CASCADES WASHINGTON WIC

Infant WIC Services Worksheet

Date: _____

Completed by: _____

☐ Initial Certification	☐ Health Assessment	☐ Other:

Family Demographics – General Information (Parent Guardian)

☐ Foster Family ☐ Participant	Last Name*	First Name*
Proof of Identification		Date of Birth*
Address*		
ZIP Code*	City*	County*
Proof of Residence*	Homeless/Incarcerated Status ☐ Homeless ☐ Incarcerated	Migrant Status

Participant Demographics

Last*	First*	
Proof of ID*	Date of Birth*	
Gender* Physical Presence: ☐ Yes ☐ No Physical Presence Exception Reason:	Foster Child: ☐ Yes ☐ No	Foster Care Entry Date: ☐ Unknown Proof of Foster Care:

General Information – Race/Ethnicity

☐ Declared ☐ Observed	Ethnicity* ☐ Hispanic ☐ Non-Hispanic	Race* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ White ☐ Native Hawaiian or Pacific Islander

Family Name: _____

Communication Information/Voter Registration

Telephone Number:			
Type: ☐ Home ☐ Cellular ☐ Work ☐ Message		☐ Primary ☐ Do Not Call	☐ Text: Carrier:
Voter Registration* ☐ Yes, wants to register ☐ No, does not want to register ☐ Not eligible to vote ☐ Already registered ☐ Declined to answer			
Language Read*	Language Spoken*	☐ Interpreter	☐ Sign Language Interpreter
Email Address:			

Preferred Method of Contact:	☐ Mail	☐ Email	☐ Phone	☐ No Contact	☐ Text

Family Income

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 #		☐ Proof seen:	☐ Proof seen:	☐ Proof seen:	☐ Proof seen:
Name	Provider 1 #		☐ Proof seen:	☐ Proof seen:	☐ Proof seen:	☐ Proof seen:
Name	Provider 1 #		☐ Proof seen:	☐ Proof seen:	☐ Proof seen:	☐ 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:			No Income	

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

Birth Length:	Birth Weight:	Weeks Gestation:
Last Seen by Physician:	Medical Health Conditions:	

Breastfeeding Information

Data Collection Date*	Are you breastfeeding?* ☐ Yes ☐ No	Ever breastfed?* ☐ Yes ☐ No ☐ Unknown
Age Infant Stopped Breastfeeding:	Reason Infant Stopped Breastfeeding:	
Complications:	Do you give your baby any formula? ☐ Yes ☐ No	
How much formula do you give your infant in 24 hours?*	Immunization Status: ☐ Unknown ☐ Up-to-Date ☐ Not Up-to-Date	

Anthro/Lab

Measurement Date* Height* Weight* Collected By:	Bloodwork Date* Hgb* or Hct* Collected By:	Exempt reason: ☐ Medical condition ☐ Religious belief ☐ Not required by policy ☐ Refusal	Deferred Reason: ☐ Will get from medical provider ☐ Illness ☐ Couldn't get value ☐ Participant not present ☐ 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	Parent/Guardian Limited Abilities to Feed Self ☐ Yes ☐ No	Maternal Intellectual Disability ☐ Yes ☐ No
Physical Activity* _____Times per Week	TV/Video Viewing* _____Hours per Day	

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 Cardholder: _____ **Prefers Card** is ☐ Mailed or ☐ Will pick-up at the clinic

Issue Benefits Prescribe Food

Formula ☐ Brand: _____	☐ Powder/Concentrate/ Ready to Feed ☐ 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

Family Name: _____

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:

CASCADES
WASHINGTON WIC

Washington State Department of Health

DOH 960-170 November 2022

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)