastfeeding women continue to be certified for the WIC program beyond 6 months and through 12 months postpartum and must continue to receive quarterly nutrition/breastfeeding nutrition education contacts through the visit they report all breastfeeding has stopped. Barely breastfeeding women beyond 6 months postpartum do not receive a food package but are counted in WIC participation.

The principal ideas for nutrition education in the federal guidelines are as follows: To emphasize the relationship between proper nutrition and good health, with special emphasis on the nutrition needs of the target population, and to raise awareness of the dangers of using drugs or other harmful substances to all pregnant, breastfeeding and postpartum women, and caretakers of children and infants participating on the program.

With the input of the participant, the nutrition provider should assist the individual who is at nutrition risk in achieving 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.

If Group Contact (Subsequent visit):

Make it interesting and informal. Use facilitative discussion. If groups are mixed statuses, you will want to make sure your topic is general so that it will cover all families. Some examples might be the new food package 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. That group contact is only a BFPC group contact. All BFPC contact is reported on the Peer Counselor Contact Log.

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.

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 at subsequent visit (pick up) a printed certificate or paper with name of session, certificate number, date and time completed. 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 two years.

If the “other” providers listed below are providing nutrition education, the lesson plans must be approved by the Regional Nutrition Director.

Nutrition Education Providers; Competent Professional Authority (CPA)

Registered Dietitian (RD)

Nutritionist

Nutrition Educator

Registered Nurse (RN)

Other Mid-Certification Nutrition Education Providers :

Registered Dietetic Technicians (RDT's)

*Community Agencies-ex. EFNEP/TNCEP workers

*Others approved by Central Office

*If these Mid-Certification Nutrition Education Providers are used in a group session a CPA must be present and provide a nutrition component.

Mid-Certification Nutrition Assessment

Infants, children and breastfeeding women certified for a period longer than six months (i.e., one year certification period) 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

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 when providing nutrition education to the homeless (refer to Chapter 2, “Food Packages for the Homeless”).

Assess living situation and determine current needs before attempting to provide education.

Depending upon food preparation and storage facilities, a discussion of food sanitation and safety may be extremely important. If necessary, exclude foods with a high potential for spoilage (liquid milk, fresh eggs).

If the participant(s) is an infant, breastfeeding is an easy and safe feeding method. For formula fed infants, the caretaker should be instructed to prepare only one bottle at a time and to discard any formula left in the bottle if refrigeration is lacking. If both safe water and refrigeration are lacking, RTF formula should be considered.

If dry milk is issued for older children (2-5 years) or adults, instructions should be given regarding mixing 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. Meeting nutritional needs continues to be the aim of the supplemental food package issuance.

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.

Proxy

Nutrition education may be provided to the proxy on behalf of the infant or child, providing the proxy has some responsibility for the care of the participant. If a proxy is used for a prenatal, her nutrition education could be provided by telephone, mail, or home visit.

Documenting Missed Appointments [CFR 246.11 (e) (4)]

Should a participant refuse nutrition education or miss an appointment resulting in a missed nutrition education contact, this must be documented.

Nutrition Care Plans

All participants will have a care plan developed in the SOAP format. The care plan includes information such as the participant's level of understanding, stage of change, client-centered goal, plan of action, and referrals.

Documentation is necessary to communicate information about the participant, what is discussed with and taught to the participant, and the plan of action based on the individual's 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. (See Chapter 3 for instructions for the WIC Records.)

High and Low Nutrition Risk

Based on the Value Enhanced Nutrition Assessment, an individual's level of risk and care are determined by the CPA at each certification. All participants, regardless of the level of risk, will have a care plan developed in the SOAP format.

SOAP Format

The SOAP note is a concise, informative communications tool that helps the provider identify, prioritize and address participant problems and progress. All sections of a good SOAP note should be related to one another, or be "linked." For example, subjective statements plus objective information are used to develop assessments that lead a workable plan.

The components of a SOAP note are:

Subjective (S)

Subjective information is the information shared by the patient and/or patient's family/caregiver. The use of facilitative discussion and motivational interviewing 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.

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;
- Provide information necessary to identify nutritional risk criteria

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.

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.

Objective (O)

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.

Assessment (A)

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. Nutrition problems or risks are identified and documented on the appropriate Woman, Infant, or Child WIC Record. Use the checklists to identify all possible WIC certification codes* (see the Nutrition Risk Criteria in Chapter 2).

*Be sure the highest priority code is listed first on the encounter form. If multiple codes are in the same priority, the CPA decides which to list first.

In this section of the WIC Record, the CPA assesses the participant's/caregiver's level of understanding or interest. For example, if the participant asks several questions and identifies actions she can take to make a behavior change her level of interest is "High". 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.

The level of nutritional risk is documented in the Assessment. This, too, is based on the CPA's evaluation of the individual. For example, 2 children were certified 6 months ago because each had a hgb of 9.6. Both were considered to be at high risk then. At the 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. The CPA should write a brief statement to explain why the level of nutritional risk is high or low.

In the assessment, the participant's Stage of Change is documented. The stages are listed and the provider selects the one(s) that apply and writes a brief description of the behavior addressed during the counseling session. Using the example above, the Stage of Change for the first child might be considered to be Precontemplative 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.

Plan (P)

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.

Writing a Concise, Informative Note:

- Complete sentences are not necessary
- Use descriptive, active verbs
- Use appropriate, approved abbreviations (See WIC-approved abbreviations in Chapter 3)
- Sign (title included) and date the SOAP note
- If counseling is targeted, a targeted note is the result

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 with the next month – have 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. 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, at first, 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

An understanding of behavior change theory helps to better understand the many factors influencing health-related behaviors and the most effective ways of promoting change. The bottom line is that programs, interventions and messages that are guided by behavior change theory have a much greater chance of achieving positive behavior change.

State Of Readiness

State of Readiness	Key Strategies for Moving to Next Stage	Counseling Dos at This Stage	Counseling Donts at This Stage
Precontemplation	Increased information and awareness, emotional acceptance	<ul style="list-style-type: none"> ● Provide personalized information ● Allow participant to express emotions about his or her disease or about the need to make dietary changes 	<p>Dont assume participant has knowledge or expect that providing information will automatically lead to behavior change.</p> <p>Dont ignore participants emotional adjustment to the need for dietary change, which could override ability to process relevant information.</p>
Contemplation	Increased confidence in ones ability to adopt recommended behaviors	<ul style="list-style-type: none"> ● Discuss and resolve barriers to dietary change. ● Encourage support networks. ● Give positive feedback about a participants abilities. ● Help to clarify ambivalence about adopting behavior and emphasize benefits. 	<p>Dont ignore the potential impact of family members and others on participants ability to comply.</p> <p>Dont be alarmed or critical of a participants ambivalence.</p>
Preparation	Resolution of ambivalence, firm commitment, and specific action plan	<ul style="list-style-type: none"> ● Encourage participant to set specific, achievable goals. ● Reinforce small changes that participant may have already achieved. 	<p>Dont recommend general behavior changes (Eat less fat.)</p> <p>Dont refer to small changes as not good enough.</p>
Action	Behavioral skill training and social support	<ul style="list-style-type: none"> ● Refer to education program for self-management skills. ● Provide self-help materials 	<p>Dont refer participants to information-only classes.</p>
Maintenance	Problem-solving skills and social and environmental support	<ul style="list-style-type: none"> ● 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 if participant is motivated. 	<p>Dont assume that initial action means permanent change.</p> <p>Dont be discouraged or judgmental about a lapse or relapse.</p>

Story M, Holt K, Sofka, D. Bright Futures in Practice: Nutrition, US Dept of Health and Human Services. 2002;257.

Breastfeeding Promotion And Support

Department of Health Breastfeeding Policy

POLICY

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 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.

OFFICE OF PRIMARY RESPONSIBILITY

Clinical Services Director, Division of Community Health Services, (615)741-7308

Regional Breastfeeding Coordinator

Each region designates a staff person to coordinate the region's breastfeeding promotion and support activities [CFR 246.11(b)(7)(ii)].

1. The qualifications for the Regional Breastfeeding Coordinator include:
 - a. Meets the qualifications for a Competent Professional Authority (CPA); has 1 year of experience in counseling women about how to breastfeed successfully; and has State-approved training in lactation management; OR
 - b. Meets the qualifications for a CPA and has the credentials of IBCLC or CLC or other certification in lactation management.

2. The roles and responsibilities include:
 - a. Overseeing the planning, implementation, and evaluation of breastfeeding promotion and support activities (Breastfeeding Access Plan) and staff training;
 - b. Provide technical assistance and consultation on breastfeeding to clinic staff and WIC participants.
 - c. Keeping current with the latest breastfeeding information and informing other regional staff of the new recommendations;
 - d. Identifying, coordinating, and collaborating with community breastfeeding resources;
 - e. Monitoring regional breastfeeding rates;
 - f. Performing the roles and responsibilities of a CPA.

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 14 percent of the total infants served (measured using Participation Reports from July 2011 through June 2012) to 16 percent a yearly monthly average (measured using Participation Reports from July 2012 through June 2013).

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, 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 and Breastfeeding Handbook Addendum, 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 Modules 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 from the Loving Support through 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 to 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 breastfeeding 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.

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 Breastfeeding Handbook.
- Appropriate use of breastfeeding education materials.

The Regional Breastfeeding Coordinator will evaluate the Breastfeeding Access Plan based on the year beginning on July 1 and ending on June 30 of the following year. 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.

Breastfeeding Support Team

Breastfeeding Support team members:

Breastfeeding Coordinators
Designated Breastfeeding Expert
All Nutrition Education Providers
All Nursing staff
Breastfeeding Peer Counselors
WIC PHOAs, and other clinic staff person in contact with WIC participants

Please see USDA's WIC Staff Roles in Breastfeeding Promotion and Support found in the Breastfeeding Handbook and in the Grow and Glow training modules for details.

Breastfeeding Peer Counselors

USDA defines WIC Breastfeeding Peer Counselors (BFPCs) as paraprofessionals without extended professional training in health, nutrition, or the clinical management of breastfeeding who are given ongoing supervision to provide basic breastfeeding information and support to healthy WIC prenatals and breastfeeding moms. BFPCs are selected from the community to be served and are trained and given ongoing supervision from the regional Breastfeeding coordinator to provide basic breastfeeding information and support to WIC participants. Breastfeeding Peer Counselors (PCs) serve as a role model for breastfeeding behaviors. TN WIC has a handful of current BFPCs who are CLCs. All of these BFPC CLCs are paraprofessionals and do not meet the definition of health care professionals or CPAs. All BFPC CLCs provide only basic breastfeeding services and yield all clinical breast-feeding management to DBEs and CPAs. All BFPC CLCs comply with Program standards set forth in Loving Support.

BFPCs must complete all 12 modules of the Loving Support through Peer Counseling: A Journey Together Training Program and practice within guidelines outlined in the Program. The Breastfeeding Handbook 2012-2013 provides additional guidance for BFPCs. In fall 2012, TN WIC will provide regions and all Breastfeeding Peer Counselors with a Breastfeeding Peer Counselor Handbook to provide additional training guid-

ance.

For breastfeeding concerns and problems beyond their scope of practice as paraprofessional BFPCs must yield to health care professionals including Breastfeeding Coordinators, Designated Breastfeeding Experts, and other CPAs. See TN WIC Breastfeeding Peer Counselor Scope of Practice: When to Yield handout found in the Breastfeeding Handbook.

Regional Breastfeeding Coordinators and any CPA supervising a PC must complete USDAs *Loving Support through Peer Counseling: A Journey Together for WIC Managers* to successfully manage Peer Counselors. Please contact Marie Latendresse, State Breastfeeding Coordinator to schedule training if you have not completed this program or if you need a refresher.

Regional Breastfeeding Coordinators must electronically send each Peer Counselor's Monthly Activity report with weekly detail by the 8th day of the following month to Marie Latendresse, State Breastfeeding Coordinator.

Prenatal Counseling/Education

Healthcare providers strongly influence the outcome of prenatal educational efforts. A neutral attitude toward breastfeeding and bottle feeding, which leaves the choice strictly to the mother, is not likely to produce an informed choice. On the other hand, 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 Handbook outlines Loving Support 3-Step Counseling Strategy process and the Breastfeeding Counseling Points for providing anticipatory breastfeeding guidance to prenatal and breastfeeding mothers.

To allow for an informed choice of infant feeding the following should be done:

1. assess attitudes and concerns toward breastfeeding at certification,
2. dispel common misconceptions,
3. provide accurate, positive information on the benefits of breastfeeding for mother and baby, and
4. discuss services provided by WIC for the breastfeeding mother. Many women make the decision about how to feed their babies early in pregnancy; therefore the most effective time to discuss breastfeeding is the first trimester.

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.

The most common concerns women have about breastfeeding:

- Lack of confidence in the ability to nourish their infants adequately.
- Embarrassment 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.

Breastfeeding Peer Counselors can assist the CPA with information gathering using the Breastfeeding Assessment portion of the Prenatal and Postpartum WIC Records during the certification visit. Only CPAs can complete the VENA Breastfeeding Assessment.

Prenatal women should be counseled on the importance of contacting her WIC clinic soon after delivery so breastfeeding support counseling can be scheduled to assure successful initiation of breastfeed. Exclusively breastfeeding woman and infants should be certified and enrolled in WIC soon after birth.

Initiating Breastfeeding

See Tennessee WIC Breastfeeding Handbook 2012-2013 for participant handouts, visual aids, professional resources, and suggested reading for counseling prenatal and breastfeeding women.

Breastfeeding counseling is given to the dyad and requires documentation on both the mother's and infant's record at each visit, including the cessation of breastfeeding and/or the infant's issuance of a fully formula food package.

Breastfeeding Food Package Change

CPAs should use caution when issuing supplemental formula to a breastfed infant until the mother's milk supply is well established (4 to 6 weeks). If a participant with an infant less than six months old is issued an FI for a breastfeeding food package, and then quits breastfeeding, she keeps her FI/CVVs in hand. If a woman has FI/CVVs past six months postpartum and is neither fully or partially breastfeeding the FI/CVVs must be recovered. The CPA issues her next cycle of FI/CVVs based on her new status. A woman is barely breastfeeding (status B) if she breastfeeds at least one time per day and her infant receives a full formula food package. A barely breastfeeding woman

past 6 months postpartum is counted as a breastfeeding woman participant and continues to receive breastfeeding counseling (document on WIC record and on Encounter) but does not receive a food package.

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.

PAGE 1:

Physical Presence: Physical presence is required at each certification visit for pregnant women. Selecting **Yes** or **No** indicates proof of presence.

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

The **participant questionnaire** provides the majority of the subjective information. The questionnaire was designed so that the participant could complete it while waiting for services. If this is not possible or practical, the nutritionist, nutrition educator, or nurse can assist her in filling out the form. Once completed, the Competent Professional Authority (CPA) reviews the responses, obtains any additional information as appropriate, and records additional pertinent subjective information on the back of the form in the comment section. Any response that represents an **inappropriate nutrition practice should be marked with an “I”**. (See Code 427 for specific inappropriate nutrition practices for women.)

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

Date of Questionnaire: Some women will have been WIC participants previously, or the participant questionnaire will 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.

Subjective information concerning breastfeeding knowledge, attitudes, and concerns is documented on Page 2 of the WIC Prenatal Record under Section A: Ask Open Ended Questions.

O: OBJECTIVE INFORMATION

Prenatal Weight Gain Grid: The grid is no longer part of the prenatal record, but is a separate form to be completed at certification. Instructions for using the form are found later in the chapter.

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.

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.

The priority of each code appears on the record, along with the code. List the highest priority code first on the Encounter Form. If two or more codes are in the same priority, the CPA can select the one to be first entry.

PAGE 2:

Breastfeeding Assessment, Promotion, Counseling and Support –The focus of the Breastfeeding Assessment 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. Just because a woman previously breastfed an infant does not mean that she will breastfeed this baby. 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 developing a plan for breastfeeding education, counseling at certification and each subsequent WIC visit can provide every prenatal with the tools to make an informed decision on the infant feeding choice best for her situation.

Note: Both the CPA and Peer Counselors can use Sections A and B to document the conversation(s). The BFPCs and BFPC CLCs must use their Contact Log for return visit documentation. .

Section B is also used by the CPA for return nutrition education visits. While the BFPC or BFPC CLC can assist in data gathering and begin basic breastfeeding education, only the CPA can complete the VENA Breastfeeding Assessment.

Section A: Ask opened ended questions – Both the CPA and the Peer Counselor (if present in clinic on the day of certification) can use Sections A to document the interview following the 3-Step Counseling Strategy Guidelines listed below. If the BFPC provides information and support during the course of the interview, documentation of those services is entered into the participant’s chart on the appropriate area. The BFPCs and BFPC CLCs must document the Contact Log for topic content at certification and all follow-up contact throughout the pregnancy.

Questions 1-3 represent conversation starters. Each of the three questions are followed by additional probing questions to help the woman explore her knowledge, attitudes, support access, barriers and concerns about choosing breastfeeding as the feeding option for her new 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.

In the areas for comments for each question, 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.

CPAs will review the comments to the questions recorded at certification and develop a plan to provide anticipatory breastfeeding education at every nutrition education contact opportunity. 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.

Section B: Affirm and Educate – Discussion on all topics with an asterisk (*) must be initiated **at the certification**. Assure the mother additional breastfeeding education will be provided at each return visit to address breastfeeding concerns and help her make an infant feeding decision. Counseling must be supportive and emphasize breastfeeding as the normal method of feeding infants. The CPA, BFPC, or both can discuss these topics. Each provider must put the date and his or her initials in the appropriate box. The

same provider can use downward arrows to indicate discussion on more than one topic.

Section C: **For all BFPCs.** Provide your signature at the bottom of the page if you gathered information for the breastfeeding certification assessment. Complete the BFPC Contact Log for every contact with the participant. If the BFPC sees the participant on the day of certification and contributes to the assessment, the BFPC can repeat the documentation on the Contact Log checklist or enter a narrative “See WIC Record” on the back of the Contact Log. After the certification visit, on BFPC contact must be entered on the Contact Log as the primary documentation.

PAGE 3:

Level of Understanding/Interest - The Competent Professional Authority (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. **A brief comment** is required to explain the level of interest.

Assessed Level of Nutrition Risk - Determination of whether a person is at **High** Nutritional Risk or **Low** Nutritional Risk is **at the discretion of the CPA**. Mark the level of risk as assessed and **write a brief comment** (required) to explain the level of nutrition risk.

Stages of Change - Individuals are at varying levels of readiness to change behaviors. Tailor any interventions to the needs and concerns of individuals at each stage of the change process. Select the stage that represents the individual’s readiness to change and **write a brief statement** (required) to identify the behavior to be changed. (Do not try to address each stage!) The Stage of Change should be related to the Client Centered Goal. Refer to the State of Readiness Table in this chapter for definitions of stages of change.

P: PLAN

Client-Centered Goal/Plan: This 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 must contain who, (if not the participant/ caregiver), what, when, where, why and how the goal is to be achieved.

The goal should be **SMART**:

S – Specific

M – Measurable

A – Achievable

R – Realistic

T – Timely

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.

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.

The items on the Materials Given checklist that are identified with an asterisk (*) must be given at the certification visit.

PAGE 4:

RETURN VISITS:

Progress toward previous goal: Follow-up on the previous goal is required. If the participant attended group education at a mid-certification visit, 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.

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 mid-certification visit is made. Include signature, title and date with all entries.

Completing The WIC Prenatal Grids

Four prenatal weight gain grids are available, based on the woman's pre-pregnancy Body Mass Index (BMI). 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:

Prepregnancy Weight Groups	Definition (BMI)	Total Weight Gain Range (lbs)	
		<u>Singleton</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 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.

NOTE: 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 the prenatal gives you, 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 Form

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, 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, BMI and provider’s initials in the spaces provided.

NOTE: HEIGHT SHOULD BE TAKEN WITHOUT SHOES.

Record follow-up weight measures, the weeks gestation, and the date the weight was taken and 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

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.

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

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.

PAGE 1:

INITIAL VISIT

Status: Select the correct status:

2 = non-breastfeeding

3 = breastfeeding with some formula supplementation

6 = exclusively breastfeeding

B = barely breastfeeding

Physical presence: Physical presence is required at each certification visit for participants. Select Yes or **No** to indicate proof of presence.

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

The **participant questionnaire** provides the majority of the subjective information. The questionnaire was designed so that the participant could complete it while waiting for services. If this is not possible or practical, the nutritionist, nutrition educator, or nurse can assist her in filling out the form. Once completed, the Competent Professional Authority (CPA) reviews the responses, obtains any additional information as appropriate, and records additional pertinent subjective information on the back of the form in the comment section. Any response that represents an **inappropriate nutrition practice should be marked with an "I"**. (See Code 427 for specific inappropriate nutrition practices for women.)

Occasionally postpartum women initiate breastfeeding but may have given up and mark the questionnaire as “non-breastfeeding”. In reviewing the questionnaire all postpartum women must be asked if they initiated breastfeeding and the WIC Special Data box on the Encounter form is marked as appropriate.

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

Date of Questionnaire: Some women will have been WIC participants previously, or the participant questionnaire will 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.

O: OBJECTIVE INFORMATION

Record the Weight, Height, and Hgb in the spaced provided. Also record the Pre-Pregnancy Weight as reported by the woman. The provider that obtains the measures must record his or her initials.

NOTE: HEIGHT SHOULD BE TAKEN WITHOUT SHOES.

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 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.

Determine the BMI

Using the prepregnancy weight the prenatal gives you, calculate the BMI by using the formula:

BMI = weight (lbs) ÷ height (in) ÷ height (in) X 703 or

BMI = weight (kg) ÷ height (cm) ÷ height (cm) X 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.

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.

The priority of each code appears on the record, along with the code. List the highest priority code first on the Encounter Form. If two or more codes are in the same priority, the CPA can select the one to be first entry.

PAGE 2:**Breastfeeding, Assessment, Promotion, Counseling, and Support**

The focus of the postpartum breastfeeding assessment is to determine if a woman initiated breastfeeding and to have a conversation with her regarding concerns or barriers, and provide her with encouragement to continue breastfeeding as long as possible. Research shows that providing women with appropriate encouragement and breastfeeding help within the first one to two weeks can often remedy barriers and help mothers to succeed with breastfeeding.

Effective breastfeeding promotion should convey that providing formula to breastfed infants, especially in the early months challenge the mother's will to breastfed 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.

Note: Both the CPA and Peer Counselors can use Sections A and B to document the conversation(s). Peer Counselors cannot document on any other page of the WIC Prenatal Record. The BFPCs and BFPC CLCs must use their Contact Log for return visit documentation.

This page is also used for WIC moms who have delivered and not yet certified as postpartum. For example, if the 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 VENA breastfeeding pump assessment information is gathered by the CPA or BFPC using Sections A through D on the WIC Postpartum Record. 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.

While status in PTBMIS 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 but must document that mother will be scheduled to return for replacement fully breastfeeding vouchers within the next week. Either way 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 until she is no longer fully breastfeeding.

Section A: Ask Each Visit- WIC's role in breastfeeding support is to help women make an informed decision about breastfeeding by providing them factual information and by helping them problem solve breastfeeding concerns including decisions about the duration of breastfeeding. Every postpartum woman must be asked if she initiated breastfeeding. By using the 3-step counseling process when asking a women each visit about how long she intends to breastfeeding WIC can help moms achieve her infant feeding plans and perhaps help moms uncover solutions to perceived barriers leading to weaning from the breast. The CPA uses this information to help determine food packages issued that visit. Use Section A to record the date breastfeeding stopped so the correct number of weeks can be entered on the Encounter forms WIC Special data box.

Section B: Only for Women Requesting a Breast Pump -While this Section is titled "Only for Women requesting a Breast Pump", a correction will be made with the next reprinting of this form, to re-title the Section as "Breast Pump & Hand Expression Information". It is important to ask every breastfeeding mother is 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.

All breastfeeding mothers are to be taught hand expression. See the Breastfeeding Handbook for educational materials, including video clips that help mothers learn to hand express. Research shows hand expressing milk after pumping results in additional extraction of one to two ounces of breast milk.

Section C: Additional Questions Only for Women Requesting a Breast Pump If a breastfeeding woman is currently using any type of breast pump, the CPA or BFPC educates her on the breast pump use, cleaning, and storage of breast milk.

Please refer to the Breastfeeding Handbook for breast pump qualification information. The CPA uses this Section to assess clinical need for the issuance of WIC breast pumps for breastfeeding problems or the infant's inability to nurse. It is outside of the scope of practice for BFPCs or BFPC CLCs to issue a breast pump to mothers who are ill or to mothers of infants with nutritional medical needs or with feeding problems unless the CPA has first assessed or reassessed the mother/infant dyad. Once the CPA documents approval of pump issuance based on the dyad assessment, the CPA can assign the BFPC present in the clinic to issue the pump. CPAs and all BFPCs are to refer to the Breastfeeding Handbook for instructions on issuing pumps to mothers of healthy infants who are separated from their babies due to work or school.

This page is also used for WIC moms who have delivered and not yet certified as postpartum. For example, if the 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 through 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. This section can be used at anytime during the duration of breastfeeding.

Section D: Affirm and Educate- Discussion on all topics with an asterisk (*) must be initiated at the certification. Assure the mother additional anticipatory breastfeeding education will be provided at each return visit to troubleshoot and address breastfeeding concerns that arise as breastfeeding continues. Counseling must be supportive and emphasize breastfeeding as the normal method of feeding infants. Should the mother request formula, staff will troubleshoot the reason and ensure she receives support from the WIC

staff with breastfeeding training from the CPA, a peer counselor, the DBE, or other health care professional who can adequately address the mother's concerns and help her to continue to breastfed. Each provider must put the date and his or her initials in the appropriate box for the topic discussed. The same provider can use downward arrows to indicate discussion on more than one topics.

This page is also used by the CPA for return nutrition education visits. While the BFPC or BFPC CLC can assist in data gathering and begin basic breastfeeding education, only the CPA can complete the VENA Breastfeeding Assessment

Section E: For all BFPCs. Provide your signature at the bottom of the page if you gathered information for the breastfeeding certification assessment. Complete the BFPC Contact Log for every contact with the participant. If the BFPC sees the participant on the day of certification and contributes to the assessment, the BFPC can repeat the documentation on the Contact Log checklist or enter a narrative "See WIC Record" on the back of the Contact Log. After the certification visit, on BFPC contact must be entered on the Contact Log as the primary documentation.

PAGE 3:

Level of Understanding/Interest - The Competent Professional Authority (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. **A brief comment** is required to explain the level of interest.

Assessed Level of Nutrition Risk - Determination of whether a person is at **High** Nutritional Risk or **Low** Nutritional Risk is **at the discretion of the CPA**. Mark the level of risk as assessed and **write a brief comment** (required) to explain the level of nutrition risk.

Stages of Change - Individuals are at varying levels of readiness to change behaviors. Tailor any interventions to the needs and concerns of individuals at each stage of the change process. Select the stage that represents the individual's readiness to change and **write a brief statement** (required) to identify the behavior to be changed. (Do not try to address each stage!) The Stage of Change should be related to the Client Centered Goal. Refer to the State of Readiness Table in this chapter for definitions of stages of change.

P: PLAN

Client-Centered Goal/Plan: This 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 must contain who, (if not the participant/ caregiver), what, when, where, why and how the goal is to be achieved.

The goal should be **SMART**:

S – Specific

M – Measurable

A – Achievable

R – Realistic

T – Timely

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 to needed to resolve the nutritional problems identified in the assessment, achieve goals, and attain positive health outcomes.

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.

The items on the Materials Given checklist that are identified with an asterisk (*) must be given at the certification visit.

PAGE 4:

RETURN VISITS:

Progress toward previous goal: Follow-up on the previous goal is required. If the participant attended group education at a mid-certification visit, 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.

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 mid-certification visit is made. Include signature, title and date with all entries.

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.

PAGE 1:

INITIAL VISIT

Status (Infant record only) – Select the correct status:

4 = fully formula fed

7 = fully breastfed

9 = partially breastfed

Physical presence: Physical presence is required at each certification visit for infants and children. Selecting **Yes** or **No** indicates proof of presence.

S: SUBJECTIVE INFORMATION.

The **participant questionnaire** provides the majority of the subjective information. The questionnaire was designed so that the parent or caregiver could complete it while waiting for services. If this is not possible or practical, the nutritionist, nutrition educator, or nurse can assist him or her in filling out the form. Once completed, the Competent Professional Authority (CPA) reviews the responses, obtains any additional information as appropriate, and records additional pertinent subjective information on the back of the form in the comment section. Any response that represents an **inappropriate nutrition practice should be marked with an “I”**. (See Code 411 and Code 425 for specific inappropriate nutrition practices for infants and children, respectively.)

To verify the questionnaire was reviewed, the CPA must sign (title included) and

date it at the bottom of the comment section.

Date of Questionnaire: Some infants and children either are or have been WIC participants previously, or the participant questionnaire was 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.

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 their initials

*Automated WHO growth charts are used in many clinics, so plotting is done electronically. User ID of provider is recorded.

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.

The priority of each code appears on the record, along with the code. List the highest priority code first on the Encounter Form. If two or more codes are in the same priority, the CPA can select the one to be first entry.

WIC-Approved Therapeutic Formulas - Use this space to record the name of the requested therapeutic formula and the month a new prescription will be needed. If another therapeutic formula request is received and approved, update this section of the record.

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

Assessed Level of Nutrition Risk - Determination of whether a person is at **High** Nutritional Risk or **Low** Nutritional Risk is **at the discretion of the CPA**. Mark the level of risk as assessed and write a brief comment (required) to explain the level of nutrition risk.

Stages of Change - Individuals are at varying levels of readiness to change behaviors. Tailor any interventions to their needs and concerns at each stage of the change process. Select the stage that represents an individual's readiness to change and **write a brief statement** (required) to identify the behavior to be changed. (Do not try to address each stage!) Refer to the State of Readiness Table in this chapter for definitions of stages of change. The Stage of Change must be related to the Client Centered Goal.

P: PLAN

Client-Centered Goal/Plan: This is something that the parent or caregiver is willing to work on, not something the CPA thinks needs to be done, and should be relative to the behavior identified in the Stage of Change. The goal must contain who, (if not the parent/ caregiver), what, when, where, why and how the goal is to be achieved.

The goal should be **SMART:**

S – Specific

M – Measurable

A – Achievable

R – Realistic

T – Timely

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 to needed to resolve the nutritional problems identified in the assessment, achieve goals, and attain positive health outcomes.

Attend group at next visit: Mark as appropriate.

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

PAGE 2:

RETURN VISITS:

Progress toward previous goal: Follow-up on the previous goal is required. If the participant attended group education at a mid-certification visit, 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 any barriers to change.

New goal: Record new goal if one is identified.

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.

Checklists: (Nutrition Counseling and Materials Given.) Record the date and indicate the subjects covered and materials given during the visit.

The Nutrition Counseling topics marked with an asterisk (*) have to be discussed at the initial certification. In addition, substance abuse must be addressed at each certification. If the required topics cannot be addressed at the specified times, it must be documented in the notes so that they can be addressed at the next contact.

The items on the Materials Given checklist that are identified with an asterisk (*) must be given at the certification visit.

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 mos	4 mos. - 6 mos.	6 mos.- 8 mos.		8 mos. - 11 mos.
Breast Milk	8-12 Fdgs.	5+ Fdgs.	3-5 Fdgs.	Breast milk	3-4 Fdgs.
Formula w/Fe	16-40 oz.	26-39 oz.	24-32 oz.	Formula w/Fe	24-32 oz.
Infant Cereal		1-2 T	4-6 T.	Infant Cereal	4-6 T.
Pl. Str. Vegetables			3-4 T	Pl. str., mashed or chopped cooked vegetables	3-4 T.
Pl. Str. Fruit			3-4 T	Pl. str., mashed or chopped cooked fruits	3-4 T.
Infant Juice			2-4 oz	Infant Juice	4-6 oz.
Str. Plain Meat or pureed egg yolk, or legumes			1-2 T	Str., chopped meat, poultry, egg yolk, cheese, yogurt or mashed legumes	1-3 T.

The infant feeding guide has been reprinted and reflects several changes but the guideline for offering infant cereal between 4 - 6 months remains the same. This recommendation 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 Associations 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 American Dietetic Association’s Pediatric Nutrition Manual. Offering infant cereal at 6 months can be emphasized in participant education.

Children	1 - 3 yrs.	4 - 8 yrs.	Females 9 - 13 yrs.
MILK GROUP 1 cup equivalent: 1 cup milk 1 cup yogurt 1 1/2 cups ice cream 1 1/2 oz. hard cheese 2 oz. American cheese 2 cups cottage cheese 1 cup pudding 1 cup frozen yogurt	2 cups	3 cups	3 cups
MEAT/PROTEIN GROUP 1 ounce equivalent: 1 oz. cooked meat, fish or poultry 1 egg 1/4 cup cooked dry beans/peas 1 tablespoon peanut butter 1 1/2 hot dogs * 1 1/2 oz. sausage * 2 slices bologna *	2 - 4 ounces	3 - 5 1/2 ounces	4 - 6 ounces
VEGETABLE GROUP** 1 cup equivalent: 1 cup raw or cooked vegetables 1 cup vegetable juice 2 cups raw leafy vegetables	1 - 1 1/2 cups	1 1/2 - 2 1/2 cups	1 1/2 - 3 cups
FRUIT GROUP ** 1 cup equivalent: 1 cup fruit or 100% fruit juice 1/2 cup dried fruit 1/2 cup = 1 small fruit	1 - 1 1/2 cups	1 - 2 cups	1 1/2 - 2 cups
GRAINS GROUP Half should be whole grain 1 ounce equivalent: (1 1/2 - 2 1/2 oz. whole grains) 1 cup ready to eat cereal 1/2 cup cooked cereal 1/2 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 oz. (2 - 4 oz. whole grains)	4 - 6 oz. (2 1/2 - 3 1/2 oz. whole grains)	5 - 7 oz.
FATS 1 teaspoon equivalent: 1 teaspoon margarine 1 teaspoon vegetable oil (canola or olive oil best) 1 teaspoon mayonnaise 1 tablespoon salad dressings	3 - 4 tsps	4 - 6 tsps	4 - 6 tsps

* = 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.

This is a general guide. Refer to My Pyramid Food Intake Pattern Calorie Level recommendations for specific information. Refer to My Pyramid Food Intake Patterns for the daily amount of food from each food group for specific calorie levels.

Females	Pregnant/Lactating 14-18 yrs. ***	Pregnant/Lactating 19-30 yrs. ***	Pregnant/Lactating 31+ yrs. ***
MILK GROUP 1 cup equivalent: 1 cup milk 1 cup yogurt 1 1/2 cups ice cream 1 1/2 oz. hard cheese 2 oz. American cheese 2 cups cottage cheese 1 cup pudding 1 cup frozen yogurt	3 cups	3 cups	3 cups
MEAT/PROTEIN GROUP 1 ounce equivalent: 1 oz. cooked meat, fish or poultry 1 egg 1/4 cup cooked dry beans/peas 1 tablespoon peanut butter 1 1/2 hot dogs * 1 1/2 oz. sausage * 3 slices bologna *	6 - 7 oz.	7 - 8 oz.	6 - 7 oz.
VEGETABLE GROUP** 1 cup equivalent: 1 cup raw or cooked vegetables 1 cup vegetable juice 2 cups raw leafy vegetables	3 - 3 1/2 cups	3 - 3 1/2 cups	3 - 3 1/2 cups
FRUIT GROUP** 1 cup equivalent: 1 cup fruit or 100% fruit juice 1/2 cup dried fruit 1/2 cup = 1 small fruit	2 - 2 1/2 cups	2 - 2 1/2 cups	2 cups
GRAINS GROUP Half should be whole grain 1 ounce equivalent: 1 cup ready to eat cereal 1/2 cup cooked cereal 1/2 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 oz. (3 1/2 - 5 oz. whole grains)	7 - 10 oz. (3 1/2 - 5 oz. whole grains)	7 - 9 oz. (3 1/2 - 4 1/2 oz whole grains)
FATS 1 teaspoon margarine 1 teaspoon vegetable oil (canola or olive oil best) 1 teaspoon mayonnaise 1 tablespoon salad dressings	6 - 8 tsps	6 - 8 tsps	6 - 8 tsps

* = 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).

Females	Non-pregnant 14 - 18 yrs.	Non-pregnant 19 - 30 yrs.	Non-pregnant 31+ yrs.
MILK GROUP 1 cup equivalent: 1 cup milk 1 cup yogurt 1 1/2 cups ice cream 1 1/2 oz. hard cheese 2 oz. American cheese 2 cups cottage cheese 1 cup pudding 1 cup frozen yogurt	3 cups	3 cups	3 cups
MEAT/PROTEIN GROUP 1 ounce equivalent: 1 oz. cooked meat, fish or poultry 1 egg 1/4 cup cooked dry beans/peas 1 tablespoon peanut butter 1 1/2 hot dogs * 1 1/2 oz. sausage * 3 slices bologna *	5 - 6 1/2 oz.	5 1/2 - 6 1/2 oz.	5 - 6 oz.
VEGETABLE GROUP** 1 cup equivalent: 1 cup raw or cooked vegetables 1 cup vegetable juice 2 cups raw leafy vegetables	2 1/2 - 3 cups	2 1/2 - 3 cups	2 1/2 - 3 cups
FRUIT GROUP** 1 cup equivalent: 1 cup fruit or 100% fruit juice 1/2 cup dried fruit 1/2 cup = 1 small fruit	1 1/2 - 2 cups	2 cups	1 1/2 - 2 cups
GRAINS GROUP Half should be whole grain 1 ounce equivalent: 1 cup ready to eat cereal 1/2 cup cooked cereal 1/2 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 oz. (3 - 4 oz. whole grains)	6 - 8 oz. (3 - 4 oz. whole grains)	6 - 7 oz. (3 - 3 1/2 oz. whole grains)
FATS 1 teaspoon margarine 1 teaspoon vegetable oil (canola or olive oil best) 1 teaspoon mayonnaise 1 tablespoon salad dressings	5 - 7 tsps	6 - 7 tsps	5 - 6 tsps

* = 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.

This is a general guide. Refer to My Pyramid Food Intake Pattern Calorie Level recommendations for specific information. Refer to My Pyramid Food Intake Patterns for the daily amount of food from each food group for specific calorie levels.

Food Intake Patterns

The suggested 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 discretionary calorie allowance that can be accommodated within each calorie level, in addition to the suggested amounts of nutrient-dense forms of foods in each group.

Daily Amount of Food From Each Group

Calorie Level	1,000	1,200	1,400	1,600	1,800	2,000
Fruits ²	1 cup	1 cup	1.5 cups	1.5 cups	1.5 cups	2 cups
Vegetables ³	1 cup	1.5 cups	1.5 cups	2 cups	2.5 cups	2.5 cups
Grains ⁴	3 oz–eq	4 oz–eq	5 oz–eq	5 oz–eq	6 oz–eq	6 oz–eq
Meat and Beans ⁵	2 oz–eq	3 oz–eq	4 oz–eq	5 oz–eq	5 oz–eq	5.5 oz–eq
Milk ⁶	2 cups	2 cups	2 cups	3 cups	3 cups	3 cups
Oils ⁷	3 tsp	4 tsp	4 tsp	5 tsp	5 tsp	6 tsp
Discretionary calorie allowance	165	171	171	132	195	267
Calorie Level	2,200	2,400	2,600	2,800	3,000	3,200
Fruits ²	2 cups	2 cups	2 cups	2.5 cups	2.5 cups	2.5 cups
Vegetables ³	3 cups	3 cups	3.5 cups	3.5 cups	4 cups	4 cups
Grains ⁴	7 oz–eq	8 oz–eq	9 oz–eq	10 oz–eq	10 oz–eq	10 oz–eq
Meat and Beans ⁵	6 oz–eq	6.5 oz–eq	6.5 oz–eq	7 oz–eq	7 oz–eq	7 oz–eq
Milk ⁶	3 cups	3 cups	3 cups	3 cups	3 cups	3 cups
Oils ⁷	6 tsp	7 tsp	8 tsp	8 tsp	10 tsp	11 tsp
Discretionary calorie allowance	290	362	410	426	512	648

- 1. Calorie Levels** are set across a wide range to accommodate the needs of different individuals. The attached table “Estimated Daily Calorie Needs” 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 & Beans Group** in general, 1 ounce of lean meat, poultry, or fish, 1 egg, 1 Tbsp. peanut butter, 1/4 cup cooked dry beans, or 1/2 ounce of nuts or seeds can be considered as 1 ounce equivalent from the meat and beans group.
- 6. Milk Group** includes all fluid milk products 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. Most milk group choices should be fat-free or low-fat. In general, 1 cup of milk or yogurt, 1 1/2 ounces of natural cheese, or 2 ounces of processed cheese can be considered as 1 cup from the milk 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. Discretionary Calorie Allowance** is the remaining amount of calories in a food intake pattern after accounting for the calories needed for all food groups—using forms of foods that are fat-free or low-fat and with no added sugars.

Estimated Daily Calorie Needs

To determine which food intake pattern to use for an individual, the following chart gives an estimate of individual calorie needs. The calorie range for each age/sex group is based on physical activity level, from sedentary to active.

	Calorie Range	
	Sedentary	Active
Children		
2–3 years	1,000	1,400
Females		
4–8 years	1,200	1,800
9–13	1,600	2,200
14–18	1,800	2,400
19–30	2,000	2,400
31–50	1,800	2,200
51+	1,600	2,200
Males		
4–8 years	1,400	2,000
9–13	1,800	2,600
14–18	2,200	3,200
19–30	2,400	3,000
31–50	2,200	3,000
51+	2,000	2,800

Sedentary means a lifestyle that includes only the light physical activity associated with typical day-to-day life.

Active means a lifestyle that includes physical activity equivalent to walking more than 3 miles per day at 3 to 4 miles per hour, in addition to the light physical activity associated with typical day-to-day life.

U.S. Department of Agriculture
 Center for Nutrition Policy and Promotion
 April 2005

Food Intake Pattern Calorie Levels

MyPyramid assigns Individuals to a calorie level based on their sex, age, and activity level.

The chart below identifies the calorie levels for males and females by age and activity level. Calorie levels are provided for each year of childhood, from 2-18 years, and for adults in 5-year increments.

Activity Level	MALES			Activity level	FEMALES		
	Sedentary*	Mod active*	Active*		Sedentary*	Mod. 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.

Food List Abbreviations

bac	bacon	las	lasagna
bis	biscuit	m	mashed
BK	baked	mac	macaroni
BLT	bacon, lettuce, tomato sandwich	mac/ch	macaroni & cheese
brd	bread	m. loaf	meat loaf
bfg or BF	breastfeeding	oj	orange juice
C	cup	p. chop	pork chop
CB	cheeseburger	PB and J or PBJ	peanut butter & jelly
cer	cereal	pot	potatoes
ch	cheese	pwd	powder
chix	chicken	qrt pdr	quarter pounder
choc	chocolate	R. Beef	roast beef
crm	creamed	sand	sandwich
crax	crackers	saus	sausage
fd	food	sc	sauce
fdg	feeding	scr	scrambled
FF	french fries	sk	skim
fr	fried	sl	slice
frt	fruit	spag	spaghetti
gr beans	green beans	svg	serving
G. Ade	Gatorade	sw. acid	sweet acidophilus
grd	ground	sw pot	sweet potatoes
hamb /wbun	hamburger with bun	T	tablespoon
ice crm	ice cream	t. grns	turnip greens
jc	juice	tom	tomato
Kaid	Koolaid	tsp or t	teaspoon
wh	whole	veg	vegetable
		ww	whole wheat

Breastfeeding Abbreviations

BoF	Bottle Feeding
Ba	Baby
DBE	Designated Breastfeeding Expert
M, Mo	Mother
PC, BFPC	Breastfeeding Peer Counselor
LC	Lactation Consultant
IBCLC	International Board Certified Lactation Consultant
C-Section	Cesarean Section
FN	Flat Nipple
IN	Inverted Nipple
L/O	Latch On
PO	Position
ref	referral, referred, referring
SN	sore nipple
MER	Milk Ejection Reflex
NSVD	Normal Single Vaginal Delivery
PN	Prenatal
PP	Postpartum
EBM	Expressed Breast Milk

Formula Abbreviations

GS Gentle	Good Start Gentle
GS Soy	Good Start Soy
GS Protect	Good Start Protect
GS Nourish	Good Start Nourish
GS Soothe	Good Start Soothe

Other Abbreviations

amt	amount	lb	pound
appt	appointment	LBW	Low Birth Weight
BMI	Body Mass Index	liq	liquid
B/P BP	Blood Pressure	Med	Medication
Cal	calorie	MVI	Multivitamin
Carb	carbohydrate	N/A	Not Applicable
Chol	cholesterol	N & V	Nausea and Vomiting
cigs	cigarettes	NICU	Neonatal Intensive Care Unit
conc	concentrate	NKA	No Known Allergies
cont	continue	NKFA	No Known Food Allergies
CVV	Cash Value Vouchers	nutr, nutri	nutrition
d	day/daily	occ	occasional
dev	development	oz	ounce
Dx	diagnosis	PCP	Primary Care Provider/ Provider
ed	education	pkg	package
esp	especially	pk	pack
F, Fa	Father	PNV	Prenatal Vitamin
FA	Folic Acid	ppd	packs per day
FeSo4	Ferrous Sulfate	preg	pregnant
FI	Food Instruments	prep	preparation
f/u	Follow Up	prob	problem
GF	Grandfather	Pt	patient
GM	Grandmother	qt	quart
grp/grps	group/groups	Rx	prescription
hr	hour	TNCare	TennCare
ht	height	Tx	Treatment
Hx	history	wt	weight
HCP	Health Care Provider	y/o	year old
IBW	Ideal Body Weight	yr	year
Kcal	Kilo calorie		

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:											
<ul style="list-style-type: none"> <input type="checkbox"/> Introduced self to client <input type="checkbox"/> Displayed understanding for other cultures <input type="checkbox"/> Ensured privacy (Kept voice low, closed door, moved to private location) <input type="checkbox"/> Offered help when needed ("Here are some pamphlets", "feed baby here", etc.) <input type="checkbox"/> Used appropriate non-verbal communication (Nodded head, made eye contact, avoided crossed arms, etc.) <input type="checkbox"/> Used respectful language <input type="checkbox"/> Focused on client when translator is used 	Follow-Up Review Comments:											
COMPLETING ASSESSMENT FORMS (QUESTIONNAIRE, TOOL, ETC.)	Initial Review Comments:											
<ul style="list-style-type: none"> <input type="checkbox"/> Reviewed client's previous plan and client-centered goal <input type="checkbox"/> Gather missing/additional information without interrupting client <input type="checkbox"/> Asked probing questions to clarify responses <input type="checkbox"/> Avoided spending extensive time on irrelevant information <input type="checkbox"/> Shared findings (ht, wt, Hgb/Hct) in a non-judgmental manner 	Follow-Up Review Comments:											
IDENTIFYING AND EXPLORING CONCERNS	Initial Review Comments:											
<ul style="list-style-type: none"> <input type="checkbox"/> Asked open-ended questions to explore client's concerns <input type="checkbox"/> Listened actively and allowed for silence <input type="checkbox"/> Validated client's concerns <input type="checkbox"/> Referred client to outside resources when needed (social services, food bank, etc) <input type="checkbox"/> Used counseling tools to start and guide conversation (questionnaire, probing questions) <input type="checkbox"/> Identified and acknowledged client's strengths (positive behaviors) <input type="checkbox"/> Maintained focus on desired health outcome (healthy pregnancy, active family) <input type="checkbox"/> Assessed level of nutritional risk <input type="checkbox"/> Identified all nutritional risks <input type="checkbox"/> Helped client explore feelings and attitudes about health concern <input type="checkbox"/> Tried to lead discussion based on nutrition assessment data if nothing was offered by client <input type="checkbox"/> Assessed the client's readiness to change (Stage of Change - SOC) <input type="checkbox"/> Helped client to identify barriers to change and possible ideas to overcome them. <input type="checkbox"/> Provided simple, accurate nutrition messages if client was receptive <input type="checkbox"/> Limited number of nutrition messages given to client per session <input type="checkbox"/> Tailored messages based on client's age, gender, culture, and feedback 	Follow-Up Review Comments:											

SETTING GOALS	1	2	3	4	5	NA	1	2	3	4	5	NA
<input type="checkbox"/> Summarized the conversation <input type="checkbox"/> Assessed for progress toward previous goal/behavior change. <input type="checkbox"/> Praised progress toward goal. <input type="checkbox"/> Identified barriers to behavior change <input type="checkbox"/> Identified suggestions/solutions to change <input type="checkbox"/> Reinforced desired outcome <input type="checkbox"/> Helped client set goal that is specific & realistic for the family's lifestyle <input type="checkbox"/> Used facilitated discussion to help client set goal that is specific & realistic for the family's lifestyle <input type="checkbox"/> Documented goal in client record	Initial Review Comments:						Follow-Up Review Comments:					
CLOSING ON A POSITIVE NOTE	1	2	3	4	5	NA	1	2	3	4	5	NA
<input type="checkbox"/> Restated the goal and checked for understanding <input type="checkbox"/> Expressed appreciation for client's time <input type="checkbox"/> Was enthusiastic about following up at next time	Initial Review Comments:						Follow-Up Review Comments:					
GROUP EDUCATION	1	2	3	4	5	NA	1	2	3	4	5	NA
<input type="checkbox"/> Was client-centered <input type="checkbox"/> Conducted facilitated discussion <input type="checkbox"/> Session was interesting and Interactive <input type="checkbox"/> Maintained master file (list of attendees, date of session, description/outline of topic)	Initial Review Comments:						Follow-Up Review Comments:					
ADDITIONAL SKILLS ASNEEDED AND APPROPRIATE	1	2	3	4	5	NA	1	2	3	4	5	NA
<input type="checkbox"/> Interpreted and compared dietary practices of WIC participants to federal policy guidelines <input type="checkbox"/> 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

Using the VENA Counseling Skills Checklist

The VENA Counseling Skills Checklist 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 checklist 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 6 for forms and pamphlets approved for distribution.

Resources by which the Special Supplemental Nutrition Program (WIC) may be strengthened/reinforced in Tennessee, directly or indirectly include:

Federal, State, Regional and Local Agencies/Agency Programs

Tennessee Department of Health, Nutrition Services Section, Local, Regional and State staff

Other public health programs in Tennessee

University Agricultural Extension programs, especially Expanded Food and Nutrition Education Programs (EFNEP)

All USDA program services relating to food/nutrition intervention

Human Resource Agency/Department of Human Services (local and state)

Department of Health and Human Services (HHS) programs, e.g., Maternal and Child Health (MCH), Maternal and Infant Care projects, Children's Special Services, etc.

Health planning agencies/groups

Schools and universities

Family and Children's Services

Tennessee Department of Health Bureau of Information Resources

Centers for Disease Control Services

Local county government/local county officials

Tennessee Department of Health Film Library/Resource Center

Tennessee Department of Education Nutrition Education and Training Program (NET Program)

Private and Volunteer Agencies, Services, Institutions, Facilities

La Leche League

March of Dimes, local, state and national foundations

Religious and church affiliated groups

American Red Cross

Charitable organizations

Child care facilities

American Hospital Association

Group homes

Private medical and health care facilities/staff and medical records

Tennessee Association For Retarded Citizens

American Heart Association

Business, Industry and Labor

National, regional and local Dairy Food and Nutrition Councils

Food industry: distributors and vendors

Pharmaceutical companies

News media

Insurance companies

Private nutrition education procurement companies

Professional Associations, Organizations, Societies

International Lactation Consultant Association

American Dietetic Association: state and district affiliates

State and local nursing associations

Medical societies

State and local home economics associations

State and local education associations

American Public Health Association

Tennessee Public Health Association

Chronic disease associations, e.g., Diabetes Associations, Kidney Foundations, American Heart Association, Lung Association, Cancer Society

Society for Nutrition Education

Health Care Facilities

Ambulatory health care facilities

Hospitals

Group homes

Primary care centers

Other

Advisory councils, committees, community groups with health care linkages

Volunteers for health related programs/food intervention programs

Data gathering systems

Libraries, area resource centers, exhibits and related community resources

Office.

Nutrition Service Plan can be found in the Regional Nutrition Director's office.

Breastfeeding Access Plan can be found in the Breastfeeding Promotion Coordinator's office.

Medical Documentation for Therapeutic Products and Special Needs Handbook can be found in the Regional Nutrition Director's office and with each Registered Dietitian

Breastfeeding Handbook can be found in the Breastfeeding Coordinator's office and at every clinic site.

Recommended Nutrition Related Website Resources

Government: (all websites based on current Dietary Guidelines for Americans and guidelines for treatment of various chronic diseases)

www.bam.gov (kids/teens website on health from CDC)
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.fruitsandveggiesmatter.gov (CDC National Fruit & Vegetable Program website)
www.fns.usda.gov/eatsmartplayhardhealthylifestyle (USDA family website for nutrition & physical activity)
www.Healthfinder.gov (US Department of Health and Human Services health finder resource)
<http://minorityhealth.hhs.gov> (Office of Minority Health)
www.ndep.nih.gov (National Diabetes Education Program)
www.nhlbi.nih.gov/health/pubs/pub_gen.htm (National Heart, Lung, & Blood Institute publications)
www.niddk.nih.gov (National Diabetes Information Clearinghouse)
www.nkdep.nih.gov (National Kidney and Urologic Disease Information Clearinghouse)
<http://snap.nal.usda.gov> (SNAP- Ed Connection)
www.surgeongeneral.gov/topics/breastfeeding (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)
www.wicworks.nal.usda.gov (WIC Works! website)
www.womenshealth.gov/breastfeeding (DHHS National Women's Health Information Center)

Nonprofit/Educational: (based on current nutrition science and have no conflict of interest)

www.aap.org (American Academy of Pediatrics)
www.eatright.org (American Dietetic Association)
www.americanheart.org (American Heart Association)
www.bfmed.org (The Academy of Breastfeeding Medicine)
www.diabetes.org (American Diabetes Association)
<http://food.unl.edu/web/fnh/home> (University of Nebraska Extension Food, Nutrition and Health)
www.fruitsandveggiesmorematters.org (Produce for Better Health Foundation)

www.healthiergeneration.org (Alliance for a Healthier Generation)
www.ilca.org (International Lactation Consultant Association)
www.lalecheleage.org (La Leche League)
www.porkandhealth.org (National Pork Producers Council)
www.school-wellness.org/Athome.aspx (Enriching Family Mealtime Kit from the National Cattlemen’s Beef Association)
www.southeastdairy.org (Southeast United Dairy Industry Association, Inc.)
www.text4baby.org (free weekly text messages for pregnant women and new moms regarding pregnancy and baby care health topics)
http://wvu.edu/~exten/infores/pubs/nut_hlth.htm (West Virginia Extension)

Other: (based on current scientific information and current nutrition care recommendations)

www.BDdiabetes.com (Becton Dickinson Company)
www.bellinstitute.com (General Mills Bell Institute)
www.bsc.gwu.edu/dpp/lsmop.htmlvdoc (Diabetes Prevention Program’s Lifestyle Change Program Manual)
<http://depts.washington.edu/hmcdiab/VivalaVidaEnglish.pdf> (Live Your Life! Control Your Diabetes)
www.Lillydiabetes.com (Eli Lilly Company)
www.numatters.com (Nutrition Matters, Inc.)

The educational materials from these websites should be previewed before use to ensure that the content is compliant with the Tennessee WIC Program nutrition 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 cosite 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

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 Personnel 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. Remember we are here to serve the public and customer satisfaction is our #1 service.

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 monitored 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.

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), the fuser wiper should be replaced to determine if that is the cause of the smearing. If this does not correct the problem, 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 Technology/Lexmark printers come with factory default settings for maximum use of toner cartridges.

Recycling Toner Cartridges

The used cartridge (that are not defective, just empty) should be put in the box that the new toner cartridge was in and sent back to the manufacturer for recycling. Ship according to instructions. Prepaid shipping labels are available from your Regional WIC Director.

Defective Toner Cartridge Return Form and Procedure

The procedure for the WIC Director or designee to follow for defective cartridges is:

1. Complete a copy of the product return form (instructions follow).
2. Fax the completed form to Source Technologies at (704) 969-7538. (You may call 1-800-922-8501, Ext. 531.)
3. They will fax back shipping instructions and an RMC# will be assigned to the cartridge. (Without the RMC# on the box, Source Technologies will not accept the box.)

Please make copies of the form and keep in a file to use for making additional copies. Areas on the form that need to be completed have asterisks. Please complete as follows:

Contact: Name and location of person responsible for sending toner cartridge.

Ship-to Address: Address of person responsible for sending toner cartridge.

Your phone: Phone number of the contact person listed above.

Your fax: Fax number of same as above.

Reason for Return (please be specific): Give a detailed explanation of why cartridge appears to be defective.

Condition of Product: This will usually be "Opened and Defective;" however, it is possible that it may be another option. Therefore, it is left blank to be completed each time.

Quantity: The number of defective cartridges you are returning for testing and replacement.

Serial No.: The serial number of the defective cartridge(s) which are being returned.

Ship to same address as listed above: Will probably be the same location as the location returning the cartridge. Each region needs to decide if clinics will take care of this themselves, or if they will send the defective cartridges to the Regional Office to handle. Either way, the location returning it will probably always be the location receiving the replacement.

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 put 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

Before shipping an out of order printer back, the serial number and state tag should be documented. A memo or an e-mail should be sent to the Attention: Robin.M.Holjes@tn.gov 615-741-0594 (Central Procurement and Payments), retiring the old state tag associated with the serial number of the out of order printer. In the same e-mail or memo, give the serial number of the replacement printer and request a new state tag for this printer. This notification may be done by someone in your regional office. Please check to determine the proper procedure in your region. Notify your Regional property officer.

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. A clerk can keep track of how many FI/ CVV numbers are remaining by monitoring the FI/ CVV inventory. 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.

Orientation of Paper

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 in the 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 to issue the correct number of FI/CVVs for the appropriate food package.

If the participant is receiving a standard food package, the system will automatically bring up the standard Food Package Code (FPC) and the associated voucher codes for that FPC. In order to do this, the CPA should write “STD” in the Next Food Package Code on the EN form and the PHOA should in turn leave them blank on the WICQ screen. The system will look at the WIC status and other fields to determine which food package and FI/CVVs 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. If a prenatal is pregnant with multiple fetuses, the system will pick this information up from the Nutritional Risk code #335 and issue the correct 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” by using the “2” in the Outcome field which means “multiple” births. Therefore, leaving the “Next FP” on the WICQ screen blank will allow the system to work for you.

If no tailoring or modifications to the foods are required, and the full nutritive value of foods are to be given, these are considered “standard” packages. For these, the system will issue automatically with the information that it has, therefore the “Next FP” should always be left blank on these:

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 correctly.

Since some new food packages will require several voucher codes, care must be taken to not exceed the ten (10) fields allowed on the WICQ screen for voucher codes. If the order exceeds the ten fields allowed, an error message will be generated about this. If this occurs, the FI/CVV's need to be spread over two WICQ screens. When this is done, it is vitally important to issue another Encounter for the 2nd WICQ. This will allow viewing of two WICQ screens on the same date when the command DWICQ is used. If a new EN is not issued and the same WICQ screen is used to issue additional FI/CVV's, the first set of FI/CVV's is "written over" and cannot be viewed when the patient returns. Following the trail is much more difficult because it must be viewed from the TVH one voucher at a time.

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 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.

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 vouchers 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 screen. 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/CVVs to Proxies

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, the parent/caregiver or an alternate signer may shop for the WIC foods.

Once the 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. The proxy can redeem the FI/CVVs at the store or the participant/parent/caregiver or an alternate may redeem the FI/CVVs. Any person redeeming the FI/CVVs must have signed the WIC FI/CVV envelope and must present it at the store.

Explain the food package and how, where, and when to spend the FI/CVV. Provide list of authorized foods, stores, and the local resource agencies as required. Emphasize that FI/CVV envelope must be presented at the store when the FI/CVVs are being transacted. Also emphasize that whoever is charged with transacting the FI/CVV must have knowledge of the current WIC food list and the procedures for transacting FI/CVVs which are described inside the FI/CVV folder.

Confirm next appointment and action due in writing for participant.

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. The quantity can be reduced even further than the quantity allowed by the voucher code.

When formula is returned and replaced with a new FI, it is logged into the clinic's formula inventory. (See Chapter 6.)

Replacing FI/CVVs 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/CVVs for the appropriate food packages, but do not try to recover the G and G2 FI/CVVs she may already have been given. Another circumstance when the vouchers a woman has been given should not be recovered would be a prenatal who miscarries. She should be allowed to keep the vouchers she has already been given and issued vouchers as a WIC Status 2 (Postpartum) through six months postpartum.

If it is beneficial to the woman to reissue the vouchers it should be done, e.g. a prenatal who delivers early and begins to fully breastfeed. She could be reissued vouchers for a WIC Status 6 (Fully Breastfeeding Woman) instead of the prenatal vouchers she might still have.

The exception to this is if she has been given FI/CVVs 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/CVVs 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/CVVs 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/CVVs 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 replacement 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.

Problematic Replacement of FI/CVVs

If a person requests to return to the clinic to have FI/CVVs replaced, and the clinic is unable to schedule him/her until after the time of the month when the system prorates FI/CVVs, they should not be penalized by not giving the full replacement. The proration should be overridden to give them the full replacement, e.g. if the system offers a P FI for a previously issued A and A2 FI, go to the "voucher print detail" section of the screen at the bottom and change the P FI to an A and add an A2 and a CVV. In the case of an infant, the proration number in front of the voucher code can be removed and a greater number of cans issued inserted.

PROCEDURE TO ISSUE WIC FI/CVVS WHEN SYSTEM IS DOWN

When the system is down (for whatever reason) 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. The two options are to be reappointed to return at another time to pick up the FI/CVVs, or to have them mailed to their home.

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. A person should not be denied FI/CVVs for the current month or have benefits reduced by proration because the system was down. 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/CVVs 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 (PH-3683).
 - 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/CVVs 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/CVVs were printed.
 - When the system is back up, follow these procedures for mailing:
1. Clerk will print the FI/CVVs for all persons in the family who were due to receive FI/CVVs when the system is down. The participant may not have FI/CVVs 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/CVVs have the possibility of arriving before the end of the month. If not, she/he should not print FI/CVVs 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/CVV's. If unable to locate the parent/guardian, an employee other than the one who printed the FI/CVV's must handle the envelopes. Employee opens the envelope, marks void on the FI/CVV's. The issuing clerk should then void the FI/CVV's on the system and place with void FI/CVV's for that day. The signed agreement should also be noted that FI/CVV's were returned as undeliverable and voided, initialed and dated by employee.
10. If parent/guardian calls to say FI/CVV's have not been received, allow three business days from date mailed to check to see if the FI/CVV's 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 = \$.44

If patient claims not received, would have to wait until redeemed and bank can send copy.

CERTIFIED MAIL = \$2.80 + first class postage .44 = \$3.24

The USPO 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 = \$2.30 by mail or \$1.10 to 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 USPO = \$3.80 (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 = \$4.95

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

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.

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 health professional 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.

In order for lost FI/CVVs to be replaced, the certifier must determine need and document such in the patient file.

Staff may implement one of the two 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.

If replacement FI/CVVs are issued, the participant should be warned that if the FI/CVVs reported lost are paid, he/she may be responsible for reimbursing the WIC Program.

Stolen FI/CVVs Stolen Vouchers

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 spent before the theft so that the correct serial numbers are reported stolen.

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.

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 LSD Report (PH-1532) 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 PH-1532, 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, wait seven (7) days and check the Covansys WIC Banking to see if the lost FI/ CVV(s) have been cashed.
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:

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/CVV's voided the same day they are printed, the void documentation on the receipts and the voided FI/CVV's match.

Void FI/CVV's 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/CVV's.

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/CVV's. (More detailed instructions previously this Chapter under "Issuing FI/CVV's".)

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 following day of every day that FI/CVV's have potential to be issued OR

With date parameters that include every day that FI/CVV's 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/CVV's 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/CVV 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 shipping to the contract bank (Covansys) for archiving and destruction.

While receipts will be shipped by the regional office to the contract bank for imaging and destruction, the voids need to be shipped to the regional office for destruction.

The Records Destruction Authority for the Voided Vouchers 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 Electronic Forms, then access the “Certificate of Records Destruction”.

<http://www.intranet.state.tn.us/generalserv/centralstores/centralstores.html>

The schedule for archiving both voids and receipts from the clinics will be 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 2012	July 2011 - September 2011
January 2013	October 2011 - December 2011
April 2013	January 2012 - March 2012
July 2013	April 2012 - June 2012

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.
- They should be sent in the order in which they were stored (chronologically by date).
- They should not be bound by any paper (paper clipped to or wrapped around them) or have any dividers (other than FI/ CVV paper marking the date), etc. between them.
- Any header (identifying messages at the beginning of a group of voids or receipts) must be written on actual FI/ CVV paper. They will be imaged also.

Receipts

- The Regional WIC Office should then make one shipment to Covansys of all the receipts in the Region.
- Covansys will image onto a CD-ROM.
- The CD-ROM will be stored at the Central WIC Office in Nashville.

Voids

- The Regional WIC Office will destroy the voids using RDA-1550 and the approved method of destruction.

Receipts and Voids From Regional Office to Bank

- Between the 1st and 7th days of the second month from the end of the quarter, the Regional Offices should prepare and ship the receipts to Covansys for imaging.
- The receipts will need to be boxed in Clinic order within each Region.
- The region should consolidate the receipts in one set of boxes and if the last boxes are not full, stuff with paper to prevent movement within the box.
- All documents should be sorted face forward, write side up.
- No paper clips, rubber bands, paper ties or anything other than FI/CVV paper.
- Each box should be labeled with:

Region Number (convert to number if region is a letter)

Region Name

Box Number ____ of ____ (e.g., 1 of 5)

Quarter (e.g., 10/97 - 12/97)

- Box 1 should include a completed form indicating:

Region Number (convert to number if region is a letter)

Total Number of boxes sent from Region.

Region Name

Quarter

Date sent

Signature of person sending

This form will be returned with the CD ROMS as confirmation of what was included in this Quarterly processing.

The lettered regional numbers are:

10 = Davidson

11 = Knox

12 = Hamilton

13 = Sullivan

14 = Madison

RECEIPT or VOID FORM FOR EACH BOX

(Should be placed on the outside of each box)

Region # _____

Region Name _____

Box Number _____ **of** _____

Quarter _____

1/13/99 Tennessee WIC Program

RECEIPT or VOID FORM FOR EACH BOX

(Should be placed on the outside of each box)

Region # _____

Region Name _____

Box Number _____ **of** _____

Quarter _____

1/13/99 Tennessee WIC Program

RECEIPT FORM FOR BOX #1

(Should be placed inside Box #1)

Region # _____

Region Name _____

Box Number _____ **of** _____

Quarter _____

Date Sent _____

Signature of Person Sending

1/13/99 Tennessee WIC Program

VOID FORM FOR BOX #1

(Should be placed inside Box #1)

Region # _____

Region Name _____

Box Number _____ **of** _____

Quarter _____

Date Sent _____

Signature of Person Sending

1/13/99 Tennessee WIC Program

Regional Office Shipping to Covansys

The Regional Office will be responsible for collecting the voids and receipts and shipping them to Covansys. Please note that there are different forms for “Receipt Form for Box #1” and “Void Form for Box #1”. Take care to use the correct form for the shipment and to send each shipment to the correct address. The forms to put in each box are not different and may be used for either shipment. The schedule will be as follows:

- Within 30 days from the end of each quarter, the voids and receipts will be brought into the Regional Office from all the clinics as staff travel to and from these sites.
- Within the first week of the next month (31-38 days from the end of the quarter), the Regions will ship the Voids and Receipts to Covansys according to the following instructions using these Covansys addresses:

Ship RECEIPTS to:
CSC Corporation - WIC Banking Processing Facility
1000 Cobb Place Blvd., Building 100, Suite 190
Kennesaw, GA 30144

DUAL PARTICIPATION REPORT

A report that identifies potential dual participants across the State within the WIC sites and between WIC and CSFP will be generated at the WIC Central Office and mailed to the Regional WIC Director for investigation.

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/CSVs 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; more than one CSFP program or between WIC and CSFP 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 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/

CVVs issued to the same person or WIC FI/ CVVs and CSPF 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/ CVVs were issued. The second set of FI/ CVVs should be recovered, if possible, from the participant and voided. If both sets of FI/ CVVs 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/ CVVs 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 6 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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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 integrated computer system. All patients who use services in the Tennessee Department of Health clinics are registered and income is reported through the PTBMIS. It is an on-line, 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 patient data to a central AS/400 located in the Office of Information Technology (OITS) of the Department. Only patient data requested by State Office personnel for statistical and reporting purposes is uploaded. The active patient 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

If WIC services are given, the WIC screen is accessed and on this one screen is captured all of the data necessary to track participant certification, nutrition education, pregnancy outcome data, breastfeeding data, and to issue FI/CVVs. The data fields are edited for logical edits and some cross-field edits. Once all the fields have been completed as necessary, 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 WIC 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/CVV 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)

Patient No.:	0000005048	Date:	Updated 03/05/95	Reg. Date:	_____	Reg. Type	_____
Tracking:	_____	Immun:	_____	Balance:	_____	Medicaid N Fam No	_____
Name:	_____	Birth Date:	_____	Age	_____	M	_____
Alias	_____						
Addr:	_____						
City	_____	State:	_____	Zip Code:	_____	County:	_____
Hphone:	_____	Wphone:	_____				
SSN:	_____	Race:	__ __ __	Sex:	__	Migrant:	_____
Occupation:	_____	Educ:	_____	School:	_____	Primary Language:	_____
Is Patient Confidential Contact?	_____	Patient Status:	_____	Census:	_____		
Addr.:	_____						
City:	_____	State:	_____	Zip Code:	_____		
Emergency Contact:	_____			Phone:	_____		
Responsible Party:	_____			Relationship to Resp. Party:	_____		
Name:	_____						
Addr.:	_____						
City:	_____	State:	_____	Zip Code:	_____		
Note:	_____						
Allergies:	_____						
Patient Type:	_____	WIC No.	_____	Folder (Y/N):	_____		
MCR	_____	Provider:	_____				
Completed By:	_____			Tape No. for Purged Records:	_____		

PTBMIS A2 SCREEN

(Refer to PTBMIS Manual)

U	
Patient No. 0000000511	Date Updated 06/05/97
Name PALMER	COBBY H Birth Date 06/20/1996
	USA Born? ____
Date of Entry into Country _____	HSIS Entry/Update Date
Country of Origin ____	HSIS Sent Date
Proficient in English (Y/N) _	SSI _____
Ethnicity	Client Status
Seasonal Farmworker _	Homeless _ Refugee _ Civil Rights ____
AFDC _	Food Stamps _ Registered to Vote? _ VFC Payor
Active Admission in Case Mgmt N	
Active EL in Managed Care N	
Active TR in Managed Care N	
Longitude :	Latitude:
Care-Give Guardian Pat#	SSN 0223-77-6186
Birth Mother Pat#	SSN 0223-77-6186 Age at Birth
First Name	Maiden
Father's Name	
10/30/97 15:05:39	

In order to link Mothers with their Infants and Children, the Mother's SSN or Patient # must be keyed on the Infant's or Child's record. If the Care-Giver Guardian is not the Birth Mother (Grandmother, Aunt, Foster Parent, etc.) a long registration screen must be completed and his/her SSN must be keyed on the infant's or child's record. Once the SSN or Pat # are entered on the infant or child's records, they are associated and may be used with the following commands from the woman's record:

WICCG – will show all infants/children for whom her SSN has been put as the care giver SSN.

WICBM – will show all infants/children for whom her SSN has been put as the birth mother SSN.

WICCGP – will show all infants/children for whom her Pat # has been put as the care giver Pat #.

WICBMP – will show all infants/children for whom her Pat # has been put as the birth mother Pat #.

PTBMIS FI (Financial Information) SCREEN

(Refer To PTBMIS Manual)

NOTE: When a participant is “adjunctively eligible” (eligible by enrollment in the Food Stamp Program; 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 to be 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). Additionally, the total income must be within the allowable income guidelines for the family size, unless the participant is adjunctively eligible.

Patient No.: 0000008168	Effective Date: _____	Eligibility _____
Patient Name: _____	Updated 00/00/95	
Responsible Name: _____	Birthdate: 00/00/00	
Responsible Addr.: _____	User ID 000000	
		TN WIC Eligible? Y
Notes: _____		
Refer Phys: _____	Attend Phys.: _____	Prior Auth.: _____
Employer Name: _____	Phone: _____	
Emancipated Minor (Y/N): _____	Sliding Scale (Y/N): _____	Number in Family: _____
Collection Status: _____	Billing Cycle: _____	Residency: _____
Proof ID: _____		
Employed: _____	Student: _____	—In-Patient Monthly Allowance—
Verification Source: _____		
Family Member	Income	Per
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total Annual Income: _____		Taxable: _____
Pri Payer: _____	Policy/ID Number: _____	Coverage Dates: _____
ABCBS TENNCARE		00/00/95 - 00/00/95
S MEDICARE	12345565667	00/00/95 -

PTBMIS CHX SCREEN

(Refer To PTBMIS Manual)

Patient No.: 0000000168 Name:

Site
00181

Chart Type

Chart #
0000000002

WICQ SCREEN

U
Patient No 0000000100 EN 0020034 Date 06/24/1997 Site 001 01 Chart 222333
Name FOWLER PORTIA A DOB 01/05/1965 Sex M Race B Mig Y M'caid N
Next Appt Time Clinic Vis Type More Appts
BENEFITS/WIC STATUS ACTIONS: _____ Immunizations Due
Next Action Due on: 01/31/1970 TERMINATE
Last: Visit NONE Vouchers Thru 09/97 FP 5STD
This: Visit 10/30/1997 Issue Thru _____ Next FP _____
CERTIFICATION/SURVEILLANCE DATA: _____ ED? _ _ (Last ED was on 06/24/1997
WIC Status _ Cert Date _ / _ /1997 Cert Reasons I _ II _ III _ Priority 5
DOM _____ Old DOM 06/24/1997 Ht In _ _ /8 Weight Lb _ _ Oz _ _ HGB _ . _
or Cent _ . _ or Kilo _ . _ HCT _
Termination Date _____ Termination Reason _
SPECIAL DATA: _____
Woman: Smoke _ EDD _____ Del _____ Infant: Mom on WIC at DOB? _
Gain During Preg _ Outcome _ Ever BF? _____ Birthweight Lb _ _ Oz _
Birth 1 Sex _ Wt Lb _ Oz _ Breastfeeding? _
Birth 2 Sex _ Wt Lb _ Oz _ If ever Breastfed, # Weeks _
Birth 3 Sex _ Wt Lb _ Oz _ Mom's DOB _____
VOUCHER PRINT DETAILS: _____ UserID _____
Month/Yr _____ DC04094
Vo Code _____ Chg Date _____
Quantity _____
10/30/97 14:58:19

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

Encounter Number – The encounter number initiated and assigned to this particular patient on the particular visit. (To establish a new encounter number, type ENL on the command line and press the ENTER key. On the ENL screen, tab once, type the number of labels needed, and press the ENTER key)

Date – Date of Encounter

Site – County Site

Chart – Clinic assigned number entered on the CHX screen that matches patient record

Patient Demographic

(Protected Fields From Other Data Sources)

Name

DOB

Sex

Race

Migrant

(These are brought forward from registration screen)

Next Appointment Information

(Protected Fields From Other Data Sources)

Next Appointment – Shows any appointment that a patient has in the Health Department in any Clinic within your AS/400

Time – Time of next appointment

Clinic – Which clinic appointment

Visit Type – What the patient 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.

Medicaid - This field should default from the patient’s financial information detail (FID) record, when the Reimbursement Code is “A”, and has an eligibility reason of “01”.

Immunizations

(Protected Fields From Other Data Sources)

Immunization Due – Date on which next immunizations are due
(Brought forward from Immunization Registry)

Benefits/WIC Status Actions

(Protected Fields From Other Data Sources)

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.

Last : Visit – Date of previous WIC visit record

Vouchers Thru - The last month for which this patient was issued FI/CVV's

FP – Food Package received on the last month FI/CVV's were issued

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)

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. Food Package Codes generate 1-3 voucher codes for each month. Only the number of months can be given that does not exceed the number of voucher codes that show at the bottom of the screen in the Voucher Print Details.)

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 Patient 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)

Certification/Surveillance Data:

ED? – Nutrition Education “Y” or “N” to show if nutrition education was given on the date of this encounter. This information must be filled out on the encounter form by the person doing the education.

Last ED was on - Date will be displayed if patient received nutrition education on prior visit.

WIC Status – Status 1-7 (Refer to WIC Manual 1-3)

Cert Date – Date of Certification of this patient

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 patient’s visit record

Ht In ___/8 – Height in inches in fractions of 1/8 (to be completed with the appropriate data from certification visit.)

Weight Lb Oz - Weight in pounds and ounces (to be completed with appropriate data from certification visit if weight not input.)

HGB – Hemoglobin (to be completed with appropriate data from certification visit.)

Cent – Height in Centimeters (to be completed with appropriate data from certification visit if height not input.)

Kilo – Weight in Kilograms (to be completed with appropriate data from certification visit if weight lb. oz. not input.)

HCT - Hematocrit (to be completed with appropriate data from certification visit if HGB not input.)

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)

Ever BF? – Enter “Y” or “N.” This question applies to WIC Status 2, 3, or 6 and to her most recent delivery.

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

Mom on WIC at DOB? – The system will determine if the infant’s mom was on WIC at the time the infant was born using the SSN from the A2 Screen of the infant and the Registration Screen of the mom. If the system puts an “N” because she is not in the system, but she says that she was on somewhere else when she was pregnant, the “N” can be changed to a “Y”. If the system put a “Y” in this field, it cannot be changed to a “N”.

Birthweight Lb Oz - Enter actual pounds and ounces.

Breastfeeding? – This field is used for Status 4 (infants of moms who are “Barely Breastfeeding”), 7, and 9. Use “Y” if the infant is currently breastfeeding. The number of weeks breastfed will be calculated from the infant’s date of birth and filled in the field “If ever Breastfed, # Weeks”. If the mother ceases breastfeeding, tab to this field and enter “N” and enter the actual number of weeks the mother breastfed the infant. (If the mother breastfed and ceased before the WICQ was initiated, enter an “N” and put the number of weeks she breastfed in the # wks field.)

If ever Breastfed, # Weeks – This field is to be completed only when Breastfeeding? field has been changed from a “Y” to an “N”. Otherwise it will calculate number of weeks the mother breastfed the infant. (If the user fails to put the correct number of weeks in this field before updating with an “N”, the weeks cannot be changed. However, the user can change the “N” to a “Y”, let it recalculate, then change it to an “N”, put in the correct number of weeks and update.

Mom’s DOB – The system will fill in mom’s date of birth if the A2 screen is properly filled out for this infant.

Voucher Print Details

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)

Quantity – Enter the quantity for infant formula only if not standard amount. Defaults to standard quantity otherwise. Quantity is only usable with formulas.

User ID – The system will fill in this field with the logged on user ID.

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.

DWICQ

Pat. No. 000000518			Birth Date 01/15/1970				
Pat. Name ELLIOTT SHARON E							
Visit Dt	Act	Stat	Cert Dt	Meas Dt	EDD	Deliv Dt	Cosite
09/18/1997	T	3	06/04/1997	06/04/1997	06/15/1997		01501
07/01/1997	V	3	06/04/1997	06/04/1997	06/15/199		01501
06/30/1997	A	2	06/04/1997	06/04/1997	06/15/1997		01501
06/05/1997	AT	1	06/04/1997	06/04/1997	12/10/1997	01501	
06/05/1997	VT	1	06/04/1997	06/04/1997		12/10/1997	01501
06/05/1997	V	1	06/04/1997	06/04/1997		12/10/1997	01501
06/04/1997	AV	1	06/04/1997	06/04/1997		12/10/1997	01501
10/30/97 15:04:21							

This command is used to view a WICQ screen by the date of the visit. To use:

1. Type DWICQ on the command line
2. All of the WIC visits for that patient will list in order of the most recent visit.
3. If the last visit is the one the user is wanting to view, simply press {Enter} and the most recent WICQ screen will appear.
4. If any other than the most recent is the one to be viewed, <Tab> to the left of the patient 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.)

TVH

Tennessee WIC Voucher System

** Voucher History Menu **

Sort History by:

_ Voucher Number : _____

_ Issue Date : _____

_ Participant Name: _____

_ Chart #: _____

_ Patient #: _____

10/30/97 15:08:37

The Tennessee Voucher History or TVH screen is the mechanism to use for researching the status of a particular FI/CSV or to void a FI/CSV. The command "TVH" will produce a menu selection screen titled Tennessee WIC Voucher System * * Voucher History Menu * * From this menu the user may select to find the FI/CSV by using one of the following sorts:

Voucher Number

Issue Date

Participant Name

Chart #

Patient #

The user must place a "X" to the left of the chosen sort method (the cursor will stop there when using TAB). 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 patient, must only 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 you are not in a current patient’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.

U							
Tennessee WIC Voucher System							
Voucher History							
Vouch #	Last Name	First Name	WIC Id	Iss Date	For	Stat	Issued by
VC	LSD	Comment:	Voided by				
00020181	PALMER	COBBY	001234	06/04/1997	06/97	V	TEST05
02	S		TEST05				
00020182	PALMER	COBBY	001234	06/04/1997	07/97	V	TEST05
01			TEST05				
00020183	PALMER	COBBY	001234	06/04/1997	08/97	V	TEST05
01			TEST05				
00020269	PALMER	COBBY	001234	06/04/1997	06/97	I	TEST05
00020300	PALMER	COBBY	001234	06/04/1997	06/97	I	TEST05
00020301	PALMER	COBBY	001234	06/04/1997	07/97	V	TEST05
01			TEST05				
00020309	PALMER	COBBY	001234	06/04/1997	06/97	V	TEST05
02	D	WASHING MACHINE				TEST05	
00020310	PALMER	COBBY	001234	06/04/1997	06/97	I	TEST05
ENTER M FOR MORE 10/30/97 15:09:21							

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:

1. Change the voucher status to a “V”.
2. The Tab will then go to the first 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 problem
- 04 = Replacement of vendor redeemed FI/ CVV

(For policy instructions on L/S/D, refer to Chapter 4.)

3. 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.
4. 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.
 5. Once all FI/CVV 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.

VIEWING VOUCHER DETAILS

To view the details of a specific FI/CVV:

1. Go to the Voucher History Screen (TVH command then select a sort).
2. 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.

3. Press {Enter} and you will see a screen with all the details the system knows about this FI/CVV number.
4. To return to the Voucher History listing, just press {Enter} again.

WICUR

(To “unvoid” or “replace” a FI/ CVV)

```
Unvoid/Replace Vouchers

Current User-Id:
Current Cosite:
Current Date:
=====

Unvoid Specific Voucher
Voucher Number to Unvoid:
=====

Replace Damaged Voucher
Voucher Number to replace:
=====

3/01/01    11:07:25
```

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 a FI/ CVV has been voided by mistake and must be unvoided. The cosite 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:

1. 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.)
2. With one <Tab> the cursor will go to the prompt for the voucher number to “un-

void". If this is the feature to use, simply enter the voucher number to unvoid. Press {Enter}.

3. 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.
4. The message "Function complete" will show on the top right of the screen.
5. If unvoiding, the FI/CVV has now been unvoided. If replacing, a FI/CVV will print with the receipt attached.

WICCG (WIC Care-Giver)

Care-Giver:							
Name ELLIOTT SHARON E				Birth Date 01/15/1970			
Patient No. 0000000518							
Kids Under Care:							
Name (LFM):	DOB:	Patient No.	Cert. Date	Term. Date	Next Act. Code	Next Act. Code	
PALMER	COBBY	H	06/20/1996	0000000511			
SMOLTZ	JOHN	B	11/12/1996	0000000514			
FLOYD	JIM		06/04/1992	0000000515			
COOKSEY	CHARLES	D	02/01/1996	0000000516			
10/30/97 15:02:28							

The WICCG command is used to identify all of the infants or children for whom a Care-Giver is responsible for in the WIC Program. To use this command:

1. Go to the Care-Giver's PTBMIS record.
(NOTE: In order for this command to execute, the Care-Giver must have at least a Registration record with her/his Social Security Number (SSN) and this same SSN or her Patient # must be on the A2 record of the infants/children she/he is responsible for in WIC.)
2. When in the Care-giver's record, at the command line, type WICCG (SSN) or WICCGP (Pat #).
3. The names, DOB, Patient #, Cert Date, Term Date, Next Act Code and Next Act Date for all infants and children for whom this Care-Giver 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 Care-Giver with more than one person receiving WIC services.

WICBM (WIC Birth Mother)

Birth Mother:

Name ELLIOTT SHARON E Birth Date 01/15/1970
Patient No. 0000000518

Kids of Birth Mother:

Name (LFM):	DOB:	Patient No.	Cert. Date	Term. Date	Next Act. Code	Next Act. Code
PALMER	COBBY	H	06/20/1996	0000000511		
SMOLTZ	JOHN	B	11/12/1996	0000000514		
FLOYD	JIM		06/04/1992	0000000515		
COOKSEY	CHARLES	D	02/01/1996	0000000516		

10/30/97 15:03:09

The WICBM command is used to identify all of the infants or children of a particular Birth Mother in the WIC Program. To use this command:

1. Go to the Birth Mother's PTBMIS record.
(NOTE: In order for this command to execute, the Birth Mother must have at least a Registration record with her Social Security Number (SSN) and this same SSN or her Patient # must be on the A2 record of the infants/children for whom she is the Birth Mother.
2. When in the Birth Mother's record, at the command line, type WICBM (SSN) or WICBMP (Pat #).
3. The names, DOB, Patient #, 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.

VOC (Verification of Certification)

TENNESSEE WIC/CSF PROGRAM

Verification of Certification

Participant No.: 0000000511
Participant Name: COBBY H. PALMER
Address: 1234 MAIN ST
NEWPORT, TN 37821
Date of Birth: 06/20/1996
WIC Status: CHILD
Local Agency: CLINTON HEALTH DEPT.
Address: P.O. BOX 429
CLINTON, TN 37717
Telephone No.: 423-457-5400
Signature (Participant, Parent or Guardian): _____

=====
Certification Date: 06/04/1997
Certification Expires: 12/04/1997
Date of Last Income Screening: 06/04/1997
Month Vouchers Issued Through: 06/97
Nutrition Risk Reason(s): DANGER OF REGRESSION
Height: 40 0/8" 0.0 CM
Weight: 20 LBS 0 OZS 0.00 KG
Hemoglobin: 99.9 GMS
HCT: 0 GMS
Issued by (Signature): _____
Comments:

To assist a WIC participant who is moving to another area while still within the certification period, a Verification of Certification (VOC) is issued. This can be automatically generated by the system by the following steps:

1. Go to the patient's WICQ screen.
2. Terminate the patient for Termination Reason #4 (Transfer/Other).
3. On the Command line, type VOC and press {Enter}.
4. 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.
5. Obtain signatures of the Participant, Parent, or Guardian and the Issuing Clerk.

NOTE: A VOC is most often given to the patient 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 patient signature, document phone, mail, or fax request.

DENR (Display Encounter Recent)

```
Pat. No. 000000518
Pat. Name ELLIOTT SHARON E      Birth Date 01/15/70
Enc. No.  Enc. Date Ser Loc Sub. Visit Status  Diagnosis-1
0002125   10/09/97  01501
0002103   09/18/97  01501
0002002   07/15/97  01501
0001955   07/01/97  01501
0001951   06/30/97  01501
0001718   06/05/97  01501
0001697   06/05/97  01501
0001677   06/05/97  01501
0001650   06/04/97  01501
0001634   06/04/97  01501
```

10/30/97 15:03:52

When wanting to view a particular Encounter of a WIC participant the DENR command may be used. To use:

1. At the command line, type DENR and press {Enter}.
2. <Tab> to the Encounter you wish to view, place an X and press {Enter}.
3. The Encounter screen will appear and that Encounter will be current.
4. 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 patients and issues FI/CVV 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 patient 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 Office of Information Technology 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 on site, 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. Recently, we have purchased read/write CD ROMs, and we back up of our hard drive files on CDs. Additionally, the combination of these would provide back up in the event of a disaster.

We recommend that all files in the regions that could not be reconstructed be backed up and stored off site.

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PARTICIPANT RIGHTS

Civil Rights

Public Notification

The following nondiscrimination statement must appear on all state or local printed materials for public distribution:

“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 Adjudication, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). WIC is an equal opportunity provider and employer.”

For TTY calls State agencies should use their own relay systems.

Whenever possible, on printed materials, a current applicable version of the nondiscrimination statement must include the revised address and telephone numbers to file discrimination complaints.

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 non discrimination does not have to be read in its entirety. Rather, a statement such as “WIC is an equal opportunity provider and employer” is sufficient to meet the nondiscrimination requirement. 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, in print size no smaller than the text the “WIC is an equal opportunity provider and employer.”

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 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 based on race, color, national origin, sex, age, or disability, has a right to file a complaint which must be processed within 90 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.

Complaints should be filed immediately with USDA, Director, Office of Adjudication, Washington, D.C. (see previous page for address).

A Copy of the complaint may be filed with the State and should be mailed to:

Director
Tennessee Department of Health
Office of Minority Health
Cordell Hull Building, 3rd Floor
425 5th Avenue North
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 and then to the state office listed above. 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.

Training

Civil Rights Training must be provided annually for all staff that has contact with WIC applicants and /or participants. The training must be provided to all new employees during orientation and prior to working in clinics. Specific subject areas for training include, but are not limited to: Collection and use of data, Effective public notification systems, complaint procedures, Compliance reviews techniques, resolution of non-compliance, Requirements for ADA, Language assistance, Conflict Resolution and Customer service. (FNS Instruction 113-1, p.2)

Compliance 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 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.

Fair Hearings

A Fair Hearing Procedure is required by Federal Regulations so that pregnant and breastfeeding women, parents, or caretakers 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 participant is determined to be ineligible, an explanation must be provided and the right to a Fair Hearing explained to that person in the language she/he can understand.

Confirmation of Fair Hearing Rights

The Fair Hearing Procedure for the WIC Program must be posted in each WIC clinic. 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). 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.

PARTICIPANT ABUSE

1. Dual Participation (References: CFR 246.7, .12 & .23, State Rules 1200-15-2-.06 and WIC Manual Chapter 4).

A participant may not intentionally receive WIC checks 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 letter of notification of disqualification must contain notice of the participant’s right to a fair hearing. It is not permissible to withhold WIC checks that would be issued for future eligible months in lieu of dual benefits previously received.

2. 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 (see sample letters that follow).

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 Notice of Ineligibility (NOI) and their right to a fair hearing.

3. Sale or Exchange of WIC Foods or WIC checks.

A warning letter may be sent if there is suspicion that WIC checks have been sold or exchanged for other than eligible WIC foods (see sample letter that follows).

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 Notice of Ineligibility (NOI) and their right to a fair hearing.

4. Verbally and/or Physically Abusive to Clinic or Vendor Staff and/or other Program Participants.

A warning letter may be sent if there is an accusation of verbal or physical abuse (see sample letter that follows).

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 Notice of Ineligibility (NOI) and their right to a fair hearing.

Local law enforcement authorities may be contacted in such a situation if determined appropriate.

Participant Sample Warning Letters

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 Intentionally Providing False or Misleading Information

(Sent Certified Mail with Return Receipt)

(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 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 towards 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

For Dual Participation

(Sent Certified Mail with Return Receipt)

Date _____

Dear _____:

The Dual Participation Report for _____ indicates that you received food instruments and/or cash value vouchers for _____ and _____ in two counties, _____ and _____ 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.

This could be an error and if there is an error, the food instruments and/or cash value vouchers may be returned to the issuing health department. I can be reached at this telephone number: _____.

Sincerely,

WIC Director

Cc: (other program involved)

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,

(Name)
WIC Director

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.

Print at least one article per year in the local newspaper that informs potentially eligible persons about the WIC Program and how to apply. 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 on the following page. 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.

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. Items with asterisks are mandatory. The list must be given to each participant at initial certification.

HOTLINES	Telephone	Days/Hours Svc.
Number	Available	
TENNCARE	1-800-669-1851	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	M-F 8 AM-4:30 PM CT	

(342-5942)
Local 2-1-1 Service 211
Community Services/Programs
Health Department
Well Child Clinic
Prenatal Clinic
Family Planning Clinic
Children's Special Services
Immunization
WIC Clinic
Private Health Care Provider
Hospital Prenatal Clinic
Hospital Pediatric Clinic
Breastfeeding Support
Migrant Health Centers
*Drug Treatment Centers
Food/Nutrition
Expanded Food & Nutrition Program
Food Bank
Emergency Food Resources
Department of Mental Health
*Alcohol/Drug Abuse Center
Alcoholics Anonymous
Narcotics Anonymous
Department of Human Services
*Families First
Day Care Centers
Handicapped Children's Association
Juvenile Court Contact
*Child Support Enforcement Agency
Foster Care
Child Abuse
*Supplemental Nutrition Assistance Program (formerly Food Stamps)
Protective Services
Handicapped Services
Hearing Impaired Center
Visually Impaired Center
Crisis Intervention
Homeless Shelters
Shelters for Abused Women
Other Community Services
Head Start Centers
Transportation Services
Civic Clubs
Churches
Social Security

"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 Adjudication, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). WIC is an equal opportunity provider and employer."

MONITORING AND AUDITS (CFR 246.19)

State Local Agency Review

1. The monitoring review schedule and monitoring tracking spreadsheet is completed prior to each fiscal year.
2. Each Local Agency is reviewed on-site by state WIC staff every 2 years, which includes 20% of their clinics and the regional office.
3. 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.
4. The letter notifying the Local Agency of the monitoring visit must have a verification of the email saved with the letter for monitoring purposes.
5. Email the Data System Specialist 30 days before monitoring the Local Agency to obtain the Participant Record Review and the Therapeutic Formula Reports.
6. The following programs are reviewed:
 - a. Administrative/Outreach/Targeting of Benefits/Fair Hearing
 - b. Certification/Health Services/Referrals/Civil Rights
 - c. Nutrition Services/Breastfeeding
 - d. Record Keeping and Accountability
 - e. Vendor ManagementThe items above are reviewed in the Local Agency, the clinic, or Regional Office.
7. 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.
8. A written (electronic) report is provided by the State WIC staff 45 days after the month of the review.
9. The Local Agency must provide a written (electronic) response with the Corrective Action Plan within 60 days of receiving the response.
10. If all agree, a written (electronic) notification of the closure of the review is sent to the Regional Director, Nutrition Director, and WIC Director.
11. If the Local Agency disagrees with the findings, supporting documentation must be submitted on the review forms (electronically).
12. Local Agencies will be revisited in 6 months if the findings are of such a nature that it is necessary.

Local Agency Review

1. The Quality Improvement (QI) Review team or 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.
2. The State WIC monitoring tools are used or the Quality Improvement review forms from the QI manual.
3. 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 \$500,000 or more in Federal awards in a year are required to obtain an annual audit in accordance with the Single Audit Act Amendments of 1996 , OMB Circular A-133, the OMB Circular Compliance Supplement and Government Auditing Standards. 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.

Instructions

Purpose

The Formula Inventory Log records formula received in the clinic from purchases with a WIC FI and distribution of infant formula from clinic to WIC participants. Participants must be issued a FI for part of the formula even only if a few cans. This ensures that the participant is counted as a WIC participant. The log should be used whenever formula is issued from Health Department stock and when recording formula received into the Health Department. Check expiration dates monthly to ensure formula does not go out of date. Inventory must be recorded monthly on the current Formula log sheet. Received and dropped shipped formula should be kept secure. Secure as defined as free from risk of loss; safe or act to make safe against adverse contingencies, to put beyond the hazard of losing. Formula logs must be updated each year with correct form from the current WIC Manual. Formula inventory must be done monthly and recorded on formula log inventory.

Use a separate sheet for each type and packaging unit of formula.

Inventory

Region	Enter region code
County	Enter county number code
Clinic	Enter clinic number code
Formula Name	Enter product name
Packing Unit	Circle powder, concentrate, or RTF and enter ounces
Date	Enter date of transaction
Formula Units Received	Enter number of formula units received from participant or drop shipped to clinic
Formula Expiration Date	Enter date formula expires (received or issued)
Formula Units Issued	Enter number of units of formula issued to participant
Total On hand	Enter number of units of formula on hand
Participant Number	Enter participant number returning or issued formula
Chart Number	Enter participant chart number returning or issued formula (Optional)
Signature	Enter signature of participant issued formula or signature of staff who received formula from participant or formula drop shipped to clinic
Inventory	Enter date of inventory and staff initials followed by an arrow down to end of month inventoried

Office Mechanics and Filing:

Retain original form in clinic for 4 1/2 years.

ORDERING WIC FORMS

Most forms and pamphlets are available through Central Stores however, there are a few publications that are kept in the Central Office. To assist with the ordering process, this section is broken down to show which forms and pamphlets can be ordered through Central Stores and those that must be requested through Central Office.

How To Order

Metros use Requisition Form GS-0943 for Central Stores orders and send to WIC Central Office. Requests for items from Central Office may be added at the end of the GS-0943 requisition form. 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.

Central Stores Forms and Pamphlets

	<u>EDISON#</u>
10 WAYS TO GET YOUR KIDS TO EAT FRUITS AND VEGETABLES (Bilingual), PK/200.....	1000080544
ABC'S OF TEACHING YOUR BABY TO USE A CUP, PK/100	1000050364
ABC'S OF TEACHING YOUR BABY TO USE A CUP, PKG/100, (Spanish)	1000080273
AGENCY APPLICATION FOR VOTER REGISTRATION, PK/250	000-00-00SS3066
BE SNACK WISE, PK/100	1000050371
BE SNACK WISE, PKG/100, (Spanish)	1000080523
CLYDE AND THE GOOD FOODS BAND, (Coloring Book) PKG/50	1000080308
CLYDE AND THE GOOD FOODS BAND, (Coloring Book)PKG/ 50 (Spanish)	1000080565
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

EDISON#

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
FOODS FOR YOUR CHILD 4 - 8 YEARS, (Spanish) PK/100.....	1000080272
FRESH FRUITS AND VEGETABLES (Bilingual) PK/.....	1000114946
FRUITS AND VEGGIES-MORE MATTERS, (Bilingual) PK/200	1000080282
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
HELP YOUR CHILD GAIN WEIGHT, PKG/100	1000050425
HELP YOUR PICKY EATER, PK/100	1000080601
HIPPA PRIVACY PRACTICES NOTICE, PKG/100.....	1000080566
HIPPA PRIVACY PRACTICES NOTICE, (Spanish) PKG/100	1000080567
KID'S ACTIVITY PYRAMID (Bilingual)	1000080392
LOST/STOLEN/DESTROYED VOUCHER REP, PD/100.....	1000051614
NOTIFICATION OF INELIGIBILITY, (Bilingual) PD/100.....	1000051951
ORAL HEALTH FOR INFANTS AND CHILDREN PKG/100.....	1000050345
ORAL HEALTH FOR INFANTS AND CHILDREN (Spanish) PKG/100.....	1000080367
PHYSICAL ACTIVITY AFTER YOU DELIVER, (Bilingual) PD/100	1000080569
PRENATAL INFANT FEEDING INTERVIEW, PD/100	1000051794
PROTECT YOUR FAMILY FROM LEAD, PKG/100	1000050341
PROTECT YOUR FAMILY FROM LEAD, (Spanish) PKG/100	1000080503
PROXY PERMISSION SHEET, PKG/100 (Bilingual).....	1000051866
RECIPE BOOK, CHEESE, PKG/100.....	1000080586
RECIPE BOOK, CHEESE, PKG/100, (Spanish).....	1000050389
RECIPE BOOK, EGGS, PKG/100.....	1000080584
RECIPE BOOK, EGGS, PKG/100, (Spanish).....	1000080524
RECIPE BOOK, MILK, PKG/100	1000080437
RECIPE BOOK, MILK, PKG/100, (Spanish)	1000050388

RELIEF FOR COMMON PREGNANCY DISCOMFORT, (Bilingual) PKG/200	1000100010
SHOP AND SAVE, PKG/100, (Bilingual).....	1000050296
SPOON FEED FOR A HEALTHY START, PKG/250.....	1000050343
SPOON FEED FOR A HEALTHY START, (Spanish) PKG/100,.....	1000080404
TENNESSEE WIC APPROVED LIST (English)	1000080410
TENNESSEE WIC APPROVED LIST (Spanish)	1000080411
THE HEALTHY WEIGH, A GUIDE TO NUTRITION AND WEIGHT MANAGEMENT, PKG/100.....	1000080543
THE HEALTHY WEIGH, A GUIDE TO NUTRITION AND WEIGHT MANAGEMENT, (Spanish) PKG/100,.....	1000080522
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
WIC BREAST PUMP RELEASE, (English/Spanish) PD/50	1000052112
WIC CHILD NUTRITION QUESTIONNAIRE, PKG/500	1000052245
WIC CHILD NUTRITION QUESTIONNAIRE, (Spanish) PKG/500	1000080366
WIC CHILD RECORD, PK/500	1000051901
WIC FOOD WHEN YOU NEED IT MOST, PKG/200	1000100009
WIC FOOD WHEN YOU NEED IT MOST, (Spanish) PKG/200,	1000080368
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 FOOD LIST - INFANT.....	1000112061
WIC FOOD LIST - INFANT (Spanish).....	1000112060
WIC FOOD LIST - WOMEN/CHILDREN.....	1000112062
WIC FOOD LIST - WOMEN/CHILDREN (Spanish).....	1000112063
WIC POSTPARTUM RECORD, PKG/500.....	1000052244
WIC PRENATAL RECORD, PKG/200	1000051785
WIC FI/CVV ENVELOPE, PKG/100 (English)	1000051704
WIC FI/CVV ENVELOPE, PKG/100 (Spanish)	1000051860
WIC WEIGHT GAIN GRID PRE PREGNANCY NORMAL WEIGHT BMI 18.5-24.9 PKG/500.....	1000139938

EDISON#

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
YOUR GUIDE TO HEALTHY EATING AND PHYSICAL ACTIVITY WHILE YOU ARE PREGNANT AND BREASTFEEDING, PKG/100	1000080414

Central Office Forms and Pamphlets

(Contact your Regional Office or Central Office to order.)

Order Folic Acid Bookmarks from Delaine Brown or Kris Dixon via e-mail:

FOLIC ACID EVERY DAY MAKE IT A HABIT BOOKMARK (English)

FOLIC ACID EVERY DAY MAKE IT A HABIT BOOKMARK (Spanish)

CENTRAL OFFICE PERSONNEL

Central Office staff, direct phone number, and areas of program assignment:

Melissa Blair, MS—Deputy Director Oversees all activities, projects and grants for Nutrition and Wellness.	532-7772
Peggy Lewis, MHE, RD, LDN—Director, Supplemental Nutrition Programs State Plans, Federal program requirements, caseload management, general policy and budget issues, USDA Correspondence.	741-0227
Rashika Alwis, MS, Accountant Allowable administrative expenditures, federal budgets, monitor Fiscal records in contract agencies, and reports 1/6 nutrition education and breastfeeding expenditures.	253-6066
Wanda Benson, Administrative Secretary and Procurement Performs Administrative Secretary duties as assigned, runs edits on keyed data, runs study reports, keys in other data for the division, dual participation.	532-8187
Delaine Brown, Secretary Supports Nutrition Services staff, reviews WIC vendor application, types correspondence, phone back up, and general secretarial duties.	253-7521
Marion Cullen, Ph.D, FRSM, Nutrition Data Liaison Pediatric Nutrition Surveillance System support and in-service training on weighing and measuring infants and children.	532-8188
Kristina Dixon, Administrative Assistant Assists Director and six Direct Reports with administrative work like travel requests, reimbursement, field staff meeting planning correspondence and all complaints.	532-6084
Billy Dodson, Food Administrator Assistant Maintain USDA correspondence for section, assignment and follow-up for vendor compliance activities, voucher paper and vendor stamp activities	532-8171
Emily Germer, BS, RD, EBT Coordinator Research, educate, plan, and prepare EBT documents.	532-8180
Tim Gill, Media Director Layout and graphics of media productions, including video and other visual aides, films on location, and supports staff in use of audio-visual equipment and PC's.	532-8170
James Graddey, BS, Data Entry Operator Enters data and tracks system reports, assists in tracking purchases, invoices, and mailings.	532-8174
Serkhail Habibi, MS, Data System Specialist Resolving data problems, participate in data system improvements, maximize use of data system extracts and disaster recovery plan.	
Ann Hopton, MA, RD, LDN, Nutritionist Coordinator of Farmers' Market Nutrition Programs, training, technical assistance, and special clinic projects.	532-8184
Perrie Hutcherson, MPH, RD, LDN, CDE, Nutritionist Nutrition education materials development and procurement, staff newsletter editor, coordinates translation of all nutrition education materials.	532-8173
Glenda King, MS, RD, Nutrition Education Specialist Monitoring visits to regional offices and clinics and review reports, technical assistance to regions and clinics, nutrition education centers, certification risk codes, therapeutic formula requests, and participant concerns and complaints.	532-7897
Marie Latendresse, MS, RD, State Breastfeeding Coordinator Coordinates breastfeeding program and peer counselor program, BF training, and breastfeeding monitoring.	741-0266
Sharon Morrow, MPA, RD, Nutrition Education Coordinator Nutrition education plans and updates, promotion of alternative nutrition education, staff training, monitoring visits to regional offices and clinics, technical assistance, and participant	532-8186

concerns and complaints.

Jerry Orenstein, BS, Food Delivery Administrator 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.	532-8177
Sherrie Patton, Receptionist/Secretary Greet visitors, answers hotline calls, and general secretarial duties.	532-8168
Evelyn Roberts, MS, Public Health Educator Outreach and coordination activities, survey and focus group activities, training on Civil Rights, and Incredible Baby Showers.	532-8190
David Sanford, Media Producer/Director Media and video production and, materials and printing management.	532-8185
Sabrina Sasser, Food Administrator Assistant Review and development of vendor policies and procedures, vendor sanction actions, TIP Report training and implementation, assistance and training for regional Vendor Management staff.	532-8172
Kathy Vaughan, MS, Data System Manager Data System Manager and interface with OITS, HSA, regional and clinic data systems users.	741-0307
Janice Williams, Administrative Assistant/CSFP CSFP Specialist, physical inventory and state tag for equipment coordinator, support staff supervisor, and assistant to the Program Director.	253-2152
Carolyn Woodard, Human Resources Representative Personnel, Time Keeper, and Job Plans.	532-9686
Michael Creighton, Office of Information Technology, WIC Liaison	741-0914

TENNESSEE DEPARTMENT OF HEALTH
 Family Health and Wellness Division/WIC and CSFP
 Cordell Hull Building, 5th Floor
 425 5th Avenue N.
 Nashville, TN 37243
 615-741-7218
 FAX: 615-532-7189
 WIC Hotline 1-800-DIAL-WIC (342-5942)

Central Office E-mail Addresses

Rashika Alwis	Rashika.Alwis@tn.gov
Wanda Benson	Wanda.Benson@tn.gov
Melissa Blair	Melissa.Blair@tn.gov
Delaine Brown.....	Delaine.Brown@tn.gov
Marion Cullen	Marion.Cullen@tn.gov
Kris Dixon	Kristina.D. Dixon@tn.gov
Billy Dodson	Billy.R.Dodson@tn.gov
Emily Germer.....	Emily.Germer@tn.gov
Tim Gill	Tim.Gill@tn.gov
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Serkhail Habibi.....	Mohammad.Serkhail.Habibi@tn.gov
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Peggy Lewis.....	Margaret.T.Lewis@tn.gov
Sharon Morrow	Sharon.Morrow@tn.gov
Jerry Orenstein	Jerry.Orenstein@tn.gov
Sherrie Patton.....	Sherrie.L.Patton@tn.gov
Evelyn Roberts	Evelyn.Roberts@tn.gov
David Sanford	David.Sanford@tn.gov
Sabrina Sasser	Sabrina.Sasser@tn.gov
Kathy Vaughan	Kathy.Vaughan@tn.gov
Janice Williams.....	Janice.E.Williams@tn.gov
Carolyn Woodard	Carolyn.Woodard@tn.gov

REGIONAL HEALTH OFFICES

Rural & Metro Regional Office staff can be reached through State GroupWise or the county email systems. All regional staff email addresses are included at the end of this section.

NORTHEAST TENNESSEE REGION (1)

1233 Southwest Ave. Extension
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)

Chattanooga State Office Bldg.
540 McCallie Avenue, Suite 450
Chattanooga, TN 37402-2013
(423) 634-3124
FAX (423) 634-1003

UPPER CUMBERLAND REGION (4)

1100 England Drive
Cookeville, TN. 38501
(931) 528-7531
FAX (931) 372-2756

MID-CUMBERLAND REGION (5)

710 Hart Lane
Nashville, TN 37243
(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)

Union City Office
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)

Jackson Office
295 Summar Drive
Jackson, TN 38301
(731) 423-6600
FAX (731) 421-5148

SHELBY COUNTY (9)
Memphis-Shelby County Health Dept.
757 Galloway
Memphis TN 38105
(901) 528-0044
FAX (901) 528-0460

DAVIDSON COUNTY (10)
Davidson County Health Dept.
311 23rd Avenue North
Nashville, TN 37203
(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 County 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		
Betsy Waters, MS, RD, IBCLC Nutrition Director/Breastfeeding Coordinator	Betsy.Waters@tn.gov	(423) 979-3200 Ext. 4597
Gail Layne, BS WIC Director	Gail.Layne@tn.gov	(423) 979-3200 Ext. 4600
Stephanie Edwards Vendor Coordinator	Stephanie.Edwards@tn.gov	(423) 979-3200 Ext. 4598
East Tennessee Region		
Delene Collins, MS, RD, LDN Nutrition Director/Breastfeeding Coordinator	Delene.Collins@tn.gov	(865) 549-5350
JoAnn Kirkland WIC Director	JoAnn.Kirkland@tn.gov	(865) 549-5316
Geanie Cooper Vendor Coordinator	Geanie.Cooper@tn.gov	(865) 549-5306
Southeast Region		
Pamela Newton, MS, RD, LDN Nutrition Director/Breastfeeding Coordinator	Pamela.Newton@tn.gov	(423) 634-5826
Helen Brakebill WIC Director (Acting)	Helen.Brakebill@tn.gov	(423) 634-5899
Sarah Simmons Vendor Coordinator	Sarah.F.Simmons@tn.gov	(423) 634-1952
Upper Cumberland Region		
Geetha Natarajan, M.S., R.D., LDN Nutrition Director/Breastfeeding Coordinator	Geetha.Natarajan@tn.gov	(931) 646-7512
Miranda Ford WIC Director	Miranda.Ford@tn.gov	(931) 520-4220
Vacant Vendor Coordinator		
Mid-Cumberland Region		
Trula Puckett, RD, LDN Nutrition Director/Breastfeeding Coordinator	Trula.Puckett@tn.gov	(615) 650-7019
Karen R. Martin WIC Director	Karen.R.Martin@tn.gov	(615) 650-7050
Willie Mae Pedigo Vendor Coordinator	Willie.Mae.Pedigo@tn.gov	(615) 794-1542 ex. 354

South Central Region

Amanda Gray, R.D., LDN Nutrition Director	Amanda.Gray@tn.gov	(931) 490-8336
Connie Ingram WIC Director	Connie.Ingram@tn.gov	(931) 490-8350
Nancy Rice, MS, LDN Breastfeeding Coordinator	Nancy.H.Rice@tn.gov	(931) 490-8374
Debbie Palmer Vendor Coordinator	Debbie.Palmer@tn.gov	(931) 490-8531

West Tennessee Region - North

Glenda Nanney, MS, RD Nutrition Director/Breastfeeding Coordinator	Glenda.Nanney@tn.gov	(731) 886-1525
Janet Hilton WIC Director	Janet.Hilton@tn.gov	(731) 886-1551
Becky Madding Vendor Coordinator	Becky.Madding@tn.gov	(731) 886-1542

West Tennessee Region - South

Janet Lakeman, MS, RD Nutrition Director/Breastfeeding Coordinator	Janet.Lakeman@tn.gov	(731) 421-6762
Janet Hilton WIC Director	Janet.Hilton@tn.gov	(731) 421-6761
Melondie Harris Vendor Representative	Melondie.Harris@tn.gov	(731) 421-6770

Shelby County

Verdis McNutt, RD Nutrition Director	verdis.mcnutt@shelbycountyttn.gov	(901) 545-7246 (901) 545-8909
Cynthia Tharp, BS WIC Director	cynthia.tharp@shelbycountyttn.gov Galloway	(901) 222-9754 (901) 522-8268
Vacant Breastfeeding Coordinator		(901) 545-8227
Acqua Banks-Woods Vendor Coordinator	acqua.banks@shelbycountyttn.gov	(901) 528-0044

Davidson County

Teresa Thomas, MS, RD WIC/Nutrition Director	Teresa.Thomas@nashville.gov	(615) 340-5368
Kelly Whipker, RD Breastfeeding Coordinator	Kelly.Whipker@nashville.gov	(615) 340-2237
Marge Manuel Vendor Coordinator	Margaret.Manuel@nashville.gov	(615) 880-2212

COUNTY DIRECTORS

Region	County	Director	Region	County	Director
2	Anderson	Art Miller	8	McNairy	Chris Morris
6	Bedford	Angie Faulkner	4	Meigs	Frances Reece
7	Benton	Tracy Bird	M	Madison	Tony Emison
3	Bledsoe	Mary Ebell	3	Marion	Charlene Nunley
2	Blount	Mickey Roberts	6	Marshall	Jason Lewis
3	Bradley	Eloise Waters	6	Maury	Elizabeth Cook
2	Campbell	Charles Turner	3	Meigs	Mary Ebell/Glen Czarnecki
4	Cannon	Michael Railling	2	Monroe	Teresa Harrill
7	Carroll	Tracy Bird	5	Montgomery	Joey Smith
1	Carter	Caroline Hurt	6	Moore	Debbie Broadway
5	Cheatham	Vincent Pinkney	2	Morgan	Laura Conner
8	Chester	Pattie Kiddy	7	Obion	Tim James
2	Claiborne	Charles Turner	4	Overton	Andy Langford
4	Clay	Andy Langford	6	Perry	David Rash
2	Cocke	Jana Chambers	4	Pickett	Andy Langford
6	Coffee	Debbie Broadway	3	Polk	Eloise Waters
7	Crockett	Mica Rudd	4	Putnam	Lisa Bumbalough
4	Cumberland	Karen Roper	3	Rhea	Jeannie Bentley
D	Davidson	William Paul	2	Roane	Laura Conner
8	Decatur	Pattie Kiddy	5	Robertson	Vanessa Watkins
4	DeKalb	Frances Reece	5	Rutherford	Dana Garrett
5	Dickson	Joey Smith	2	Scott	Art Miller
7	Dyer	Tim James	3	Sequatchie	Charlene Nunley
8	Fayette	Chris Morris	2	Sevier	Jana Chambers
4	Fentress	Andy Langford	9	Shelby	Yvonne S. Madlock
3	Franklin	Charlene Nunley	4	Smith	Frances Reece
7	Gibson	Danna Taylor	5	Stewart	Evelyn Vaillencourt
6	Giles	Jason Lewis	S	Sullivan	Gary Mayes
2	Grainger	Sherrie Montgomery	5	Sumner	Hal Hendricks
1	Greene	Shaun Street	8	Tipton	Mica Rudd
3	Grundy	Charlene Nunley	5	Trousdale	Lee A. Wood
2	Hamblen	Sherrie Montgomery	1	Unicoi	Rebekah English
H	Hamilton	Becky Barnes	2	Union	Charles Turner
1	Hancock	Susan Venable	4	Van Buren	Karen Roper
8	Hardeman	Chris Morris	4	Warren	Michael Railling
8	Hardin	Pattie Kiddy	1	Washington	James T. Carson
1	Hawkins	Susan Venable	6	Wayne	Steve Hall
8	Haywood	Dana Taylor	7	Weakley	Tim James
7	Henderson	Pattie Kiddy	4	White	Michael Railling
6	Hickman	David Rash	5	Williamson	Becky Brumley
5	Houston	Evelyn Vaillencourt	5	Wilson	Lee A. Wood
5	Humphreys	Joey Smith			
4	Jackson	Angie Hassler			
2	Jefferson	Sherrie Montgomery			
1	Johnson	Caroline Hurt			
K	Knox	Martha Buchanan			
7	Lake	Tim James			
6	Lawrence	Steve Hall			
6	Lewis	David Rash			
6	Lincoln	Debbie Broadway			
2	Loudon	Teresa Harrill			
3	McMinn	Jeannie Bentley			

NUTRITION EDUCATION CENTERS

Anderson County Health Department
710 N. Main Street
Clinton TN 37716
Coordinator: Patricia Campbell
patricia.A.campbell@tn.gov
Phone: 865-425-8804 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 P.O. Box 758
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 Covin
Haley.Covin@tn.gov
Phone: 931-967-3826 Fax: 931-962-1168

Greene County Health Department
810 W. Church Street P.O. Box 159
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 St. P.O. Box 267
Sneedville TN 37869-0267
Coordinator: Lisa Pearson
lisa.pearson@tn.gov
Phone: 423-733-2228 Fax: 423-733-2428

Johnson County Health Department
715 West Main St.
Mountain City TN 37683
Coordinator: Devon Brown
devon.c.brown@tn.gov
Phone: 423-727-9731 Fax: 423-727-4153

Hawkins County Health Department
201 Park Blvd. P.O. Box 488
Rogersville TN 37857-0488
Coordinator: Lisa Pearson
lisa.pearson@tn.gov
Phone: 423-272-7641 Fax: 423-272-3086

Jackson Madison County Health Department
589 East College Street
Jackson, TN 38301
Coordinator: Julie V. Mayfield
Jmayfield@jmchd.com
Phone: Tel: 731-423-3020 Fax: 731-927-8601

Knox County Health Department
140 Dameron Ave.
Knoxville TN 37917-6413
Coordinator: Lori Emond
lorna.emond@knoxcounty.org
Phone: 865-215-5048 Fax: 865-215-5066

Lawrence County Health Department
2379 Buffalo Road
Lawrenceburg TN 38464-4810
Coordinator: Katie Burgess
Katie.Burgess@tn.gov
Phone: 931-762-9406 Fax: 931-766-1592

McMinn County Health Department
393 County Road 554 (P.O. Box 665)
Athens TN 37303
Phone: 423-745-7431 Fax: 423-744-1604

Montgomery County WIC Clinic
330 Pageant Lane
Clarksville TN 37040
Coordinator: Sandra Ludwig
Sandra.K.Ludwig@tn.gov
Phone: 931-551-8777 Fax: 931-503-0691

Roane County Health Department
1362 N. Gateway Ave.
Rockwood TN 37854
Coordinator: Alice Ware
alice.ware@tn.gov
Phone: 865-354-1220 Fax: 865-354-0112

Rutherford County Health Department
100 West Burton St. P.O. Box 576
Murfreesboro TN 37133-0576
Coordinator: Mary Belle Hunter
marybelle.hunter@tn.gov
Phone: 615-898-7785 Fax: 615-898-7829

Shelby County Health Department
Southland Mall Clinic
1287 Southland Mall
Memphis TN 38116
Coordinator: Verdis McNutt
Verdis.McNutt@co.shelby.tn.us
Phone: 901-346-0081 Fax: 901-346-0006

Sumner County Health Department
1005 Union School Road
Gallatin TN 37075
Coordinator: Kimber Storrs, RD
Kimber.Storrs@tn.gov
Phone: 615-206-1100 Fax: 615-206-9742

Washington County Health Department
415 State of Franklin Rd.
Johnson City TN 37604-6093
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 Ricker
Jennifer.N.Ricker@tn.gov
Phone: 423-743-9103 Fax: 423-743-9105

TENNESSEE WIC CLINICS BY COUNTY

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

BEDFORD REGION 6 CLINIC 0201
BEDFORD COUNTY HEALTH DEPARTMENT
140 DOVER STREET
SHELBYVILLE 37160
Tel: 931-684-3426 or 931-684-0000
Fax: 931-684-5860

BENTON REGION 7 CLINIC 0301
BENTON COUNTY HEALTH DEPARTMENT
225 HOSPITAL DRIVE
CAMDEN 38320
Tel: 731-584-4944
Fax: 731-584-8831

BLED SOE REGION 3 CLINIC 0401
BLED SOE COUNTY HEALTH DEPARTMENT
617 OLD ALVIN YORK BX 277
PIKEVILLE 37367
Tel: 423-447-2149
Fax: 423-447-6777

BLOUNT REGION 2 CLINIC 0501
BLOUNT COUNTY HEALTH DEPT
301 MCGHEE ST.
MARYVILLE 37801
Tel: 865-983-4582
Fax: 865-983-4574

BRADLEY REGION 3 CLINIC 0601
BRADLEY COUNTY HEALTH DEPT
201 DOOLEY STREET S.E.
CLEVELAND 37311
Tel: 423-728-7020
Fax: 423-479-6130

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

CAMPBELL REGION 2 CLINIC 0701
CAMPBELL COUNTY HEALTH DEPARTMENT
162 SHARP PERKINS RD, PO BOX 418
JACKSBORO 37757-0418
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

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

CARTER REGION 1 CLINIC 1001
CARTER COUNTY HEALTH DEPARTMENT
403 EAST G. STREET
ELIZABETHTON 37643
Tel: 423-543-2521
Fax: 423-543-7348

CHEATHAM REGION 5 CLINIC 1101
CHEATHAM COUNTY HEALTH DEPT.
162 COUNTY SERVICES DRIVE
ASHLAND CITY 37015-1787
Tel: 615-792-4318
Fax: 615-792-6794

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

CLAIBORNE REGION 2 CLINIC 1301
CLAIBORNE COUNTY HEALTH DEPARTMENT
620 DAVIS DR., PO BOX 183
TAZEWELL 37879-0183
Tel: 423-626-4291
Fax: 423-626-2525

CLAY REGION 4 CLINIC 1401
CLAY COUNTY HEALTH DEPARTMENT
115 GUFFEY STREET
CELINA 38551-4088
Tel: 931-243-2651
Fax: 931-243-3132

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
315 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.
131 S. WEBB AVE., PO Box 1010
CROSSVILLE 38557-1010
Tel: 931-484-6196
Fax: 931-456-1047

DAVIDSON REGION D
LENTZ PRIMARY CARE CLINIC 1901
LENTZ HEALTH CENTER CLINIC 19LW
311 23RD AVE NORTH
NASHVILLE 37203
Tel: 615-340-7793 or
615-340-2237 (SUPERVISOR)
Fax: 615-340-8530

DAVIDSON REGION D CLINIC 1910
EAST HEALTH CENTER
1015 E. TRINITY LANE
NASHVILLE 37216
Tel: 615-862-6625 or
615-862-6624 (SUPERVISOR)
Fax: 615-862-7938

DAVIDSON REGION D CLINIC 1921
WOODBINE HEALTH CENTER
224 ORIEL AVENUE
NASHVILLE 37210
Tel: 615-862-7940
Fax: 615-340-2194

DAVIDSON REGION D CLINIC 1921
WOODBINE NUTRITION CENTER
222 ORIEL AVENUE
NASHVILLE 37210
Tel: 615-862-7925 or 615-862-7922
Fax: 615-862-7950

DAVIDSON REGION D CLINIC 19MW
MATTHEW WALKER HEALTH CENTER
1035 14TH AVE. NORTH
NASHVILLE 37208
Tel: 615-324-9696
Fax: 615-324-9664.

DAVIDSON REGION D CLINIC 19MM
MEHARRY WIC CLINIC
1005 DR. D. B. TODD BLVD.
WIC CLINIC 4th FLOOR, Suite 400
NASHVILLE 37208
Tel: 615-321-2970
Fax: 615-321-2960

DAVIDSON REGION D CLINIC 19SN
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 37166-3504
Tel: 615-597-7599
Fax: 615-597-1349

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

DICKSON REGION 5 CLINIC 2201
DICKSON COUNTY HEALTH DEPARTMENT
301 WEST END
DICKSON 37055-1725
Tel: 615-446-2839
Fax: 615-441-1900

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

DICKSON REGION 5 CLINIC 2203
WHITE BLUFF CLINIC
200 SCHOOL RD.
WHITE BLUFF 37187
Tel: 615-797-5056
Fax: 615-797-5051

GILES REGION 6 CLINIC 2801
GILES COUNTY HEALTH DEPARTMENT
209 S CEDAR LANE
PULASKI 38478
Tel: 931-363-5506
Fax: 931-424-7020

DYER REGION 7 CLINIC 2301
SARAH RICE MILLER HEALTH CENTER
1755 PARR AVE.
Dyersburg 38024
Tel: 731-285-7311
Fax: 731-285-2610

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

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

GREENE REGION 1 CLINIC 3001
GREENE COUNTY HEALTH DEPARTMENT
810 W. CHURCH ST., PO BOX 159
GREENEVILLE 37743-0159
Tel: 423-798-1749
Fax: 423-798-1755

FENTRESS REGION 4 CLINIC 2501
FENTRESS COUNTY HEALTH DEPARTMENT
240 COLONIAL CIRCLE, SUITE A
PO BOX 636
JAMESTOWN 38556-0636
Tel: 931-879-9936
Fax: 931-879-9938

GRUNDY REGION 3 CLINIC 3101
GRUNDY COUNTY HEALTH DEPARTMENT
HWY 56, PO BOX 65
ALTAMONT 37301
Tel: 931-692-3641 or 931-692-3418
Fax: 931-692-2201

FRANKLIN REGION 3 CLINIC 2601
FRANKLIN COUNTY HEALTH DEPT.
338 JOYCE LANE
WINCHESTER 37398
Tel: 931-967-3826
Fax: 931-962-1168

HAMBLEN REGION 2 CLINIC 3201
HAMBLEN COUNTY HEALTH DEPARTMENT
331 WEST MAIN STREET
MORRISTOWN 37814
Tel: 423-586-6431
Fax: 423-586-6324

GIBSON REGION 7 CLINIC 2701
GIBSON COUNTY HEALTH DEPARTMENT
1250 MANUFACTURER'S ROW
TRENTON 38382
Tel: 731-855-7601
Fax: 731-855-7603

HAMILTON REGION H CLINIC 3359
SOUTHSIDE HEALTH CENTER
100 EAST 37TH STREET
CHATTANOOGA 37410
Tel: 423-778-2716
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
CLINIC 3318
HAMILTON HEALTH DEPT/HOSPITAL
921 EAST 3RD STREET
CHATTANOOGA 37404
Tel: 423-209-8220
Fax: 423-209-8314

HAMILTON REGION H CLINIC 3317
TEEN LEARNING CENTER-MAURICE KIRBY
HSAT
921 EAST 3RD STREET
CHATTANOOGA 37404
Tel: 423-209-8220
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 37033-1407
Tel: 931-729-3516
Fax: 931-729-5029

HOUSTON REGION 5 CLINIC 4201
HOUSTON COUNTY HEALTH DEPARTMENT
60 TOWN 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 MURRY STREET
PO BOX 312
GAINESBORO 38562-0312
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 38462-1410
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
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 37083-0026
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: 731-927-8601

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 37091-2804
Tel: 931-359-1551
Fax: 931-359-0542

MAURY REGION 6 CLINIC 6001
MAURY COUNTY HEALTH DEPARTMENT
1909 HAMPSHIRE PIKE
COLUMBIA 38401
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-SUITE #103
1850 BUSINESS PARK
CLARKSVILLE 37040
Tel: 931-551-8777
Fax: 931-503-0694

MOORE REGION 6 CLINIC 6401
MOORE COUNTY HEALTH DEPARTMENT
251 MAJORS BLVD., P.O. BOX 196
LYNCHBURG 37352
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 38570-2301
Tel: 931-823-6260
Fax: 931-823-5821

PERRY REGION 6 CLINIC 6801
PERRY COUNTY HEALTH DEPARTMENT
31 MEDICAL DR.
LINDEN 37096
Tel: 931-589-2138
Fax: 931-589-5414

PICKETT REGION 4 CLINIC 6901
PICKETT COUNTY HEALTH DEPARTMENT
1013 WOODLAWN DRIVE
BYRDSTOWN 38549-3401
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
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

SHELBY REGION 9 CLINIC 7917
CAWTHON PUBLIC HEALTH CLINIC
1000 HAYNES
MEMPHIS 38114
Tel: 901-222-9891
Fax: 901-222-9888

ROBERTSON REGION 5 CLINIC 7401
ROBERTSON COUNTY HEALTH DEPT.
900 S BROWN STREET
SPRINGFIELD 37172-2920
Tel: 615-384-0208 or 615-384-4504
Fax: 615-384-0245

SHELBY REGION 9 CLINIC 7921
HOLLYWOOD CLINIC
2500 PERES
MEMPHIS 38108
Tel: 901-515-5500
Fax: 901-458-5591

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

SHELBY REGION 9 CLINIC 7923
MEMPHIS HEALTH CENTER-WIC
360 E.H. CRUMP BLVD.
MEMPHIS 38126
Tel: 901-261-2000
Fax: 901-775-2938 (Administration)
or 901-948-9910 (Med)

RUTHERFORD REGION 5 CLINIC 7503
NORTH RUTHERFORD COUNTY HEALTH
DEPT.
108 DAVID COLLINS DRIVE
SMYRNA 37167
Tel: 615-355-6175
Fax: 615-459-7996

SHELBY REGION 9 CLINIC 7925
SHELBY CROSSING CLINIC
6170 MACON RD.
BARTLETT 38134
Tel: 901-222-9800
Fax: 901-222-9821

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

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

SEQUATCHIE REGION 3 CLINIC 7701
SEQUATCHIE CO. HLTH DEPT
16939 RANKIN AVE.
DUNLAP 37327
Tel: 423-949-3619
Fax: 423-949-6507

SHELBY REGION 9 CLINIC 7956
SOUTHLAND MALL CLINIC
1287 SOUTHLAND MALL
MEMPHIS 38116
Tel: 901-222-9828
Fax: 901-222-9856

SEVIER REGION 2 CLINIC 7801
SEVIER COUNTY HEALTH DEPARTMENT
709 MIDDLE CREEK RD.
SEVIERVILLE 37862
Tel: 865-453-1032
Fax: 865-429-2689

SHELBY REGION 9 CLINIC 7976
MILLINGTON CLINIC
8225 HWY 51 NORTH
MILLINGTON 38053
Tel: 901-873-4433
Fax: 901-872-6941

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 7983
HICKORY HILL CLINIC
6590 KIRBY CENTER COVE
SUITES 101 & 104
MEMPHIS, TN 38115
Tel: 901-365-1045 or 901-365-1077
Fax: 901-365-0583

SHELBY REGION 9 CLINIC 7989
GALLOWAY WIC CLINIC
477 NORTH MANASSAS
MEMPHIS 38105
Tel: 901-522-8268
Fax: 901-521-7125

SMITH REGION 4 CLINIC 8001
SMITH COUNTY HEALTH DEPARTMENT
251 JOY ALFORD WAY
CARTHAGE 37030
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 DEPART-
MENT
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 37110-1310
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
102 JV MANGUBAT DRIVE
WAYNESBORO 38485
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 DEPART-
MENT
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