

Date: _____

Completed by: _____

<input type="checkbox"/> Initial Certification	<input type="checkbox"/> Subsequent Certification	<input type="checkbox"/> Complete Assessment	<input type="checkbox"/> Other:
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Family/Participant Demographics – General Information

<input type="checkbox"/> Foster Family <input type="checkbox"/> Participant	Last Name*	First Name*
Proof of Identification*		Date of Birth*
Address*		
ZIP Code*	City*	County*
Proof of Residence*	Homeless/Incarcerated Status <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated	Migrant Status

Communication Information/Voter Registration

Telephone Number:				
Type: <input type="checkbox"/> Home <input type="checkbox"/> Cellular <input type="checkbox"/> Work <input type="checkbox"/> Message		<input type="checkbox"/> Primary <input type="checkbox"/> Do Not Call	<input type="checkbox"/> Text: Carrier:	
Voter Registration* <input type="checkbox"/> Yes, wants to register <input type="checkbox"/> No, does not want to register <input type="checkbox"/> Not eligible to vote <input type="checkbox"/> Already registered <input type="checkbox"/> Declined to answer				
Language Read*		Language Spoken* <input type="checkbox"/> Interpreter <input type="checkbox"/> Sign Language Interpreter		
Email Address:				
Preferred Method of Contact: <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> No Contact <input type="checkbox"/> Text				

Participant Demographics

General Information – Race/Ethnicity

<input type="checkbox"/> Declared <input type="checkbox"/> Observed	Ethnicity* <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race* <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander
Physical Presence: <input type="checkbox"/> Yes <input type="checkbox"/> No		Physical Presence Exception Reason:	

Family Income

Family Size*	No. of Expected Infants*	Total Family Size*				
Family - Adjunct Participation						
	Medicaid Title 19	State or Federal non-Title 19	SNAP	TANF	FDPIR	Adj elig Household member not on WIC
Name	Provider 1 #		<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:
Name	Provider 1 #		<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:
Name	Provider 1 #		<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:	<input type="checkbox"/> Proof seen:
Self Declared Income (gross income received in the past 30 days): _____						

Income Details (leave blank if family is adjunctively eligible)

Source	Proof	Frequency	Amount	Duration
Zero Income Declaration Reason:			<input type="checkbox"/> No Income	

Woman Health Information – Begin using Assessment Questions Staff Tool for Participant Centered Risk Assessment

Pre-Pregnancy Weight*	Nicotine and Tobacco Products Used	Cigarettes Per Day	Alcohol Use
lb. oz.			Drug Use

Pregnancy

Last Menstrual Period* OR Expected Delivery Date*:	First Prenatal Healthcare Visit Date: No. of Healthcare Visits:	Number of Fetuses this Pregnancy:	Currently Breastfeeding?
Pregnancy Induced Health Conditions:		Health Conditions:	

Breastfeeding Information

Data Collection Date*	Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ever breastfed?*			
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Complications:			Do you give your baby any formula? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Age Infant Stopped Breastfeeding:			Reason Infant Stopped Breastfeeding:			
Pregnancy History						
Delivery Date:	Fetus Count:	Outcome:	Delivery Type:	Wks Gestation:	Birth Length:	Birth Weight:

Anthro/Lab

Measurement Date*	Bloodwork Date*	Exempt reason:	Deferred Reason:
Height* Weight*	Hgb* or Hct*	<input type="checkbox"/> Medical condition	<input type="checkbox"/> Will get from medical provider
Collected By:	Collected By:	<input type="checkbox"/> Religious belief	<input type="checkbox"/> Illness
		<input type="checkbox"/> Not required by policy	<input type="checkbox"/> Couldn't get a value
		<input type="checkbox"/> Refusal	<input type="checkbox"/> Participant not present
			<input type="checkbox"/> Equipment failure

Family Assessment

In the past few weeks, have you or your child been in an enclosed space while someone smoked or vaped? * ☐ Yes ☐ No

Do you ever feel unsafe at home? Have you felt afraid of your partner or family member?

Medical Provider 1:

Medical Provider 2:

Medical Provider 3:

Where did you first hear about WIC?
(initial cert only)

☐ *Word of mouth*

☐ *Health Care
Referral*

☐ *Don't know or
didn't answer*

☐ *Other:*

Dietary & Health

Dietary Assessment

Listen and assess for:
Inappropriate Nutrition Practices
(Record risk and appropriate reason)

Notes:

Eco-Social (optional) Participant

Recipient of Abuse ☐ Yes
☐ No

Limited Abilities ☐ Yes
to Feed Self ☐ No

Maternal Intellectual ☐ Yes
Disability ☐ No

Dietary Supplement ☐ Yes
During Pregnancy ☐ No

Assigned Risk Factors

Risk factors:

Notes:

Certification Signature

Complete and attach forms that were signed
(R&R, Temporary Certification for Missing Proof of Income, etc.)

Certification Summary

High Risk (Professional Discretion) ☐ Yes ☐ No

EBT Card Cardholder: _____

Prefers Card is ☐ Mailed or ☐ Will pick-up at the clinic

Issue Benefits:

Prescribe Food

Milk Substitution

☐ Tofu (Number of pounds: _____)

☐ Yogurt

☐ Other _____

☐ Medical Documentation Form (attach)

Issue Food Instruments

☐ Family Issuance Day: _____ (New Participants - date information is entered into Cascades)

☐ Number of Months of Issuance (Issuance Frequency) _____

Care Plan

Referrals

- ☐ _____
- ☐ _____
- ☐ _____

Nutrition Education Topics (Family or Individual)

☐ Topic: _____

Maintain Goals

- ☐ Add goals: _____
- ☐ Add goals: _____

Notes: (additional space on back page)

Next Appointment:

Family Alerts:

Reason Paper Copy Used:

Paper Copy Entered

☐ Yes

**INFORMATION FOR DOCUMENTING IN THE
CASCADES CARE PLAN:**

The Three Steps to Goal Setting

1. Use an open ended question to ask the participant about their next step.
2. Help narrow the goal to something that feels achievable to the participant.
3. Summarize and express confidence.

A nutrition assessment note includes:

- The appointment type as the title.
- The participant's or caregiver's thoughts and feelings about the topic(s).
- The information offered/shared/discussed about the topic(s).
- The participant's or caregiver's goal, if ready to set a goal, or document that they weren't ready to set one.
- Additional information for future support and follow up.
- Document the nutrition education topic(s) discussed and mark as "Complete" in the Care Plan – Nutrition Education.

Notes:



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For persons with disabilities this document is available on request in other formats.

To submit a request, please call 1-800-841-1410 (TDD/TYY 711)