CERTIFICATION POLICIES AND PROCEDURES

TABLE OF CONTENTS

SECTION:	SUBJECT:		EFFECTIVE DATE:
2.13	Transferring Participants and the Use of Verification of Certification		October 1, 1995
	2.13A	Sample Verification of Certification	
2.14	Eligibility of Aliens and Alien Students		October 1, 1998
2.15	Eligibility of Persons Affiliated with Institutions		October 1, 1995
2.16	Participant Present for Certification		October 1, 1992
2.17	WIC Overseas Program		October 1, 2001
	2.17A	DoD WIC Overseas Program Participant Profile/Verification of Certification	
	2.17B	Has been removed	
2.18	Applicant/Participant Record Retention		October 1, 1993
2.19	Identification Folder		April 5, 1991
	2.19A	Identification Folder	
2.20	Designee/Proxy Authorization		October 1, 1996
2.21	Homeless Individual		May 1, 1993
	2.21A	Has been moved to 2.04A	
2.22	Appointment Waiting List		October 1, 1993
2.23	Establishment of Applicant Identity		October 1, 1992
	2.23A	Proof of Identity Affidavit	
2.24	Establishment of Participant Category		April 1, 1993
2.25	Voter Registration		October 1, 1995
	2.25A	Voter Registration Application	
	2.25B	Voter Registration Certification form	October 2013
2.26	Changed to Policy and Procedure 2.34		
2.27	Immunization Record (DtaP) Screening		May 24, 2003
2.28	Blood Lead Screening Requirement		October 1, 2003
	2.28A	Lead Risk Screening Tool for Women and Children	November 7, 2017
2.29	This policy has been removed		
2.30	This policy has been removed		

SECTION:	SUBJECT:		EFFECTIVE DATE:
2.31	Assessment of Nutritional Risk		October 1, 1990
	2.31A	Nutritional Risk Criteria Guidelines	
	2.31B	CHART: Nutrition Risks	
2.32	Weight and Height Measurement Requirement		December 18, 1991
	2.32A	Procedures to Collect Weight and Height/Length Measurements	
2.33	Hemoglobin Test Requirement		December 18, 1991
	2.33A	Standard Hemoglobin Testing Procedure	
	2.33B	Non-invasive Hemoglobin Testing Procedure	
2.34	Nutrition and Health Information Requirement		October 1, 1996
	2.34A	Provision of Nutrition Services	
	2.34B	has been removed	
	2.34C	has been removed	
	2.34D	has been removed	
2.35	This policy has been removed		
2.36	Certification of Participants in Hospitals		October 1, 2011
2.37	Use of Volunteers in the WIC Program		October 1, 2012
2.38	This policy has been merged into 2.10		October 1, 2012
	2.38A	has been removed	
	2.38B	has been removed	October 1, 2013
	2.38C	has been removed	October 1, 2013
	2.38D	has been removed	October 1, 2013
2.39	Participant Referrals		November 18, 2019

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.00
Effective Date: October 1, 1993
Revised Date: October 3, 2023

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Overview of the Certification Procedure**

A. Policy

Pregnant, breastfeeding, or postpartum women, infants, and children who apply to receive WIC benefits, including those who currently participate but are re-applying because their certification period is about to expire, are known as applicants. Certification is the implementation of criteria and procedures to assess and document each applicant's eligibility for the Program. Local agency staff shall follow the same basic procedure when certifying applicants.

B. Procedure

In determining the eligibility of an applicant and certifying qualified applicants, local agencies shall assure that:

1. The applicant is informed that:

    a. The purpose of the WIC Program is to promote desirable health outcomes through nutrition education, breastfeeding support, special supplemental foods, and referrals during critical times of growth and development.
    b. The relationship between the participant (or participant's caregiver) and WIC staff is a partnership with open dialogue and two-way communication and encourage them to ask questions throughout the process.
    c. They will be notified of the determination of eligibility or ineligibility during this visit.
    d. Each participant must reapply at the end of the certification period and be reassessed for eligibility.
    e. They will need to read (or have read to them) the Program Rights and Responsibilities and sign that they have received a copy.

2. The certifier will ensure that:

    a. A participant focused approach to communication and good customer service practices are followed.
    b. Applicant confidentiality is protected.
    c. Demographic information is correct.

i. Race and ethnicity shall be obtained during the initial certification. Best practice at subsequent certification appointments is to confirm the accuracy of the data.

d. The applicant meets current income eligibility requirements.
e. The applicant meets current residency requirements.
f. The applicant meets current identity requirements.
g. The applicant is categorically eligible as a pregnant, postpartum, or breastfeeding woman, an infant, or a child under the age of five.
h. The applicant is asked about voter registration status and offered the opportunity to register to vote, as appropriate.
i. The applicant is evaluated for nutritional risk by collecting and evaluating relevant information that includes:
    i. Height or length and weight measurements;
    ii. Hemoglobin or hematocrit test results, as applicable; and
    iii. Health and nutrition information.
j. If an infant or child, the applicant receives a review of his/her immunization history up to age two and is referred to their health care provider if needed.
k. If pregnant or a child, the applicant is referred for a blood lead test and given information about the dangers of lead poisoning, if it cannot be determined that the test has been performed.
l. All pregnant, postpartum and breastfeeding women and caregivers of infants and children are provided a list of local resources for alcohol and substance use counseling and treatment.
m. All adult applicants are provided written information about the Medicaid Program and if not currently participating, are given a referral to the Medicaid Program.
n. All adult applicants and caretakers are provided information on, and when appropriate, given referrals to other health related and public assistance programs, such as:
    i. Breastfeeding Support
    ii. Dental Services
    iii. Supplemental Nutrition Assistance Program (SNAP)
    iv. Expanded Food and Nutrition Education Program
    v. Food banks and pantries
    vi. Homeless facilities
    vii. Family Planning Services
    viii. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program (Maryland Healthy Kids)
    ix. Head Start
    x. Immunization Services
    xi. Pre- and Post-natal care
    xii. Well Child Care
    xiii. Mental Health Services
    xiv. Smoking Cessation Programs
    xv. Temporary Cash Assistance (TCA)

xvi. Other local services that may be applicable to the applicant's needs.

o. Any family member(s) deemed eligible for the Program receive(s) at the initial certification, and thereafter, as needed:
    i. A prescription for the most appropriate food package using information obtained during the certification, including any food preferences.
    ii. An explanation of what the WIC foods are and why they were selected, that the foods are supplemental and intended for the participant(s), and what to do if a change in the food package is needed.
    iii. Participant focused nutrition education that is appropriate for categorical status and targeted to reducing nutritional risk(s) identified during the certification.
    iv. If pregnant, information verbally and in writing, about the benefits of and contraindications to breastfeeding.
    v. A food instrument and an explanation on how to shop with it and the importance of preventing loss or theft.
    vi. A list of WIC authorized foods and vendors.
    vii. An explanation of the need to return to the clinic for future appointments, as appropriate.
    viii. An appointment date and time to obtain the next allotment of food benefits and secondary nutrition education contact.
    ix. Information about how to contact the clinic.
    x. Encouragement to participate in the local agency's nutrition education activities.
    xi. Encouragement to keep and be on time for all appointments.
    xii. Instruction to explain Program information, including the use of food instruments and procedures for WIC appointments, to all persons identified in the management information system as proxies or designees.

p. The applicant reads (or has read to them) and receives a copy of the Program Rights and Responsibilities form before electronically signing to acknowledge understanding and receipt of such.

q. A verification of certification is issued to every migrant family as well as military families or others who are likely to be relocating within the certification period.

References:

- 7CFR 246.7 Certification of Participants
- 7CFR 246.11 Nutrition Education
- COMAR 10.54.01 Eligibility, Participation, and Benefits
- SFP 01-032, WIC Final Policy Memorandum 2001-1, Clarification of WIC's FY 2001 Appropriations Act Provision Regarding Blood Lead Screening

- SFP 06-056 Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy (HQ Policy Memo 2006-5)

Revisions:

04/2008	A 17. added wording that the ID folder is required to pick up and redeem food instruments
10/2008	Changed Food Stamps to read Supplemental Nutrition Assistance Program SNAP
01/2009	Changed Supplemental Nutrition Assistance Program SNAP to read Food Supplement Program
10/2010	Added B2 and B5. Reordered B 1-6
10/2011	Specified in A.2. that an applicant may live or work in the service area of the local agency. Added participant focused in A.12 Added clarification to B.6.
10/2012	Minor language changes/clarifications
10/2013	Changed WOW to management information system and Applicant's Rights and Responsibilities to Participant's Rights and Responsibilities; added electronic signature. Consolidated A.10 and A.24.
10/2015	Reorganized information; added information from and deleted Policy and Procedure 2.35.
06/2017	Updated with eWIC terminology, removed reference to ID folders
07/2020	Changed Participant's Rights and Responsibilities to Program Rights and Responsibilities; added pregnancy to lead referral; clarified illegal substance use based on updated policies 2.12, 2.28, and 2.31
10/2023	Clarified best practice regarding the race and ethnicity question.

Policy and Procedure 2.01 has been renamed as Policy and Procedure 7.60.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.02
Effective Date: October 1, 1990
Revised Date: **October 7, 2024**

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Certification of Applicant**

A. Policy

To be certified as eligible for the WIC Program, applicants shall meet the following criteria for eligibility in accordance with policies established by the State agency.

a. Establishment of Applicant Identity (Policy and Procedure 2.23);

b. Residency requirements (Policy and Procedure 2.04);

c. Income eligibility requirements (Policy and Procedure 2.05); and

d. Assessment of nutritional risk (Policy and Procedure 2.31).

B. Procedure

The local agency shall:

1. Use the management information system or the manual certification form provided by the State agency (Attachment 2.02A) to certify all applicants in accordance with the policies and procedures listed in section A and other related policies and procedures.

2. Advise the participant or the head of household of the Program's rights and responsibilities as outlined in Policy and Procedure 2.12 *Program Rights and Responsibilities.*

3. Ensure that the staff determining eligibility follow policies and procedures appropriately and document what was presented by the applicant in the management information system.

Attachments:

2.02A Manual Certification/Mid-Certification Form

References:

1. 7 CFR 246.7

Revisions:

10/1999	
07/2002	Added Establishment of Identity in A. Policy
10/2007	updated Nutrition Risk Policy Name and Number
10/2011	clarified the policy in B.2d
10/2012	Changed B.1 to indicate that WOW or Attachment 2.02A should be used to complete the mid-certification appointment as well as the certification. Changed name of Attachment 2.02A to Manual Certification/Mid-Certification Form.
10/2013	changed name of policy to Certification of Applicant, deleted B.2.a-e, moved a portion of B.2.d to Policy and Procedure 7.66, B.2.e is already reflected in Policy and Procedure 2.33 and 2.32, added new language for B.2 and B.3., removed attachment 2.02B
10/2015	Added Maryland WIC Program Nutrition Care Referral Form to Attachment 2.02A.
06/2017	Updated Attachment A to include eWIC language and to reflect new high risk categories, updated B.3 to reflect needed staff signatures based on new separation of duties guidelines.
11/2017	Update Attachment A to include new nutrition risk questions and new high-risk categories.
12/2019	Update Attachment A to include new nutrition risks, new medical questions and add yogurt to food package options.
7/2020	Corrected name of policy 2.12 to Program Rights and Responsibilities; added new diabetes questions to 2.02A
11/2021	Updated Attachment A to include new medical questions related to exposure to tobacco products. Reformatted revision dates to be consistent with master formatting.
04/2023	Updated Attachment A to reflect changes to medical and nutrition questions in the management information system.

10/2024 Updated Attachment A to reflect changes to nutrition questions in the management information system.

Maryland WIC Program Manual
☐Certification/Recertification ☐Mid-Certification Form

Clinic:	Certification Date:

Family Information	Last Name	First Name	MI	DOB
Head of Household				
				Designee
Proxy #1				☐
Proxy #2				☐

	Street Address	Mailing Address ☐Same as Street Address	
Street			☐ No Mailing
City, State, Zip			
County			

Phone		Type	Land Mobile	Comment		No Calls
Primary	☐ Yes ☐ No	Contact	Call Text			☐Yes ☐No
Phone		Type	Land Mobile	Comment		No Calls
Primary	☐ Yes ☐ No	Contact	Call Text			☐Yes ☐No

E-mail Address		Family Size	

Income Information

Adjunct Eligibility Program(s)	☐MA ☐SNAP ☐TCA	Notes
Adjunct Eligibility Card Number		☐ N/A MCV ☐ Foster Child # of Expected Infants_____

Income

Income Provider Name	Interval	Amount	Source	Documentation	

Additional Family Information

Primary Language if not English		Translator: Required ☐ Waived ☐	
Proof of Residency		☐ N/A MCV	
Voter Registration	☐ Already Registered ☐ Provided Help ☐ Given Form ☐Not Interested ☐ Other		
Pickup Interval	☐ Trimonthly ☐Bimonthly ☐Monthly	**Internet Usage**	☐Yes ☐No ☐ Unknown
Referred From			
Disability			
Other Information	☐Military ☐Migrant ☐Homeless/Shelter ☐Residential Facility		

Participant Information (Woman)

Last Name		First Name		MI		DOB	
		Proof of Identity					
Physician Name		Proof of Pregnancy		☐ N/A MCV			
Physician Telephone		Source of Health Care					

Hispanic or Latino?	☐ Yes ☐ No			
American Indian or Alaska Native				
Asian				
Black or African American				
Native Hawaiian or Other Pacific Islander				
White				

Cert Action

LMP		EDD		Actual Delivery Date	
Category	**Cert Start**	**Cert End**	**Cert Reason**	**Physical Presence**	**Not Present Reason**

Pregnancy Information

1. When did you see a doctor for this pregnancy?

☐ Haven't ☐ Date of 1st visit:

1a. What has your doctor told you about getting flu and Tdap shots while you're pregnant?

2. What special concerns does your care provider have?

- ☐ Twins, triplets or more
- ☐ Weight loss while pregnant
- ☐ Hyperemesis gravidarum
- ☐ Gestational diabetes
- ☐ Fetal growth restriction (IUGR)
- ☐ None or unknown

3. Is this your first pregnancy?
☐Yes ☐No

Date of last live birth:

3a. Tell me about any medical issues with your past pregnancies.

- ☐ Baby born 5 pounds, 8 ounces or less
- ☐ Baby born 9 pounds or more
- ☐ Baby born 37 weeks or earlier
- ☐ Baby born with a birth defect
- ☐ Two or more miscarriages (less than 20 weeks)
- ☐ Pregnancy loss (20 weeks or more)
- ☐ Stillbirth or death before 1 month of age
- ☐ Gestational diabetes
- ☐ History of Preeclampsia
- ☐ None of these

WPP/BE/BP:

1. Tell me about this last pregnancy.
- ☐ Baby born 5 pounds, 8 ounces or less
- ☐ Baby born 9 pounds or more
- ☐ Baby born 37 weeks or earlier
- ☐ Twins, triplets or more
- ☐ Baby born with a birth defect
- ☐ Miscarriage (less than 20 weeks)
- ☐ Pregnancy loss (20 weeks or more)
- ☐ Stillbirth or death before 1 month of age
- ☐ Caesarean "C" section
- ☐ Gestational diabetes
  Had a follow up diabetes test? Y or N
  Plan to have a follow up test? Y or N
- ☐ History of Preeclampsia
- ☐ None of these

2. Were you ever pregnant before this last time? ☐ No ☐ Yes

Date of last live birth?

Medical Information (Women)

1. Do you have any health problems or recent illnesses that concern your doctor?
   ☐None ☐Some Specifiy_____

2. What medicine do you take regularly? ☐ None ☐Takes Specify_____

3. What vitamins do you take regularly?	☐ None ☐ Prenatal vitamin w/Iodine ☐ Prenatal vitamin ☐ Iron Pill ☐ Multivitamin ☐ Folic acid pill ☐ Herbal supplement ☐ Other: _____
4. What dental problems are you having? ☐ None ☐ Missing or extracted teeth ☐ Untreated Caries ☐ Gum Disease ☐ Other _____	Have a dental provider? ☐ No ☐ Yes
5. Do you have any food allergies diagnosed by a health care provider?	☐ None ☐ Peanuts ☐ Nuts ☐ Milk ☐ Soy ☐ Eggs ☐ Fish ☐ Shellfish ☐ Wheat ☐ Sesame ☐ Other:_____

6. Do you eat or want to eat things that are not food? ☐No ☐Yes Specify_____

7. Do you: ☐ smoke tobacco Number per day____ ☐ Use Nicotine Products Specify: _____

   Are you exposed to tobacco products in enclosed areas? ☐ No ☐ Yes

8. Do you use: ☐None ☐recreational (street) drugs ☐marijuana ☐medications not prescribed

9. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐ No ☐ Yes
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐ No ☐ Yes

10. What concerns do you have about the safety of you or your children? ☐ Some concerns ☐ None

Wt/Ht/Bloodwork

Date	LBS	OZ	IN	1/8 IN	Weeks	Hgb	Comment

Pre Pregnancy Weight		**Weight at Delivery**	
Have you had a blood lead test?	☐No ☐Yes ☐Don't Know		

Participant Information (Infant – Child)

Last Name		First Name		MI		DOB	
Sex assigned at birth	☐**Male** ☐ **Female**		**Proof of Identity**	☐ N/A MCV			
Physician Name							
Physician Telephone Number			**Source of Health Care**				

Hispanic or Latino?	☐**Yes** ☐**No**			
American Indian or Alaska Native				
Asian				
Black or African American				
Native Hawaiian or Other Pacific Islander				
White				

Cert Action (Infant – Child)

Immunization Status:		Record Date Given:			
Immunization Document:	☐ Yes ☐ No	**DTaP #1**		**DTaP#2**	
		DTaP#3		**DTaP#4**	

Breastfeeding Now:	☐ Yes ☐ No	**Amount of BF**	☐Exclusive ☐Mostly (<14oz formula) ☐Some (>14oz formula)	
Ever Breastfed:	☐ Yes ☐ No ☐Unknown	**Age when routinely fed something other than breastmilk?** _____months _____ weeks _____ days		**Food Type**
Date/Age BF Ended		_____months _____ weeks _____ days		**Reason**

Category	**Cert Start**	**Cert End**	**Cert Reason**	**Physical Presence**	**Not Present Reason**

Medical Information (Infant – Child)	No	Yes	Specify
1. Tell me about any health concerns for your child in the past 6 months.			
2. What medicines does your child take on a regular basis?			
3. What vitamins or supplements do you give your child?			
4. What dental problems does your child have?			☐ White or dark spots on teeth ☐ Dental caries ☐ Extracted teeth ☐Other: _____
Has he/she seen dentist?			Name: Phone:
5. Where does the drinking water you use for your child/infant come from?			☐ City (fluoride) ☐ Well ☐ City (no fluoride) ☐ Outdoor Spring/Cistern ☐ Store-bought (w/fluoride) ☐ Don't Know ☐ Store-bought (no fluoride) ☐ None
6. Does your child eat or want to eat things that are not food?			If yes, what?
7. Does your child have any food allergies that have been diagnosed by a health care provider?			☐ Milk ☐ Soy ☐ Eggs ☐ Nut ☐ Peanuts ☐ Shellfish ☐ Fish ☐ Wheat ☐ Sesame ☐ Other _____
8. Is this child exposed to tobacco products in enclosed areas? ☐ No ☐ Yes ☐ Don't Know			

9. Mother (only if present)	Height (inches)		Weight (lbs)	
10. Father (only if present)	Height (inches)		Weight (lbs)	
11. How do you feel about your child's growth? ☐ Too slow ☐ Just right ☐ Too fast				

Wt/Ht/Bloodwork

Date	LBS	OZ	IN	1/8	R/S	Hgb	Comment

Infant Preterm or Early Term	☐	**Weeks of Gestation**		**Birth Weight**	_____lbs _____oz	**Lead Test** ☐Yes ☐No ☐Don't Know

Participant Information (Infant – Child)

Last Name		**First Name**		**MI**		**DOB**	

Sex assigned at birth	☐**Male** ☐ **Female**	**Proof of Identity**	☐ N/A MCV
Physician Name			
Physician Telephone Number		**Source of Health Care**	

Hispanic or Latino?	☐**Yes** ☐**No**		
American Indian or Alaska Native			
Asian			
Black or African American			
Native Hawaiian or Other Pacific Islander			
White			

Cert Action (Infant – Child)

Immunization Status:		Record Date Given:			
Immunization Document:	☐ Yes ☐ No	**DTaP #1**		**DTaP#2**	
		DTaP# 3		**DTaP#4**	

Breastfeeding Now:	☐ Yes ☐ No	**Amount of BF**	☐Exclusive ☐Mostly (<14oz formula) ☐Some (>14oz formula)	
Ever Breastfed:	☐ Yes ☐ No ☐Unknown	**Age when routinely fed something other than breastmilk?** _____months _____ weeks _____ days		**Food Type**
Date/Age BF Ended		_____months _____ weeks _____ days		**Reason**

Category	**Cert Start**	**Cert End**	**Cert Reason**	**Physical Presence**	**Not Present Reason**

Medical Information (Infant – Child)	No	Yes	Specify
1. Tell me about any health concerns for your child in the past 6 months.			
2. What medicines does your child take on a regular basis?			
3. What vitamins or supplements do you give your child?			
4. What dental problems does your child have?			☐ White or dark spots on teeth ☐ Dental caries ☐ Extracted teeth ☐Other: _____
Has he/she seen dentist?			Name: Phone:
5. Where does the drinking water you use for your child/infant come from?			☐ City (fluoride) ☐ Well ☐ City (no fluoride) ☐ Outdoor Spring/Cistern ☐ Store-bought (w/fluoride) ☐ Don't Know ☐ Store-bought (no fluoride) ☐ None
6. Does your child eat or want to eat things that are not food?			If yes, what?
7. Does your child have any food allergies that have been diagnosed by a health care provider?			☐ Milk ☐ Soy ☐ Eggs ☐ Nut ☐ Peanuts ☐ Shellfish ☐ Fish ☐ Wheat ☐ Sesame ☐ Other _____
8. Is this child exposed to tobacco products in enclosed areas? ☐ No ☐ Yes ☐ Don't Know			

9. Mother (only if present)	Height (inches)		Weight (lbs)	
10. Father (only if present)	Height (inches)		Weight (lbs)	
11. How do you feel about your child's growth? ☐ Too slow ☐ Just right ☐ Too fast				

Wt/Ht/Bloodwork

Date	LBS	OZ	IN	1/8	R/S	Hgb	Comment

Infant Preterm or Early Term	☐	**Weeks of Gestation**		**Birth Weight**	_____**lbs** _____**oz**	**Lead Test** ☐Yes ☐No ☐Don't Know

Risk Factors		
Participant #1		
Participant #2		
Participant #3		
Participant #4		

Nutrition Education Topics		
Participant #1		
Participant #2		
Participant #3		
Participant #4		
Goal:		

Referrals (R = referral to; C= Consent to share participant information)			
Nutrition Care – R	Immunizations – R	Dental – R	SNAP – R/C
Breastfeeding – R	Health Care Provider – R/C	Medical Assistance – R/C	Temporary Cash Assistance – R/C
Substance Use Counseling – R	Other referrals: _____		
Local Provider:			**R/C**

Food Package Requested			
Participant #1:	Milk Type:	Yogurt/Cheese/Tofu	Dry Beans/Can Beans/P.B.
Participant #2:	Milk Type:	Yogurt/Cheese/Tofu	Dry Beans/Can Beans/P.B.
Participant #3:	Milk Type:	Yogurt/Cheese/Tofu	Dry Beans/Can Beans/P.B.
Participant #4:	Milk Type:	Yogurt/Cheese/Tofu	Dry Beans/Can Beans/P.B.

Next Appointment		
Type:	**Method**:	**Note:**

Comments / Notes		
Initials of staff member who entered information into WOW verifying completion _____		
Recert/MCV: Family called to notify that their benefits are loaded:	☐Left message ☐Person answered	**Date of contact: _____**

Certification: PSV scheduled for family to pick-up eWIC card **Date: _____**	☐Family has transportation concerns and requested staff mail eWIC card ☐Address verified ☐Next appointment made and is entered in WOW ☐Shopping List mailed with eWIC card

Codes

Proof of Residency	Proof of Identity	
Confirmation of Residency Form	Birth Certificate/Registration	Crib Card
Driver's License	Driver's License	Foster Care Health Passport
Homeless Shelter	Hospital Birth Record	Medical Assistance Card
Lease	Immunization Record	Marriage License
MVA Identification	Other (system note required)	No Proof
Migrant Camp Resident	Proof of Age/Majority	Passport/Visa
No Proof	Proof of Identity Affidavit	School ID
Official Mail	Proof of Identity Card	WIC Identification Folder
Other (system note required)	Social Security Card	Visual Personal Recognition
Utility Bill	Immigration/Naturalization Record	
	Military Records/ID Card or Discharge Papers	

Proof of Pregnancy	Source of Income	Income Documentation
Health Care Provider's Note No Proof Not Applicable Other (system note required) Physical Appearance Pregnancy Test Results/Sonogram VOC WIC Referral Form	Alimony or Child Support Contributions from Other Persons Dividends or Interest on Savings or Bonds, Income from Estate Foster Care Military LES Net Income from Farm and Non-Farm Self-Employment Pending Public Assistance or Welfare Payments Retirement Savings or Checking Account Social Security Unemployment Compensation VOC /Transfers Wages, Salary, Commissions, Fees or Cash Payments for Service Worker's Compensation	Dividends or Interest on Savings or Bonds Declined to self-report Foster Child Status Verification Income Self Declaration Form Income Tax Returns Letter from Employer Military LES No Proof Other Cash Income Received or Withdrawn from Any Source Pay Stubs Private Pensions or Annuities Retirement Pensions or Veteran Payment Self-Employment Social Security Documentation Social Services Budget Letter Unemployment Insurance VOC W-2 Form

Women

Name_____

1. Tell me about any problems you have with eating.
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Mouth pain
   - ☐ Heartburn
   - ☐ Constipation
   - ☐ Don't feel like eating
   - ☐ No time to eat
   - ☐ Can't find the foods I like
   - ☐ None of these

2. What times do you eat in a typical day?
   ☐ Morning ☐ Noon ☐ Evening ☐ Snacks _____(number)

3. Tell me what kinds of foods you eat most days:
   - ☐ Bread, tortillas, or crackers
   - ☐ Cold or hot cereal
   - ☐ Noodles, macaroni, or rice
   - ☐ Fish or shellfish
   - ☐ Fruit
   - ☐ Green leafy salads
   - ☐ Orange or red vegetables
   - ☐ Green vegetables
   - ☐ Dry beans /canned beans
   - ☐ Tofu
   - ☐ Peanut butter or nuts
   - ☐ Meat, chicken, or turkey
   - ☐ Eggs
   - ☐ Cheese or yogurt
   - ☐ Hot dogs, sausage, cold cuts or bacon
   - ☐ Ice cream or pudding
   - ☐ Cookies, cake, pie or donuts
   - ☐ Chips, fried snacks, or popcorn

4. What do you drink in a typical day?
   - ☐ Milk
   - ☐ Water
   - ☐ Fruit juice
   - ☐ Soda or fruit-flavored drinks
   - ☐ Diet soda
   - ☐ Coffee or tea (hot or cold)
   - ☐ Herbal tea
   - ☐ Beer, wine, or drinks with alcohol
   - ☐ Other: _____

   Milk Type
   - ☐ Whole
   - ☐ 2%
   - ☐ 1% or fat free
   - ☐ Lactose reduced
   - ☐ Evaporated
   - ☐ Powdered
   - ☐ Soy milk

5. What, if any, foods do you avoid for health reasons? ☐ No ☐ Yes: _____(foods)

6. Do you follow any personal eating plan or diet?
   ☐ None ☐ Fasting ☐ Vegan ☐ Low Carbohydrate/High Protein
   ☐ Metabolic ☐ Raw Foods ☐ Other: _____

7. Describe how you include physical activity in your day.
   How much time? ☐ None ☐15 minutes ☐30 minutes ☐1 hour ☐ More than 1 hour

8. Would you like information on other food resources beyond WIC?
   ☐ No ☐ Yes

9. If there were one thing you could change about how or what you eat, what would it be?

(Infant) Birth – 3 months Baby's Name: _____

1. What does your baby drink?
   - ☐ Breastmilk at breast: From: ☐ Parent ☐ Someone other than parent
   - ☐ Pumped breastmilk: From: ☐ Parent ☐ Someone other than parent
     From: ☐ Bottle ☐ Cup with a lid ☐ Cup
   - ☐ Formula _____oz per day
   - ☐ Other _____

   -- How many times does your baby drink:
   Breastmilk at breast ____ times in 24 hours Pumped breastmilk _____times in 24 hours
   Formula ____ times in 24 hours Other _____times in 24 hours

   -- How many ounces does your baby drink from a bottle or cup at each feeding?
   Breastmilk ☐Less than 2 ☐ 2 to 3 ☐ 4 to 5 ☐ 6 to 7 ☐ 8 or more
   Formula ☐Less than 2 ☐ 2 to 3 ☐ 4 to 5 ☐ 6 to 7 ☐ 8 or more

2. About how long does it take for your baby to eat? ____ min. at breast ____ min. from bottle/cup

3. What concerns, if any, are you having with breastfeeding?
   - ☐No milk at 4 days postpartum ☐Breast engorgement ☐Recurrent plugged ducts
   - ☐Weak suck ☐Mastitis ☐Flat or inverted nipples
   - ☐Cracked, bleeding, or severely-sore nipples ☐Jaundice ☐Difficulty with latch-on
   - ☐Tandem nursing of 2 siblings (not twins) ☐No problems ☐Other: _____
   - ☐ Pain with breastfeeding

4. How do you know when you baby is hungry?
   ☐ Sucks on hand ☐ Fusses ☐ Gets restless ☐ Cries ☐ Don't Know ☐ Other: _____

5. How do you know when your baby is full?
   ☐ Pushes nipple out ☐ Turns away ☐ Gets sleepy ☐ Don't Know ☐ Other: _____

6. How does your baby act after eating?
   ☐ Is happy and satisfied
   ☐ Takes too long to eat ☐ Spits up a lot ☐ Stays hungry
   ☐Wants to sleep, not eat ☐Acts fussy or cries a lot ☐ Other

7. How many wet and dry diapers does your baby have in 24 hours?
   Wet diapers: ☐ Less than 6 ☐ 6 to 8 ☐ 9 or more
   Dirty diapers: ☐ 0 to 1 ☐ 2 to 5 ☐ 6 or more

Tell me how you make and store the bottles:

8. How do you sterilize the bottles and water? ☐ Sterilize incorrectly ☐Sterilize correctly ☐ N/A
9. How do you mix formula? ☐ Mixed incorrectly ☐ Mixed correctly ☐ N/A
10. How do you store the formula or breastmilk? ☐ Stored incorrectly ☐ Stored correctly ☐ N/A
11. How do you warm the bottle? ☐ Warmed incorrectly ☐ Warmed correctly ☐ N/A
12. Is there cereal or other food in the bottle? ☐ No ☐ Yes
13. Is baby put to bed with bottle or is bottle propped? ☐ No ☐ Yes
14. What do you do if he/she doesn't finish the bottle?
    ☐Try to get baby to finish ☐Save it for later ☐None of these
15. Do you feed the baby any other food?
    ☐ None ☐ Fruit ☐ Meats ☐ Cereal ☐ Vegetables ☐ Other: _____
16. Does anyone give the baby honey, Karo syrup, or sugar? ☐ No ☐ Yes
17. If there were one thing you could change about feeding this baby, what would it be?

18. Was mom on WIC during this pregnancy? ☐ No ☐ Yes
    If no, would mom have been eligible with a priority 1 risk? ☐ No ☐ Yes
19. Are you interested in other food resources beyond WIC? ☐ No ☐ Yes

(Infant) 4 – 12 months Baby's Name: _____

Please tell us how feeding is going.

1. What does your baby drink?

☐ Breastmilk at breast:	From	☐ parent		☐someone other than the parent	
☐ Pumped breastmilk:	From	☐parent		☐someone other than the parent	
	From:		☐Bottle	☐Cup with lid	☐Cup
☐ Formula ___oz./day	from:		☐Bottle	☐Cup with lid	☐Cup
☐ Plain water	from:		☐Bottle	☐Cup with lid	☐Cup
☐ 100% fruit juice	from:		☐Bottle	☐Cup with lid	☐Cup
☐ Sugar-sweetened drinks	from:		☐Bottle	☐Cup with lid	☐Cup
☐ Cow or other milk	from:		☐Bottle	☐Cup with lid	☐ Cup
☐ Other_____	from:		☐Bottle	☐Cup with lid	☐ Cup

2. How many times does your baby drink:

Breastmilk at the breast _____ times in 24 hours

Pumped Breastmilk _____ times in 24 hours

Formula _____ times in 24 hours

Other _____ times in 24 hours

Skip to question 8 if you do not bottle-feed your baby.

3. How many ounces does your baby drink from a bottle or cup at each feeding?

Breastmilk	☐ Less than 2	☐ 2 to 3	☐ 4 to 5	☐ 6 to 7	☐ 8 or more
Formula	☐ Less than 2	☐ 2 to 3	☐ 4 to 5	☐ 6 to 7	☐ 8 or more
Cow milk	☐ Less than 2	☐ 2 to 3	☐ 4 to 5	☐ 6 to 7	☐ 8 or more

--- Do you add cereal or other food to the bottle or cup?

Breastmilk ☐ No ☐ Yes Food: _____

Formula ☐ No ☐ Yes Food: _____

Tell me how you make and store formula:

4. How do you mix formula? ☐ Mixed incorrectly ☐ Mixed correctly ☐ N/A

5. How do you store breastmilk or formula?

Breastmilk ☐ Stored incorrectly ☐ Stored correctly ☐ N/A

Formula ☐ Stored incorrectly ☐ Stored correctly ☐ N/A

(Infant) 4 – 12 months Continued

6. How do you warm the bottle? ☐ Warmed incorrectly ☐ Warmed correctly ☐ N/A

7. Is baby put to bed with bottle or is bottle propped? ☐ No ☐ Yes ☐ N/A

8. What foods have you offered your baby?

☐Baby cereal	☐Green vegetables	☐Dry beans or tofu	☐Baby dinners	☐None of these
☐Regular cereal	☐Orange vegetables	☐Meat/Meat sticks	☐Baby desserts	
☐Noodles or rice	☐Other vegetables	☐Chicken or turkey	☐Cookies/Sweets	
☐Bread or tortillas	☐Fruit	☐Eggs	☐Chips/Puffs	

9. What feeding skills does your baby have? ☐ Eats from a spoon ☐ Eats with fingers ☐ None of these

10. How do you know when your baby is hungry?

☐ Facial expression ☐ Makes sounds ☐ Body Movement ☐ Don't know ☐ Other: _____

11. How do you know when your baby is full? ☐ Facial expression ☐ Won't sit still ☐ Fusses ☐ Turns away, closes mouth ☐ Pushes or slaps at food ☐ Don't know ☐ Other _____

12. What do you do if your baby doesn't finish the bottle/cup or food you give him?

☐ Try to get baby to finish ☐ Saves food for later ☐ None of these

13. How do you feel about the amount of food your baby eats: ☐ Too little ☐ Just enough ☐ Too much

14. How often does your baby eat with the family? ☐ Most of the time ☐ Sometimes ☐ Rarely

15. If there was one thing you could change about feeding this baby, what would it be?

16. Are you interested in other food resources beyond WIC? ☐ No ☐ Yes

Child

Child's name _____

1. Describe how your family is physically active together _____

2. How much time does your child spend in active play?

☐ None ☐ 15 minutes ☐ 30 minutes ☐ 1 hour ☐ More than 1 hour

3. How many hours did your child sit and watch TV or videos yesterday?

☐ None ☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ More than 3 hours

4. Tell me how you feel about mealtimes: ☐ Mostly pleasant ☐ Sometimes pleasant ☐ Rarely pleasant

5. How do you feel about how much your child eats? ☐ Eats too little ☐ Eats just enough ☐ Eats too much

6. What are the usual times your child eats during the day? ☐ Morning ☐ Noon ☐ Evening ☐ Snacks___

7. Which of these foods do you offer during the day?

☐ Bread or tortillas	☐ Green vegetables	☐ Eggs
☐ Crackers	☐ Orange or red vegetables	☐ Cheese or yogurt
☐ Cereal	☐ Fish or shellfish	☐ Hot dogs, sausage or coldcuts
☐ Noodles or macaroni	☐ Meat or chicken	☐ Ice cream or pudding
☐ Rice	☐ Dry bean/canned beans	☐ Cookies, cake, pie, or donuts
☐ Fruit	☐ Tofu	☐ Hard or chewy candy or fruit snacks
☐ Potatoes or corn	☐ Peanut butter	☐ Chips, popcorn, or nuts

8. Child drinks from: ☐ Cup ☐ Cup with lid ☐ Baby Bottle

9. What does your child drink?

☐ Breastmilk	Milk Type
☐ Breastmilk not from mother	☐ Whole
☐ Formula _____ (name)	☐ 2%
☐ Milk _____ (oz per day)	☐ 1% or fat free
☐ Water _____ (oz per day)	☐ Lactose reduced
☐ Fruit Juice _____ (oz per day)	☐ Evaporated
☐ Soda, fruit-flavored drinks or sweetened tea	☐ Powdered
☐ Other: _____	☐ Soy milk

10 How often do you or another adult sit and eat with this child?

☐ Most of the time ☐ Sometimes ☐ Rarely

11 Does your child refuse to eat foods or meals? ☐ Most of the time ☐ Sometimes ☐ Rarely

- If your child won't eat, what do you do? ☐ Tries to get child to eat
  ☐ Gives different food
  ☐ Offers reward
  ☐ Saves food for later
  ☐ Other _____
  ☐ N/A

Is your child on a special diet? ☐ N/A ☐ Metabolic ☐ Vegan ☐ Raw foods ☐ Other

12. Would you like information on other food resources beyond WIC? ☐ No ☐ Yes

13. If there were one thing you could change about feeding this child, what would it be?

Maryland WIC Program Nutrition Care Referral Form

Participant Name _____ Date referred_____

WIC Staff Signature _____

	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
Alcohol and Substance Use	◆	◆	◆	◆					
Breastfeeding Complication(s):	◆	◆	◆		◆	◆			
Breastfeeding Infant or Mother at Nutritional Risk	◆	◆	◆		◆	◆			
Breastmilk provided not from mother					◆	◆	◆	◆	◆
Drug Nutrient Interaction	◆	◆	◆	◆	◆	◆	◆	◆	◆
Failure to Thrive (FTT) Diagnosis					◆	◆	◆	◆	◆
Fetal Alcohol Spectrum Disorder (FASD) Diagnosis					◆	◆	◆	◆	◆
Fetal Growth Restriction (FGR) Diagnosis	◆								
Gestational Diabetes (GDM) Diagnosis	◆								
History of Gestational Diabetes	◆	◆	◆	◆					
History of Preeclampsia	◆	◆	◆	◆					
Hyperemesis Gravidarum Diagnosis	◆								
Hypertension/prehypertension	◆	◆	◆	◆				◆	◆
Lead Poisoning in last 12 months: ≥ 5.0 ug/dl women & infants; ≥ 3.5 ug/dl children	◆	◆	◆	◆	◆	◆	◆	◆	◆
Low Birth Weight ≤ 5 lb, 8 oz					◆	◆	◆		
Low Hemoglobin/Hematocrit < 10.0 g or < 30%	◆	◆	◆	◆	◆	◆	◆	◆	◆
Low Maternal Weight Gain + Underweight	◆								
Medical Condition _____	◆	◆	◆	◆	◆	◆	◆	◆	◆
Multi-Fetal Gestation	◆								
Pica (Eating or wanting to eat non-food items)	◆	◆	◆	◆	◆	◆	◆	◆	◆
Post-Bariatric Surgery	◆	◆	◆	◆					
Preterm ≤36 6/7 weeks gestation **Or Early Term ≥**37 0/7 and ≤38 6/7 weeks gestation					◆	◆	◆		
Slowed/Faltering Growth weight loss ≥7% before 2 weeks of age; any weight loss between 2 weeks-6 months					◆	◆	◆		
Small for Gestational Age Diagnosis					◆	◆	◆		
Special Diet: Vegan, Fasting, Metabolic	◆	◆	◆	◆		◆	◆	◆	◆
Underweight Weight/length ≤ 2.3rd percentile					◆	◆	◆		
Underweight Weight/length ≤ 5th percentile								◆	◆

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.03
Effective Date: January 31, 1992
Revised Date: July 7, 2025

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Benefit Waiting List

A. Policy

1. When the local agency is serving its maximum assigned caseload or funds are not available, a priority waiting list of applicants shall be maintained from which the highest priority applicants can be selected to participate in the Program when caseload slots become available. Priority is determined by the nutritional risk status and length of time an applicant has remained on the waiting list.

2. Applicants for Program benefits shall be placed on the priority benefit waiting list in accordance with the following criteria:

   a. Priority I. Pregnant women, breastfeeding women, and infants at nutritional risk as demonstrated by hematological or anthropometric measurements, or other documented nutritionally related medical conditions which demonstrate the need for supplemental foods.

   b. Priority II. Except those infants who qualify for Priority I, infants up to 6 months of age born to women who participated in the Program during pregnancy, or to women who did not participate in the Program while pregnant but whose medical records document that they were at nutritional risk during the pregnancy due to nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions which demonstrated the person's need for supplemental foods.

   c. Priority III. Children and postpartum, non-breastfeeding women at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions which demonstrate the need for supplemental foods.

   d. Priority IV. Pregnant women, breastfeeding women, and infants at nutritional risk because of an inadequate dietary pattern or whose only risk factor is homeless or migrant farmworker.

e. Priority V. Children at nutritional risk because of an inadequate dietary pattern or whose only risk factor is homeless or migrant farmworker.

f. Priority VI. Postpartum, non-breastfeeding women at nutritional risk because of an inadequate dietary pattern or whose only risk factor is homeless or migrant farmworker.

B. Procedure

1. State Agency Responsibility

The state agency shall continuously monitor program operations and expenditures to ensure maximum use of grant funds. Upon determination that there are insufficient funds to continue to provide program benefits to all eligible applicants, the state agency shall initiate procedures to establish a waiting list of eligible applicants. The state agency shall notify the local agencies of the nutritional risk priority levels that will be on the waiting list and the effective date for starting the waiting list.

The state agency shall advise the local agencies of the procedures for:

- placing persons on the benefit waiting list;
- updating client information while on the benefit waiting list;
- transferring a client from benefit waiting list status to active participant status.

2. Local Agency Responsibility

Applicants that visit the local agency during open clinic hours to request Program benefits shall be notified of their placement on the waiting list within 10 days for pregnant, infant, or migrant farmworker applicants and within 20 days for all other applicants. Refer to Policy and Procedure 2.09 *Processing Standards for Applications*.

When applicants are assigned to the waiting list, the certifier shall explain why the applicant is being placed on the waiting list, the priority system, the operation of the waiting list and their right to a fair hearing. The person shall also be advised to contact the local agency should there be changes to the information collected to determine eligibility.

3. Procedures for transferring a wait list person to active participant status:

a. When funds are available to increase caseloads, the state agency shall provide the local agency the priority nutritional risk in which all persons shall be activated and the effective date to be activated.

b. When additional caseload slots become available either through increased funds or from individual participants reaching the end of their certification, the local agency shall contact the individuals on the waiting list. Contacts shall be made in order of priority (highest to lowest) and date (oldest to newest). When contacted, local agency staff will confirm that the individual would still like to participate, confirm demographic information, schedule appointments if necessary and issue benefits as needed. Local agency staff shall also remind participants of their rights and responsibilities and their certification end date.

Attachments:

References: 7 CFR 246.7 e(4)
7 CFR 246.7 f (1)
USDA Memo June 12, 2024, WIC Caseload Management and Cost Saving Strategies

Revisions

April 1999	
10/2012	Changed reference from 7CFR 246.7 e (1) to 7 CFR 246.7f(1)
10/2012	Deleted references to WOW
07/2025	Updated to reflect current procedure in management information system and added 6/12/2024 memo as a reference.

Policy and Procedure Number: 2.04
Effective Date: October 1, 1990
Revised Date: November 18, 2019

SECTION: **ELIGIBILITY AND CERTIFICATION**

SUB**JECT:** **Residency Requirements**

A. Policy

To be certified as eligible for the WIC Program, the applicant must reside in Maryland and live, work, or receive other services within the local agency's service area as defined by the State agency. Length of residency within the service area may not be used as an eligibility requirement. This policy is intended to:

1. Prevent simultaneous participation in more than one local agency;

2. Yield more accurate data on the extent to which each local agency is meeting the program needs of its citizens; and

3. Prevent residents of a local agency from being denied WIC benefits because benefits are being provided to participants who live outside the local agency's service area.

B. Procedure

The local agency shall:

1. Require and document in the management information system that all applicants provide documentation of residency at each certification. Accepted documentation shall include but not be limited to:

    a. Official mail, including mail sent from the Maryland WIC Program, less than 30 days old, sent to the applicant's home address;

    b. Copy of a lease or mortgage for the current address; or

    c. Valid State of Maryland driver's license or identification card with the current address or a change of address card;

    d. A selection of “Other” requires a note in the applicant’s record.

2. Allow the applicant up to 30 days after the certification to provide documentation of residency. If documentation is not provided by the end of the 30-day certification, then the participant **shall** be terminated by the management information system. Participants may have their certification end date restored to the full certification period if documentation is provided before the 30 days has expired. Under no circumstances may a second, subsequent 30-day certification period be used if the applicant fails to provide the required documentation of residence before the temporary certification period expires. Refer to Policy and Procedure 2.10.

3. Use the Confirmation of Residency form (Attachment 2.04A) during extenuating circumstances only. These circumstances may include applicants that are unable to prove residency due to: migrant status, homelessness, natural disaster, or a domestic violence situation.

Attachments:

2.04A Confirmation of Residency

References: 7 CFR 246.7 (c)(2)(i)
COMAR 10.54.01.06

Revisions:

10/01/08	deleted Attachment 2.04A
01/21/09	deleted Attachment 2.04A in B. 12
10/01/10	changed reference from 7 CFR 246.7 (b) (1) to 7 CFR (c) (2) (i)
10/2013	minor wording and format changes, changed WOW to management information system, referenced the participant's rights and responsibilities form will be signed electronically, clarified B.1.a-d
10/2014	added language on short certs
1/2017	clarified can "live, work, or receive other services" in local agency service area; updated references from COMAR 10.54.01.04A to 10.54.01.06 and removed FNS Instruction 803-1 Rev which was incorporated into 7 CFR 246
11/08/2017	Removed reference to electronically signing the R&R as this is in policy 2.12 and no longer applies here.
11/18/2019	Referred to P&P2.10, moved 2.21A to attachment A here as it applies to more than just homeless people; clarified when the attachment may be utilized.

MARYLAND STATE WIC PROGRAM
Confirmation of Residency

I,_____, hereby certify that I am currently
(Applicant/Parent/Guardian)

living in_____
(Print County name or Baltimore City)

and am asking the WIC Program to use the following street address for their records:

_____

_____

_____

_____
Signature

Policy and Procedure Number: 2.05
Effective Date: July 24, 1995
Revised Date: 1/29/2026

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Income Eligibility Requirements

A. Policy

To be eligible to participate in the Maryland WIC Program, applicants must have a gross household income of less than or equal to 185% of the Federal Poverty Level Income Guidelines. Applicants shall provide documentation of all income in the household for the past 28-31 days or the past 12 months, whichever shows a more accurate reflection of household income. Family size shall be determined following Policy and Procedure 2.06. Income guidelines shall be adjusted annually each spring and be implemented concurrently with the Medicaid income guidelines.

An applicant may be considered adjunctively income eligible if:

1. The applicant is participating in one of the following programs:

    a. Temporary Cash Assistance (TCA);
    b. Supplemental Nutrition Assistance Program (SNAP);
    c. Medical Assistance (MA) under Title XIX of the Social Security Act;
    d. Certain other means tested programs as approved by the state WIC office and that:
        i. Routinely require documentation of income
        ii. Have income guidelines at or below those of WIC
        iii. Show the applicant’s period of eligibility in the program

2. Or a member of the applicant's household is:

    a. Receiving TCA, or SNAP; or is
    b. A pregnant woman or an infant currently participating in the MA Program under Title XIX of the Social Security Act;

    The head of household or designee must present documentation showing eligibility/participation in one of these programs and must also be probed to self-declare household income.

Applicants who are determined to be income ineligible must be informed of the decision in writing and are entitled to a fair hearing; refer to Policy and Procedure 2.11. *Notice of Ineligibility or Termination and Right to a Fair Hearing.*

B. Procedure

Income Determination:

Local agencies shall require that all applicants provide proof of adjunct eligibility or proof of all family or household gross income.

1. Determination of Adjunctive Eligibility

Local agency staff shall verify, if applicable as described in A.1 or A.2, an applicant's, or a member of an applicant's household, current participation in MA, TCA or SNAP in the following manner:

a. Medical Assistance:

i. enter the applicant's MA number and last name into the adjunct eligibility Medicaid interface section of the management information system; or

ii. using an established provider number the local agency may confirm eligibility online at www.emdhealthchoice.org; or

iii. using an established provider number the local agency may confirm eligibility via telephoning the Medical Assistance Program Eligibility Verification System (EVS) at: 1.866.710.1447

b. TCA and SNAP (Independence Card):

i. require the applicant to provide proof of recent benefits by showing an ATM or store receipt dated within 30 days or by showing a balance in their online account. Verify the account number being shown is the same account number embossed on the Independence card or;

ii. telephone the Eligibility Verification System (EVS) at: 1.800.997.2222

Verification of MA, TCA, SNAP, or an approved means tested program may also include a notification letter that identifies the respective program and the person's period of eligibility.

Applicants who are determined to be adjunctively eligible shall still be probed for a verbal report of gross household income. If the applicant is unable, or unwilling, to verbally report their income they shall not be restricted from continuing their certification.

2. Determination of Family/Household Gross Income

a. Refer to Attachment 2.05B for the acceptable types of income. Income may consist of but is not limited to:
   i. Wages;
   ii. Social security benefits;
   iii. Child support
   iv. Unemployment benefits
   v. Cash from other persons

b. Local agencies shall consider the family's current rate of income with the last 28-31 consecutive days (most recent income) or the income of the family during the past 12 months (annualized average income) whichever more accurately reflects the family status.

c. Dates of the earning statements shall be consecutive and at least one of the pay periods shall fall within 30 days prior to the appointment. Individuals with regular, consistent earnings, such as those earning a salary, may only need to provide one earning statement to sufficiently document income. If income is variable, then documentation that shows income for the entire month is required.

3. Income Exclusions

a. Income determination for military personnel is the total entitlements found on the Leave and Earnings Statement (LES) **less any funds** received for:

- Basic Allowance for Housing **(BAH),**
- Family Supplemental Subsistence Allowance **(FSSA),**
- Cost of Living Outside of the Continental United States **(OCONUS COLA)**
- Prepayments into the Veteran's Educational Assistance Program **(GI BILL).**
- Hostile Fire/Imminent Danger Pay **(HFIDP)**
- Hardship Duty Pay **(HDP)**
- Overseas Housing Allowance **(OHA)**
- Family Separation Housing **(FSH)**

To determine income eligibility, subtract the deductions from the total entitlements and compare the amount to the income guidelines.

Refer to Attachment 2.05D for a description of possible acronyms used on the LES. Refer to Attachment 2.05E for a summary of

allowances to include or exclude from the LES.

b. The value of in-kind housing and other in-kind benefits;

c. Loans, not including amounts to which the head of household has constant or unlimited access.

d. Payments or benefits provided under certain federal programs or acts listed in federal regulations 7CFR 246.7(d)(2)(iv)(D) are excluded from consideration as income by federal legislative prohibition;

4. Income Clarifications

a. **Newborns of adjunctively eligible households** may be considered eligible without additional income documentation. The medical assistance number of the now postpartum woman may be used for the newborn up to six weeks of age. Households that receive SNAP or Temporary Cash may be used for the newborn without additional documentation

b. **Self-employed persons** are assessed for WIC income eligibility using net income (adjusted gross) rather than gross income. Net income is determined by using the applicant's most recently completed Internal Revenue Service tax return. The adjusted gross income figure indicated on the completed federal tax return should be used. Local agencies may choose to establish limitations on the length of time a federal tax form is accepted unless the restrictions cause undue hardship to the applicant.

c. **Foster Children**: A foster child is considered a family of one. Payments made by the welfare agency or from any other source for the care of the foster child shall be the income of the foster child. Foster children are enrolled in Medical Assistance and by their participation are adjunctively eligible. Follow the procedures to verify current participation in Medical Assistance.

i. **Kinship Foster Care:** Formal Kinship Care is when Department of Social Services (DSS) places the child with a relative. Informal Kinship Care is when a relative or non-relative adult provides care and custody of the child due to family hardship, without involvement of DSS. Legal custody is not required. Children in Kinship care shall be counted as a household of one. Kinship care families may be eligible for SNAP, TCA, and/or Medical Assistance. Payments received by the welfare agency or other source shall be used as income for the child.

d. **Child support payments** are counted as income for both the parent receiving the child support payment and the parent making the child support payment. An infant or child is to be counted in the family size of the parent or caretaker with whom the infant or child resides.

e. **Employees on Strike or Furlough**: Persons from families with adult members placed on temporary strike or furlough shall be assessed based on income during the period of the strike or furlough. Participants certified in this situation shall be issued benefits in monthly increments. Participants shall be instructed to call the WIC office each month to ascertain if additional benefits are necessary or if the work situation has been resolved. Once the participant returns to work their income shall be reassessed to determine if they remain eligible.

f. **Withdrawals from Savings**: Persons using withdrawals from savings as income shall be asked to provide a bank statement showing the amount of funds that have been withdrawn in the last 28-31 days.

g. **Lump Sum Payments as Income**: Lump sum payments may be classified in two ways: 1) as reimbursements for lost assets; or 2) as money that is intended for income. Lump sum payments for reimbursement of lost assets (such as insurance money for damage to a vehicle) shall not be counted as income. Lump sum payments that are intended as income shall be counted as income. Examples of this include but are not limited to bonuses, lottery winnings, workman's compensation, severance pay, etc. Lump sum payments shall be considered in the way that most accurately reflects the economic situation of the household. If income is determined annually then the entire lump sum shall be included; if income is determined based on the current month then the lump sum shall be divided by 12 to reflect a monthly amount.

Income Documentation

5. Documentation of Adjunctive Eligibility

a. Staff shall document which program the applicant/participant is adjunctively participating in under the income screen in the management information system.

b. MA or Independence Card identification numbers shall be entered into the management information system under the adjunct eligibility section.

6. Documentation of Family/Household Income

a. Applicants not adjunctively eligible shall provide documentation substantiating reported income for all members of the economic unit. Such documentation may include but is not limited to: pay stubs, social security statements, earnings or bank statements, child support documentation, unemployment benefit statements, income tax forms, etc. Documentation may be provided in hardcopy or in an electronically secure format.

b. Exceptions to income documentation:

i. Valid **Verification of Certification (VOC) cards** may serve as documentation of income eligibility for in-stream migrant farmworkers and their family members, and participants transferring into Maryland from another state. If a VOC card reflects that an in-stream migrant farmworker's certification period has expired, the VOC card may still serve as income documentation if the VOC card reflects that an income determination was made within the past 12 months.

Transferring families that are non-migrant shall be probed for income changes if the move required a change in employment unless less than 90 days remain in the certification period. Refer to Policy and Procedure 2.13 *Transferring Participants and the Use of VOC Cards.*

ii. **Self-Declaration of Income Statement**

Attachment 2.05C, the *Self-Declaration of Income Statement* may be used if an applicant:

- Is homeless (refer to P&P 2.21 *Homeless Individuals*)
- claims to have no income, or
- is paid in cash.

Clients that claim zero income shall be asked questions to determine who pays the rent and buys the food. After verifying that the applicant has zero income, request that the applicant complete the *Self-Declaration of Income Statement* (Attachment 2.05C).

c. Staff shall document all reported income in the family screen of the management information system.

No Proof and Changes to Income

7. No Proof of Income

Applicants who do not have adequate documentation of household

income shall receive up to 30 days after the certification start date to provide income documentation. Participants may have their certification end date restored to the full certification period if documentation is provided before the 30 days has expired. If documentation is not provided by the end of the 30 days, the participant shall be terminated by the management information system. Under no circumstances may a second, subsequent 30 day certification period be used if the applicant fails to provide the required documentation of income.

8. Income Changes during a Certification Period

a. If a participant, parent or caregiver reports income changes during a certification period which exceed Program income eligibility guidelines, the participants are subject to termination. In such cases, if less than 90 days remain in the certification period, income determination may be postponed until the time of recertification. If greater than 90 days remain in the certification period, income shall be re-evaluated.

b. Participants and family members who were determined income eligible on the basis of adjunctive eligibility, may not be disqualified from the WIC Program during their certification period solely because they no longer participate in the adjunctive programs. Participants shall be asked to provide income documentation and local agency staff shall re-evaluate the family income to determine if they are income eligible.

c. If a participant is found to be income ineligible during an active certification period, all members of the family participating in the WIC Program based on that participant's income eligibility shall be disqualified at that time in accordance with Policy and Procedure 2.11 *Notice of Ineligibility or Termination and the Right to a Fair Hearing*.

Attachment(s)

2.05A	Maryland Income Guidelines
2.05B	Types of Income
2.05C	Self-Declaration of Income Statement
2.05D	Common Military Pay/Allowances Acronyms
2.05E	Chart of Common Military Allowances

References:

1. CFR Part 246.7 (d)
2. COMAR 10.54.01.07
3. WIC Policy Memorandum #2023-6 Streamlining Certification – Documentation Guidance

4. WIC Policy Memorandum #2025-4, 3/27/2025 2025-2026 Income Eligibility Guidelines
5. WIC Policy Memorandum #2011-7, June 8, 2011 Conversion Factors for WIC Income Eligibility Guidelines
6. WIC Policy Memorandum #2010-02, November 2, 2009 Exclusion of Combat Pay from WIC Income Eligibility Determination
7. WIC Final Policy Memorandum #2003-3, March 20, 2003 Family Size and Income Determinations for Military Families
8. WIC Policy Memorandum #99-06, March 30, 1999 Impact of the Children's Health Insurance Program (CHIP) on WIC Adjunct Income Eligibility
9. SFP 93-012, November 4, 1992 WIC Income Eligibility and Natural Disasters
10. Policy Memorandum 92-14, July 9, 1992 Lump Sum Payments as Income
11. FNS Instruction 803-14 April 1, 1988 Eligibility of Special Populations

Revisions:

4/99	Changed AFDC to TCA
8/02	Revised B.9. to include on-base and off-base housing.
4/05	Deleted School Lunch as adjunct eligibility
12/05	B.1.e Added National Flood Insurance Program (NFIP) to list. B.1.g. Added FSSA to the deductions for military LES.
10/06	Revised B. 2. c. New EVS name and telephone number
10/07	Revised B. 1. e. to include loans
11/07	Revised B. 1. g. to include Attachment 2.05D
03/08	Revised B. 1. G Deleted FSSA from reductions in military income and added OCONUS COLA and GI BILL to reductions
04/08	Revised B. 1. g to add FSSA to reductions in military income; added Attachments 2.05E & 2.05F
10/08	Changed Food Stamps to read Supplemental Nutrition Assistance Program (SNAP)
01/09	Changed Supplemental Nutrition Assistance Program (SNAP) to read Food Supplement Program
07/10	Combat pay can be deducted in determining income eligibility B.1.g. and 2.05E, Reduced short cert from 60 days to 30 days in B.1.h.
10/10	Changed reference from 7 CFR 246.7 (c.) to 246.7 (d)
10/11	Included DEIP and DESP as income exclusions in B.1.g.Changed examples of income in B.1.a
10/12	Added B.4. Income Changes during a Certification Period
10/13	Added language to clarify B.1.h, and B.1.f, Changed WOW to management information system, removed pharmacy assistance program and weatherization program as adjunct options, included "other means tested" programs as possible adjunct choices, added VOC cards as a means to prove income. Deleted attachment 2.05F. Moved footnote on the medical assistance family planning program to page 5.
04/14	Updated Attachment 2.05A with the new 2014 Income Guidelines
04/15	Updated Attachment 2.05A with the new 2015 Income Guidelines
04/16	Updated Attachment 2.05A with the new 2016 Income Guidelines; corrected format and outline numbering.

04/17 Updated Attachment 2.05A with the new 2017 Income Guidelines

11/17 Clarified that a family member participating in the SNAP program income qualifies the whole family.

05/18 Updated Attachment 2.05A with the new 2018 Income Guidelines

03/19 Reorganized to more closely match federal regulations; added income clarification section including applicants on strike/furlough and lump sum payments; updated military deductions; added procedure for applicants paid in cash; updated references; changed attachment C to a self-declaration of income form; updated attachments D and E.

05/19 Updated Attachment 2.05A with the new 2019 Income Guidelines.

06/20 Clarified Title XIX of the Social Security Act funding required for medical assistance to be used as adjunct eligibility, added Medicaid interface option to confirmation options, updated attachment 2.05A with new income guidelines.

04/21 Update Attachments 2.05A English and Spanish with the 2021 Income Eligibility Guidelines.

05/22 Update attachments 2.05A English and Spanish with the 2022 Income Eligibility Guidelines.

04/23 Update attachments 2.05A with the 2023 Income Eligibility Guidelines.

06/24 Implemented guidance from WIC policy memo 2023-6. Updated attachment A with 2024-2025 income guidelines.

12/24 Removed attestation portion of 2.05C and made updates to B.6.b.ii to remove any reference to the attestation portion.

03/25 Update attachment 2.05A with 2025-2026 Income Eligibility Guidelines and updated references accordingly.

01/26 Added guidance on Kinship Care B.4.c.i.

Income Eligibility Guidelines for
Maryland WIC Program Benefits

Effective April 4, 2025

185 Percent of the Federal Poverty Income Guidelines

Family Size	Annual Income	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	$28,953	$2,413	$1,207	$1,114	$557
2	$39,128	$3,261	$1,631	$1,505	$753
3	$49,303	$4,109	$2,055	$1,897	$949
4	$59,478	$4,957	$2,479	$2,288	$1,144
5	$69,653	$5,805	$2,903	$2,679	$1,340
6	$79,828	$6,653	$3,327	$3,071	$1,536
7	$90,003	$7,501	$3,751	$3,462	$1,731
8	$100,178	$8,349	$4,175	$3,853	$1,927
For each additional family member add	+$10,175	+$848	+$424	+$392	+$196

Tabla de Ingresos para Determinar Elegibilidad
en los Beneficios del Programa WIC

Efectivo a 4 de abril de 2025

El Porcentaje de acuerdo a la Guía Federal de Ingresos
de Pobreza es 185

Grupo Familiar	Ingreso Anual	Ingreso Mensual	Dos veces al mes	Ingreso Quincenal	Ingreso Semanal
1	$28,953	$2413	$1,207	$1,114	$557
2	$39,128	$3,261	$1,631	$1,505	$753
3	$49,303	$4,109	$2,055	$1,897	$949
4	$59,478	$4,957	$2,479	$2,288	$1,144
5	$69,653	$5,805	$2,903	$2,679	$1,340
6	$79,828	$6,653	$3,327	$3,071	$1,536
7	$90,003	$7,501	$3,751	$3,462	$1,731
8	$100,178	$8,349	$4,175	$3,853	$1,927
Para cada miembro de la familia adicione	+$10,175	+$848	+$424	+$392	+$196

TYPES OF INCOME

For the purpose of the WIC Program, "income" means gross cash income before deductions. Other sources of income include:

a) Monetary compensation for services, including wages, salary, commissions, or fees;
b) Net income from farm and non-farm self-employment;
c) Social Security benefits;
d) Dividends or interest on savings and bonds, income from estates or trust or net rental income;
e) Public assistance or welfare payments;
f) Unemployment compensation;
g) Government civilian employee or military retirement pensions or veteran's payments;
h) Private pensions or annuities;
i) Alimony or child support payments;
j) Regular contributions from persons not living in the household;
k) Net royalties;
l) Other cash income which is defined as, but not limited to, cash amounts received or withdrawn from any source including savings, investments, trust accounts, grants and scholarships except Pell Grants, State Student Incentive Grants and National Direct Student Loans and others listed in 7CFR 246.7(d)(2)(iv)(12) and other resources which are readily available to the applicant or family

Maryland WIC Program
Self-Declaration of Income Statement

Head of Household Name: _____
Last First Middle Initial

Address: _____

City/Zip Code: _____

Telephone: _____ Family Size: _____

I, _____, am unable to provide documentation of my income because I:

- ☐ Work for Cash
- ☐ Have No Income/am Homeless
- ☐ Other (system note required) _____

I certify that my hourly, daily, weekly, monthly, annual income is: _____.
(circle one)

Head of Household Signature Date

This institution is an equal opportunity provider.

Programa WIC de Maryland
Autodeclaración de Ingresos

Nombre del/la cabeza de familia: _____
Apellido Nombre Inicial segundo nombre

Dirección: _____

Ciudad y código postal: _____

Teléfono: _____ Cantidad de miembros de la familia: _____

Yo, _____ no puedo entregar documentación de mis ingresos, porque:

- ☐ Trabajo por dinero en efectivo
- ☐ No tengo ingresos/no tengo vivienda
- ☐ Otro (se requiere nota del sistema)

Certifico que mi ingreso por hora, diario, semanal, mensual, anual es: _____
(marque con un círculo)

_____
Firma del/la cabeza de familia Fecha

Esta institución es un proveedor que ofrece igualdad de oportunidades.

COMMON MILITARY PAYS/ALLOWANCES SEEN WHEN DETERMINING WIC INCOME ELIGIBILITY

This list has been developed to provide WIC staff with a better understanding of the common acronyms used on military Leave and Earning Statements (LES) which are used when determining income eligibility for WIC clients. More information regarding military pay can be found at www.military.com\benefits

BASIC ALLOWANCES (BAS)

BAS is intended to provide meals for the service member; its level is linked to the price of food.

BASIC ALLOWANCE FOR HOUSING (BAH)

BAH is a housing allowance intended to provide improved, quality housing for military families living off-base. **BAH is not counted as income in determining eligibility.**

CAREER ENLISTED FLYER INCENTIVE PAY (CEFIP)

A Navy or Air Force service member may be eligible to receive CEFIP if he/she is considered "Career Enlisted Flyer" by the military. If this is the case, the service member may be eligible for continuous, monthly incentive pay.

CAREER SEA PAY

Active Duty Enlisted Service Members or Commissioned Officers on sea duty are entitled to Career Sea Pay up to $750 a month.

CLOTHING ALLOWANCE

A clothing allowance may be issued to help a member pay for his/her uniforms. This is an annual pay given primarily to enlisted members. While it is counted as income it may be divided out to a monthly amount.

COMBAT PAY - HARDSHIP DUTY PAY (HDP)

Hardship Duty Pay is a special pay used as additional compensation for service members who are either serving in locations where living conditions create undue hardship or are performing designated hardship missions. **HDP is not counted as income in determining eligibility.**

COMBAT PAY - HOSTILE FIRE/IMMINENT DANGER PAY (HFIDP)

A service member may be paid special pay at the rate of $225 for any month in which he/she was entitled to basic pay. **HFIDP is not counted as income in determining eligibility.**

COST OF LIVING ALLOWANCE (CONUS COLA) & (OCONUS COLA)

COLA is a cash allowance intended to enable an equitable standard of living in areas where the cost of living is unusually high in the continental U.S. If the cost of living in the area where the member is assigned is the same or lower than the average in the U.S.,

COLA is not authorized. COLA provided to military personnel residing in the continental U.S. (CONUS) is different from Overseas Continental United States (OCONUS) COLA which is provided to military personnel residing in designated overseas high-cost living areas. **CONUS COLA is counted as income in determining WIC eligibility. OCONUS COLA is not counted as income and should be deducted when determining WIC eligibility.**

FAMILY SEPARATION ALLOWANCE (FSA)

This pay is for service members with dependents that meet the eligibility criteria to receive an additional $250 per month. Service members will receive FSA pay from the day of departure from the home station and will end the day prior to their return arrival at the home station.

FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE (FSSA)

This allowance, based on household size and income, may not exceed $500 per month. It is provided to low-income members of the Armed Forces to bring a household's income up to 130% of the Federal Poverty Standard**. FSSA is not counted as income in determining eligibility.**

FOREIGN LANGUAGE PROFICIENCY PAY or Bonus (FLPP or FLPB)

An officer or enlisted member of the Armed Forces who has been certified as proficient in a foreign language or dialect may be paid Foreign Language Proficiency Pay or Bonus (FLPP or FLPB).

HAZARDOUS DUTY INCENTIVE PAY (HDIP)

Service members who perform hazardous duties such as flying duty as non-crew members, parachute jumping, demolition of explosives, handle toxic fuels, flight deck duty, etc. may be eligible for HDIP on a monthly basis.

MILITARY SURVIVOR BENEFITS PLAN (SBP)

The Uniformed Services Survivor Benefit Plan (SBP) was created by Congress in 1972. SBP is the sole means by which survivors can receive a portion of military retired pay. Without it –retired pay stops on the date of death of the retiree. The dollar amount of the survivor's benefits pay depends on the coverage elected by the service member upon retirement.

OVERSEAS EXTENSION PAY

Select service members who extend an overseas tour of duty may be eligible for this entitlement. It may be paid monthly or in one annual lump sum. While it is counted as income, if paid in one annual sum it may be divided out to a monthly amount for income determination.

OVERSEAS HOUSING ALLOWANCE (OHA)

OHA is a monthly allowance paid to services members stationed overseas and authorized to live in private housing to defray the cost of rent and utilities. **OHA is not counted as income in determining eligibility.**

SELECTIVE RETENTION BONUS (SRB)

SRB may be paid to an enlisted member who meets certain conditions. Retention bonus amounts may vary depending on the member's prior years of service. The member receives 50% of the bonus up front and the remaining balance is paid in annual installments over the life of the reenlistment contract. SRB is counted as income but may be divided out to a monthly amount for income determination.

SPECIAL DUTY ASSIGNMENT PAY (SDAP)

All enlisted active service members who perform duties designated as extremely difficult or requiring a high level of responsibility in a military skill may be paid SDAP. Amounts paid monthly based on duties range from $75 to $450.

VETERAN'S EDUCATIONAL ASSISTANCE PROGRAM OR THE GI BILL

Service members pay into an education program, the Veteran's Educational Assistance Program or the GI Bill, and the military matches the amount. When these individuals subsequently attend school/college, they receive a monthly check for school expenses.

Payments taken out upfront from a military person's salary that are placed into the education assistance program are not counted as income. However, there is no Federal law which permits the amount of the monthly checks that are subsequently received by the individual for school expenses from being excluded from income in determining financial eligibility.

CHART OF COMMON MILITARY PAYS/ALLOWANCES SEEN WHEN DETERMINING WIC INCOME ELIGIBILITY

Cannot be Deducted from Total Entitlements	Can be Deducted from Total Entitlements
Basic Allowances (BAS)	Basic Allowance for Housing (BAH)
Overseas Extension Pay	Overseas Housing Allowance (OHA)
Hazardous Duty Incentive Pay (HDIP)	Family Separation Housing (FSH)
Career Enlisted Flyer Incentive Pay (CEFIP)	Combat Pay: • Hostile Fire/Imminent Danger Pay (HFP) • Hardship Duty Pay (HDP)
Career Sea Pay	
Clothing Allowance	
Cost of Living Allowance (COLA or CONUS COLA)	Overseas Continental United States Cost of Living Allowance (OCONUS COLA)
Family Separation Allowance (FSA)	Family Subsistence Supplemental Allowance (FSSA)
Foreign Language Proficiency Pay or Bonus (FLPP or FLPB)	
Military Survivor Benefits Plan (SBP)	
Payments received from the Veteran's Educational Assistance Program (GI BILL)	Payments into the Veteran's Educational Assistance Program (GI BILL)
Selective Retention Bonus (SRB)	
Special Duty Assignment Pay (SDAP)	

Policy and Procedure 2.05F
has been removed.

October 2008

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.06
Effective Date: October 1, 2003
Revised Date: May 20, 2020

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Family Size Determination

A. Policy

To be certified as eligible for the WIC Program, a family shall have a gross income which is less than or equal to 185% of the Federal Poverty Income Guidelines. A family is defined as "a group of related or nonrelated individuals, who are not residents of an institution, but who are living together as one economic unit." For the purposes of WIC, the terms “family,” “household,” and “economic unit” may all be used interchangeably.

An economic unit must have its own source of income that is adequate to sustain the unit. More than one economic unit may reside under the same roof. Local agency staff shall establish whether or not more than one economic unit lives under one roof through appropriate questioning to make a reasonable determination as to whether or not there is general economic independence of the units, i.e. that financial resources and support are retained independently.

B. Procedure

At each certification, local agencies shall ask the applicant/caregiver or designee the number of persons residing in the household and document the number in the management information system.

The following questions may need to be addressed to determine if an applicant is an economic unit of one, or is part of a larger economic unit:

- Is the applicant responsible for all of their own expenses and bills?
- What type of income do they receive?
- Who provides food, clothing, housing, medical?
- Is the applicant primarily independent with minimal in-kind goods and services or primarily reliant on others?

In determining family size, the following criteria shall apply:

1. If the pregnant woman’s family income exceeds the Maryland Income Guidelines for the size of her family, her eligibility should be reviewed using a family size increased by one or by the number of expected multiple births. In the case of multiple births, the pregnant woman must

provide documentation of the number of multiple births from her doctor if her income eligibility is assessed using a family size increased by the number of expected multiple births.

i. Local agencies shall not be required to implement this policy in those individual cases where increasing a pregnant woman's family size by the number of the unborn child or children conflicts with cultural, personal, or religious beliefs of the woman.

ii. In situations where the family size has been increased for a pregnant woman, the same increased family size shall also be used for any of her categorically eligible family members.

2. A pregnant minor still residing with her parent(s) may be counted as part of their household. Local agency staff should attempt to determine, as with all applicants, the degree of economic independence and the degree of support the minor provides for herself. If the minor is primarily responsible for her own needs and receives limited support from others, she may be considered her own economic unit.

3. An infant or child is to be counted in the family size of the parent or caretaker with whom the infant or child resides or who has majority custody. In cases of equally split custody, Local Agencies should probe further into the living situation and may use their discretion to determine in which household the child should be counted.

4. If an infant, child, or other family member resides in a school or institution and the parent or caretaker continues to provide the economic support, that person is counted in the family size of that parent or caretaker. Otherwise the person is not to be counted.

5. If an infant or child is a foster child living with a family but remains the legal responsibility of a welfare or other agency, the foster child shall be a family of one. Payments made by the agency or from any other source for the care of that foster child shall be the income of the foster child only.

6. If a family has an adopted child or any other person for whom a family member has accepted legal responsibility, that person is counted in the family size for that family if the person lives with the family or is in a school or institution paid for by the family.

7. If a family is providing shelter to a WIC applicant who is homeless, that family would not be counted in the family size of the applicant (Refer to P & P 2.21 B.1. c.).

8. Individuals residing in one unit to share living costs, but not co-mingling

assets may be counted as separate economic units. Example: A pregnant woman who shares an apartment with her sister to afford rent and utilities yet retains her own proportionate share of household, living, and personal expenses may be counted as 2 economic units. Local agency staff may need to ask probing questions to make this determination.

Attachments:

References:

1. CFR Part 246.7 (d)
2. COMAR 10.54.01.07B
3. FNS Instruction 803-3
4. Policy Memo 2013-3 Income Eligibility Guidance section IV(D)

Revisions:

01/2009	Renamed 2.05A to 2.06
10/2012	Minor language changes/clarification in Policy A.
10/2013	Changed WOW to management information system; clarified B.1.
5/20/2020	Added probing question suggestions to policy; added paragraph regarding pregnant minors and clarified joint custody and multiple economic units in one dwelling

Policy and Procedure 2.07 has been renamed as Policy and Procedure 2.33

October 2007

Policy and Procedure 2.08 has been renamed as Policy and Procedure 2.31

October 2007

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.09
Effective Date: March 18, 1992
Revised Date: June 6, 2025

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Processing Standards for Applications**

A. Policy

The local agency shall process applications and notify applicants of their eligibility or ineligibility within the following time frames:

a. Pregnant women, infants, migrant farm workers and their family members shall be notified of their status in the program within 10 calendar days of their first request in person, at a WIC site, to participate. The state agency may provide an extension of the notification period to a maximum of 15 calendar days for those local agencies submitting a written request, including justification, of the need for an extension.

b. All other applicants shall be notified within 20 calendar days of their first request in person to participate.

c. Local agencies shall issue food instruments to the applicant at the time of notification that they are eligible for the program. The food instrument shall provide benefits for the current month or the remaining portion thereof and shall be redeemable immediately upon receipt by the participant. (Refer to Policy and Procedure 4.10 and 4.39)

d. If the applicant is eligible for the program but must be placed on a waiting list, the applicant shall be advised as above (a or b as appropriate). The local agency shall advise the applicant of how they will be notified when space is available on the program. (Refer to Policy & Procedure 2.03)

e. If the applicant is ineligible, they shall be advised in writing within 10 or the 20 calendar days (as described in a. or b. above) of their status, the reason for the ineligibility, and their right to a fair hearing. (Refer to Policy & Procedure 2.11) Provide the applicant with the name, address and telephone number of emergency food assistance programs and other referral resources in the area.

B. Procedure

Local agencies shall abide by the above policy.

Reference(s):

1. 7CFR 246.7 (f)(2)
2. COMAR 10.54.01.12 E

Revisions:

10/2010	Changed reference from 7CFR 246.7 (e)(2)(iii) to 246. 7 (f) (2).
10/2011	Added reference to Policy and Procedure 2.11
10/2012	Format corrections in A.e
06/2025	Format corrections, ensure accuracy with updated streamlining of certifications, correct COMAR from 10.54.01.06 to 10.54.01.12

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.10
Effective Date: October 1, 1990
Revised Date: July 7, 2025

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Certification, Mid-Certification, and Shortened Certification Periods**

A. Policy

1. Program benefits shall be based on certification periods established in the management information system in accordance with the following time frames:

    a. Pregnant women shall be certified for the duration of their pregnancy and up to the last day of the month in which the infant turns six weeks old or the pregnancy ends (miscarriage, stillbirth, etc.).

    b. Postpartum women shall be certified up to the last day of the sixth month after the baby is born or the pregnancy ends (miscarriage, stillbirth, etc.).

    c. Breastfeeding women shall be certified up to the last day of the month of the infant's first birthday as long as they are breastfeeding.

    d. Infants certified before six months of age will be certified until the last day of the month in which the infant turns one year old.

    e. Infants certified from age six months to age one will be certified up to the last day of the sixth month from the date of the certification.

    f. Children certified at age one year or older will be certified up to the last day of the month one year from the date of the certification or the month in which the child turns five years of age.

2. In the event of the state agency reaching its maximum caseload or a funding shortfall, the state agency may implement a waitlist and/or mid-certification benefit discontinuation following policy and procedure 2.03. If a waitlist is implemented the state agency may also require certification periods of approximately every six months in accordance with 7 CFR 246.7(g)

3. A participant's certification period may be extended by not more than 30 days on a case-by-case basis if categorically eligible. Reasons for extending a certification period may include but are not limited to: insufficient appointment times to conduct a certification or to sync family members' certification periods.

4. A participant's certification period may be shortened for reasons that may include but are not limited to termination or voluntary withdrawal from the program. For applicants that have at least one qualifying nutrition risk and are able to present at least two out of the three required eligibility documents during a certification appointment (identity, residency, and income), the following timeframes apply:

   a. Failure to provide documentation of identity shall result in a shortened certification of 30 days with no subsequent certification allowed until documentation of identity is presented. Refer to P&P 2.23.

   b. Failure to provide documentation of residency shall result in a shortened certification of 30 days with no subsequent certification allowed until documentation of residency is presented. Refer to P&P 2.04.

   c. Failure to provide documentation of income shall result in a shortened certification of 30 days with no subsequent certification allowed until documentation of income is presented. Refer to P&P 2.05.

   d. Failure to provide documentation of proof of pregnancy for a pregnant woman shall result in a shortened certification of 60 days with subsequent certifications allowed until the participant is visibly pregnant. Refer to P&P 2.24.

   e. Failure to provide missing documentation prior to the expiration of a shortened certification will result in the certification ending and the applicant must reapply as a new applicant.

5. Certification periods for eligible infants, children, and breastfeeding women that last longer than six months shall have the required nutrition and health assessment approximately mid-way through the certification, also known as a mid-certification visit.

B. Procedure

1. Certification periods are established in the management information system with the start date based on the date of eligibility determination. The length of the certification is based on applicant category and age as noted in A.1.

A pregnant woman's length of certification shall be determined by her expected due date (EDD) as self-reported or calculated by her last menstrual date (LMP). Both the EDD and LMP shall be documented in the management information system.

If a pregnant woman has a loss of pregnancy during an active certification period, her certification period shall terminate on the last day of the month in which the loss occurred. She should be encouraged to recertify as a postpartum woman.

2. Certification periods that are extended by not more than 30 days shall be documented in the management information system. Only one 30-day extension is allowed per certification period. Circumstances that this may apply to include but are not limited to; insufficient appointment times to conduct a certification or to synchronize family members' certification periods.

3. Certification periods that are shortened shall be documented in the management information system. In cases of a shortened certification due to lack of necessary documentation, the participant shall be given an opportunity to provide the necessary documentation prior to the end of the shortened certification period.

   If the missing documentation is provided prior to the expiration of the shortened certification, and the participant remains eligible, then the length of the certification is based on applicant category and age as noted in A.1.

   If the missing documentation is not provided before the shortened certification expires then a new certification process shall be initiated.

   If a participant receives a shortened certification for identity, residency, or income, and that is followed by either a successfully completed certification or a minimum of 6 months passing, the participant is eligible for a second subsequent shortened certification for the same no-proof reason.

4. For certification periods longer than six months, the required mid-certification health and nutrition assessment (MCV) shall occur according to the following timeframes:

Infants certified between 0-5 months of age	● MCV ideally between 4-7 months of age
Infants certified between 6-11 months of age	● MCV not required

Children certified between 1-4 years of age	● MCV approximately halfway through the certification
Pregnant Women	● MCV not required
Breastfeeding Women	● MCV approximately halfway through the certification ideally in conjunction with the infant MCV between 4-7 months.
Postpartum Women	● MCV not required

Attachment(s):

2.10A Short Certification Letter

Reference(s):

1. 7CFR 246.7 (g)(1)(i-v)
2. 7CFR 246.11 (a)(2)
3. 7CFR 246.11 (e)(3)
4. WIC Policy Memorandum #2023-6: Streamlining Certification – Documentation Guidance
5. USDA Guidance for Providing Quality WIC Nutrition Services during extended Certification periods (August 29, 2011)
6. COMAR 10.54.01.13

Revisions:

12/2006	Extended cert periods to the end of the month
10/2010	Changed reference from 7CFR 246.7 (f) to 246.7(g)
10/2012	Changed reference from 7CFR 246.7 (g) to 7 CFR 246.7 (g)(1)(iii-v), and changed certification periods 1. d, e, and f to correspond
10/2013	Updated references to 7CFR 246.7 (g)(1)(i-v) and COMAR 10.54.01.13
8/22/2018	Merged previous P&P2.38 on extended certs into this policy, defined when MCV appointments should occur, added statements on short certs
2/2023	Addition of short certification letter as attachment A.
09/2023	Added guidance from memo 2023-6 regarding short certifications
07/2025	Added that certifications may be reduced to six months in the event of a waitlist; added reference to policy 2.03 Benefit Waitlist; clarified that the expiration of a shortened certification results in a new application.

Maryland WIC Program

Short Certification Notice

<DATE OF CERTIFICATION>

<HOH NAME>
< HOH ADDRESS>
<CITY>, MD <ZIP>

Re: Notification of Short Certification

Dear <HOH NAME>:

Because we do not have all the information we need to complete a certification, we have temporarily certified **<PARTICIPANT NAME>** for a short, <ONE/TWO>-month certification period that will end <TERMINATION DAY AND DATE>.

Additional information needed to complete the certification includes:

- □ Proof of pregnancy
- □ Proof of identity
- □ Proof of residency
- □ Proof of income

If the needed information is provided by <TERMINATION DATE>, **<PARTICIPANT NAME>** may remain eligible to continue receiving WIC benefits. If the needed information is not provided by the above date or, based on the information provided, you are determined not to be eligible, then you will be terminated from the Program.

If you have any questions, please call the <LOCAL AGENCY NAME> at <LOCAL AGENCY NUMBER>.

Sincerely,

_____
<LOCAL AGENCY NAME>
<LOCAL AGENCY ADDRESS>

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.

El Programa WIC de Maryland

Aviso de certificación por un tiempo corto

<DATE OF CERTIFICATION>

<HOH NAME>
< HOH ADDRESS>
<CITY>, MD <ZIP>

Tema: Aviso de certificación por un tiempo corto

Estimado/a <HOH NAME>:

Debido a que no tenemos toda la información que necesitamos para completar la certificación, hemos certificado a **<PARTICIPANT NAME>** por un periodo corto de <ONE/TWO> mes(es) que terminará el <TERMINATION DAY AND DATE>.

La información adicional necesaria para completar la certificación incluye:

- □ Prueba de embarazo
- □ Prueba de identificación
- □ Prueba de dirección
- □ Prueba de ingreso

Si provee la información requerida antes del <TERMINATION DATE>, **<PARTICIPANT NAME>** puede ser eligible para seguir recibiendo los beneficios de WIC. Si la información requerida no se provee antes de la fecha de arriba, o según la información dada, se determina que usted no es eligible, su participación en el Programa WIC terminará.

Si tiene alguna pregunta, por favor llame a la agencia de <LOCAL AGENCY NAME> al <LOCAL AGENCY NUMBER>.

Atentamente,

_____
<LOCAL AGENCY NAME>
<LOCAL AGENCY ADDRESS>

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: https://www.fns.usda.gov/sites/default/files/resource-files/usda-program-discrimination-complaint-form-spanish.pdf, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) correo:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; o
(2) fax:
(833) 256-1665 o (202) 690-7442; o
(3) correo electrónico:
program.intake@usda.gov

Esta entidad es un proveedor que brinda igualdad de oportunidades.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.11
Effective Date: October 1, 1995
Revised Date: February 27, 2023

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Notice of Ineligibility or Termination and the Right to a Fair Hearing

A. Policy

The WIC Program regulations have established time frames to inform applicants and participants of their ineligibility or eligibility as written in P&P 2.09 Processing Standards for Applications.

A person found ineligible for the Program shall be advised in writing at the time of determination using the Ineligibility Notice Attachment 2.11A. The written notice shall include:

a. The reason(s) for the ineligibility;

b. The name and telephone number of the person to contact about their ineligibility; and

c. The due date to request a fair hearing.

Applicants have the right to request a fair hearing within sixty (60) days of the determination of ineligibility. Requests for fair hearings may be either in writing or verbal, stating the desire to present their case to a higher authority. Completed requests for fair hearings shall be faxed to the Office of Administrative Hearings using the MDH Transmittal Form 2.11C.

B. Procedures

New Applicants

1. When a new applicant is found ineligible for the Program, Local Agency staff shall print and complete the Ineligibility Notice from the print documents section of the management information system.

2. Local Agency staff shall give a completed copy of the Ineligibility Notice to the applicant/caregiver and inform them of:

   a. the reason for the ineligibility;
   b. the right to request a fair hearing;
   c. the due date to request a fair hearing; and
   d. the name and telephone number of the person to contact regarding the determination.

   If an applicant/caregiver refuses to take the Ineligibility Notice, the notice shall be mailed to the head of household name and address on file.

3. When an Ineligibility Notice is given to a participant, Local Agency staff shall document in the Miscellaneous/Communications section that the Ineligibility Notice was given and the reason for the ineligibility.

4. Local agencies shall maintain a file containing copies of the completed Ineligibility Notice as well as the income and/or residency documentation provided by the applicant/caregiver that was used to determine that the applicant was ineligible. The file shall be maintained following the record retention schedule in P&P 6.00.

Existing Participants

1. A participant found ineligible for the Program at any time during the certification period shall be advised in writing of the reason(s) for ineligibility, the termination date, and of the right to a fair hearing.

   Reasons for ineligibility during a certification period and the termination notice timeframes are:

   <u>15-day Notification of Termination</u>:
   a. No longer categorically eligible;
   b. Changes to income or family size making them income ineligible per P&P 2.05;
   c. No longer have a required nutritional need; or
   d. Sanctions for Program Abuse per P&P 4.23.

   Clients that are terminated with a 15-day notification due to *categorical ineligibility* may not receive any food benefits. Any remaining or future food benefits already issued shall be voided.

   Clients terminated with a 15-day notification for reasons b-d above may receive food benefits if they were eligible for them until the date of termination. Any future food benefits already issued shall be voided.

2. Local Agency staff shall print and complete the Ineligibility Notice from the print documents section of the management information system.

3. When an Ineligibility Notice is given to a participant, Local Agency staff shall document in the Miscellaneous/Communications section that the Ineligibility Notice was given and the reason for the ineligibility.

4. A copy of the completed Ineligibility Notice shall be handed to, or mailed to, the head of household.

5. Local agencies shall maintain a file containing copies of the completed Ineligibility Notice as well as the income and/or residency documentation provided by the applicant/caregiver that was used to determine that the applicant was ineligible. The file shall be maintained following the record retention schedule in P&P 6.00.

6. A written notice of termination is not required when terminating for failure to pick up food benefits for two consecutive issue months. The participant is advised of this policy at certification and signs the Rights and Responsibilities (Attachment 2.12A) acknowledging the policy.

Request for a Fair Hearing:

1. When a fair hearing is requested either verbally or in writing, Local Agency staff or the participant shall complete attachment 2.11B Request for a Fair Hearing, which advises the applicant/caregiver that notification of a hearing date will be provided by the Office of Administrative Hearings.

2. Upon receipt of the Request for a Fair Hearing, Local Agency staff shall transmit the request to the Office of Administrative Hearings using the MDH Transmittal Form Attachment 2.11C. The transmittal form can also be found in the Forms section of the management information system.

3. Participants who request a fair hearing to appeal the termination of benefits before the date entered on the Ineligibility Notice shall continue to receive WIC benefits until the Hearing officer reaches a decision or the certification period expires, whichever occurs first. This does not apply to applicants denied benefits at initial certification, participants whose certification period has expired or participants who become categorically ineligible for benefits.

Attachments:
2.11A Ineligibility Notice
2.11B Request for a Fair Hearing
2.11C Transmittal for MDH Appeals

References:

1. CFR 246.7 (h)
2. CFR 246.7 (j)
3. COMAR 10.54.01.06 D

Revisions:

04/1999	Changed AFDC to TCA
06/1999	New address on Attachment 2.11B
10/2003	WICWINS references
10/2007	New A. 5. Reassess income when informed during a certification period. New A.8. Categorically ineligible
04/2008	Used the name “Ineligibility Notice” when referring to Attachment 2.11A
10/2008	Revised A.3.c. to indicate the Local Agency’s role in transmitting the appeal on behalf of the Applicant/Participant. Added new Transmittal for DHMH Appeals form, Attachment 2.11C
01/2009	Changed Food Stamp to read Food Supplement Program in A.6.
10/2010	Changed “in communication notes” to “Alerts.” Changed reference from 7CFR246.7 (l) to 246.7 (j).
10/2011	Deleted obsolete reference to WOW in A.7 Changed reference from 7CFR 246.7(j) to 7CFR 246.7(h)
10/2013	Revised wording to reflect changes due to revised/electronic format of the Participant Rights and Responsibilities.
06/17/2017	Changed reference from food instruments to food benefits in B.1. Updated 2.11A to remove reference to checks.
10/01/2018	Rewrote policy section to remove duplicative parts that are already in 2.09 and moved lines that were really procedure to further down in the document. In procedure section separated out new applicants, existing applicants, and procedure for fair hearing requests; specified that ineligibility notices must be given in writing even if it must be mailed; updated references. Removed paragraphs regarding income determination mid-cert and adj. elig and moved them to 2.05. Updated attachments: A is now both the ineligibility notice and a termination notice; B removed participant from the name; C corrected name for MDH.
08/31/2021	Clarified status of food benefits for clients terminated with a 15-day notification; updated process for documenting in the MIS; indicated length of time documentation shall be kept.
02/27/2023	Updated non-discrimination statement on attachment A.

Ineligibility/Termination Notice

<Today's Date>

<HoH Name>
<Address>
<City, State Zip>
WIC Applicant/Participant <Participant Name> (<Participant ID>):

Based on the information we have, it has been determined that:

☐ you are not eligible to participate in the WIC Program at this time.

☐ your certification with the WIC Program will be terminated on <TERMINATION DATE>. If you ask for a Fair Hearing before <TERMINATION DATE>, you will still receive food benefits until the court reaches a decision or your certification period expires, whichever occurs first. This does not apply if your certification period has already expired or you have been determined to be categorically ineligible for the program.

This determination has been made based on the following reason(s):

- ☐ You are not categorically eligible.
- ☐ Your family income is too high for the receipt of WIC benefits.
- ☐ You do not live in the Agency's service area.
- ☐ You are not considered by the Agency's certifying staff to have a required nutritional need.
- ☐ All current WIC funding is being used, so you are being placed on the waiting list for participation.
- ☐ Other: _____

If you think this is not correct, please call <LA PHONE NUMBER> to talk about it.

You have the right to a fair hearing on this denial of WIC benefits. If you think you should receive WIC benefits and you want to appeal this denial of WIC eligibility, you may request a hearing on the denial by filling in the Request for Fair Hearing, which has been included with this letter, and giving it to a WIC staff person or mailing it to the address below by <TERMINATION DATE + 45 DAYS>.

<Local Agency Name>
<Address>
<City, State Zip>

Attn: <Local Agency Point of Contact>

You may also telephone your request for a Fair Hearing by calling the <LOCAL AGENCY NAME> WIC Program by <TERMINATION DATE + 45 DAYS>. The WIC Office will transmit your Fair Hearing request to the Maryland State Office of Administrative Hearings, which will schedule and conduct the Fair Hearing. At the hearing, you and anyone else you want, such as a relative, friend, or lawyer will be able to tell the Administrative Law Judge why you think you should receive benefits.

If you are found ineligible for WIC when you first apply or at a recertification, you can ask for a hearing, but you will not receive any food benefits while you wait for the hearing.

_____
Local WIC Representative

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Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, found online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. . The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by::

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax: (833) 256-1665 or (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Aviso que no es eligible / Aviso de término

<TODAY'S DATE>

<HoH Name>
< HoH Address>
<City, State Zip>
Solicitante / participante de WIC <Participant Name> (<Participant ID>):

Según la información que tenemos, se determina que:

- □ usted no es eligible para participar en el Programa WIC en este momento
- □ su certificación con el Programa WIC terminará el <TERMINATION DATE>. Si solicita una audiencia justa antes del <TERMINATION DATE>, seguirá recibiendo los beneficios de alimentos hasta que el tribunal tome una decisión o hasta que su periodo de certificación se venza, lo que ocurra primero. Esto no aplica si su periodo de certificación ya se venció o si se determina que no califica para el programa debido a su categoría.

Esta decisión se ha tomado por la/las siguiente(s) razón(es):

- □ No es eligible debido a su categoría.
- □ Sus ingresos familiares son demasiado altos para recibir los beneficios de WIC.
- □ No vive en el área de servicio de la agencia.
- □ Para ser eligible, se requiere que tenga una necesidad nutricional y el personal de la agencia no considera que la tenga.
- □ Todos los fondos actuales de WIC se están usando, así que usted está en la lista de espera para participar.
- □ Otro: _____

Si cree que esta decisión no es correcta, por favor llame al <LA PHONE> para hablar sobre esto.

Tiene derecho a una audiencia justa por la negación de los beneficios de WIC. Si cree que debe recibir los beneficios de WIC y desea apelar esta decisión, puede solicitar una audiencia sobre la negación. Para solicitar la audiencia debe llenar la Solicitud de Audiencia Justa, que se encuentra adjunta a esta carta, y entregarla a un miembro del personal de WIC o puede enviarla a la siguiente dirección, antes del <TERMINATION DATE + 45 DAYS>.

<Local agency name>
<Address>
<City, State Zip>

Attn: <Local Agency Point of Contact>

También puede solicitar una audiencia justa al llamar al Programa WIC de <Local Agency Name> antes del <TERMINATION DATE + 45 DAYS>. La oficina de WIC enviará su solicitud de audiencia justa a la Oficina de Audiencias Administrativas del Estado de Maryland, la cual programará y realizará la audiencia. En la audiencia, usted y cualquier persona que desee, como un pariente, amigo o abogado podrán decirle al Juez de Derecho Administrativo por qué considera que debería recibir los beneficios.

Adjunto 2.11A

Si se determina que no es elegible para WIC cuando aplica por primera vez o en su renovación, puede solicitar una audiencia, pero no recibirá los beneficios de comida mientras espera por la audiencia.

_____
Representante local del WIC

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La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: https://www.fns.usda.gov/sites/default/files/resource-files/usda- program-discrimination-complaint-form-spanish.pdf, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) **correo:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; o

(2) **fax:**
(833) 256-1665 o (202) 690-7442; o

(3) **correo electrónico:**
program.intake@usda.gov

Esta entidad es un proveedor que brinda igualdad de oportunidades.

REQUEST FOR A FAIR HEARING

I am requesting a fair hearing pursuant to WIC Program regulations. My reason(s) for requesting a hearing is (are): (Give any information which you this is important to your appeal.)

_____

_____

_____

_____

_____

_____

_____

_____

Date: _____ Signature: _____

WIC Applicant/Participant:

<Applicant/Participant Name>

<Address>

<City, State Zip>

WIC Participant ID: <Part ID>

WIC Family ID: <Family ID>

Date of Birth: <DoB>

Please make any corrections here (print clearly):

_____

_____

_____

_____

_____

_____

Specific information concerning Fair Hearing procedures and scheduling will be provided to you by the Office of Administrative Hearings with the hearing scheduling notice the Office of Administrative Hearings will send to you. Complete this form and mail it to:

<Local Agency Name>
<Address>
<City, State Zip>
Attn: <Local Agency Point of Contact>

You may also telephone your request to the WIC Office by calling: <Local Agency Phone>.

Send or Fax To: Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031
410-229-4262
Fax 410-229-4268

TRANSMITTAL FOR MARYLAND DEPARTMENT OF HEALTH APPEALS
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

_____
Specify County of Applicant/Participant

Transmitting Official: _____ **Date Appeal Received:** _____

Telephone Number: _____ **Name of Case:** _____

Agency File No.: (if any) _____

Appellant (#1) and/or Appellant's Counsel (#2)

(#1) Name: _____
LAST FIRST MI

Address: _____

_____

_____ ZIP_____

Telephone No.: _____

(#2) Name: _____
LAST FIRST MI

Address: _____

_____

_____ ZIP_____

Telephone No.: _____

Department's Representative(s)

(#1) Name: _____
LAST FIRST MI

Address: _____

_____

_____ ZIP_____

Telephone No.: _____

(#2) Name: _____
LAST FIRST MI

Address: _____

_____

_____ ZIP_____

Telephone No.: _____

Appeal Category: Women, Infants and Children's Program

PLEASE ATTACH APPEAL LETTER AND ANY CORRESPONDENCE RELATING TO CASE

For Local Agency Use Only

Transmittal Form Instructions

Specify County of Applicant/Participant

Indicate the County of Applicant or Participant for whom you are submitting a hearing request. (If Baltimore City, indicate Baltimore City)

Transmitting Official:

Indicate name of Local Agency official submitting the Appeal.

Name of Case:

Enter Applicant's or Participant's name vs. Local WIC Agency Name
(e.g. Jane Doe vs. Garrett County WIC Program)

Agency File No.:

Complete only if your Local Agency has developed an internal tracking procedure or log for appeals. Otherwise, leave blank.

Appellant (#1) and/or Appellant's Counsel (#2)

Enter the name of the Applicant or Participant in #1. If the Applicant or Participant is being represented, provide the name of this individual in #2

Department's Representative(s)

Enter the name of the Local Agency Coordinator in #1. If necessary, use #2 to indicate additional staff such as the Certifier or Clinic Supervisor whose attendance at the hearing may be necessary.

Attach a copy of the Ineligibility Notice and the Fair Hearing Request Notice and any other correspondence, if applicable, and transmit via Fax or mail to the Office of Administrative Hearings at:

Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031
410-229-4262
Fax 410-229-4268

For Local Agency Use Only

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.12
Effective Date: October 1, 1990
Revised Date: February 27, 2023

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Program Rights and Responsibilities

A. Policy

1. Applicants or their caregiver or designee must be advised of the Program rights and responsibilities. These Program rights and responsibilities are listed on the *Maryland WIC Program Rights and Responsibilities* (Attachment 2.12A) and include the following information:

   a. A statement of nondiscrimination and information on how to file a discrimination complaint.

   b. A statement explaining the right to appeal any decision made by the WIC agency regarding eligibility, and information on the method for requesting a fair hearing.

   c. A statement regarding health services and nutrition education that will be made available by the agency.

   d. A statement that the Program has been explained to, and is understood by, the applicant, caregiver, or designee.

   e. A statement that the applicant has provided correct information for this application, because intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued and subject the participant to civil and criminal prosecution under State and Federal law.

   f. A statement that any information provided to the Program can be released to persons directly involved with the administration, enforcement, or audit of the program or to public organizations designated by the Secretary of the Maryland Department of Health.

   g. A statement that unused or expired benefits cannot be rolled over to another month or replaced.

2. The caregiver may designate up to two individuals to sign the *Maryland WIC Program Rights and Responsibilities.*

B. Procedure:

1. Certification using the management information system:
Local agencies shall ensure that all applicants or their caregiver or designee:

   a. Prior to signing, read, or have read to them, the *Maryland WIC Program Rights and Responsibilities*;

   b. Prior to signing, are informed that they are receiving a copy of the *Maryland WIC Program Rights and Responsibilities*; and

   c. Sign[1] their full name acknowledging that they have read or have had someone read to them the *Maryland WIC Program Rights and Responsibilities* and that they have received a copy of the *Maryland WIC Program Rights and Responsibilities*.

2. Manual Certification:
Local agencies shall ensure that all applicants or their caregiver or designee:

   a. Prior to signing, read, or have read to them, the *Maryland WIC Program Rights and Responsibilities*;

   b. Prior to signing, are informed that they are receiving a copy of the *Maryland WIC Program Rights and Responsibilities*;

   c. Sign[1] their full name, where indicated, acknowledging that they have read or have had someone read to them the *Maryland WIC Program Rights and Responsibilities* and that they have received a copy of the *Maryland WIC Program Rights and Responsibilities*.

   Local agency staff shall complete the Income and Nutritional Risk Determination areas of the form. A signature is required of the staff who has completed each portion of the certification.

Attachments:

2.12A Maryland WIC Program Rights and Responsibilities

References: 7 CFR 246.7 (j)

[1] Signatures may be a traditional wet signature, electronic/digital, image of signed statement, and/or documentation by the Staff that the R&R was read to the participant.

COMAR 10.54.01.16

Revisions:

10/99	
5/03	
5/09	deleted sentence in B7 regarding initials
2/2010	Changed designee to proxy and included participant in the name of the form Changed reference from 7 CFR 246.7 (i) to 7 CFR 246.7(i)(j)
10/2013	Added distinction between automated and manual certifications, reference to electronic signatures, removed authorization for release of immunization information.
10/2015	Emphasized that the R & R must be read by or read to the participant and the participant is notified that they are receiving a copy prior to obtaining a signature.
1/2017	Added A.1.g and updated 2.12A to incorporate eWIC.
11/2017	Replaced DHMH with Maryland Department of Health and removed check references from 2.12A
8/22/2018	Reworded to include applicant or remove reference to either participant/applicant where possible.
2/27/2023	Updated non-discrimination statement on *Maryland WIC Program Rights and Responsibilities* and clarified “signature”.

MARYLAND WIC PROGRAM
Rights and Responsibilities

My Rights

- **WIC foods:** I will get a food instrument (eWIC card) to buy healthy foods.
- **Nutrition information:** I will get information about healthy eating and active living.
- **Breastfeeding support:** WIC will help and support me with breastfeeding.
- **Health care information:** I will get information about immunizations and other services I might need.
- **Fair treatment:** The rules for applying for WIC are the same for everyone. I can ask a WIC employee for a Fair Hearing if someone tells me I cannot be on WIC and I do not agree.
- **Common courtesy:** WIC and store staff will treat me with courtesy and respect. I can tell WIC staff that I would like to file a complaint if I am not treated with respect. I can also file a complaint with USDA at the address below.
- **Transfer information:** If I am moving, I can transfer my WIC to another state. I can ask for transfer paperwork to take with me.

My Responsibilities

I understand that:

- WIC does not give all the food or formula needed for a month and that unused benefits do not carry over to the next month.
- If I lose my eWIC card it can be replaced. If my food benefits expire before I receive a new eWIC card, the benefits will not be replaced.
- Information that I provide to the WIC Program is being submitted in connection with the receipt of Federal assistance. Program officials may verify information provided to them.
- Information that identifies a WIC participant shall be released to those persons directly connected with the administration, enforcement, or audits of the Program.
- The Secretary of the Maryland Department of Health may authorize the release of information to representatives of public organizations that serve persons who are eligible for the WIC Program. A list of these organizations is available upon request from the WIC Program.
- Information released to organizations will only be used for the purpose of determining the eligibility of WIC participants for programs that it administers, conducting outreach to WIC participants for such programs, evaluating the State's responsiveness to the health care needs and outcomes of WIC participants, or to simplify the procedures for participating in those programs.

I agree to follow the rules below. I will:

- Always bring my proof of identification (ID) to every clinic visit.
- Provide all documents requested by the WIC Program in a timely manner.
- Use WIC foods and formula only for the person on WIC.
- Report lost, stolen, or damaged eWIC cards as instructed.
- Make sure any person I name to use my benefits knows the WIC Rights and Responsibilities. I will teach them how to use my benefits properly.
- Keep my WIC appointments or call the clinic to reschedule. If I fail to pick-up benefits two times in a row I may be removed from the Program.
- Not sell, give away or trade my, eWIC card, foods, or formula for money, credit, rain checks or other items. If I have WIC items I can't use, I will return them to the clinic.
- Not post WIC items for sale or trade on the internet.
- Not swear, yell, harass, threaten, or physically harm WIC or store staff; or damage WIC or store property.
- Not enroll a child who is not in my legal or designated care.
- Not enroll in WIC in more than one State or get benefits from more than one WIC clinic each month.

I agree to give true and complete information about:

- My identity, pregnancy status and address.
- The number of all people living in my household.
- The total income of all people living in my household.
- Being on Medicaid, the Maryland Supplemental Nutrition Assistance Program, also referred to as Food Stamps or SNAP, or Temporary Cash Assistance (TCA).
- All changes in life circumstances (for example, I will notify WIC if I have changes in my income or family size or if I move).

My signature in the WIC system means that:

- The information I have provided for eligibility determination is correct to the best of my knowledge.
- I understand and agree that intentionally making a false or misleading statement or misrepresenting, hiding, or withholding facts may result in my having to pay the WIC Program, in cash, the value of food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law and disqualification from the WIC Program.
- I have been, or will be, issued a food instrument (eWIC card) for my household.
- I have asked any questions I have about WIC and they have been answered.
- I understand what my rights and responsibilities are.
- I understand that if I fail to comply with my responsibilities that I may be disqualified from the WIC Program.

The following participants were certified on _____:

#1: _____ #3: _____

#2: _____ #4: _____

_____ _____
Signature of Applicant/Caregiver/Designee Signature of WIC Staff

For Manual Certifications Only:

☐ Income Determination _____ ☐ Nutrition Risk Determination _____
Staff Signature Staff Signature

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

Derechos y responsabilidades del PROGRAMA WIC DE MARYLAND

Mis derechos

- **Alimentos de WIC:** Recibiré un instrumento de comida (tarjeta electrónica de WIC) para comprar comida saludable.
- **Información de nutrición:** Recibiré información sobre la alimentación saludable y un estilo de vida activa.
- **Apoyo para amamantar:** WIC me ayudará y me apoyará con la lactancia materna.
- **Información sobre servicios de salud:** Recibiré información sobre las vacunas y otros servicios que pueda necesitar.
- **Tratamiento justo:** Las reglas para solicitar WIC son las mismas para todos. Puedo solicitar una audiencia justa a un empleado de WIC si alguien me dice que no puedo estar en el programa WIC y no estoy de acuerdo.
- **Cortesía común:** El personal de WIC y de la tienda me tratarán con cortesía y respeto. Puedo decirle al personal de WIC que me gustaría presentar una queja si no me tratan con respeto. También puedo presentar una queja al Departamento de Agricultura de los Estados Unidos (United States Department of Agriculture, USDA) en la dirección escrita abajo.
- **Información de transferencia:** Si me mudo, puedo cambiarme al programa WIC de otro estado. Puedo pedir que me den los documentos de transferencia.

Mis responsabilidades

Entiendo que:

- WIC no proporciona todo los alimentos o la fórmula necesaria para un mes y los beneficios que no se usan no se pasan para el mes siguiente.
- Si pierdo mi tarjeta electrónica de WIC, puede ser reemplazada. Si mis beneficios de comida se vencen antes de recibir una nueva tarjeta electrónica, los beneficios no serán reemplazados.
- La información que doy al programa WIC es presentada en conexión con el recibo de la asistencia federal. Los funcionarios del programa pueden verificar la información que se les presentó.
- La información que identifica al participante de WIC se les dará a las personas que están directamente relacionadas con la administración, la ley o las auditorías del programa.
- La Secretaría del Departamento de Salud de Maryland puede autorizar la revelación de información a los representantes de las organizaciones públicas que atienden a personas que califican para el programa WIC. Una lista de estas organizaciones está disponible si la pide al programa WIC.
- La información que se le da a las organizaciones sólo se usará con el propósito de determinar la elegibilidad de los participantes de WIC para programas que estén bajo su administración, hacer campañas de promoción de tales programas para los participantes de WIC, de evaluar las respuestas del Estado ante las necesidades de cuidado de salud y los resultados de los participantes en WIC, o para simplificar los procedimientos para participar en estos programas.

Acepto seguir las reglas que están a continuación: Yo:

- Siempre llevaré la prueba de identificación (ID) a todas las citas.
- Proporcionaré a tiempo todos los documentos solicitados por el programa WIC.
- Usaré la comida y la fórmula de WIC sólo para la persona registrada en WIC.
- Reportaré, según las instrucciones, las tarjetas electrónicas de WIC perdidas, robadas o dañadas.
- Me aseguraré de que las personas que nombré para usar mis beneficios conozcan los derechos y responsabilidades de WIC. Les enseñaré como usar los beneficios de la forma adecuada.
- Asistiré a las citas de WIC o llamaré a la clínica para cambiar las citas. Si no recibo los beneficios dos meses seguidos, pueden retirarme del Programa.
- No venderé, regalaré ni cambiaré la tarjeta electrónica de WIC, ni la comida ni la fórmula a cambio de dinero, crédito, cupones o por ningún otro artículo. Si no puedo usar alguno de los beneficios que saqué, los regresaré a la clínica.
- No pondré en venta o intercambio ningún beneficio de WIC en el Internet.
- No insultaré, gritaré, acosaré, amenazaré, ni físicamente haré daño, al personal de WIC o de la tienda; no destruiré ninguna propiedad de WIC ni de la tienda.
- No inscribiré a ningún niño que no esté bajo mi cuidado legal.
- No me inscribiré en el programa WIC en más de un estado ni recibiré beneficios mensualmente de más de una clínica de WIC.

Acepto dar información completa y verdadera sobre:

- Mi identidad, estado de embarazo y dirección.
- El número de todas las personas en mi hogar.
- El ingreso total de las personas en mi hogar.
- Mi participación en Medicaid, el Programa de Asistencia Nutricional Suplementaria de Maryland, también conocido como el programa de estampillas de comida o SNAP, o Asistencia Temporal en Efectivo (Temporary Cash Assistance, TCA).
- Todos los cambios relacionados con las circunstancias de la vida, (por ejemplo: notificaré a WIC en caso de que tenga algún cambio en mi ingreso, en el número de personas en mi familia o si cambio de dirección).

Mi firma en el sistema WIC significa que:

- La información que he dado para determinar si soy eligible es correcta, según mi conocimiento.
- Entiendo y acepto que dar información falsa, engañosa o tergiversar, ocultar o retener datos puede resultar en que tenga que pagar, en efectivo, al programa WIC, el valor de los beneficios que he recibido de forma inapropiada y puedo enfrentarme a una acusación criminal o civil, ante la ley federal y estatal y que me descalifiquen del programa WIC.
- Me dieron o me van a dar un instrumento de comida (tarjeta electrónica de WIC) para mi familia.
- He hecho las preguntas que he tenido sobre WIC y han sido respondidas.
- Entiendo cuáles son mis derechos y responsabilidades.
- Entiendo que, si no cumplo con mis responsabilidades, puedo ser descalificado del programa WIC.

Los siguientes participantes fueron certificados el _____:

#1: _____ #3: _____

#2: _____ #4: _____

_____ _____

Firma del solicitante/cuidador/designado Firma del personal de WIC

Solo para certificaciones manuales:

☐ Determinación del ingreso ☐ Determinación del riesgo de nutrición

_____ _____

Firma del personal Firma del personal

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o
comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: https://www.fns.usda.gov/sites/default/files/resource-files/usda-program-discrimination-complaint-form-spanish.pdf, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del
demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) correo:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax:
(833) 256-1665 o (202) 690-7442; o

(3) correo electrónico:
program.intake@usda.gov

Esta entidad es un proveedor que brinda igualdad de oportunidades.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.13
Effective Date: October 1, 1995
Revised Date: **May 28, 2020**

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Transferring Participants and the Use of the Verification of Certification**

A. Policy

A participant presenting a valid Verification of Certification (VOC) has already been certified for WIC and has been guaranteed the right to complete their certification period. If the receiving local agency has a waiting list but is enrolling some new participants, then such persons must be enrolled and allowed to finish out their certification periods even if the local agency is not serving the priority level. If the receiving local agency is not serving any new persons, the person must be placed on the wait list ahead of all waiting applicants, regardless of the priority level under which they were certified. In the event a local agency reserves caseload slots for a short period of time for Priority I participants and a person presents a valid VOC to the local agency, that individual must be enrolled before a Priority I applicant.

If the certification period stated on the VOC presented by the applicant has expired, the applicant shall reapply for WIC benefits according to Maryland certification policies and procedures.

At the time of certification, a VOC shall be issued to every participant who is a member of a family in which there is a migrant farmworker or any other participant who is likely to be relocating during the certification period.

A VOC document will be used to**:**

1. Ensure that every participant who is a member of a family in which there is a migrant farm worker or any other participant who is likely to relocate during the certification period, has written proof of their certification and eligibility. This policy also applies to WIC participants affiliated with the military who may be transferred overseas refer to Policy & Procedure 2.17- WIC Overseas Program.

2. Ensure that participants transferring into Maryland WIC from a WIC agency in another state are provided continuous benefits. Refer to Policy and Procedure 2.17 for WIC participants affiliated with the military who are returning from overseas.

Program regulations require that a VOC contain the following information:

i. Name of the participant
ii. Date the certification was performed
iii. Date income eligibility was determined: this may be different than the certification date
iv. The nutritional risk of the participant in clear language
v. Date the certification expires
vi. The signature and printed name of the certifying local agency official (does not have to be the person who performed the certification)
vii. The name, address, and phone number of the certifying agency
viii. An identification number (which may be the WIC participant ID number) or other form of VOC accountability

B. Procedure

1. IN-STATE LOCAL AGENCY TRANSFERS

Outgoing Transfers

Any participant advising the local agency that they will be moving to another local agency within the State shall be given information on how to contact the new local agency.

Incoming Transfers

a. If a participant from another local agency within the State requests a transfer to a new local agency, the receiving local agency shall initiate transfer procedures in the management information system.
b. When accepting a transfer from another local agency within the State, the receiving local agency shall:

    i. Follow the in-state family transfer procedure in the management information system.

    ii. Obtain proof of identity and proof of residency refer to Policy and Procedure 2.23 and 2.04.

    iii. Update the address, phone number, family size and head of household, as necessary. Add any new family members and respond to any system Alerts.

    iv. If the local agency receives information indicating that the participant’s household income has changed and greater than 90 days remain in the certification period; the local

agency shall redetermine income eligibility following Policy and Procedure 2.05 Income Requirements.

v. If applicable, retrieve and destroy any participant ID folder issued from the sending local agency and issue a new ID folder with the receiving local agency stamp.

vi. Determine what benefits have been issued to the participant and follow the local agency guidelines for issuing future benefits, if appropriate.

vii. Make the appropriate appointment.

2. OUT-OF-STATE-TRANSFERS

Outgoing Transfers

a. Any participant advising the local agency that they will be moving out-of-state or is a member of a family with a migrant farmworker, must be given a VOC and if possible, the contact information of the WIC Program in the area where the participant is moving. Refer to Policy and Procedure 2.17 for instructions on issuing a VOC for WIC participants affiliated with the military who will be transferred overseas.

b. The VOC must be signed by the head of household or designee **and** a local agency staff person authorizing certification. A VOC may be sent in a secure manner if the participant faces a hardship in coming to the WIC office.

c. If a VOC is reported lost or stolen by a participant, it must be noted in the Notes screen of the management information system with the date reported and initials of the person accepting the report. The VOC can then be reissued.

d. Other state WIC agencies requesting VOCs may be directed to the WIC helpdesk at 410.767.5166. If the local agency chooses to assist the requesting agency, they may not require a client release of information in order to provide VOC information. Local agencies may require a written request on letterhead be submitted to assure confidentiality.

Incoming Transfers

The local agency shall:

a. Accept the data on the VOC for the duration of that certification period. The transferring participant should not be penalized if the original agency does not complete the VOC properly. Local agencies shall accept an incomplete VOC as long as the VOC contains the person's name, date of certification, and the certification period has not expired. If possible, it is recommended that the local agency contact the original agency if information is missing or appears to be altered. State contact information can be found at www.fns.usda.gov/wic/wic-contacts.

b. Verify participant identity according to Policy and Procedure 2.23 - Establishment of Applicant Identity.

c. Verify residency according to Policy and Procedure 2.04 – Residency Requirements.

d. Determine if household income has changed. If the local agency receives information indicating that the participant's household income has changed and greater than 90 days remain in the certification period; the local agency shall redetermine income eligibility following Policy and Procedure 2.05 Income Requirements. The income determination shall be waived for migrant farm workers and their family members if the income eligibility has been determined within 12 months.

e. Ask the person presenting the VOC to read or read to them the Program Rights and Responsibilities and electronically sign their full name acknowledging acceptance of the Program Rights and Responsibilities.

f. Honor all nutritional risk conditions from other WIC programs for the duration of the certification period stated on the VOC.

g. Retrieve and destroy any WIC issued identification folder from the sending agency.

h. Retrieve and destroy any food instruments from the sending agency. In the event the participant does not present their food instruments from the original agency, the original agency shall be contacted to determine last benefits received. Duplicate benefits shall not be issued. If the participant has unredeemed benefits from the current benefit period, the receiving agency should, to the extent practicable, provide food benefits that ensures the participant receives the maximum monthly allowance for that month.

i. Issue a Maryland WIC food instrument in accordance with P&P4.30 Food Instrument Issuance and Replacement.

j. Determine if the client is receiving a WIC medical nutritional formula. If so, the sending agency shall be contacted for confirmation of special formula issuance. In the event the sending agency cannot be contacted, the WIC medical nutritional can be approved for 30 days and the caregiver provided a copy of the Maryland Medical Documentation Form P&P3.02C to have completed by a local health care provider unless this causes a hardship for the client.

Attachments: 2.13A Sample VOC

References:
7 CFR 246.7 (k)
7 CFR 246.7 (h)(1)(i)
COMAR 10.54.01.17
Policy Memo 2016-4 Verification of Certification
Policy Memo 2016-4 Frequently Asked Questions issued 11/25/2016
WIC Policy Memorandum 2001-4 WIC Overseas Program and VOC Cards

Revisions

10/01/2003	WICWINS References
10/01/2010	Deleted from Incoming Transfers c. enter a risk code. Changed reference from 7 CFR 246.7(j) to 7 CFR 246.7(k)
10/01/2011	Clarified the steps for in state family transfers in B.1.b.(i-v); Added to Procedure: Participants shall only be transferred into a local agency at the request of the participant.
10/01/2012	Deleted references to WOW and minor language and format changes
10/01/2013	Revised wording to include the new Participant Rights and Responsibilities form procedures.
10/01/2014	Added proof of identity in B. 2. Incoming Transfers section b. per WIC Policy Memorandum 2001-4
6/7/2017	New guidance Policy Memo 2016-4 Verification of Certification and updated language to be compatible with eWIC
11/08/2017	Clarified transfer process for out of state requests and when to redetermine income.
05/28/2020	Moved policy statements out of procedure section and clarified we can issue benefits to a transfer with EBT as long as we do not exceed federal maximums.

Attachment 2.13A

Maryland WIC Program
Verification Of Certification

VOC No.
100054297
Date Printed: 11/03/2016

Participant Name: Sample Voc

Participant Number: 201117070

Date of Birth: 05/25/2015 **Priority:** 3 **Height:** 2 ft 4 in.

Income Determ Date: 05/27/2016

Eligibility Begins: 05/27/2016 **Ends:** 05/31/2017 **Weight:** 19 lbs. 2 oz.

Last Benefit Issued:

Bloodwork Data: 05/27/2016 HGB = 12.5

First Date To Spend: 07/22/2016

Comment:

Last Date To Spend: 08/21/2016

Termination Date: **Term Reason:**

Nutritional Risks:
Prematurity
Low Birth Weight (LBW)

Signature and Title

Towson Health Center
1046 Taylor Ave.
Towson, MD 21286
(410) 887-5995

No Signature Obtained

Head of Household/Designee Signature

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.14
Effective Date: October 1, 1998
Revised Date: October 1, 2012

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Eligibility of Aliens and Alien Students**

A. Policy

The WIC Program regulations do not require citizenship so aliens, including students, are in no way categorically ineligible for the WIC Program.

Participation in the WIC Program does not give rise to a public charge determination in that no reimbursement of WIC benefits is required when the individual applies for immigration or citizenship.

B. Procedure

If a WIC Program participant experiences any action by Immigration and Naturalization Service (INS) field agents because of their participation in the WIC Program, please notify the State WIC Office immediately with specific details and copies of the INS documents or forms.

Attachments:

References:

SFP 98-140, SFP 98-079, SFP 97-036

Revisions October 2012 – minor formatting change

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.15
Effective Date: October 1, 1995
Revised Date: October 1, 2011

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Eligibility of Persons Affiliated with Institutions**

A. Policy

1. The WIC Program regulations state that WIC Supplemental food "shall not be issued for use in institutions which serve meals". However, it is not the intent of program regulations to unconditionally exclude otherwise eligible persons affiliated with institutions from the WIC Program. Local agencies are encouraged to extend benefits to institutionalized persons who may be at high risk and consequently in need of the WIC Program, provided the applicants who reside in institutions (e.g. shelter) are eligible for WIC under the following conditions.

    a. The institution does not accrue financial or in-kind benefit from a person's participation in WIC.

    b. Food items purchased with WIC food instruments are used only by those for whom they are prescribed.

    c. No institutional constraints are placed on the ability of the WIC participant to partake of supplemental foods and all associated WIC services made available by the WIC local agency.

2. The Maryland WIC Program is not at this time extending benefits to those women who are incarcerated.

B. Procedure

1. Local Agency staff should evaluate the situation for each person residing in a shelter on an individual basis. If any of the above conditions would be violated, the applicant would not be considered eligible to receive WIC benefits.

2. If the individual situation allows the participant to have access to foods provided by the WIC Program, food instruments tailored to the participant's needs should be issued. Such tailoring should include the prescription of non-perishable foods and/or smaller quantities of

perishable foods. All circumstances should be documented in the WIC record and reevaluated regularly for changes in circumstances.

Attachments:

References: CFR Part 246.7 (m)
FNS Instruction 803-13

Revisions:
10/1/2011 Changed reference from CFR 246.7 (o) to 246.7 (m)

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.16
Effective Date: October 1, 1992
Revised Date: October 3, 2023

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Physical Presence Requirements for Certification

A. Policy

Eligibility determination is best conducted in person, by staff who can assess patterns of weight loss, weight gain, or poor linear growth. The presence of other medical conditions, which would render the child eligible for certification, can also be discerned, and social conditions that require intervention can be identified when the applicant is present at the time of certification. Likewise, the mid-certification visit is best performed with having the participant physically present to perform nutrition assessment and to address other medical or social needs.

Exceptions to the physical presence requirement for certification are to be determined by the local agency on a case-by-case basis, and may be granted for the following reasons:

Disabilities: individuals who have a disability or condition that would prevent them from being physically present. Examples of such circumstances include medical conditions that:

- necessitate the use of medical equipment that is not easily transportable; or
- require confinement to bed rest; or
- may be exacerbated by coming into the clinic.

Ongoing health care: an infant or child who is receiving ongoing health care; was present at their initial certification; *and* the physical presence requirement poses an unreasonable barrier to participating in the program.

Working caregivers: an infant or child who was present at their initial certification; was present at certification within the one-year period of the most recent determination; *and* is under the care of one or more working caregivers whose working status presents a barrier to bringing the infant or child in to the clinic.

Infants < 8weeks of age: an infant < 8 weeks of age who cannot be present at certification for a reason determined appropriate by the local agency, and for whom all necessary certification information is provided.

As it is desirable to conduct nutritional assessments in person, exceptions to this policy for ongoing health care or working caregivers shall not be granted for consecutive certifications i.e. a child must be present a minimum of once every two years. In addition, an infant < 8 weeks of age granted an exception cannot later be granted an exception for working caregivers or for receiving ongoing health care since they were not present at the initial certification.

B. Procedure

1. All applicants for program services must be physically seen by WIC program staff at the time of certification except for the conditions listed above. Best practice is that the local agency will first attempt to arrange for an alternate method of certifying the applicant. Alternate methods may include scheduling the applicant to come to an alternate location or scheduling an appointment outside of normal clinic hours.

2. If the local agency cannot arrange an alternate method of certification and determines that it is in the best interest of the applicant to grant an exception to the physical presence requirement, then the following shall be required:

    a. <u>Exceptions related to disabilities:</u>

        The applicant or their caregiver shall present documentation from a health care professional of growth and biochemical data that is in adherence to policies 2.32 and 2.33.

    b. <u>Exceptions related to ongoing health care for infants and children:</u>

        The caregiver shall present documentation from a health care professional of growth and biochemical data that is in adherence to policies 2.32 and 2.33.

    c. <u>Exceptions related to working caregiver for infants and children:</u>

        The caregiver shall present documentation from a health care professional of growth and biochemical data that is in adherence to policies 2.32 and 2.33. Evidence supporting the caregivers working status, such as a current paystub or a letter from an employer, may also be requested.

d. Exceptions related to infants < 8 weeks of age:

The caregiver shall present documentation from a health care professional with weight and length data no more than 60 days old.

3. Use of referral data have occasionally shown inaccurate growth patterns. When using referral data, staff must exercise caution to determine whether the referral data are depicting real problems with growth or are reflective of poor measurements.

4. Local agencies shall stress the positive long-term benefits of WIC nutrition services and encourage the participant to attend and participate in scheduled mid-certification appointments for nutrition assessment and education. In the event a participant fails to be present for a mid-certification visit however the caregiver/proxy/designee is available, then the nutrition history, food package, and risk factors may be updated in person or remotely. Anthropometric data may be obtained from a healthcare provider in accordance with policies 2.32 and 2.33 or a subsequent lab appointment scheduled, and benefits issued. If no one appears for the appointment and remote contact cannot be made, then benefits shall not be issued.

5. Exceptions to the physical presence requirement for certification must be documented by the local agency in the participant's file.

6. The number of exceptions and the circumstances involved will be reviewed by the state agency as part of the local agency management evaluation review process.

References:

CFR 246.7 (o)
USDA Policy Memorandum #2006-5 VENA
USDA *Guidance for Providing Quality WIC Nutrition Services during Extended Certification Periods* dated August 29, 2011

Revisions:

10/2010	Added reference CFR 246.7 (o)
10/2012	Added mid-certification language. Added B.2.a-c. Improved formatting
10/2013	Deleted the 2nd paragraph in Policy section which allowed as an exception to this policy “infants certified as priority II based solely on the mother’s WIC enrollment or documented priority I status during pregnancy.” References: Deleted SFP 89-143; added USDA Policy Memorandum #2006-5. Clarified timeframes for height, weights and bloodwork obtained from private providers in B.1.c
10/2015	In B.1.b., deleted reference to arranging for a home visit
08/2018	Removed P&P2.38 reference and reworded for consistency between policies; clarified extenuating circumstances and removed

	requirement that documentation be from a HCP.
08/2020	Added additional exceptions to physical presence to be in alignment with 7.CFR 246.7(o), and changed title of policy
10/2023	Clarified that contact must be made to issue benefits and that a MCV can be done remotely or in person as long as an attempt is made to obtain anthropometric data.

Policy and Procedure Number: 2.17
Effective Date: October 1, 2001
Revised Date: November 18, 2019

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**WIC Overseas Program**

A. POLICY

1. Background

The Department of Defense (DoD) is authorized by law to establish and operate a program like WIC, using DoD funds, for United States (U.S.) active duty military personnel and other support staff stationed overseas and their dependents. DoD has delegated the responsibility to administer the WIC Overseas Program to its Assistant Secretary of Defense (Health Affairs)/TRICARE Management Activity (TMA).

Information about DoD's WIC Overseas Program can be accessed by calling 1-(877) 267-3728 or 1-(210) 341-3336 or the Web Site at:

http://www.tricare.mil/wic/

2. Impact on USDA's WIC Program

Legislation limits eligibility in the WIC Overseas Program to:

a. Active duty service members and their family members;

b. DoD civilian employees and their family members; and

c. DoD contractors and their family members.

All other eligibility requirements for the WIC Overseas Program mirror USDA's WIC Program requirements. Further legislation and DoD guidelines provide that WIC Program participants who are transferred overseas and meet the eligibility requirements noted above are eligible to participate in the WIC Overseas Program until the end of their certification period.

Because the WIC Overseas Program has been designed to mirror USDA's WIC Program, WIC Overseas Program participants who return to the U.S. with a valid WIC Overseas Program Verification of Certification (VOC) must be provided continued participation in the USDA's WIC Program until the end of his/her certification period. The WIC Overseas Program VOC is

a full-page document titled, WIC Overseas Participant Profile Report (Attachment 2.17A). In accordance with WIC policy, if the local agency has a waiting list for participation, transferring participants must be placed in the waiting list ahead of all waiting applicants regardless of the priority of their nutrition risk criteria.

B. PROCEDURE

1. Issuance of WIC VOC

Local agencies shall issue a WIC VOC from the management information system to WIC participants affiliated with the military who will be transferred overseas. Refer to Policy and Procedure 2.13. WIC clinics are not responsible for screening and determining eligibility for WIC Overseas Program eligibility. WIC participants issued a VOC when they transfer overseas must be instructed that:

a. There is no guarantee that the WIC Overseas Program will be operational at the overseas site where they will be transferred; and

. b. Issuance of a WIC VOC does not guarantee continued eligibility and participation in the WIC Overseas Program. Eligibility for the overseas program will be determined at an overseas WIC service site.

2. Acceptance of a WIC Overseas Program VOC

Local agencies shall accept a valid WIC Overseas Program VOC presented at a WIC clinic by WIC Overseas Program participants returning to the U.S. from an overseas assignment. In accepting a VOC, local agencies are reminded that at a minimum, the following elements on the cards are essential:

a. The participant's name;
b. The date the participant was certified; and
c. The date that the current certification period expires.

WIC Overseas Program participants arriving in a WIC clinic and showing a VOC with only these three pieces of information should be treated as if the VOC contains all of the required information. However, if questions arise, contact information for WIC Overseas Offices can be found at:

http://www.tricare.mil/wic/

Local agencies are also reminded that individuals presenting a valid VOC must provide proof of residency and identity, with limited exceptions, in accordance with the WIC Program policies.

In accordance with WIC policy, if the local agency is at its maximum caseload and has a waiting list for participation, transferring participants

must be placed on the waiting list ahead of all waiting applicants regardless of the priority of their nutrition risk criteria.

Attachments: 2.17A DoD WIC Overseas Program Participant Profile Report/Verification of Certification (VOC)

References: SFP 01-076 Impact of Implementation of the DoD's WIC Overseas Program on the USDA WIC Program

Revisions:

10/01/07	Revised 2.17B
01/21/09	Changed revised date on page 1 to October 1, 2007
10/2011	Updated link to website. Updated information in 2.17B
10/2012	Minor language changes; updated information in Attachment 2.17B
10/2015	Updated web address for WIC Overseas
11/19/2019	Removed "card" wherever referenced; deleted Overseas Program contacts Attachment B, staff will use website for contact information

FOR OFFICIAL USE ONLY

WIC Overseas Participant Profile Report

Visit Date: Thursday, July 29, 2010
WIC Overseas Site ID : 3005 Camp Foster, Japan

TEST A NEWPARTINFANT
Participant ID : 01/0001

Encounter Type : New Certification

Certification Dates: 07/29/2010 - 07/31/2011

Participant Category : Infant
Gender : Female
DOB : 07/22/2010
Age : 7 Days
Participant Type : Dependent of a member of the armed forces stationed overseas

Economic Unit : 3
Address : 123 ALA
APO, AE, 96386
Home Phone :
Work Phone :
Home Email :

Sponsor Name : TEST T TEST
Grade : E-1
DEROS: 12/22/2010

Non-Sponsor Name :
Home Phone :
Work Phone :
Work Email :

Address : 123 ALA
APO, AE, 96386

Source of Health Care:
MTF : AKAMINE LC
PCM : DR. ELIZABETH LEONARD

VOC

Measurements	Value	Date
Hematocrit:		
Weight :	8.00	07/29/2010
Length :	17.00	07/29/2010

Nutritional Risks		Priority
103	Underweight or at risk of becoming underweight	1
411	Inappropriate Nutrition Practices for Infants	4

Draft Use Dates : 07/29/2010 - 08/27/2010 08/28/2010 - 09/26/2010 09/27/2010 - 10/26/2010
Food Package : IBP1-3PBF

Food Instrument 1
2 - 12/12.3/12.4/ 12.5/12.6/12.9 oz. cans powder Enfamil Gentlease/GS Gentle Plus/ GS Protect Plus/Similac Sensitive/ Similac Advance/Enfamil Premium Lipil/ Enfamil Lipil

Food Instrument 2
2 - 12/12.3/12.4/ 12.5/12.6 oz. cans powder Enfamil Gentlease/GS Gentle Plus/ GS Protect Plus/Similac Sensitive/ Similac Advance/Enfamil Premium Lipil; OR 1 - 12.9 oz. can powder Enfamil Lipil

Food Instrument 3
1 - 12/12.3/12.4/ 12.5/12.6/12.9 oz. can powder Enfamil Gentlease/GS Gentle Plus/ GS Protect Plus/Similac Sensitive/ Similac Advance/Enfamil Premium Lipil/ Enfamil Lipil

Participant Rights and Obligations: I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. I understand I have a right to appeal any decision which I am aggrieved. This certification form is being submitted in connection with the receipt of Federal Funds. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the Federal agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under Federal Law. I hereby certify that I am not currently enrolled in any other WIC or WIC Overseas program. I understand that to do so would be deliberate misuse of program benefits and could result in the loss of these benefits.

Participant or Parent/Guardian Signature:	Date:	Competent Professional Authority
Test Test	08/12/10	Auto Staff Signature
Print Name: TEST TEST		

Attachment 2.17B has been removed

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.18
Effective Date: October 1, 1993
Revised Date: August 22, 2018

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Applicant/Participant Record Retention

A. Policy

The management information system maintains historical participant data which includes information used to make the eligibility determination.

If not scanned into the management information system, local agency clinics shall maintain paper files, according to the time schedule specified in Policy and Procedure 6.00, for the following documents:

1. Completed Ineligibility Notification forms and documentation for applicants determined to be ineligible for WIC Program benefits;

2. Incoming VOC from other states and the WIC Overseas Program;

3. Signed paper Participant Rights and Responsibilities form (when unable to obtain signature in the management information system);

4. Signed Release of Liability for breast pumps or aids.

5. Copies of documentation from a one person clinic as required in P&P 7.82 Separation of Duties

B. Procedure

Local agencies shall abide by the above policy and paper files shall be made available for review during Local Agency management evaluations (P&P 7.81).

References:

7 CFR 246.25
COMAR 10.54.01

Revisions:

10/01/2002	WICWINS References
10/01/2013	Deleted requirement to maintain copies of participant rights and responsibilities form except for manual certifications.
6/7/2017	Referenced policy 6.00, replaced reference CFR 246.7 with 7 CFR 246.25, removed check receipt due to eWIC and added A.4 and A.5
8/22/2018	Updated name of Policy 7.82; changed “fair hearing forms” to “completed ineligibility forms”.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.19
Effective Date: April 5, 1991
Revised Date: July 7, 2025

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Identification Folder**

A. POLICY

1. A standard statewide Identification (ID) Folder may be issued and validated by local agencies for participants, proxies, or caregivers to use as identification at the WIC clinic. If there is more than one member of a family on the WIC Program only one folder shall be issued.

2. An ID Folder that will be used for identification at the clinic must be validated as described below.

B. PROCEDURE

1. The ID Folder shall be completed and validated by local agency staff in the following manner and as illustrated on Attachment 2.19A:

   A- Print the name of the participant(s) and ID number(s)

   B- Print the Head of Household name and obtain their signature.

   C- Either local agency staff or the Head of Household shall print the name(s) of the proxy(ies). Instruct the Head of Household to obtain the signature of their proxy(ies).

TO VALIDATE THE IDENTIFICATION FOLDER, TWO STAMPS MUST BE USED:

D- Validate the ID Folder by using the stamp containing the local agency and/or county code.

E- Validate the ID Folder by using the stamp with the local agency's name and telephone number.

F- This section can be used to document the type and time of the next appointment.

Attachment (s)
1. Attachment 2.19A: Identification Folder

References:
1. 7 CFR 246.7(c)(2)(i)
2. COMAR 10.54.01.05

Revisions:

10/2008	Section B.e. Deleted requirement of the local agency address on the ID Folder
01/2009	Section B.2. Deleted requirement of the local agency address on the ID Folder
10/2009	Updated to match the format on the new Identification Folder
01/2010	Changed designees to proxies
02/2010	Changed caretaker to caregiver. Clarified B.5 A-C
10/2010	Changed reference from 7 CFR 246.7(o) to 7 CFR 246.7 (r)
10/2012	Attachment 2.19A Changed information on what to bring for a mid-certification visit (MCV) to reflect all categories eligible for an extended certification period.
10/2015	Removed requirement to have WIC symbol on the local agency stamp.
6/2017	Updated with eWIC terminology and made folder issuance optional. Attachment A update with branded colors and eWIC terminology.
07/2025	Updated COMAR and CFR references; updated image of folder in attachment A to match the new branding.

shorter panel - 5.125"

OUTSIDE
5.25"

5.25"

9.375" high

MY WIC APPOINTMENT SCHEDULE

Participant's Name	Date & Time	Appointment Type

WHAT SHOULD I BRING TO MY APPOINTMENT?

R - Recertification Bring proof of all income in the home, proof of physical address, this folder or another form of identification, all persons being recertified, and their medical card if they have one. Also bring immunization records for children under age 2.

CPU/IND - Class Pick Up Bring this folder or another form of identification. You will get helpful nutrition information and your next set of benefits.

MCV - Mid Cert Visit Bring your baby/children/self and this folder or another form of identification. WIC staff will check weight and growth, and hemoglobin if needed. Also bring immunization records for children under 2.

PSV - Participant Service Visit Bring this folder and any other items requested. WIC staff will update your record.

NC - Nutrition Care Bring this folder or another form of identification and your baby or child if requested. You will get special nutrition information.

BFF - Breastfeeding Follow-up Bring this folder or another form of identification and your baby. A WIC breastfeeding specialist or peer counselor will provide one on one support for you and your baby.

When your baby is born, call your local WIC agency to schedule an appointment. Bring your baby, this folder (or another form of identification), proof of all income in the home, proof of physical address, and baby's crib card or birth certificate.

WIC MARYLAND
BETTER NUTRITION, BRIGHTER FUTURE

1-800-242-4942 | www.mdwic.org

@MDH.WIC
/MARYLANDWIC

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW, Mail Stop 9410
Washington, D.C. 20250-9410; or

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor | Aruna Miller, Lt. Governor | Meena Seshamani, Secretary, MDH

C-71/0625

PARTICIPANT IDENTIFICATION FOLDER

WIC MARYLAND
BETTER NUTRITION, BRIGHTER FUTURE

Names of Participants (print)	WIC Identification Number

Persons Authorized to Conduct WIC Business

Head of Household (print)	Signature
Proxy (print)	Signature
Proxy (print)	Signature

If this folder is found, please contact the local WIC agency below:

Local WIC Agency	Card Valid Only with Stamp Here

WHAT YOU CAN EXPECT FROM WIC...

Breastfeeding support to help you be successful and give your baby the best start.

Nutrition Education to help you feed your family the healthiest way.

Information to get healthcare, immunizations and other services.

WIC Foods for healthier moms, babies, and children.

Fairness in the way you are treated by WIC staff.

Remember, breastfeeding is best for you and your baby.

WHAT WIC EXPECTS FROM YOU...

Keep appointments. Please call your local WIC clinic if you need to reschedule.

Remember WIC benefits are like money. Please try not to lose your eWIC card. Care for it the same way you care for your money.

Use your eWIC card correctly. If you have questions, call your local WIC clinic.

Buy only the foods listed on the Authorized Food list.

Shop at WIC approved stores. You may shop at any Maryland WIC approved store.

Call your local WIC clinic if any of your information changes.

QUESTIONS?

Ask your local WIC staff or call the Maryland WIC office at **1-800-242-4942** or visit our website at **www.mdwic.org**

4" high pocket

SIDE 1 - OUTSIDE - WITH PRINTING

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.20
Effective Date: October 1, 1996
Revised Date: August 22, 2018

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Designee/Proxy Authorization

A. Policy

1. The local agency shall inform the head of household at the time of certification that:

    a. The head of household may designate a proxy or proxies, not to exceed two, to receive and/or redeem WIC benefits on their behalf.

    b. The head of household may authorize the proxy to also be a designee who can bring an infant or child participant to the clinic for subsequent certifications on their behalf. If so designated, local agency staff shall document in the participant's record.

    c. It is the head of household's responsibility to inform their proxy/designee how to pick up and redeem WIC benefits; and

    d. The proxy/designee is subject to program sanctions as specified in Policy and Procedure 4.23.

2. The head of household shall be permitted to change or add a proxy/designee at any time during the certification period by informing the local agency of the change.

3. The head of household may retain the same proxy/designee(s) for subsequent certifications.

4. A WIC employee may act as a proxy/designee for a participant with the approval of the local agency coordinator. The employee shall not participate in any way in executing a certification or the issuance of WIC benefits for a participant when they are acting as a proxy/designee for a participant as stated in Policy and Procedure 4.01 and 7.82.

B. Procedure

1. Choosing a proxy/designee

    a. The local agency shall ask the head of household at the initial certification if they would like to choose one or two persons designated as a proxy to pick up and/or redeem WIC benefits.

    b. If a proxy has been requested, the local agency shall enter the name(s) of the proxy(ies) in the appropriate field in the participant's record.

    c. The local agency shall ask the head of household at the initial certification if they would like to authorize one or both of the proxies to serve as a designee who can bring an infant or child participant to the clinic for subsequent certifications on their behalf. If the head of household agrees, local agency staff shall document in the management information system.

    d. If the local agency is issuing a WIC ID Folder, the staff shall instruct the head of household to have their proxy(ies)/designee(s) sign the WIC ID Folder on the appropriate line(s) per Policy and Procedure 2.19.

2. The head of household shall be responsible to instruct their proxy(ies)/designee(s) how to pick up and redeem the WIC benefits.

3. The proxy/designee shall present valid identification (Refer to P&P2.23) when picking up WIC benefits at the local agency. The local agency shall ensure that the proxy(ies)/designee(s) name is listed in the management information system before issuing benefits.

4. The proxy/designee shall be subject to the sanctions listed in Policy and Procedure 4.23.

5. The head of household may request the local agency to change a proxy/designee by submitting the request in writing, in person, or by telephone if the local agency staff can verify the identity of the caller. The local agency may prohibit the changing of a proxy/designee if unable to verify the identity of the individual making the request.

Attachments:

References: 7 CFR 246.12(r)(1)
COMAR 10.54.01.04

Revisions:

10/01	Changed proxy to designee
10/03	WICWINS References
01/10	Changed designee to proxy/designee; added description of designee
02/10	Corrected policy number in B.5
10/10	Changed reference from CFR 246.12(o) and (p) to 246.12(r)(1)
10/12	Corrected Policy reference in A.1.d. Deleted references to WOW and minor language changes/clarifications.
6/7/2017	Updated for eWIC terminology and optional WIC ID folder
8/22/2018	Removed 4.09 which no longer exists; added 4.01 and 7.82, minor word changes and added COMAR reference

Policy and Procedure Number: 2.21
Effective Date: May 1, 1993
Revised Date: January 29, 2026

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Homeless Individuals**

A. POLICY

Identify homeless individuals, determine their eligibility and provide appropriate benefits expeditiously to maximize the benefits of the provision of authorized foods and nutrition education.

B. PROCEDURE

The local agency shall abide by the above policy by adhering to the following:

1. Identify a homeless individual by the following definition:

   "Homeless individual" means a woman, infant or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

   a. A supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designated to provide temporary living accommodations;

   b. An institution that provides a temporary residence for individuals intended to be institutionalized;

   c. A temporary accommodation in the residence of another individual which cannot exceed 365 days; or

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

2. To be certified as eligible for the WIC Program, homeless individuals shall meet the following criteria for eligibility in accordance with policies and procedures established by the State Agency:

   a. Residency requirements as outlined in Policy and Procedure 2.04. Consideration shall be given to a homeless individual who cannot provide proof of residency. Although a street and mailing address

is a required field in the WOW record, a permanent address is not required. The homeless applicant shall complete a Confirmation of Residency form (Attachment 2.04A). The local agency shall assist by asking the following:

(i) if the applicant frequently stays at one shelter, can that shelter's address be used;

(ii) if the applicant uses a "day shelter" (a shelter for the homeless which is open only during the day), can that shelter's address be used;

(iii) if the applicant can use the address of a relative or a friend; or

(iv) if no address is available, can the address of the local WIC clinic be used.

b. Homeless applicants who reside in homeless shelters which **do not** meet the conditions in B.5 are not eligible for WIC food benefits.

c. Income eligibility requirements as outlined in Policy & Procedure 2.05.

Consideration shall be given to a homeless individual who cannot provide proof of income. If a homeless applicant does not have the facilities to store written documentation for income verification, the local agency shall accept a self-declaration of income from the applicant. A homeless applicant who has no source of income or support is clearly income eligible.

d. Nutritional risk as outlined in Policy and Procedure 2.31.

3. To provide the benefit of supplemental foods necessary to accommodate the homeless individual, food packages can be tailored to meet the needs of the homeless individual who may not have the facilities to store or utilize the usual WIC supplemental foods.

4. To provide the benefit of nutrition education which is relevant to the homeless individual, specific education concerning the use and the storage of foods should be offered in addition to other topics.

5. Local agencies should ensure that homeless facilities meet certain conditions:

a. The homeless facility does not accrue financial or in-kind benefit

from a person's participation in the Program, e.g. by reducing its expenditures for food service because its residents are receiving WIC foods;

b. Foods provided by the WIC Program are not subsumed into a communal food service, but are available exclusively to the WIC participant for whom they were issued; and

c. The homeless facility places no constraints on the ability of the participant to partake of the supplemental foods and nutrition education available under the Program.

6. The local agency shall:

a. Contact the homeless facility at least once every six months to ensure continued compliance with conditions described in B.5; and

b. Request that the homeless facility notify the local agency if it ceases to meet any of these conditions.

7. In those cases where the local agency has not determined if a homeless facility meets the conditions of B.5, the local agency shall:

a. Contact the homeless facility to make this determination;

b. Inform applicants that the local agency will contact the homeless facility to determine if the facility meets certain conditions required by federal regulations for applicants to be eligible for WIC; and

c. Inform applicants that they will be notified by mail or telephone within the regulatory timeframe (refer to Policy and Procedure 2.09) of their eligibility status.

8. Homeless applicants and participants must be referred to appropriate health and human service agencies, such as:

a. Local welfare/TCA client assistance services

b. Homeless shelters

c. Food pantries/meal programs

d. Supplemental Nutrition Assistance Program

e. Medical Assistance

If necessary, a referral phone call should be made on behalf of the homeless applicant to food and shelter resources in the local area.

Attachment(s):

References:

1. 7 CFR Part 246.2, 246.7(m), 246.10(b)(1)(ii) and (b)(2)(ii)(D)

Revisions:

04/1999	Revised definition to include “which cannot exceed 365 days” and changed AFDC to TCA
01/2009	Changed Food Stamps to read Food Supplement Program in B. 8.d.
10/2011	Clarified B.2.b and citation 246.7(m)
12/2019	Moved Confirmation of Residency attachment to 2.04A
01/2026	3. Added that food packages can be tailored; 8 added mandatory referrals to SNAP and MA; clarified references

This attachment has been moved to 2.04A

Policy and Procedure Number: 2.22
Effective Date: October 1, 1993
Revised Date: October 1, 2012

SECTION: **ELIGIBILITY AND CERTIFICATION**

SUBJECT: **Appointment Waiting List**

A. Policy

Once a person's certification period is over, the participant must reapply for WIC benefits and compete for WIC appointments with other persons within their priority levels. It is generally easier for current participants to obtain WIC appointments because they are already in the system and more difficult for new applicants to obtain access to the system. Therefore, special efforts must be made to ensure that high-priority new applicants are able to gain access to WIC appointments in a timely manner.

An Appointment Waiting List shall be implemented and maintained if, due to staff or space limitations, the local agency cannot schedule and process the applicant who requests an appointment for certification or recertification by telephone within the regulatory timeframes. The names of applicants who request in person, at a WIC site, to participate in the Program cannot be placed on an appointment waiting list. These applicants must be interviewed and notified of their eligibility or ineligibility according to the processing standards described in Policy and Procedure 2.09. An appointment waiting list should be implemented as a short-term solution. When a local agency decides to implement an appointment waiting list, the local coordinator shall notify the State WIC Director in writing, regarding:

a. The date an appointment waiting list has been implemented;

b. The priorities that will be given appointments;

c. The anticipated length of time that the appointment waiting list will be maintained; and

d. The measures that will be pursued to resolve the problems of lack of resources and/or space.

B. Procedure

1. Establishing an appointment waiting list.

a. The local agency should determine the priorities that can be served in a timely fashion and should provide appointments to those applicants who will most likely fall into those priorities.

b. Recertification:

As a WIC participant's certification period draws to an end, local agency staff must determine whether a recertification appointment should be scheduled. This decision is based on the individual's potential new priority status when assessed. Persons likely to remain in Priority I must be given highest priority for appointments, followed by those who would be Priority II, III, IV, etc. Recertification appointments should be given consistent with procedures for giving new appointments.

c. New Certification:

Applicants who telephone the WIC Program to request an appointment should be scheduled according to priority. However, local agency staff may not have enough information to determine which priorities these applicants will be. The following guidelines shall apply:

i. Pregnant and breastfeeding women will be given highest priority;
ii. Infants will be given second priority; and
iii. Children and postpartum women who are believed to have a nutritionally significant medical condition or other risk factor which would place them in Priority III will be given third priority.

d. Local agencies should make every effort to schedule pregnant women within 10 days of the request, whether the request is made in person or by telephone.

e. Any infant who appears to have a condition qualifying as a Priority I risk must be given an appointment within 10 days of the request, whether in person or by telephone.

2. The local agency shall establish an appointment waiting list, which contains the following information:

a. Name, address and contact telephone number of the individual for whom the appointment is requested or if the individual is an infant or child, the parent or guardian of the infant or child;

b. Name of individual for whom the appointment is requested;

c. Date the appointment was requested; and

d. Category of the individual for whom the appointment is requested, i.e.:

i. Pregnant woman;
ii. Infant;
iii. Breastfeeding woman;
iv. Child; or
v. Postpartum women.

3. Implementing an appointment waiting list.

When an appointment becomes available, the local agency shall contact the individual, or the parent or guardian of an infant or child, from the appointment waiting list according to the:

a. Highest priority according to category, which is:

i. Pregnant woman;
ii. Infant;
iii. Breastfeeding woman;
iv. Child; and
v. Postpartum woman; and

b. Earliest calendar date appointment was requested; and

c. The highest priority applicants (e.g. pregnant woman) must all be given appointments before the second highest priority can be given appointments

Attachments:

References:

Revisions:
10/2012 Corrected spacing issues

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.23
Effective Date: October 1, 1992
Revised Date: September 24, 2019

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Establishment of Applicant Identity**

A. POLICY:

To be certified as eligible for the WIC Program, applicants shall meet criteria for eligibility in accordance with policies established by the State Agency. In determining eligibility, all applicants must provide proof of identity. Identification must also be confirmed at subsequent appointments, prior to issuing benefits, and when a participant requests to make a change to their account.

B. PROCEDURE:

Local agencies shall require that all applicants provide proof of identity and document the type of proof presented in the management information system. Identification provided electronically may be used at the discretion of the local agency.

1. At initial certification one of the following documents shall be an acceptable proof of an applicant's identity:

    a. Birth registration or birth certificate: official copy bearing State or Municipal seal; or seal of foreign government or province;

    b. Hospital birth record: usually bears child's footprints, date of birth and signature of physician or registered nurse;

    c. Crib card bearing child's name and date of birth;

    d. Immunization record;

    e. Baptismal record: official copy bearing the seal of the issuing church;

    f. Confirmation record: official copy bearing the seal of the issuing church;

    g. School identification card;

    h. Military records: this may include a military identification card or discharge papers;

i. Marriage certificate/marriage license;

j. Driver's license;

k. Age of Majority identification card;

l. Passport, Visa or Foster Care Health Passport;

m. Immigration or Naturalization record;

n. Social Security Card;

o. Medical Assistance card; or

p. Any other documentation that establishes the applicant's identity except a WIC Verification of Certification, which may not be used for proof of identification.

2. At subsequent recertification appointments documents from B.1. may be provided for proof of identification. Additionally, one of the following documents shall be an acceptable proof of identity:

    a. Scanned photo identification for the applicant on file in the Maryland WIC management information system;

    b. Validated Maryland WIC Identification Folder; or

    c. Visual personal recognition.

3. Applicants that are unable to provide proof of identity may use the Proof of Identity Affidavit form 2.23A. Criteria to use this form include, but are not limited to, a homeless applicant, victims of fire or theft, illegal aliens, or teenagers who were put out of their homes. Staff should request that the participant bring proof of identity to their next appointment, if possible.

4. If an applicant does not provide any of the documentation listed in B.1 – 3 above, the local agency shall enter “No Proof” in the Proof of Identity field in the management information system. Local agencies shall allow the applicant up to 30 days after the certification to provide documentation of identity. If documentation is not provided by the end of the 30 day certification, then the participant shall be terminated by the management information system. Participants may have their certification end date restored to the full certification period if documentation is provided before the 30 days has expired. Under no circumstances may a second, subsequent 30 day certification period be used if the applicant fails to

provide the required documentation of identity.

5. At all other appointment types or contacts, documents from B.1. and B.2. are preferred for proof of identification, but verbal verification of identification may be used. Local agencies that elect to use verbal verification shall request a minimum of two identifiers from the participant record, such as date of birth, and mailing address.

Attachments: 2.23A Proof of Identity Affidavit

References:
1. CFR 246.7 (c)(2)(i)
2. SFP 99-078 *Strengthening Integrity in the WIC Certification Process*

Revisions:

July 2002	Added check pick up appointments to C
April 2008	Added at authorized stores to C.
October 2010	Changed reference from 7 CFR 246.7(k)(2) to 7 CFR 246.7(c)(2)(i)
October 2014	added language about short certs
06/07/2017	Removed VOC as a valid form of ID and added Maryland WIC ID folder to the list rather than written in a paragraph.
09/24/2019	Added clarification regarding scanned identification, verbal verification of ID, and edited attachment A.

Maryland WIC Program
Proof of Identity Affidavit

I am unable to provide proof of my/my child's identity because: _____

_____

_____.

_____ _____

Name of applicant present for Certification | Applicant's Date of Birth

_____ _____

Head of Household's (HOH) Full Name | HOH's Date of Birth

_____ _____

Physical Address: Street Address | Phone Number

_____

Physical Address: City, State, Zip Code

By signing this affidavit, I am certifying that the above information is correct to the best of my knowledge. I have not made a false or misleading statement or intentionally withheld facts to obtain WIC benefits.

_____ _____

Head of Household or Designee Signature | Date of Signature

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.24
Effective Date: April 1, 1993
Revised Date: October 7, 2024

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Establishment of Participant Category

A. Policy

To be certified as eligible for the WIC Program, applicants shall meet categorical criteria for eligibility. The category of applicants shall be established according to the following definitions:

Pregnant woman (PG) means a woman determined to have one or more embryos or fetuses in utero.

Postpartum woman (WPP) means a woman up to six months after termination of pregnancy.

Breastfeeding woman means a woman up to one year postpartum who provides their breastmilk to their infant (who is certified on WIC) on average of at least once per day. A non-birth parent who is providing breastmilk to an infant they are legally responsible for, may be certified as a breastfeeding parent. Two participants cannot be certified as breastfeeding parents for the same infant (see Policy and Procedure 5.09). There are two subcategories of breastfeeding women. They are:

> **Exclusively breastfeeding woman (BE)** means a woman who has at least one infant who receives breastmilk on average of at least once per day and no formula from the Program.
>
> **Partially breastfeeding woman (BP)** means a woman who has at least one infant who receives breastmilk on average of at least once per day and formula from the Program. The categories of partially breastfeeding-mostly and partially breastfeeding-some will be applied in conjunction with the amount of formula allotted to the breastfeeding infant.

Infant means a person under one year of age.

> **Exclusively breastfeeding infant (IBE)** means an infant whose main source of nutrition is breastmilk and receives no formula from the

Program.

Partially breastfeeding infant (IBP) means an infant who receives breastmilk on the average of at least once per day and formula from the Program. An infant **partially breastfeeding-mostly** receives ≤ 14 ounces per day of reconstituted formula from the Program. An infant **partially breastfeeding-some** receives >14 ounces per day of reconstituted formula from the Program.

Formula fed infant (IFF) means an infant whose main source of nutrition is infant formula and does not receive breast milk on average of at least once per day.

Child (C1, C2, C3, C4) means a person who has had a first birthday but has not yet attained a fifth birthday.

B. Procedure

The management information system determines participant categories by using the birth date and pregnancy or breastfeeding status entered. Local agency staff shall change a participant's pregnancy or breastfeeding category according to established management information system procedures.

Although it is desirable that the pregnant applicant presents documented proof of pregnancy, federal Program regulations do not require documentation as a condition of eligibility; and WIC benefits cannot be denied to a pregnant applicant who does not provide documented proof of pregnancy. Local agencies shall allow pregnant participants up to 60 days after certification to provide documentation.

The local agency may ask the applicant to provide proof of pregnancy as long as the applicant does not incur a cost to verify pregnancy. If available, local agencies shall refer the pregnant applicant to a clinic where a pregnancy test can be performed without cost to the applicant.

If documentation of pregnancy is not provided in 60 days, the participant shall be reassessed for: (1) a second 60 day period if the pregnancy is not obvious (e.g. the woman does not look pregnant) with a request that proof of pregnancy be provided; or (2) a reinstatement of the existing certification period if pregnancy is obvious.

With each successful contact with a breastfeeding infant's parent or designee, the Breastfeeding Intake grid shall be updated to assure breastfeeding categories are accurate. If the amount of breastfeeding remains the same as previously documented, staff shall document with today's date to indicate the current status.

References:

1. CFR 246.2 Definitions
2. CFR 246.7 (c)(2)ii Eligibility Criteria and Basic Certification Procedures

Revisions

10/2003	WICWINS References
10/2012	Changed 60 days to 30 days for short cert
10/2015	Changed 30 days to 60 days and clarified referral for free pregnancy testing if available
9/2020	Removed WOW verbiage; updated references; clarified definition of breastfeeding and added definitions of partial breastfeeding for both women and infants
10/2024	Edited breastmilk to be one word rather than two. Added information that non-birth parents who breastfeed an infant can be certified as breastfeeding participants. Added paragraph in policy section documenting requirement to update breastfeeding intake grid with each successful participant contact.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number 2.25
Effective Date: October 1, 1995
Revised Date: October 1, 2013

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Voter Registration**

A. POLICY.

The intent of the National Voter Registration Act of 1993 is to increase the number of citizens registered to vote and to establish safeguards that ensure a citizen's right to register to vote. The Act is designed to increase the number of Americans registered to vote by requiring many public agencies, including local agency WIC certification clinics, to provide registration opportunities to their clients or anyone else requesting to be registered to vote.

Local agencies shall provide all individuals applying for WIC Program benefits or the parent/caregiver/designee of individuals applying for WIC Program benefits an opportunity to register to vote at each certification and recertification visit.

Local agencies shall also provide assistance to other individuals who express an interest in registering to vote at any time.

B. PROCEDURE.

The local agency shall:

1. Inform each applicant or the applicant's parent/caregiver at the initial certification:

    a. "As part of the services of the WIC Program we are offering you the opportunity to register to vote."

    b. "Applying to register to vote, declining to register to vote, or refusing to complete the Voter Registration Agency Certification section of the Applicants Right and Responsibility form will not affect your participation in the WIC Program."

    c. "If you are not registered to vote where you now live, would you like to apply to register to vote?"

2. Ask the applicant or the applicant's parent/caregiver at the initial certification to:

   a. Read or have read to them the Voter Registration Certification form (Attachment 2.25B);

   b Provide a response to question number 1 on the Voter Registration Agency Certification form and enter the response in the management information system; and

   c. Sign on the electronic signature device as instructed by the local agency staff.

3. For those WIC applicants or parents/caregivers/designees who want to register to vote and other individuals who express an interest:

   a. Give the individual the voter registration application (Attachment 2.25A);

   b. Ask the individual if he/she would like help in completing the voter registration application;

   c. Provide assistance to those individuals who would like help in completing the registration application; and

   d. Ask the individual if he/she would like the WIC Office to mail the completed voter registration application to the local election board.

   e. Individuals who accompany the applicant or the parent/caretaker of an infant or child applicant who express an interest in registering to vote do not need to complete the Voter Registration Agency Certification section of the Applicant's Rights and Responsibilities form.

4. Local agency staff shall document in the management information system, the applicant or the applicant's parent/caregiver/designee response to the voter registration questions.

5. Advise the applicant or the applicant's parent/caregiver/designee that the voter registration applications can be transmitted to the local Board of Elections in one of two ways:

   a. Directly by the applicant; or
   b. By the local agency office.

   An applicant or the applicant's parent/caregiver may, if he or she chooses, mail the voter registration application directly to the appropriate State

election official rather than returning it to the local agency office for transmittal. The local agency office providing voter registration services is prohibited from requiring registrant to mail the form.

If the local agency mails the completed voter registration application, the local agency shall date stamp each completed card in the two sections the applicant filled in and forward the card within 5 days to the appropriate registration official as listed on the form (Attachment 2.25A). The local agency must provide regular, visible means for collecting voter registration applications.

6. When a clinic serves a significant proportion of non-English speaking applicants or applicants with limited English and many applicants speak the same language, the local agency shall ensure:

   a. That required voter registration information is provided to such persons in the appropriate language orally and in writing; and

   b. That bilingual staff or interpreters are available to assist in completing the voter registration application.

C. ADMINISTRATION.

1. The local agency shall administer the voter registration program by:

   a. Appointing a person to be in charge of, and responsible for, voter registration activities;

   b. Training all employees involved with registration activities; and

   c. Ensuring the accountability of voter registration forms.

2. Local agency staff working on voter assistance activities shall not:

   a. Directly or indirectly seek to influence an applicant's political preference or party or answer any question regarding party other than he must be enrolled in a party in order to vote in a primary election;

   b. Make any statement to an applicant or take any action the purpose or effect of which is to discourage the applicant from registering to vote; or

   c. Make any such statement to an applicant or take any action the purpose or effect of which is to lead the applicant to believe that a

decision to register or not to register has any bearing on the availability of WIC Program services or benefits.

Attachments: 2.25A Voter Registration Application
2.25B Voter Registration Certification form

References: National Voter Registration Act of 1993
State of Maryland House Bill 650

Revisions

October 1999	
October 2003	WICWINS References
October 2008	Changed “clinic” to read “certification and recertification in B.1 and B.4 Changed the term “declination form” to “Applicant’s Rights and Responsibilities form” and entered table in B.5
January 2009	Changed “clinic” to read “certification and recertification in B.1 that failed to be corrected in 10-08
October 2012	Corrected typo in C.2.c
October 2013	Revised wording to include the revised Participant Rights and Responsibilities form procedures.

! After This Form Is Filled Out, You Must Sign And Mail It To Your County Board of Elections.
It Cannot Be Processed If It Is Faxed or E-mailed, Because It Requires An Original Signature.

MARYLAND VOTER REGISTRATION APPLICATION

TO REGISTER, YOU MUST

- Be a U.S. citizen;
- Be a Maryland resident;
- Be at least 16 years old*;
- Not be under guardianship for mental disability or if you are, you have not been found by a court to be unable to communicate a desire to vote;
- Not have been convicted of buying or selling votes;
- Not have been convicted of a felony, or if you have, you have completed serving a court-ordered sentence of imprisonment, including any term of parole or probation for the conviction.

*You may register to vote if you are at least 16 years old but cannot vote unless you will be at least 18 years old by the next general election.

DEADLINE INFORMATION

- This application must be postmarked no later than 21 days before an election.
- If your application is complete and you are found to be qualified, a Voter Notification Card will be mailed to you.
- The submission of this form to an individual other than an official, employee, or agent of a County Board of Elections does not assure that the form will be submitted or filed in a timely manner.

YOU CAN USE THIS FORM TO

- Register to vote in federal, state, county, and municipal elections in Maryland.
- Change your name, address, or party affiliation.

INSTRUCTIONS

- If you do not have a current, valid Maryland driver's license or MVA ID card, you must enter the last 4 digits of your social security number. The statutory authority allowing officials to request the last 4 digits of your social security number is Election Law Article, § 3-202. The number will only be used for registration and other administrative purposes. It will be kept confidential.
- Complete Items 1–11 in Voter Registration Application. Sign and date Item 12. If you are registered to vote in another Maryland county or another state, you must complete Items A–B in Last Voter Registration.
- You must register with a party if you want to take part in that party's primary election, caucus or convention. Check one box only.
- Address and mail the application to your County Board of Elections, using the list on the back panel.

VOTER REGISTRATION APPLICATION PLEASE COMPLETE IN BLACK INK

1 *Are you at least 16 years old?* ☐ *Yes* ☐ *No*
Are you a U.S. citizen? ☐ *Yes* ☐ *No* **If you answer NO to either question, do not complete this form.**

2 *Check boxes that apply and complete Items 3–12.*
☐ *New Registration* ☐ *Name Change* ☐ *Party Affiliation Change* ☐ *Address Change*

3 *Last Name* | *First Name* | *Middle* | *Suffix*

4 *Sex:* ☐ *Male* ☐ *Female*

5 *Birth Date:* *Month* / *Date* / *Year*

6a **MARYLAND** *Driver's License or MVA ID Number* **MANDATORY** *(If you have neither see instructions)*

6b *Social Security Number (last 4 digits)*

6c ☐ *Check here if you do not have either a current, valid Maryland driver's license / MVA ID card or a Social Security Number*

7 *Maryland Residence Address:* *Street Number* | *Street Name* | *Apt. No.* | *City or Town* | *Zip Code* | *County*
☐ *Check here if you reside in Baltimore City.*

8 *Mailing Address (if different from Item 7)*

9 *Party (check one):* ☐ *Democratic Party* ☐ *Republican Party* ☐ *Green Party* ☐ *Libertarian Party* ☐ *Americans Elect Party*
☐ *Unaffiliated (independent of any party)* ☐ *Other – Specify* _____

10 **CONTACT INFORMATION**
Daytime Phone: *Email (optional):*

11 ☐ *Check here if you would like information on polling place assistance for elderly, disabled or voters unable to write or read the ballot.*
☐ *Check here if you would like information on working as an election judge for your County Board of Elections.*

12 *Under penalty of perjury, I hereby swear or affirm: I am a U.S. citizen. ■ I am a Maryland resident. ■ I am at least 16 years old. ■ I have not been convicted of buying or selling votes. ■ I have not been convicted of a felony, or if I have, I have completed serving a court-ordered sentence of imprisonment, including any term of parole or probation for the conviction. The information in this application is true to the best of my knowledge, information and belief.*
Signature (required) | *Date*
X

LAST VOTER REGISTRATION INFORMATION (if applicable)

A *Name on Last Registration:* *Last Name* | *Title (Jr., Sr., etc.)* | *First Name* | *Middle Name* | *Date of Birth*

B *Address on Last Registration:* *Street Number* | *Street Name* | *Apt. No.* | *City or Town* | *Zip Code* | *State*

Maryland State Board of Elections SBE 03-202-1 Rev 09/12 Internet VRA

! After This Form Is Filled Out, You Must Sign And Mail It To Your County Board of Elections. It Cannot Be Processed If It Is Faxed or E-mailed, Because It Requires An Original Signature.

MARYLAND VOTER REGISTRATION APPLICATION

WARNING

Giving false information to obtain voter registration is perjury and punishable by a fine of up to $1,000, or by imprisonment for up to 5 years, or both.

PERSONAL RECORDS NOTICE/CONFIDENTIALITY

This form collects personal information for voter registration purposes. If you are not registered to vote and you refuse to provide this information, you will not be allowed to vote in Maryland. You may update your voter registration at any time at your County Board of Elections. Except for items specified as confidential, voter registration records are generally available for public inspection; they may also be shared with jury commissioners/clerks or other government agencies as provided by law. The law prohibits use of voter registration records for commercial solicitation purposes. If you decline to register to vote, that fact will remain confidential and will be used only for voter registration purposes.

If you register to vote, the identity of the office at which the application is submitted will remain confidential and will be used only for voter registration purposes.

QUESTIONS

Visit the State Board of Elections website at www.elections.state.md.us to verify your registration, find your polling place, and find out other important information. If you have any questions, call your County Board of Elections or the State Board of Elections at the numbers listed on the back of the application.

If you register to vote, the identity of the office at which the application is submitted will remain confidential and will be used only for voter registration purposes.

! Large type Voter Registration Applications available upon request to your County Board of Elections or the State Board of Elections.

County Board of Elections

Allegany County
701 Kelly Road, Suite 213
Cumberland, MD 21502-2887
301-777-5931

Anne Arundel County
P.O. Box 490
Glen Burnie, MD 21060-0490
410-222-6600

Baltimore City
Charles L. Benton Bldg.
417 E. Fayette Street, Rm. 129
Baltimore, MD 21202-3432
410-396-5550

Baltimore County
106 Bloomsbury Avenue
Baltimore, MD 21228
410-887-5700

Calvert County
P.O. Box 798
Prince Frederick, MD 20678-0798
410-535-2214
DC Line 301-855-1376

Caroline County
Health & Public Services Bldg.
403 S. Seventh Street, Suite 247
Denton, MD 21629-1335
410-479-8145

Carroll County
300 S. Center Street, Rm. 212
Westminster, MD 21157-5248
410-386-2080

Cecil County
200 Chesapeake Blvd.
Suite 1900
Elkton, MD 21921-6395
410-996-5310

Charles County
P.O. Box 908
La Plata, MD 20646-0908
301-934-8972
301-870-3167

Dorchester County
501 Court Lane, Rm. 105
P.O. Box 414
Cambridge, MD 21613-0414
410-228-2560

Frederick County
Winchester Hall
12 E. Church Street
Frederick, MD 21701-5447
301-600-VOTE (8683)

Garrett County
Public Service Center
2008 Maryland Highway, Suite 1
Mountain Lake Park, MD 21550-6349
301-334-6985

Harford County
133 Industry Lane
Forest Hill, MD 21050-1621
410-638-3565

Howard County
9770 Patuxent Woods Drive, Suite 200
Columbia, MD 21046
410-313-5820

Kent County
135 Dixon Drive
Chestertown, MD 21620-1141
410-778-0038

Montgomery County
P.O. Box 4333
Rockville, MD 20849-4333
240-777-VOTE (8683)
TDD 800-735-2258

Prince George's County
16201 Trade Zone Ave., Suite 108
Upper Marlboro, MD 20774
301-430-8020

Queen Anne's County
P.O. Box 274
Centreville, MD 21617-0274
410-758-0832

St. Mary's County
P.O. Box 197
Leonardtown, MD 20650-0197
301-475-7844 ext. 1100

Somerset County
P.O. Box 96
Princess Anne, MD 21853-0096
410-651-0767

Talbot County
P.O. Box 353
Easton, MD 21601-0353
410-770-8099

Washington County
35 W. Washington Street
Room 101
Hagerstown, MD 21740-4833
240-313-2050

Wicomico County
P.O. Box 4091
Salisbury, MD 21803-4091
410-548-4830

Worcester County
100 Belt Street
Snow Hill, MD 21863-1300
410-632-1320

Maryland State Board of Elections SBE 03-202-1 Rev 09/12 Internet VRA

MARYLAND WIC PROGRAM

VOTER REGISTRATION AGENCY CERTIFICATION

1. If you are not registered to vote where you live now, would you like to apply to register to vote here today?

   YES _____ NO _____ ALREADY REGISTERED _____

2. **IF YOU DO NOT CHECK ANY, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

3. Applying to register or declining to register to vote will not affect the assistance that you will be provided by this agency.

4. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private.

5. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether or register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

   Maryland State Board of Elections
   PO Box 6486
   Annapolis, MD 21401-0486
   800-222-8683

6. If you decline to register to vote, your decision will remain confidential and be used only for voter registration purposes.

7. If you decide to register to vote, information regarding the office to which the application was submitted will remain confidential, again to be used only for voter registration purposes.

Applicant's Signature: Date:

Applicant Name:

PROGRAMA WIC DE MARYLAND

CERTIFICADO DE LA AGENCIA DE REGISTRO DE VOTANTES

1. ¿Si no está registrado en el lugar donde vive para votar, quisiera registrarse para votar aquí el día de hoy?

   SÍ _____ NO _____ ESTOY REGISTRADO _____

2. **SI NO ELIGE NINGUNA OPCIÓN, SE CONSIDERARÁ QUE HA TOMADO LA DECISIÓN DE NO REGISTRARSE AHORA PARA VOTAR.**

3. Registrarse o no registrase para votar, no afectará la ayuda que le proporcionará esta agencia.

4. Si necesita ayuda para completar el formulario de solicitud de registro del votante, le brindaremos nuestra asistencia. La decisión acerca de buscar o aceptar ayuda es suya. Puede completar la solicitud en privado.

5. Si considera que alguien interfirió con su derecho de solicitar o declinar el registro para votar, su derecho a la privacidad para decidir si registrarse o solicitar el registro, o su derecho de elegir su propio partido político u otra preferencia política, puede enviar un reclamo a:

   Maryland State Board of Elections
   PO Box 6486
   Annapolis, MD 21401-0486
   800-222-8683

6. Si decide no registrarse para votar, su decisión será confidencial y se usará solo para fines de registro del votante.

7. Si decide registrarse para votar, la información de la oficina a la cual se envió la solicitud será confidencial, y una vez más se usará solo para fines de registro del votante.

Firma del interesado: Fecha:

Nombre del interesado:

Policy and Procedure 2.26 was changed to Policy and Procedure 2.34.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.27
Effective Date: May 24, 2003
Revised Date: July 28, 2020

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Immunization Record Screening (DTaP)**

A. Policy

Low income children are more likely than higher income children to be delayed in receiving standard immunizations, placing them at high risk for potentially serious diseases including diphtheria, pertussis, measles, mumps, and rubella. As an adjunct to programs that provide immunizations, local agencies shall perform immunization screening, determine a child's need for immunizations, provide immunization information and referrals with caregivers, including where to get a child immunized, and share information with local immunization offices.

B. Procedure:

1. The local agency staff person making the applicant's certification appointment shall:

    a. request that a documented record of immunization for all infant or child applicants under 2 years of age be brought to the appointment;

    b. inform the caregiver that appropriate immunization status and provision or release of immunization information is not a requirement for application or participation in the WIC Program.

2. At each certification local agencies shall:

    a. Enter into the management information system whether a documented immunization record was received. A documented record includes a caregiver's hand-held immunization record from the health care provider, an immunization registry, an automated data system or a client chart.

    b. Enter into the management information system the actual dates DTaP immunization(s) were received. The current recommended immunization schedule can be found on the Center for Disease Control's website.

c. Ask the caregiver to request that the health care provider clarify the dates if the document is difficult to read. If the documented immunization record is difficult to read, select “illegible” from the dropdown under the “special” column on the immunizations screen.

d. Inform the caregiver of the apparent status of the immunizations based on the information provided on the immunization screen in the management information system. The message will either be that the immunizations are on schedule (*Good or OK*), or that the child needs to be referred to their health care provider (*Due or Refer).* If the child appears to be on schedule, congratulate the caregiver and encourage them to continue to follow through with timely immunizations. Those infants and children whose status is due, refer, or whose record was illegible or not provided to the local agency, shall be referred to their health care provider or local immunization program for immunization services. This referral shall be documented in the participant’s record.

e. Have information available in clinic regarding the recommended immunization schedule and provide this information to the caregiver if needed.

f. Advise the caregiver that the *Participant Immunization Report*, which can be printed from the immunization screen at the local agency's discretion, cannot be used as a documented immunization record for the child.

3. Local agencies may at their discretion, and in accordance with policy and procedure 7.70, contact the health care provider or local immunization program to receive actual immunization dates for those clients who did not provide a documented record. Local agency staff choosing this option may accept the information verbally and should request a copy of the record (electronic or physical) from the health care provider or immunization program.

4. Local agencies shall provide aggregate or cumulative immunization information to the local health department's immunization program on a monthly basis.

References:

SFP 01-111 Immunization Screening and Referral in WIC SFPD #01-7

Revisions:

10/01/08 Section B. 3. Changed WOW User’s Manual to read WOW clinic help screen

10/2010	Section B. 4. Clarified role of designee
10/2012	Deleted references to WOW
1/2017	Updates in procedure due to changes in the management information system. Clarified appropriate educational material resource of CDC or Maryland Immunization Program handouts.
7/28/2020	Clarified that a written document is preferred but actual dates of immunization can be received verbally from the health care provider or local immunization program using the Immunet data registry and removed procedure from the policy section.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.28
Effective Date: October 1, 2003
Revised Date: November 9, 2023

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Blood Lead Screening Requirement**

A. Policy

When completing the medical assessment of an applicant, local agency staff shall ask the participant/parent or caregiver if the applicant has had a blood lead test to screen for lead poisoning. If it cannot be determined that the test has been performed, the local agency staff shall refer the participant/parent or caregiver to a program where the test can be obtained and offer information regarding the dangers of lead poisoning.

The Maryland Healthy Kids Program Schedule of Preventive Care requires that health care providers complete a verbal lead assessment starting at 6 months of age and repeated at each visit through 5 years of age. A blood lead test is required at the ages of 12 and 24 months.

B. Procedure

1. Staff shall ask the participant/parent or caregiver if the applicant has had a blood lead test. If the response is “no” or “don’t know,” staff shall:

   For women applicants:
   - Offer education such as the *Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children* and direct her to discuss any positive responses with her health care provider.
   - Document the referral and education in the management information system.

   For children applicants:
   - Explain why children may need a blood test for lead;
   - Offer education such as the *Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children* or the age appropriate *Help Me Be Healthy* and direct the parent or caregiver to discuss any positive responses with the child’s health care provider;
   - Recommend that the caregiver inquire about the blood lead test at the child’s next scheduled health care appointment;

- Provide information about medical assistance if the child has no source of health care;
- Provide supplemental information about childhood lead poisoning; and
- Document the referral and nutrition education in the management information system.

For infant applicants:

- Infants do not routinely receive blood lead tests. If the caregiver indicates that the infant has been tested for suspected elevated blood lead staff shall:
    i. Document the blood lead level in the management information system, if known
    ii. Offer education such as the *Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children*
    iii. Refer the family to the health care provider or the health department if not already being followed and;
    iv. Document the referral and nutrition education in the management information system.

2. Staff may provide information about the importance of the blood test and the dangers of lead poisoning by:

    - Highlighting the message about the need for a blood lead test in the *Help Me Be Healthy* pamphlets for children aged 12 and 24 months to remind caregivers to discuss the issue with their child's health care provider.

    - Both the *Lead Poisoning: Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children* and the *Help Me Be Healthy* pamphlets are available through the Maryland WIC Distribution Center.

3. If the woman or child has had a blood test for lead and the test result is known, staff shall enter the blood test result in the Medical Screen of the participant.

Attachments: 2.28 A Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children

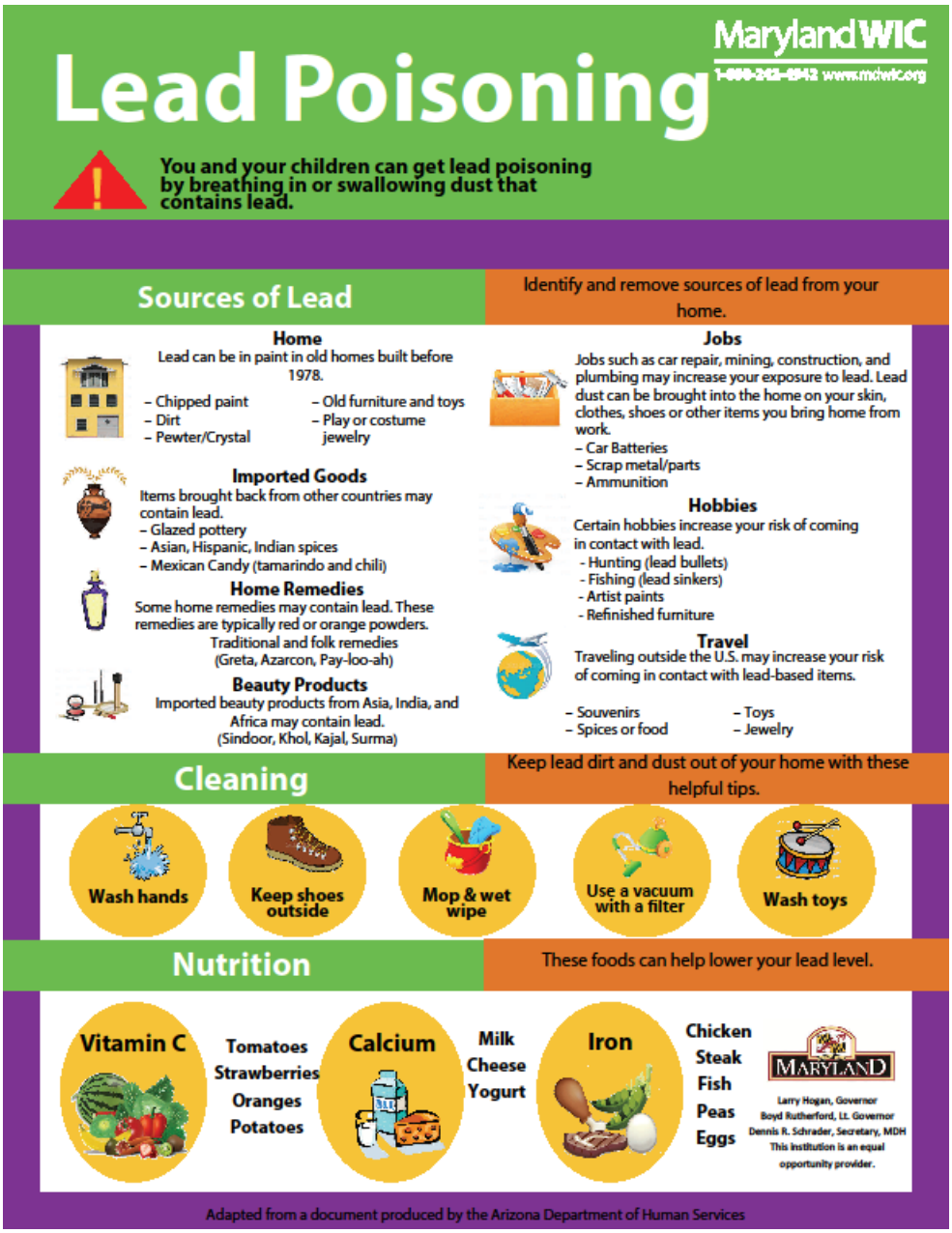
Reference: WIC Final Policy Memo 2001-1
SFP 93-113 WIC's Role in Screening for Childhood Lead Poisoning

Revisions:

10/2011	Updated MDE website
10/2012	Updated MDE website
01/2018	Removed MDE website; Updated procedure to include

	screening of women applicants and added attachment A
10/2023	Clarified instructions of infants vs children

Maryland WIC Lead Risk Screening Questionnaire for Pregnant or Breastfeeding Women and Children



Maryland WIC Lead Risk Assessment Tool for Pregnant or Breastfeeding Women and Children

If you answer "Yes" or "Don't Know" to ANY of the questions or have concerns about lead, please discuss them with your health care provider. A blood lead test may be needed.

Question	Yes	No	Don't Know
1. Do you or your child/children eat any nonfood items, such as clay, crushed pottery, soil, paint chips, paper, or baking soda?			
2. Does your child often put items such as jewelry or keys in his/her mouth?			
3. Have you or your child/children ever lived in or often visited a home or building built before 1978 with peeling or chipping paint or that has been repaired?			
4. Have you or your child/children ever spent a lot of time outside the United States?			
5. -Do you use products from other countries such as health remedies, spices, or food? -Do you use traditional "kohl" make up? (also known as "kajal" or "kuul")			
6. Do you serve or store food in lead crystal, handmade or imported pottery, or pewter?			
7. Have any of your children, their playmates, or others in your home had lead poisoning?			
8. Do you have a child who was born before January 1, 2015, who has not had a blood lead test?			
9. -Do you or others in your household have a job that involves exposure to lead, like auto repair; plumbing; painting; ship building; steel welding; battery, glass, or lead manufacturing; or work with lead bullets? -Do your children have contact with an adult whose job or hobby involves exposure to lead?			
10. Do you or others in your household have hobbies or activities likely to cause regular exposure to lead, like making stained glass, pottery, fishing lures or sinkers; gun and rifle activities; refinishing furniture; renovating or remodeling homes?			
11. Do you or your children live near an active lead smelter, battery recycling plant, other lead-related industry, or near a road where soil and dust may be contaminated with lead?			
12. Do you eat deer meat or other animals shot with lead bullets?			
13. Do you have any bullets in your body from past gunshot wounds?			

Adapted from the 2016 Maryland Guidelines for the Assessment and Management of Childhood Lead Exposure. Maryland Department of Health and Mental Hygiene, and the Minnesota Department of Health.

Policy and Procedure 2.29 has been removed.

October 2008

Policy and Procedure 2.30 has been removed.

October 2008

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.31
Effective Date: October 1, 1990
Revised Date: 1/7/2026

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Assessment of Nutritional Risk**

A. Policy

To be certified as eligible for the WIC Program, an applicant who meets the categorical, residency, and income eligibility requirements shall also be assessed for nutritional risk. Nutritional risk assessment shall include the collection and evaluation of relevant information to determine the presence of federally defined risk factors and to provide the most appropriate nutrition services.

B. Procedure

1. **To perform a nutritional risk assessment of applicants/participants, the local agency shall:**

   a. Obtain and evaluate relevant information that includes:

      - Height (or length) and weight measurements, as described in Policy and Procedure 2.32;
      - Hemoglobin or hematocrit test results, as described in Policy and Procedure 2.33; and
      - Nutrition and health information, as described in Policy and Procedure 2.34.

   b. Enter the data obtained from 1.a. into the applicant's management information system (MIS) record to document and generate nutrition risk factors.

   c. Review all MIS-generated risk factors to ensure that they are correct based on accurate data entry.

   d. Document each risk factor in the applicant's MIS record.

   e. Use the results of the nutritional risk determination to provide the most appropriate nutrition education messages and to make referrals.

Attachments:

2.31A	Nutritional Risk Criteria: Guidelines for Interpretation
2.31B	CHART: Nutrition Risk Criteria

References:

1. 7 CFR 246.7 (e)
2. COMAR 10.54.01.06 C (2)
3. WIC Policy Memorandum 2011-5 WIC Nutrition Risk Criteria
4. WIC Nutrition Services Standards, Standard 7
5. SFP 06-05 Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy
6. SFP 09-057 WIC Policy Memorandum 98-9, Revision 10: Nutrition Risk Criteria

Revisions:

10/10 Renumbered Attachment 2.31 B as 2.31A
Revised new Attachment 2.31A as follows:
Women: Deleted Table WP. Changed Table WN to Table N. Revised definitions of Gestational Diabetes, Diabetes, and Fetal Growth Restriction. Added new risks: History of Preeclampsia, Hypertension/Prehypertension, Post Bariatric Surgery, and Pre-Diabetes.

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Renumbered attachment 2.31C as 2.31B
Revised new Attachment 2.31Bas follows:
Women: Changes were made to Underweight, Overweight, Low Maternal Weight Gain, High Maternal Weight Gain, Hx Gestational Diabetes, Multi-fetal Gestation, Gestational Diabetes, Diabetes Mellitus, GI Disorders, and in Nutrition Practices, the amount of iron was reduced.

Women: Risk codes were added for new conditions including History of Preeclampsia; Hypertension/Prehypertension; Pre-Diabetes; in GI Disorders, Post Bariatric Surgery, and in Nutrition Practices, requiring an iodine supplement.

Infants and Children: changes were made to diabetes mellitus, GI disorders, and Hypertension/Prehypertension. In Nutrition Practices, the following risks were added: Eating unapproved local fish, not giving appropriate fluoride and/or vitamin D supplements.

Deleted Table WP: Weight Status of Pregnant Women
Changed Table WN: Weight Status of Breastfeeding and Postpartum Women to Table W: Weight Status of Pregnant, Breastfeeding and Postpartum Women.
Revised Table H: High Maternal Weight Gain to meet new weight guidelines.
Changed reference from 7 CRF 246.7(d) to 7 CFR 246.7(e)

01/12 Combined Attachments A and B
Revised Attachment A as follows:
Women: Added two thyroid conditions. Added contact information for metabolic

dietitians to Inborn Errors of Metabolism.

Infants and Children: changed cut off values for Underweight/At Risk of Underweight, Obese, Overweight/At Risk of Overweight, Short Stature/At Risk of Short Stature, Low Head Circumference. Added new risk: High Weight for Length. Changed risk names to reflect cut off values. Added two thyroid risks. Added contact information for metabolic dietitians for Inborn Errors of Metabolism.

10/13 Attachment 2.31A: Provided more background information on the following risks: Lactose Intolerance, Food Allergies, Celiac Disease, and Failure to Meet Dietary Guidelines. Added Recipient of Abuse.

10/14 Attachment 2.31A, made the following Procedure changes.
Risk condition *Breastfeeding Mother of Infant at Nutritional Risk*: Changed *"If the* infant is certified before the breastfeeding mother, this risk criterion may be assigned to the woman" to "This risk criterion shall be assigned to a breastfeeding mother of an infant at nutritional risk" and *"*Refer participants whose infants have been identified with any risk criteria below to the breastfeeding specialist" to "Refer participants….to the breastfeeding specialist and to the CPA for Nutrition Care counseling."

Risk condition *Breastfeeding Infant of Mother at Nutritional Risk*: Changed "If the breastfeeding mother is certified before the infant, this risk criterion may be assigned to the infant" to **"**This risk criterion shall be assigned to the breastfeeding infant of a mother at nutritional risk."

05/16 Attachment 2.31A updated Nutrition Risk Criteria related to clarify medical conditions and risk criteria definitions.

10/16 Changed the high risk blood lead level to 5 micrograms/dl for both women and children. Added Breastfeeding Complications or Potential Complications to pregnant woman high risk list and Breastfeeding Mother of Infant at Nutritional Risk to both pregnant woman and breastfeeding high risk lists.
Removed Inadequate Growth risk from both infants and children.

11/17 Revised Attachment 2.31A Nutritional Risk Criteria to clarify medical conditions and risk criteria definitions and background information.

11/19 Updated Justification and Implications for WIC Nutrition Services in Attachment 2.31A for Low Maternal Weight Gain, Hyperemesis Gravidarum, Nutrient Deficiency or Disease, Alcohol or Substance Use, Possibility of Regression, Transfer of Certification, Woman Primary Caregiver with Limited Ability, Drug Nutrient Interaction, History of Preeclampsia, Pregnant Woman Currently Breastfeeding, Hypertension and Prehypertension, and Fetal Alcohol Disorder. Removed Maternal Weight Loss risk and incorporated into Low Maternal Weight

Gain risk.

08/21 Updated risk criteria as follows: Failure to Thrive - added additional background and counseling information. Pregnancy at a Young Age - revised from 18 years old to ≤20 years old and added additional background and counseling information. High Parity & Young Age - discontinued risk as it is now covered by Pregnancy at a Young Age. Nicotine and Tobacco Use - changed risk name from Maternal Smoking to Nicotine and Tobacco Use. Definition/Cut off value now includes any product which contains nicotine and/or tobacco to include but not limited to cigarettes, pipes, cigars, electronic nicotine delivery systems (ENDS) (e.g., e-cigarettes, vaping devices), hookahs, smokeless tobacco (e.g., chewing tobacco, snuff, dissolvables), or nicotine replacement therapies (e.g., gums, patches); added additional background and counseling information. Environmental Tobacco Smoke Exposure - included information in Nicotine and Tobacco Use risk section.

06/22 Updated upper lead level cut-off for children to ≤ 3.5ug/dL in Attachment 2.31A.

02/23 Updated 2.31A by replacing breast milk with breastmilk (one word).

10/23 Updated background, justification, and implications for WIC Nutrition Services in Attachment 2.31A for Low Hematocrit/Low Hemoglobin, Elevated Blood Lead Levels, Eating Disorders, Mental Illnesses, and Recipient of Abuse.

Pending Updated HIV/AIDS with new breastfeeding information. Updated CHART: Nutrition Risk Criteria to match updated 10/23 risks. Removed CHART from 2.31A and renamed it 2.31B Nutrition Risk Criteria. Updated Table of Contents.

1/26 Updated background, justification, and implications for WIC Nutrition services in Attachment 2.31A for Low Birth Weight, Food Allergies, and Inappropriate Nutrition Practices for Women. Updated Breastfeeding Complications-Woman and -Infant, Breastfeeding Infant and Woman with Nutritional Risk, and Pregnant Woman Breastfeeding to separate Breastfeeding Risks between high and low risks. As needed, included “consider contacting *participant’s* specialist RD”. Removed History of Low Birth Weight which is no longer a risk. Deleted Lists 1, 2, 3, 4, and 5 from Charts and Lists. Adjusted 2.31B Risks CHART to reflect changes to 2.31A.

MARYLAND

BETTER NUTRITION, BRIGHTER FUTURE

Nutritional Risk Criteria: Guidelines for Interpretation

Nutritional Risk Criteria: Guidelines for Interpretation contains all of the allowed nutritional risk criteria that may be applied when determining nutritional risk eligibility of women, infants, or children who apply for WIC Program benefits. No additional risk criteria may be used.

Each **risk criterion** is listed with its definition or cut-off value, justification, WOW code number, and participant category or categories to which it applies. Risk criteria that require nutrition care counseling or referral to a breastfeeding specialist are identified. Guidance is included for the evaluation of each risk criterion and participant focused counseling goals are included. If additional guidance is needed regarding the applicability of a risk criterion, State Agency Nutrition or Breastfeeding Services staff should be consulted.

Tables include information and procedures used to evaluate specific risk criteria.

Frequently Asked Questions address common questions to assist certifiers in assigning specific risk criteria appropriately.

Nutritional risk documentation is required by Federal WIC regulations. Each participant record must document the specific nutritional risk condition(s) for which the applicant was found eligible to receive Program benefits. Appropriate documentation must be included in the record to substantiate the condition(s) and to validate conformance with the definition of the condition(s). Some nutritional risk criteria permit the applicant or caregiver to self-report that the applicant has a condition diagnosed by a physician. A self-reported diagnosis should prompt the CPA or CPPA to validate the presence of the condition by asking more pointed questions related to the diagnosis.

Definitions

In order to ensure consistency in determining nutritional risk eligibility across the State, the following definitions should be applied during the applicant's evaluation:

Date of Conception:	Occurs on the 14th day following the onset of the last menstrual period (LMP).
Trimester:	• First trimester = conception through completed week 13 of gestation. • Second trimester = week 14 through completed week 26 of gestation. • Third trimester = week 27 through completed week 40 of gestation.
Week of gestation:	The last completed week of gestation as estimated by use of a State WIC issued gestation wheel.
Routine:	A feeding, dietary, or lifestyle practice that currently occurs on more than one occasion.

Priority Levels

To be considered at nutritional risk, an applicant must exhibit at least one of the nutritional risk criteria listed in this attachment. Risk criteria fall into one of six priority levels:

Priority I A pregnant or breastfeeding woman or an infant at nutritional risk because of:

a. Detrimental or abnormal nutritional conditions detected by biological or anthropometric measurements;

b. Other documented nutritionally related medical conditions; or

c. Conditions that directly affect the nutritional health of an individual, including depression, smoking, alcoholism or drug use.

Priority II Except for an infant who qualifies for Priority I, Priority II is:

a. An infant younger than 6 months old born to a woman who was a Program participant during her pregnancy;

b. An infant younger than 6 months old born to a woman who was not a Program participant during pregnancy but whose medical records document that the woman was at nutritional risk during the pregnancy due to nutrition conditions detectable by biochemical or anthropometric measurements or other documented, nutritionally related medical conditions that demonstrated the individual's need for supplemental foods; or

c. A breastfeeding mother of a breastfed infant who has been certified in the Program as Priority II.

Priority III A child or postpartum, non-breastfeeding woman at nutritional risk because of:

a. Detrimental or abnormal nutrition conditions detected by biochemical or anthropometric measurements;

b. Other documented nutritionally related medical conditions; or

c. Conditions that directly affect the nutritional status of an individual, including depression, smoking, alcoholism or drug use.

Priority IV A pregnant or breastfeeding woman or an infant at nutritional risk because of:

a. Dietary deficiencies that impair or endanger health; or

b. Conditions that predispose the individual to inadequate nutritional patterns, including homelessness or migrancy; and

c. Breastfeeding woman or infant at nutritional risk because of possibility of regression of nutritional status.

Priority V A child at nutritional risk because of:

a. Dietary deficiencies that impair of endanger health;
b. Conditions that predispose the child to inadequate nutritional patterns including homelessness or migrancy; or
c. Possibility of regression of nutritional status.

Priority VI A postpartum non-breastfeeding woman at nutritional risk because of:

a. Dietary deficiencies that impair of endanger health;
b. Conditions that predispose the individual to inadequate nutritional patterns including homelessness or migrancy; or
c. Possibility of regression of nutritional status.

Maryland WIC Program Scope of Practice – based on USDA WIC Nutrition Services Standards, August 2013.

Definitions

Scope of Practice - Encompasses a staff position's range of unique roles and activities in the provision of information, counseling and support to WIC participants. Each staff position's scope of practice is defined by the required qualifications and job-specific responsibilities for that position.

High Risk – A designation of a participant based on the nutrition risk condition(s). Criteria for a participant being designated "high risk" are based on State agency policy. The nutrition services associated with "high risk" includes an individual care plan, more frequent nutrition education contacts and the provision of nutrition services by a registered dietitian (or other professional).

Nutrition Services Staff

Standard 3 Staff Qualifications, Roles and Responsibilities

Section G. The local agency ensures that the Competent Professional Authority (CPA) has all of the following qualifications:

1. Is a physician or nutritionist (Master's or Bachelor's degree in Nutritional Sciences, Community Nutrition, Clinical Nutrition, Dietetics, Public Health Nutrition or Home Economics with emphasis in Nutrition), dietitian, registered nurse, physician's assistant certified by the National Committee on Certification of Physician's Assistants or certified by the State medical certifying authority, or a State or local medically trained health official.
2. Has successfully completed a competency-based training program on performing the duties of a CPA.
3. Has literacy and language skills appropriate to address the needs of diverse participants.

Section H. The local agency ensures that the CPA performs the following roles and responsibilities within a participant-centered framework to meet participant needs:

1. Assesses and documents a participant's risk(s).
2. Prescribes food packages.
3. Provides nutrition education, including breastfeeding promotion and support that is responsive to the identified needs/interests of each participant.
4. Identifies the need for individual care plans.
5. Refers participants to other health and social services and provides appropriate follow-up to referrals.
6. Implements individual care plans for low-low risk participants.
7. When the CPA is a qualified nutritionist, implements individual care plans for high-risk participants, otherwise, identifies and refers high-risk participants to a qualified nutritionist.
8. Documents nutrition services provided, including referrals and follow-up to referrals.

9. Ensures that screening and referrals for lead testing and immunizations using a documented immunization record is performed.

Section M. The local agency has access to a qualified nutritionist to provide nutrition services to high-risk participants. The nutritionist has the following qualifications:

1. Has successfully completed a training program approved by the State agency on the provision of WIC nutrition services to high-risk participants AND
2. (Preferably) has credentials of a Registered Dietitian (R.D.) or eligible for registration with the Academy of Nutrition and Dietetics' Commission on Dietetic Registration; if applicable, has State license or certified as a nutritionist/dietitian OR
3. Holds a Bachelor's degree in the field of nutrition from an accredited college or university OR
4. Holds a Master's or Doctoral degree in nutrition from an accredited college or university.

Table of Contents

Alcohol and Substance Use

(3721) **Categories: PG, BE/BP, WPP**

Defined as:

Pregnant Woman:

- Any alcohol use
- Any illegal substance use and/or abuse of prescription medications.
- Any marijuana use in any form.

Breastfeeding or Non-Breastfeeding Postpartum Woman:

- Alcohol Use:
  - High Risk Drinking: Routine consumption of ≥8 drinks per week or ≥4 drinks on any day.
  - Binge Drinking: Routine consumption of ≥4 drinks within 2 hours.
- Any illegal substance use and/or abuse of prescription medications.
- Any marijuana use in any form (breastfeeding women only).

A woman identified with alcohol or marijuana use, any illegal substance use, or abuse of prescription medications should have Nutrition Care counseling.

Best Practice: provide Nutrition Care follow-up in 3-6 months.

Breastfeeding is contraindicated for women identified with ongoing binge drinking, marijuana use, illegal drug use, or prescription drug abuse. See Neonatal Abstinence Syndrome (and below) for recommendations for Breastfeeding while taking Methadone or other supervised withdrawal medications.

A woman compliant with methadone or other maintenance treatment may be certified using the Drug Nutrient Interaction risk by checking Supervised Drug Maintenance Program in the medical conditions drop down list.

Justification:

Maternal substance use during and after pregnancy can have a long-term impact on both the mother and her child:

- Nutrition Issues: Vitamin and mineral deficiencies and malnutrition, damage to vital organs and nervous system, and decreased immunity.

- Obstetrical and Prenatal Complications - Substance use (and withdrawal from them) during pregnancy may cause constriction of uterine blood vessels leading to insufficient blood flow to the placenta, separation of the placenta from the uterus, maternal hypertension, maternal hemorrhage, and/or premature labor. These complications may in turn increase risk of fetal loss, premature birth and still birth.
- Personal Health and Safety – Substance use is associated with increased likelihood of death by illness, accident or suicide; intimate partner violence; sexually transmitted diseases, unintended pregnancy, poor parenting practices, child neglect and abuse, physical and mental impairments, frequent arrests and incarceration, and estrangement for primary family and related support.
- Societal Impacts - Substance use is associated with an unstable family structure, separation and divorce, and potential for involvement of Child Protective Services (CPS). The Child Abuse Prevention and Treatment Act [42 U.S.C. § 5106a(b)] requires States to have policies and procedures in place to notify CPS agencies of substance-exposed newborns and to establish a plan of safe care for newborns identified as being affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure. For more information about State-specific requirements please see: https://www.childwelfare.gov/topics/systemwide/laws-policies/state/.

Impact on Children - Children who are exposed to alcohol and other substances prior to birth can experience long-term cognitive, behavioral, social and emotional developmental consequences.

The WIC Program has a mandate to provide information about the dangers of substance abuse to all newly certified participants or their caregivers and to provide referral information regarding substance abuse counseling and treatment to all pregnant, breastfeeding, or postpartum women. A woman who is pregnant may be receptive to supportive counseling that encourages her to avoid substances that can harm her fetus.

The substance-abusing woman should be encouraged to seek treatment and be given information about substance abuse programs in her community.

Alcohol can disrupt body functions by causing nutrient deficiencies of vitamins and minerals. Alcohol inhibits fat absorption and thereby impairs absorption of vitamins A, E, and D which are normally absorbed along with dietary fats. Deficiencies of minerals such as calcium, magnesium, iron, and zinc are common in people who misuse alcohol.

There is no safe consumption of alcohol during pregnancy. Exposure to alcohol in utero can damage the developing fetus at any stage and is the leading preventable cause of birth defects and intellectual and neurodevelopmental disabilities. Alcohol itself can also restrict nutrient flow to the fetus and can result in the infant being born with a Fetal Alcohol Spectrum Disorder (FASD). Fetal Alcohol Syndrome (FAS) is the most severe type of FASD, and can include abnormal facial features, growth and central nervous system problems as well as problems with learning, memory, attention span, communication, vision, or hearing. (See risk *Fetal Alcohol Spectrum Disorder* for more information.)

Marijuana is the illicit drug used most frequently by women of child-bearing age. There is no known safe amount of marijuana use during pregnancy. When inhaled, the smoke goes into the lungs and immediately passes through the membranes and enters the bloodstream. THC can pass from the mother to the unborn child through the placenta if marijuana is ingested or inhaled during pregnancy. Children who are exposed to THC prior to birth can experience decreased academic ability, cognitive function and ability to remain attentive. Although some states have legalized marijuana for a variety of medical conditions upon a doctor's recommendation, as well as for recreational use, marijuana has been shown to have negative effects on brain development. Therefore, it is recommended that pregnant and breastfeeding women not use marijuana.

Opiates and synthetic narcotics (e.g., heroin, oxycodone, Vicodin, Narco, Percocet, morphine, dilaudid) have serious health risks associated with their use including endocarditis; coma or sudden death from overdose; risk of HIV; and, if injected, viral hepatitis and other infections. Substance use during pregnancy can lead to neonatal abstinence syndrome (NAS), withdrawal symptoms by an infant after birth. Prenatal opioid exposure increases the risk of low birth weight, stillbirth and sudden infant death syndrome (see *Neonatal Abstinence Syndrome*).

Alcohol and Substance Use during Breastfeeding

The American Academy of Pediatrics (AAP) recommends that **alcoholic beverages** be minimized and limited to occasional intake for breastfeeding women as follows:

- Consult with a health care provider before consuming alcohol.
- Do so only if breastfeeding is well established, consistent and predictable.
- Minimize alcoholic beverages to occasional intake.
- Limit to a single alcoholic drink (not more than one unit of alcohol) and wait at least 1 ½ - 2 hours before breastfeeding or expressing milk that will be fed to the baby, to ensure the alcohol is not likely to be present in the milk.
- Breastfeed the infant or express human milk before consuming alcohol.

Due to the lipophilic nature of THC found in **marijuana**, it is tremendously fat-soluble and therefore is readily transferred to human milk. Marijuana can impact the neurobehavioral development of the infant, and the AAP considers it to be a contraindication to breastfeeding.

The maternal use of **illegal substances** and the **misuse of prescription medicine** is a contraindication to breastfeeding. However, according to the AAP, appropriate maternal use of **prescribed medication, other than marijuana, is not a categorical contraindication to breastfeeding**. For situations in which the mother is undergoing pharmacologic therapy, the benefits of breastfeeding must outweigh the potential risk of substance exposure to the infant. For example, research has shown that adequately nourished narcotic-dependent mothers should be encouraged to breastfeed if they are enrolled and compliant in a supervised medication-assisted treatment program and have negative toxicology screens for HIV and illicit drugs. (See *Neonatal Abstinence Syndrome*.)

For more information, please see the *Substance Use and Prevention Manual: Screening, Education and Referral Resource Guide for Local WIC Agencies*: https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide

Implications for WIC Nutrition Services

WIC staff are required to refer participants known or suspected of substance use, to existing assessment agencies for professional evaluation and treatment, as appropriate. In addition to providing referrals and coordinating/facilitating services, WIC's role is to educate women participants, parents, and caretakers of participating infants and children about substance use–related problems with the intended effects of increasing participants' access to information about the dangers of substance use and abuse during pregnancy and breastfeeding as well as postpartum. WIC also provides supplemental foods that are rich in the nutrients lost from alcohol and substance misuse. WIC staff can:

- Provide referrals (and follow-up on the referral) for professional assessment and treatment. **Do not advise a woman who uses narcotics to stop using on her own.** This step should be taken only under the supervision of a physician or treatment specialist.
- Encourage women to improve their lifestyle and health habits during pregnancy and postpartum, since the concern for fetal health and/or the desire to be a good role model can be a powerful motivator to reduce or stop substance use.
- Emphasize the importance of substance abuse treatment during the postpartum period to safeguard the health of the mother and reduce the risk in subsequent pregnancies
- Recommend the Dietary Guidelines for Americans to address nutrition deficiencies associated with substance use.
- Provide breastfeeding promotion and support to women enrolled in and compliant with supervised medication-assisted treatment programs.
- Recommend that the ingestion of beverages containing alcohol be minimized and limited to occasional intake for breastfeeding women. Provide instruction to wait at least 1 ½ - 2 hours after consuming up to one standard size alcoholic drink before breastfeeding or expressing milk that is fed to the baby. (If less than the appropriate amount of time has elapsed, the woman should be advised to express her milk and discard it.)
- Refer to community resources for alcohol and substance use support groups.

Procedure:

Assess alcohol intake and substance use:

* One serving or standard size drink is:

- 1 can beer (12 fluid ounces);
- 5 ounces wine; or
- 1/2 fluid ounces liquor (1 jigger gin, rum, vodka, whiskey (80 proof), vermouth, cordials, or liqueurs).

Breastfeeding Complications or Potential Complications - Woman

(6021) **Categories: BE/BP, PG**

Defined as: A breastfeeding woman with any of the complications or potential complications for breastfeeding below.

Refer a woman identified with breastfeeding complications or potential complications to the CPA or IBCLC/DBE as indicated below. Best Practice: see participant immediately; if not possible, within five days.

Justification:

Breastfeeding complications or potential complications can result in inadequate intake and/or Failure to Thrive in the infant. Complications can also cause the mother to produce a lower milk supply. Severe engorgement, often caused by shallow latch, infrequent or ineffective nursing, can result in inadequate milk transfer, pain and diminished milk supply. If not resolved, this can lead to additional complications, such as plugged/clogged ducts, mastitis, and abscess. A plugged/clogged duct results from obstruction of a milk duct.

Failure of milk to come in by 4 days postpartum could result from maternal illness or perinatal complications.

Persistent nipple pain, cracks, and bleeding are symptomatic of a shallow latch and may promote infection. Impaired milk flow can lead to a diminished milk supply and inadequate intake by the infant. Latch-on by the infant can be difficult when nipples are flat or inverted but can be improved by appropriate interventions. Mastitis is a breast infection causing a flu-like illness that can threaten the health of the mother as well as the success of breastfeeding. Medical treatment is necessary.

The woman over 40 years of age may be at risk of a reduced milk supply as a result of hormones and breast changes. Tandem nursing may increase the nutritional requirements of the mother. Care must be taken to ensure adequacy of breastmilk.

Procedure:

Determine if the woman has any of these complications or potential complications:
The following risks can be handled by a CPA or IBCLC/DBE:

- **engorgement in first week—**review positioning and latch. Provide comfort techniques, as needed.
- **flat or inverted nipples**--review positioning and latch. Babies latch onto the breast, not the nipple.
- **age 40 years or older**--review signs of getting enough milk and provide suggestions for increasing milk supply. If milk supply seems inadequate with appropriate stimulation, refer to IBCLC/DBE.
- **tandem nursing** (breastfeeding siblings who are not twins) – Review signs of getting enough milk. Check adequacy of weight gain for both children. Review feeding routine and discuss feeding the infant first, if older sibling is taking more milk supply.

The following risks shall be handled by an IBCLC/DBE:

- **Severe breast engorgement or engorgement after first week** – review positioning, engorgement, and breast soreness. Teach lymphatic drainage. Provide comfort techniques, as needed.
- **Plugged ducts or recurrent plugged ducts** – teach lymphatic drainage. Assess what might promote plugged ducts and discuss avoiding those things.
- **Cracked, bleeding, severely sore nipples** – review positioning and latch. Consider breast shells, purified lanolin, nursing pads, and use of expressed breastmilk to heal, as appropriate.
- **Mastitis** – advise mother to continue nursing and seek medical advice from her healthcare provider; Remind mother that infection is in the breast tissue, not in her milk. Encourage completing prescription provided by HCP. Teach lymphatic drainage; Assess what may have contributed to development of mastitis and discuss ways to avoid such.

Refer to the *Maryland WIC Breastfeeding Kardex* and Breastfeeding Protocols for information about the complications above.

Breastfeeding Complications or Potential Complications – Infant

(6031) **Categories: IBE/IBP**

Defined as: A breastfed infant with any of the complications or potential complications for breastfeeding.

An infant with breastfeeding complications or potential complications should be referred to the CPA or IBCLC/DBE as indicated below.

Best Practice: see participant immediately; if not possible, within 5 days.

Justification:

- Breastfeeding complications or potential complications can result in inadequate intake and/or Failure to Thrive in the infant. Complications can also cause the mother to produce a lower milk supply.
- A weak or ineffective suck may be due to prematurity, sleepiness, or a medical or physical problem and can result in inadequate breastmilk intake and a diminished milk supply in the mother.
- Difficulty with latch on may be due to maternal nipple conditions or positioning.
- Inadequate urination or stooling may be an indicator of an inadequate intake of breastmilk. The infant is at risk of Failure to Thrive and the mother, of a diminished milk supply.
- Jaundice occurs when bilirubin accumulates in the blood and the skin or whites of the eyes take on a yellowish color. Jaundice can be caused by a variety of reasons, which range from normal physiologic processes to true medical problems. Sometimes early jaundice is caused by inadequate breastmilk feeding and can be overcome by frequent breastmilk feedings. It is best to refer individuals with jaundice to their health care professionals who can determine the cause and recommend treatment.

Procedure:

Using collected information, determine if the breastfed infant has any of these complications or potential complications for breastfeeding:

The following risks can be handled by the CPA or IBCLC/DBE

- **less than 6 wet diapers per day** – babies who are less than 6 days old should have at least one wet diaper per day of life (1 on day one, 2 on day two, etc.). Babies who are 6 days old, or older should have at least 6 wet diapers per day.
- **inadequate stooling (for age as determined by a physician or other health care professional) –** baby should have at least 3 stools/day from day 6 to day 30. After that, stooling is varied by baby. Some have daily stools while others may stool once every other day and others may have as little as one bowel movement per week.

The following risks shall be handled by the IBCLC/DBE:

- **Weak or ineffective suck** – review positioning and latch. Provide special latch techniques, as appropriate, and suggest waking a sleepy baby, if needed. Provide information for suck training, if appropriate.
- **Difficulty latching on to the breast** – review various positions and latch. Provide suggestions for pillow placement under the baby and /or mother's arm(s), as needed.

- **Jaundice** – Refer to infant healthcare provider, if not already seen for this condition. Provide recommendations for frequent feeding and waking baby for feeds at least every three hours, if appropriate based on the type of jaundice.

  Refer to the *Maryland WIC Breastfeeding Kardex* and Breastfeeding Protocols for information about the complications above.

Breastfeeding Infant of Mother at Nutritional Risk

(7021) **Categories: IBE/IBP**

Defined as: Breastfeeding infant of mother at nutritional risk.

Justification:

A breastfed infant is dependent upon the mother's milk as the primary source of nutrition. Special attention should, therefore, be given to the health and nutritional status of the mother.

Procedure:

This risk criterion shall be assigned to the breastfeeding infant of a mother at nutritional risk. The priority level of the risk criterion is based upon the mother's priority, I or IV.

Refer breastfeeding mothers with any of the risk criteria below to the CPA for Nutrition Care counseling:

- Underweight
- Low Hemoglobin/Hematocrit
- Elevated Blood Lead
- Breastfeeding Complications/Potential Complications – follow procedures for Breastfeeding Complications risk factor
- Pregnant Woman Currently Breastfeeding
- Alcohol or Illegal Drug Use
- Maternal Smoking
- Medical Condition, Nutrition-Related

Review collected information before providing counseling. Refer to the *Maryland WIC Breastfeeding Kardex and Breastfeeding Protocols*.

Participant Focused Counseling:

- The mother of a breastfed infant can:
  - State the eating, feeding, and lifestyle practices she can follow to promote optimal health, growth, and development.
  - State strategies to follow as her infant grows and circumstances change, to ensure breastfeeding success.

Breastfeeding Mother of Infant at Nutritional Risk

(6011) **Categories: BE/BP, PG**

Defined as: A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk. Mother must be at the same priority as at-risk infant.

Justification:

A breastfed infant is dependent upon the mother's milk as the primary source of nutrition. Special attention should be given to the health and nutritional status of the mother.

The interconceptional period is an opportune time to assist the woman in adopting healthful dietary and lifestyle practices.

Procedure:

This risk criterion shall be assigned to a breastfeeding mother of an infant at nutritional risk. The priority level of the risk criterion is based upon the infant's priority, I, II, or IV.

Refer participants whose infants have been identified with any risk criteria below to the CPA or IBCLC/DBE as indicated for Nutrition Care counseling and breastfeeding support:

The following risks can be handled by a CPA:

- **Low Hemoglobin/Hematocrit**
- **Elevated Blood Lead**
- **Medical Condition, Nutrition Related – work with IBCLC/DBE if participant has accompanying Breastfeeding complications**

The following risks shall be handled by the IBCLC/DBE:

- Underweight – assess for milk transfer and provide suggestions, as needed. Check position and latch. Consider test weights and/or periodic weight checks.
- Inadequate Growth – assess for milk transfer and provide suggestions as needed. Check position and latch. Consider test weights and/or periodic weight checks.
- Failure to Thrive – assess for milk transfer and provide suggestions as needed. Check position and latch. Consider test weights and/or periodic weight checks.
- Breastfeeding Complications/Potential Complications- follow procedure for Breastfeeding Complications risk factor
- Low Birth Weight – assess for milk transfer, adequate intake/feedings, and provide suggestions as needed. Check position and latch. Consider test weights and/or periodic weight checks.
- Prematurity – assess for milk transfer, adequate intake/feeding, and provide suggestions as needed. Check position and

latch. Consider test weights and/or periodic weight checks.

- Small for Gestational Age – assess for milk transfer, adequate intake/feeding. Check position and latch. Consider test weights and/or periodic weight checks.
-

Review dietary and lifestyle practices. Refer to the *Maryland WIC Breastfeeding Kardex* and Breastfeeding Protocols.

Participant Focused Counseling: The breastfeeding mother can state the food and lifestyle choices she can make to promote optimal health for herself and her breastfed infant.

Complementary Feeding Process

(4281) **Categories: IBE, IBP, IFF, C-1**

Defined as: An infant or child who has begun to or is expected to begin to 1) consume complementary foods and beverages, 2) eat independently, 3) be weaned from only consuming breastmilk or infant formula, or 4) transition from a diet based on infant/toddler foods to one based on the Dietary Guidelines for Americans is at risk of inappropriate complementary feeding.

Justification:

Complementary feeding is the gradual addition of foods and beverages to the diet of an infant and young child. The process of adding complementary foods should reflect the physical, intellectual, and behavioral changes as well as the nutrient needs of the infant or child. Caregivers may not recognize signs of developmental readiness and may offer foods and beverages that are inappropriate in type, amount, consistency, and/or texture.

To manage the process of complementary feeding successfully, caregivers must make decisions about what, when, where, and how to offer foods according to the child's:

- Energy and nutrient requirements
- Fine, gross, and oral motor skills
- Emerging independence and desire to learn to self-feed
- Need to learn healthy eating habits through exposure to a variety of nutritious foods.

Procedure:

This risk factor may be assigned only to infants and children from 4 through 23 months and for whom a complete nutrition assessment has been performed and for whom no other risk is identified.

Participant Focused Counseling:

Anticipatory guidance is the focus of the session. The caregiver can state the stage-appropriate feeding practices she can follow that promote optimal health, growth, and development of her child.

Depression

(3611) **Categories: PG, BE/BP, WPP**

Defined as: Presence of clinical depression, including postpartum depression, diagnosed, documented, or reported by a physician, clinical psychologist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.
A participant identified with depression should have Nutrition Care counseling.

Best Practice: Provide Nutrition Care follow-up in 3-6 months.

Justification:

Depression is common during **pregnancy**, especially in the last trimester. Women who experience depression during pregnancy are less likely to seek prenatal care. They may also suffer from episodes of nausea/vomiting or initiate/increase the use of drugs, alcohol and nicotine. They are at risk for preeclampsia, preterm delivery or delivery of low birth weight infants, and have higher perinatal mortality rates.

Depression among **pregnant adolescents** is almost twice as high as among their adult counterparts and non-pregnant adolescents, because the physiologic and psychological changes of pregnancy are superimposed on the normal developmental changes of adolescence. Teens who are under stress, lack social and/or family support, experience significant loss, or have attention, learning, or conduct disorders are at greater risk for developing clinical depression. Depression in young people often occurs with mental disorders, substance abuse disorders, or physical illnesses, such as diabetes. They are more likely to delay or refuse prenatal care and have subsequent short-interval pregnancies (within 24 months) and poor pregnancy outcomes.

Postpartum depression is related to the influence of reproductive hormones on stress hormones, immune markers, or sleep quality, and lasts longer than "baby blues" which peak four to five days after delivery and resolve by the 10th postnatal day.

Breastfeeding is protective of maternal mood. Breastfeeding reduces the stress responses commonly found in the post-partum period. The hormones associated with lactation, oxytocin and prolactin have both antidepressant and anxiolytic (anti-anxiety) effects. (However, breastfeeding problems like nipple pain can increase the risk of depression and should be addressed promptly.)

Breastfeeding mothers may experience more restful sleep. It is well documented that new mothers experience sleep disturbances, independent of their feeding choices. This lack of sleep can lead directly to an increase in inflammation and increase in maternal stress, which can lead to depression in the early postpartum period. Several small studies showed that breastfeeding mothers actually get more sleep than their bottle/formula-feeding counterparts.

Procedure:

During the nutrition assessment, be sensitive to questions related to depression. If the woman responds affirmatively about feelings that have lasted more than two weeks, encourage follow-up with her health care provider, other resources available in the local area, and/or reliable resources online (see below).

Participant Focused Counseling:

Awareness of a mother's mental health status can assist the WIC nutrition professional in providing individualized breastfeeding support. Depressed mothers should be encouraged to continue breastfeeding as it can protect infants from the harmful effects of maternal depression. Additionally, if breastfeeding is going well, it may assist in a mother's recovery from depression.

Nutrition issues that should be discussed:

- Eating a healthy diet. Research has identified likely links between nutrient deficiency and mood for folate, vitamin B-12, vitamin D, calcium, iron, selenium, zinc, and Omega-3 fatty acids
- Including fish as recommended in the *Dietary Guidelines for Americans*, available from:https://www.myplate.gov/life-stages/pregnancy-and-breastfeeding
- Asking her health care provider about omega-3 fatty acid supplements
- Being physically active. Exercise is anti-inflammatory and boosts mood. Routine exercise helps individuals with depression lower inflammation over time and is a positive coping strategy for stress. Exercise can help boost mood in the short term, but it is the cumulative impact of regular exercise that can stave off depression significantly.
- Getting enough sleep
- Referrals for counseling care. The following are web-based resources for State and local agencies to locate reliable services:
  • The *Substance Abuse and Mental Health Services Administration* (SAMHSA) Mental Health Treatment Locator is found at http://www.samhsa.gov/ and provides comprehensive information on mental health resources and/or facilities. This website provides informational materials about different mental health conditions. The SAMHSA's National Helpline is also available 24-hour-a-day, 365-day-a-year to provide referrals to local support networks and resources for individuals dealing with mental health issues or substance abuse problems at 1-800-662-HELP (4357).
  • *MentalHealth.gov* provides one-stop access to U.S. government mental health information and resources from the *Centers for Disease Control and Prevention*, *FindYouthInfo.gov*, *MedlinePlus* and *National Institutes of Health*, *National Institute of Mental Health (NIMH)* and *SAMHSA*. Resources are available for the general public, health and emergency preparedness professionals, policy makers, government and business leaders, school systems and local communities.

  • *Mental Health America's* website can be used to help individuals locate mental health treatment services, including affordable treatment for those without insurance, in their community. This website also includes links to other sites that provide specialized treatment referrals for specific illnesses and information about the specific illness.

Drug Nutrient Interaction

(3571) **Categories: ALL**

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

A participant identified with this risk criteria should have Nutrition Care counseling.

Best Practice: Consider contacting the participant's Specialist RD before counseling and assigning food package.

Justification:

The focus of this risk is on the impact that medications may have on an individual's nutritional status, which can be physical, chemical, physiologic, and/or pathophysiologic.

Over-the-counter and prescription medications may impact nutritional status directly or indirectly. Direct impacts of medications on nutritional status include changes to:

- The absorption and the distribution of the nutrient
- The metabolism of the nutrient
- The rate at which the nutrient is excreted.

Direct impacts of medications may be severe enough to lead to nutrient deficiency and/or nutrient toxicity, which can then impact bodily systems such as bone formation, immune system function, and energy metabolism.

Indirect impacts of medications on nutritional status include:

- Changes to appetite
- Changes to taste and smell
- A dry or sore mouth
- Epigastric distress, nausea, vomiting, diarrhea, and/or constipation.

Indirect medication side-effects can impact the amount and/or variety of foods eaten and may lead to weight changes and/or the development of nutrient deficiency diseases. Some medications that are known to cause the indirect side-effects listed above include pain medications, such as **oxycodone** and **hydrocodone**, and **medications to treat cancer**.

Research on the overall incidence and prevalence of nutrient and drug interactions remains limited. The following table provides a summary of medications that are commonly used and their associated potential impacts on nutritional status. For a comprehensive list of food and medication interactions, WIC programs should reference resources such as the *Physician's Desk Reference* or the most current *Food Medication Interactions* guide. Additional information on medications can also be found online at: https://medlineplus.gov/druginformation.html.

Breastfeeding and Medication Use

Medication use in the postpartum period can sometimes pose challenges to breastfeeding. While many medications are safe to use while breastfeeding, some are not compatible with breastfeeding or should be used with caution. If breastfeeding women require medication, then medications should be chosen that are not contraindicated with breastfeeding, if possible. It is thus very important for the mother to discuss her breastfeeding status and goals with her health care provider to determine the best infant feeding and medication plan. Information and recommendations on the use of specific medications while breastfeeding can be found at the National Institutes of Health's LactMed Drugs and Lactation Database (https://www.ncbi.nlm.nih.gov/books/NBK501922/) and in the most recent version of *Hale's Medication and Mothers' Milk*. Note that while these resources provide useful information, WIC staff need to refer women to their health care provider to discuss the safety of taking specific medications while breastfeeding. For additional guidance on breastfeeding and medication use, please refer to the Food and Nutrition Service's WIC *Breastfeeding Policy and Guidance,* specifically section 1.4, "When Mothers Should Avoid Breastfeeding" (https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC-Breastfeeding-Policy-and-Guidance_1.pdf).

Implications for WIC Nutrition Services

For participants who are currently taking a medication with known nutrient interactions, WIC staff can:

- Refer the participant/caregiver to their health care provider or pharmacist to discuss the potential nutrient related side-effects and weight fluctuation of medications they take.
- Encourage improved intake of whole grains, legumes, dairy, lean protein, fruits, and vegetables, as appropriate.
- Inform the participant/caregiver of foods or beverages that provide nutrients that may be impacted by the medication.
- Provide education on nutrient-dense foods (when appropriate), meal frequency, portion sizes, and fluid intake when medications induce poor appetite, nausea, or vomiting.
- Provide education on fiber and fluid intake and physical activity to manage constipation related side-effects.
- Provide education on fluid intake, moist foods, and dental care when medications cause a dry mouth.
- Refer women who are either breastfeeding or planning on breastfeeding to their health care provider to determine the best infant feeding and medication plan.

Additional Resources for WIC Staff:

• For information on food and medication interactions:

o *Physician's Desk Reference* (most recent edition)

o *Food Medication Interactions* (most recent edition)

o National Institute of Health's Medline Plus Database on Drugs, Herbs and Supplements (https://medlineplus.gov/druginformation.html)

For information and recommendations on the use of medications while breastfeeding:
o Food and Nutrition Service's WIC *Breastfeeding Policy and Guidance,* specifically section 1.4 "When Mothers Should Avoid Breastfeeding" (https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC-Breastfeeding-Policy-and-Guidance_1.pdf)
o National Institutes of Health's LactMed Drugs and Lactation Database (https://www.ncbi.nlm.nih.gov/books/NBK501922/)
o Hale's *Medication and Mothers' Milk* (most recent edition)

Medication	Medication Purpose	Impact on Nutritional Status
Amiloride (Midamor)	Diuretic	Loss of appetite, nausea, diarrhea, vomiting. May reduce magnesium excretion
Calcium Carbonate (Tums)	Antacid	Vomiting, constipation, loss of appetite; decrease absorption of iron, zinc, magnesium, fluoride
Chlorthalidone (Hygroton)	Diuretic	Upset stomach, vomiting, diarrhea, loss of appetite; increased zinc excretion
Ciprofloxacin	Antibiotic	Nausea, vomiting, stomach pain, diarrhea; decreased zinc absorption
Furosemide (Lasix)	Diuretic	Constipation, diarrhea; increased magnesium excretion w/chronic use
Lansoprazole (Prevacid) & Omeprazole (Prilosec)	Proton pump inhibitors	Constipation, nausea, diarrhea; reduced iron absorption, poor iron repletion w/supplements
Levothyroxine (Synthroid, Levothoid, Levoxly)	Thyroid hormone	Diarrhea, vomiting; decreased appetite and weight loss
Metformin	Antihyperglycemic	Diarrhea, indigestion, constipation; decreased appetite; decreased absorption of folate and vitamin B12
Methadone	Analgesic (Opioid)	Weight gain; dry mouth, nausea, vomiting, constipation
Ondansetron (Zofran)	Antiemetic, antinauseant	Constipation; rarely, decreased potassium levels
Phenobarbital	Antiepileptic	Nausea, vomiting; decreased vitamin D & K; decreased calcium absorption; decreased folate levels
Prednisone	Corticosteroid	Calcium depletion/osteoporosis; Calcium & vitamin D supplement recommended with long-term use.
Rantidine (Zantac)	Antiulcer, AntiGERD, Antisecretory	Constipation, diarrhea, nausea, vomiting; decreased iron and vitamin B12 absorption
Sertraline (Zoloft)	Antidepressant	Nausea, diarrhea, constipation, vomiting; anorexia and weight loss
Sulfasalazine	Ulcerative Colitis	Diarrhea, appetite loss, vomiting; decreased folate absorption

Eating Disorders

(3580) **Categories: PG, BE/BP, WPP**

Defined as: severe disturbances in a person's eating behaviors and related thoughts and emotions. Eating disorders include but are not limited to: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED).

The presence of an eating disorder diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.

A participant identified with an eating disorder should have Nutrition Care counseling. Consider contacting the participant's Specialist RD before assigning food package.

Best Practice: Provide Nutrition Care follow-up in 3-6 months.

Justification:

Eating disorders are caused by a complex interaction of genetic, biological, behavioral, psychological, and social factors. They are extremely prevalent in the United States and associated with the highest morbidity and mortality of any mental illness.

Comorbidities that commonly occur with eating disorders include anxiety, bipolar disorder, depressive disorders, and substance use disorders. If left untreated, eating disorders can be serious and even fatal. Eating disorders are associated with an increased risk of premature death, including from electrolyte disturbances, dehydration, suicide, and alcoholism, among other causes. Total annual mortality attributable to eating disorders amounts to 10,200 deaths per year, equating to 1 death every 52 minutes.

The three most common eating disorders are:

- **Anorexia Nervosa (AN) (3582)** – involves a severe restriction of calories; there may be a fear of weight gain and strict "rules" about eating. AN is a syndrome of self-starvation involving significant weight loss of 15 percent or more of ideal body weight.
- **Bulimia Nervosa (BN) (3581)**– involves recurrent episodes of binge eating followed by compensatory behaviors collectively referred to as purging and can include exercise as such a behavior. This could include vomiting or using laxatives or exercising excessively. Patients with BN are, by definition, at normal weight or above.
- **Binge-Eating Disorder (BED)** (**3583**)– involves recurrent episodes of binge eating which are characterized by eating an amount of food that is larger than what most people would eat in a similar period of time under similar circumstances and a sense of lack of control over-eating during the episode. Unlike BN, periods of binge-eating are not followed by purging or

excessive exercise. As a result, people with binge-eating disorder often are overweight or obese.

In the U.S., BED is the most common type of eating disorder. Other less common types of eating disorders include Avoidant/Restrictive Food Intake Disorder (ARFID) and Rumination Disorder.

Eating disorders are typically associated with thin, white, affluent females. However, there is very little research among low-income communities, so there is limited ability to assess this pathology among other groups.

Complications of Eating Disorders during Pregnancy and Postpartum

Research suggests that about 7% of pregnant women are affected by an eating disorder. Eating disorders have been linked to poor health outcomes for pregnant and postpartum women including *depressive symptoms during pregnancy*, postnatal depression**, and poor infant attachment or maternal bonding.

Pregnant women with eating disorders may have specific maternal macro- and micronutrient deficiencies. When energy and nutrient stores are low and not sufficiently restored through healthy eating, as in AN, the mother can become severely malnourished which can lead to depression, exhaustion, and many other serious health complications. Women with BN who continue to purge during pregnancy are at increased risk of dehydration, chemical imbalances, or even cardiac irregularities.

Some women experience an exacerbation of eating disorder symptoms during pregnancy including body image disturbances and abnormal stress from normal pregnancy weight gain whereas other women with eating disorders may experience relief from their symptoms during pregnancy. However, even when an eating disorder improves during pregnancy, eating disorder symptoms frequently relapse to their highest level almost immediately after delivery.

For women with eating disorders, pregnancies are often unplanned and eating disorder pathology is associated with delayed development, prematurity, hypotrophy, stillbirth, difficult delivery, and postnatal depression. The following table summarizes the health outcomes for both the woman and infant that may result from an eating disorder.

Possible Health Outcomes for Women and Infants by Eating Disorder

	Anorexia Nervosa	Bulimia Nervosa	Binge-Eating Disorder*
Health Outcomes for Woman	• **Higher risk of cesarean delivery** • **Hyperemesis** • **Higher risk of anemia** • **Antepartum hemorrhage†** • **Hypertension** • **Stillbirth** • **Miscarriage** • **Malnutrition** • **Electrolyte imbalance** • **Fluid imbalance** • **Bone loss** • **Changes in brain function**	**Higher risk of cesarean delivery** • **Hyperemesis** • **Stillbirth** • **Miscarriage** • **Malnutrition** • **Electrolyte imbalance** • **Fluid imbalance** • **Postpartum depression** • **Wearing down of tooth enamel** • **Heart problems**	Higher risk of cesarean delivery • Gestational hypertension • Gestational diabetes • Bone loss • Heart attack • Stroke • Arthritis • High cholesterol • Miscarriage • Delivery complications • Postpartum depression
Health Outcomes for Infant	• Underweight • Low birthweight • Small-for-gestational- age • Slow fetal growth • Intrauterine growth restriction • Preterm birth • Microcephaly • Perinatal death	• Dehydration • Chemical imbalance • Cardiac irregularities • Microcephaly • Preterm birth • Low birthweight	• Large-for-gestational-age

*Added as a diagnosis to the DSM-5 in 2013, there is limited research on the health outcomes of BED for both the woman and infant.

† Bleeding from the genital tract in the second half of pregnancy (34)

Complications of Eating Disorders While Breastfeeding

Research is inconclusive as to whether eating disorders affect breastfeeding rates. Some research shows that women with a history of eating disorders may be slightly less likely to initiate breastfeeding, whereas other research shows no difference in initiation and cessation of breastfeeding between mothers with and without eating disorders. Although there is limited research on the impact of eating disorders on breastfeeding rates, returning to eating disorder behaviors in the postpartum period may result in a shorter duration of breastfeeding and may impact the interaction a mother has with her infant as well as her relationship with her partner.

Diagnosis and Treatment

The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5) outlines the diagnostic criteria that must be met to diagnose an eating disorder. A person with an eating disorder may display one symptom or many, and a person's appearance may not always display the amount of physical or emotional danger they are experiencing. Someone that appears to be a "healthy weight" can have an eating disorder and need treatment. Although there are formal guidelines that professionals use to diagnose eating disorders, as specified in the DSM-5, unhealthy eating behaviors exist on a continuum and the severity of individual criteria are considered in making a diagnosis.

There is no standardized screening for eating disorders during pregnancy and it is uncommon for a medical practitioner to screen pregnant patients for disordered eating symptoms. Women are often reluctant to inform medical staff of their struggle with eating disorders, likely the result of anxiety and guilt about harming the fetus. Lack of screening and diagnosis has the potential to increase adverse health outcomes for women who do not receive treatment or assistance to address the eating behavior symptoms and/or pathology.

Treatment of eating disorders depends on the disorder and symptoms displayed, but typically involves psychotherapy. Depending on the severity of eating disorder symptoms, admission to a specialized residential or hospital-based treatment program can be lifesaving. Treatment plans are tailored to the individual's needs, should involve a multidisciplinary team such as a therapist, dietitian, and physician, and may include one or more of the following:

- Individual, group, and/or family psychotherapy
- Medical care and monitoring
- Nutritional counseling
- Medications

Additionally, obtaining adequate health insurance coverage for inpatient treatment for eating disorders remains a challenge due to the apparent gap between research on variables associated with outcomes and the formulas used for reimbursement.

Implications for WIC Nutrition Services

The role of WIC is not to diagnose or treat an eating disorder but to reinforce and support the medical nutrition therapy that the WIC participant is receiving.

Discussing eating disorders, body weight, weight loss, or weight gain can trigger behaviors associated with eating disorders. Therefore, it is important for WIC staff to be sensitive when discussing eating disorders.

For individuals affected by an eating disorder, staff can:

- If available, refer the participant to a health care provider (HCP) with expertise in eating disorders. The participant can work with the provider to create a plan for healthy eating and weight gain.
- Reinforce nutrition counseling/advice that is provided by the eating disorder treatment team/plan.
- Encourage the participant to be honest with their HCP and WIC staff regarding past or present struggles with an eating disorder or disordered eating.
- Encourage the participant to seek or refer the participant to individual counseling and/or support groups during and after pregnancy to help them cope with their concerns and fears regarding food, weight gain, body image, and the new role of parenting.
- Encourage the participant to attend other classes on pregnancy, childbirth, child development, and parenting skills.
- Educate participants that it is important for their prenatal HCP to weigh them as this information is essential to tracking the health of the baby .
- Encourage the participant to discuss with their HCP about blind weighing: standing on the scale backwards, and not sharing the number with them.
- When possible, the CPA should coordinate with the participant's HCP to obtain referral data such as height, weight gain, etc.
- Encourage the participant to talk to their HCP before attending a prenatal exercise class to make sure it fits with their recovery plan.
- Modify conversation with the participant to avoid topics that are likely to provoke eating disordered behaviors (e.g., topics related to body weight, body shape, and calories).

Participant Centered Counseling

When a participant reveals an eating disorder, it is appropriate to affirm them for being aware of the eating disorder, sharing

the information with the WIC certifier, and trusting the certifier with the information.

During the Nutrition Care counseling, the CPA can:

- Invite the participant to share the recommendations of her HCP.
- Ask permission to contact the HCP, so that the CPA can support the HCPs recommendation, and, where possible, help create a food package that supports those recommendations.
- Engage the participant in sharing the steps already taken and progress made and plans for next steps.
- The CPA can ask permission to offer ideas for incorporating foods that interest the participant.
- The CPA can offer to discuss any issues the participant is having with foods in the WIC food package and offer options for the participant to consider.

Elevated Blood Lead

(2111) **Categories: All**

Defined as:
Children: Blood lead level (BLL) of ≥ 3.5 µg/deciliter within the past 12 months* *Current Centers for Disease Control and Prevention reference value.

Women and Infants: Blood lead level (BLL) of ≥ 5 µg/deciliter within the past 12 months* *Current Centers for Disease Control and Prevention reference value.

A child participant who has a venous blood lead level of ≥ 3.5 ug/dl or higher should have Nutrition Care counseling.

A woman or infant participant who has a venous blood lead level of ≥ 5 ug/dl or higher should have Nutrition Care counseling.

Best Practice: see participant immediately; if not possible, within five days. Provide Nutrition Care follow up in one month.

Each who answers *No* or *Don't Know* to the question, *Have you had a Blood Lead test?* should be offered the Lead Screening Tool and directed to discuss any positive responses with their health care provider.

Justification:
The toxic effects of lead have been observed in every organ system and there is no known safe level of exposure. Even low levels of lead exposure can have harmful and irreversible neurological, renal, cardiovascular, hematological, immunological, reproductive, and developmental effects. Evidence also suggests that lead exposure can have detrimental respiratory, hepatic, endocrine, gastrointestinal, musculoskeletal, and ocular effects, and increase risk of all cancers.

Lead exposure during pregnancy or postpartum can affect the mother, the developing fetus, and breastfeeding infant during critical stages of development. Lead readily crosses the placenta, and lead exposure during pregnancy is associated with increased risk of miscarriage, preterm birth, and decreased birth size (weight, length, and head circumference); fetal brain, kidney, and nervous system damage; and lifelong learning and behavior problems. Lead can also transfer from maternal blood to breastmilk, and ultimately to the breastfeeding infant, although the amount of blood lead transfer appears to be small with little impact on the infant.

Lead exposure is most common in young children because they have greater contact with lead sources and higher

gastrointestinal absorption. Children's developing nervous systems are more vulnerable to lead exposure. Elevated BLL in children has been associated with adverse neurological and behavioral outcomes including learning and memory, attention, hyperactivity, impulsivity, irritability, delinquency, and altered visual-motor integration, dexterity, postural sway, and changes in hearing and vision.

Prevalence of Lead Exposure

Over the four decades from 1976 to 2016, federal regulations on use of lead in gasoline, plumbing and other consumer products helped reduce population BLLs significantly among children ages 1 to 5 years from 15.2 to 0.83 ng/dL, and among women of childbearing age (15 to 49 years) from 10.37 to 0.61ng/dL in the U.S.

Despite this progress, sociodemographic disparities have persisted. Low-income and certain racial/ethnic minority populations continue to be disproportionately affected by lead exposure because these groups more commonly live in communities and housing with greater lead contamination.

Disparities Among Women

Lead exposure is more prevalent among certain subpopulations, including women with low-income, of older age, born outside the U.S., of "other" race/ethnicity (i.e., other than black, white, Hispanic, or Mexican American), previous pregnancies, and a higher number of live births. In particular, recent immigrants, migrants, and refugee women are at increased risk of lead exposure since they have commonly lived in areas where ambient lead exposure is relatively high. These groups may also be more likely to consume products contaminated with lead such as traditional remedies, herbal supplements, spices, candies, cosmetics, and jewelries or amulets.

Disparities Among Children

Between 2011 to 2016, an estimated 262,235 children ages 1 to 5 years had BLLs $\geq$5 µg/dL (note: the studies summarized here were conducted prior to October 2021, when the BLRV was $\geq$5 µg/dL).
Subpopulations with greater prevalence of lead exposure include children 1 to 2 years old, non-Hispanic Black race/ethnicity, low-income (including children participating in WIC), and children born in Mexico, living in older housing, and living in the Northeast or Midwest regions of the U.S. compared to West and South regions.

Between 1999 and 2016, population mean BLL was greatest for non-Hispanic Black children at all ages under 5 years compared to other racial/ethnic groups (non-Hispanic White, Hispanic, and Other) as was the proportion of non-Hispanic Black children ages 1 to 5 with BLL ≥5 µg/dL. Further, greater proportions of non-Hispanic Black children had higher BLLs,

with Black children accounting for all children with BLL ≥40
µg/dL.

Lead exposure is also more common among refugee children in the U.S., particularly among children from certain countries of origin and country of last residence (e.g., India, Afghanistan, Burma, and Nepal).
Children, as well as adults, may also be at risk for elevated BLL after arrival due to continued use of lead- contaminated spices, candies, traditional cosmetics, and cookware.

Sources of Lead Exposure
The most common sources of lead exposure in the U.S. are lead-based paint chips and dust, lead-contaminated soil, and lead in drinking water, usually from living in public or private housing, or attending schools with lead plumbing built before 1978, before lead paint was banned, or with lead pipes or plumbing.
Living near a highway, airport, powerplant, smelter, or hazardous waste site may also cause lead exposure through contaminated soil or air.

Other sources of lead exposure:

- Working in manufacturing, construction, services, and mining that involve working with lead-based products.
- Hobbies or activities that involve working with lead-based products such as casting, stained glass, pottery, painting, glassblowing, and screen printing.
- Smoking cigarettes or e-cigarettes, chewing tobacco, and exposure to second-hand smoke.
- A variety of consumer products such as storage batteries, solders, tire weights, pottery glazes, leaded crystal glassware, cosmetics, hair dyes, jewelry, antiques, gunshot and ammunition, relic fishing sinkers, and imported children's toys.
- Imported foods, candies, and spices, including:
    - Candy with ingredients such as chili powder and tamarind (lead can get into the candy when drying, storing, and grinding the ingredients are done improperly). Ink from plastic or paper candy wrappers may also contain lead that leaches or seeps into the imported candy.
    - Certain commonly used spices, particularly those purchased abroad in Georgia, Bangladesh, Pakistan, Nepal, and Morocco.
- Cultural and traditional medicines, including:
    - Ba-baw-san: a Chinese herbal remedy used to treat colic pain or to pacify young children.

    - Daw Tway: a digestive aid used in Thailand and Myanmar (Burma).
- Greta and Azarcon (also known as alarcon, coral, luiga, maria luisa, or rueda): Hispanic traditional medicines used for an upset stomach, constipation, diarrhea, and vomiting. They are also used on teething babies.
- For additional examples, refer to the CDC's table of Examples of regional or culture-specific exposures associated with elevated blood lead levels in children

Among pregnant and lactating women, the most common sources of lead exposure include:

- Working in certain occupations.
- Practicing pica (ingesting non-nutritive substances such as soil or paint chips).
- Using herbal or traditional remedies or imported cosmetics.
- Using traditional lead-glazed ceramic pottery for cooking and storing food.
- Living in an older home during a renovation.
- History of lead exposure since bone lead stores persist for decades and are mobilized into the blood during periods of increased bone turnover including pregnancy and lactation.

Key Recommendations for Initiation of Breastfeeding:

- Mothers with BLLs < 40 µg/dL should breastfeed.
- Mothers with confirmed BLLs ≥40 µg/dL should begin breastfeeding when their blood lead levels drop below 40 µg/dL.

Until then, they should pump and discard their breastmilk.

Key Recommendations for Continuation of Breastfeeding (2):

- Breastfeeding should continue for all infants with BLLs below 5 µg/dL.
- Infants born to mothers with BLL ≥ 5 µg/dL and <40 µg/dL can continue to breastfeed unless there are indications that the breastmilk is contributing to elevating BLLs.

Lead Screening and Testing

Lead exposure prevention and reduction are primary prevention strategies for preventing long-term damage from even low-level lead exposure. CDC recommends that public health and clinical professionals focus screening efforts on neighborhoods and children at high risk based on age of housing and sociodemographic risk factors and work together to develop screening plans

responsive to local conditions using local data. CDC supports these efforts through cooperative agreements with state and local health departments that fund lead exposure prevention activities including blood lead testing. Where state or local screening plans do not exist, CDC recommends universal BLL testing.

Pregnant women identified with blood lead levels ≥5 µg/dL should be tested at the time of birth to establish a baseline to guide postnatal care for the mother and infant. Lactating women with BLL ≥5 µg/dL should be referred for follow-up testing at an interval according to the BLL.

All Medicaid-enrolled children are required to be tested at ages 12 and 24 months, or at age 24–72 months if they have not previously been screened.

For infants, the American Academy of Pediatrics recommends a risk assessment at 6 and 9 months, and if positive, appropriate follow up action. Risk assessment questions appropriate to local lead hazards should be developed by local health care professionals in collaboration with state, county, or local health authorities.

CDC's specific screening guidelines for newly arrived refugees recommend that all refugee infants and children <16 years old and pregnant and breastfeeding women be screened for lead exposure with a blood test. Refugee adolescents > 16 years of age should be screened if there is a high index of suspicion, or clinical signs/symptoms of lead exposure. Follow up screening should occur 3 to 6 months later for all children under 6 years old, children and adolescents 7 to 16 years of age who had BLLs ≥3.5 µg/dL or who has a risk factor, and pregnant or lactating adolescents (<18 years of age) who had BLLs at or ≥3.5 µg/dL at initial screening. In addition, all newly arrived pregnant or breastfeeding women should be prescribed a prenatal or multivitamin with adequate iron and calcium.

Nutrition and Lead Exposure

Adequate consumption of both calcium and iron, which compete with lead for intestinal absorption, have been found to decrease lead absorption. During pregnancy, adequate calcium intake may reduce maternal bone resorption and thereby reduce the mobilization of lead stored in the bone into the blood. Iron deficiency can be an indicator of lead poisoning as they often co-occur (see risk #201 for more information about iron deficiency anemia). Participants with elevated BLL should be provided with nutritional advice emphasizing adequate calcium and iron intake and pregnant participants should be encouraged to take a prenatal vitamin as prescribed by their healthcare provider.

Procedure:

When a participant has been diagnosed with lead poisoning:

- Evaluate iron status, as iron deficiency anemia and elevated blood lead frequently occur together.
- Evaluate calcium intake: Inadequate dietary calcium intake generally affects lead absorption. Results from some studies indicate that dietary calcium (when consumed at Adequate Intake levels) competitively inhibits lead absorption.
- Evaluate vitamin C intake: The antioxidant, vitamin C, has been shown to have natural chelating properties, enhancing the urinary elimination of lead from the body.
- Review lifestyle/dietary habits that explain or contribute to lead exposure, including:
    - Eating dirt, clay, or other non-foods (pica)
    - Review eating habits for protective nutrients: regular mealtimes, foods rich in iron, calcium, and vitamin C

Nutrition Education:

- Adequate intake of calories and nutrients such as calcium and iron help protect against lead uptake.
- Certain housekeeping practices can minimize the risk of exposure to lead.

Participant Focused Counseling:

- Offer lead brochure to any participant who answers *No* or *Don't Know* to the lead test question, *Have you had a blood lead test?*
- Offer to discuss using WIC foods high in calcium, iron, and vitamin C to protect against lead absorption, especially those in their WIC food packages
- Suggest a woman, infant, or child who eats dirt, clay, or other non-foods discuss this habit with physician.
- Recommend all pregnant and breastfeeding women and caregivers of children review the Lead Screening Tool, and discuss any items answered *Yes* or *Don't Know* with her health care provider.

Failure to Thrive

(1341) **Categories: IBE, IBP, IFF, C-1, C2-4**

Defined as: Diagnosis of Failure to Thrive (FTT) by a health care professional as self reported by applicant/participant/caregiver; or as reported or documented by a physician or someone working under physician's orders.

An infant or child identified with FTT should have Nutrition Care counseling.
Best Practice: see participant immediately; if not possible, within 5 days, with a Nutrition Care follow-up in 1-3 months

Justification:

Failure to Thrive (FTT) is a serious growth problem with an often complex etiology. It may be a mild form of protein-energy malnutrition (PEM) that is manifested by a reduction in the rate of growth. Regardless of the etiology of FTT, there is inadequate nutrition to support weight gain. Education, referrals, and service coordination can aid the mother/caregiver in developing skills, knowledge, and or assistance to care for an infant or child with Failure to Thrive.

The following table includes factors that can contribute to undernutrition and increase the risk for FTT in infants and children:

Medical/Nutritional/Developmental	Behavioral/Feeding Practices	Environmental/Psychosocial
General conditions: • Prematurity, low birth weight, and small for gestational age • Exposure to substances in utero • Any chronic medical condition	• Infrequent feeding or not appropriately responding to hunger cues • Poor caregiver-infant/child interactions, especially when feeding • Inappropriate feeding based on infant/child's stage of development • Improper breastfeeding positioning or technique	• Poverty, food insecurity, and homelessness • Caregiver's lack of knowledge about appropriate nutrition and feeding • Caregiver with limited ability to make appropriate feeding decisions/prepare food, including those with a mental health disorder, intellectual disability, or substance use disorder • Family stressors such as unemployment, separation, or incarceration
Inadequate intake, which can be caused by: • Neurological disorders • Developmental delays, including autism spectrum disorders • Dental problems including cleft lip, cleft palate, and dental caries • Enlarged tonsils or adenoids		

• Feeding problems including insufficient or ineffective breastmilk transfer, weak suck, swallowing problems, and poor appetite • Gastrointestinal problems, including gastroesophageal reflux, frequent vomiting, and constipation • Chronic or frequent infections (These can lead to reduced intake, which can further compromise the immune system, thus contributing to additional infections and FTT.) • Lead poisoning (This can lead to anorexia, constipation, and abdominal pain. Reduced intake can then lead to calcium and iron deficiencies, further exacerbating the lead poisoning and FTT.)	• Incorrect preparation of infant formula • Excessive fluids other than breastmilk/formula for infants • Once foods are started, not providing appropriate support (such as a high chair) while eating • For children, inconsistent timing of feeding or allowing to graze on food/beverages throughout day • Restrictive diet, including vegan, low-fat, or food allergy-related • Feeding in a chaotic household with multiple caregivers • Neglect or abuse	• Inadequate access to appropriate foods, including culturally preferred foods
Inadequate absorption, which can be caused by: • Food allergies and lactose intolerance • Celiac disease • Gastrointestinal problems, including chronic diarrhea or vomiting and malformations • Protein-losing enteropathy • Pancreatic conditions, including cystic fibrosis • Inborn errors of metabolism		

Failure to thrive in infants/children, especially when severe or prolonged, can have several harmful effects, including the following:

- Dehydration and nutrient deficiencies
- Compromised immune system and increased risk of infections
- Increased susceptibility to lead poisoning (when calcium and iron deficiencies are present) Long-term impaired cognitive development, including learning difficulties
- Long-term problems with socioemotional development
- Long-term lower than average weight and/or height

Treatment

The goal of FTT treatment is to achieve optimal growth while also addressing whatever factors may be contributing to the FTT. Catch-up growth (growth at a faster rate than normal for age) is usually necessary; according to the American Academy of Pediatrics, a typical catch-up rate is 2-3 times the average weight gain for age. As treatment progresses, the rate of catch-up growth is continually adjusted as needed until growth is deemed appropriate.

Thus, growth must be measured frequently and assessed over time. It is also important to watch for relapse, as a history of FTT is associated with reoccurrence of FTT in the future.

During treatment, close follow-up by the health care provider and other health professionals is crucial. A multidisciplinary approach is often used, including collaboration among the family, pediatrician, dietitian, developmental therapist, and others.

Nutrition therapy is a core component of treatment, starting with nutrition assessment. A comprehensive assessment should take the following into account: feeding history, current intake, breastfeeding/formula feeding, the caregiver-infant/child feeding relationship, feeding timing/environment, and nutrition knowledge/beliefs. Nutrition and breastfeeding counseling are individualized to the infant/child and typically focus on increasing consumption of calories, protein, and micronutrients. The health care provider may also suggest providing a multivitamin that includes the Recommended Dietary Allowance for all vitamins, iron, and zinc during the period of rapid growth, as well as additional iron or vitamin D if there are deficiencies.

If behavioral interventions are not effective, treatment providers may recommend nutritional/caloric supplements be given for a limited time to achieve catch-up growth. These include supplemental formula for breastfed infants, high calorie/concentrated formulas for infants, and high calorie beverage supplements for children. If treatment is not effective, hospitalization may be needed, though this is rare. This may occur if the infant/child has a severe safety or health risk, including having a serious infection, medical condition, malnourishment, or dehydration.

Implications for WIC Nutrition Services

WIC staff can provide the following nutrition services to infants and children with failure to thrive:

• Learn about and reinforce the health care team’s plan of care for treating the participant’s FTT. Encourage caregivers to keep all health care appointments.

• Offer breastfeeding support to breastfeeding dyads. Refer to the WIC Designated Breastfeeding Expert, if available, or other professional breastfeeding support when needed.

• Offer participant-centered nutrition counseling based on a thorough assessment and on caregiver's concerns and interests. Suggestions to caregivers may include the following, based on the situation:

- Increasing children's intake of calorically-dense food
- Correctly preparing infant formula
- Reducing volume of fluids consumed, if excessive, to appropriate amounts (other than breastmilk or formula for infants)
- Allowing children to choose how much and which foods to eat (from what is offered)
- Feeding children at consistent times and not allowing child to graze on foods and beverages throughout the day
- Feeding in a supportive setting (such as a table or highchair) and in a distraction-free environment

• Provide individualized food packages, tailored to meet the increased nutritional needs of the infant/child.

• Reinforce the importance of following recommended vaccination schedules, as FTT is sometimes associated with a compromised immune system.

• Offer individualized referrals based on the household's needs and interests, including referrals to financial assistance, food assistance, cooking classes, housing, transportation, childcare, adult education/career services, and substance use services. Consider referrals that promote a nurturing, responsive caregiver-infant/child relationship, including those to local home visiting programs, parenting programs, and early intervention services.

Procedure:

Determine if the infant or child has a diagnosis of Failure to Thrive.
Review collected information about feeding practices, medical conditions, and caregiver lifestyles that could lead to a poor rate of growth.

Fetal Alcohol Spectrum Disorders (FASDs)

(3821) **Categories: ALL**

Defined as: Presence of condition diagnosed by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.
Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase that encompasses a range of possible diagnoses, including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE)

A participant identified with FASDs should have Nutrition Care counseling.
Best Practice: see participant immediately; if not possible, within 5 days. Provide Nutrition Care follow-up in 3-6 months.

Justification:

FASD is the leading preventable cause of birth defects and intellectual and neurodevelopmental disabilities.
FASD is an umbrella term describing the range of effects that can occur in an individual whose mother consumed alcohol during pregnancy. These effects include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. Often, a person with FASD has a mix of these conditions.
These conditions can affect each person in different ways and can range from mild to severe. A person with FASD might have any or a combination of the following conditions:

- Facial abnormalities, such as a smooth ridge between the nose and upper lip (this ridge is called the philtrum).
- Small head size, short stature, low body weight.
- Sleep and sucking problems as an infant.
- Hyperactive behavior, difficulty with attention, poor memory, difficulty in school (especially with math), learning disabilities, poor reasoning and judgment skills.
- Poor coordination, speech and language delays, intellectual disability or low IQ.
- Problems with the heart, kidneys, bones, vision, or hearing.

The severity of alcohol's effects on a fetus primarily depends on the following:

Quantity – the amount of alcohol consumed by a pregnant woman per occasion.
Frequency – the rate at which alcohol is consumed or is repeatedly consumed by the pregnant woman.
Timing – the specific gestational age of the fetus when alcohol is consumed by the pregnant woman.

Fetal Alcohol Spectrum Disorders Diagnoses
Different terms are used to describe FASDs, depending on the type of symptoms.

Fetal Alcohol Syndrome (FAS) was the first form of FASD discovered. It represents the most involved end of the FASD spectrum. A diagnosis of FAS requires evidence of prenatal alcohol exposure; evidence of central nervous system (CNS) abnormalities (structural or functional); a specific pattern of the following three facial abnormalities: narrow eye openings, a smooth area between the lip and the nose (vs. the normal ridge), and a thin upper lip; and growth deficits either prenatally, after birth, or both.

A child with FAS may have problems with learning, memory, attention span, communication, vision, and/or hearing. Also, people with FAS often have a hard time in school and trouble getting along with others.
FAS is the only part of the spectrum with guidelines for diagnosis. Diagnosing FAS can be challenging because other medical disorders have similar symptoms, and there are no standard medical tests for diagnosis.

Alcohol-Related Neurodevelopmental Disorder (ARND) requires evidence of both prenatal alcohol exposure and CNS abnormalities, which may be structural or functional (a complex pattern of cognitive or behavioral problems not consistent with developmental level that can only be explained by prenatal alcohol exposure). Other symptoms of FAS may or may not be present.

Alcohol-Related Birth Defects (ARBD) include problems with the heart, kidneys, bones, or hearing. People with ARBDs might have a combination of these. ARBD is rarely seen alone but rather as a secondary disorder accompanying other FASD conditions (e.g., FAS and ARBD).

Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) requires evidence of both prenatal alcohol exposure and CNS involvement (cognition, self-regulation, and adaptive functioning impairment). A child or youth with ND-PAE will have problems with 1) thinking and memory, where the child may have trouble planning or may forget material he or she has already learned; 2) behavior problems, (severe tantrums, mood issues, and difficulty shifting attention from one task to another), and 3) trouble with day-to-day living, (bathing, dressing for the weather, playing with other children). In addition, the mother must have consumed more than 13 alcoholic drinks per month of pregnancy or more than 2 alcoholic drinks in one sitting.

Prenatal Alcohol Exposure (PAE) may be associated with altered acquisition and distribution of body mass with increasing age. A study by Werts and colleagues suggested that children with PAE may be at risk for nutritional deficiencies, inappropriate food preferences, disordered eating patterns, medication use, and the stressful dynamics surrounding food preparation and mealtime. PAE may be associated with female obesity, constant snacking, lack of satiety, constipation, and low vitamin D status.

Growth and Development of Children with FASD
The estimated prevalence of FASD in populations of first-grade schoolchildren (~6.5-7.8 years old) is as high as 20-50 per 1,000 in the United States and some Western European countries.
In a study conducted by Spohr and others, it was found that although the characteristic craniofacial malformations of FAS/FAE diminished over time, microcephaly, a poorly developed philtrum, a thin upper lip, and, to a lesser degree, short stature and

underweight (in boys) persisted. In females, adult body weight increased. Although some catch-up growth occurred, a large proportion of the subjects had growth deficiency.
Retrospective research demonstrated that children may be more affected by prenatal alcohol exposure based on the following variables regarding the mother:

• Poor pre-pregnancy or prenatal nutrition

• Multiple pregnancies and births

• Lower-than-average pre-pregnancy or prenatal weight, height, and body mass index (BMI)

• Maternal smoking

• Maternal age (effect on child increases with mother's age)

• Has family members or peers who drink heavily

One study indicated that, anecdotally, children with FASD are often "picky eaters", some have autistic-like taste and texture sensitivities, and many have behavioral challenges such as rigidity and oppositionality. Children with FASD had lower intakes of saturated fats, vitamin D, and calcium. They may not meet the recommended intakes for several nutrients and have a dietary pattern that could benefit from improving intakes of dairy products, green leafy vegetables, vegetable oils, nuts, eggs, and fish. Most (>50%) did not meet the Adequate Intake for fiber, n-3 fatty acids, vitamin K, or choline, or the Recommended Dietary Allowance for vitamin D, vitamin E, or calcium.

Another study indicated that children with FASD were more likely to have a past diagnosis of underweight. Mean BMI was significantly reduced for males but not females. Abnormal eating patterns are common in children with FASD and may contribute to their delayed growth and nutritional inadequacies. Children with FASD were significantly more likely to experience delayed acquisition of age-appropriate eating skills, compared with controls. The median age for solid foods introduction was significantly older for children with FASD as was their age at self-feeding.

Breastfeeding may prevent or improve neurodevelopmental disorders for children with FASDs and has been shown to improve IQ. Infants with facial abnormalities may have breastfeeding challenges such as difficulty with latch, sucking, or swallowing; and individualized breastfeeding support will likely be needed. (See *Alcohol or Substance Use* for more information regarding breastfeeding and alcohol use.)

There is no cure for FASDs, but research shows that early intervention treatment services can improve a child's development. There are many types of treatment options, including medication to help with some symptoms, behavior and education therapy, parent training, and other alternative approaches. Certain protective factors can help reduce the effects of FASD and help people with these

conditions reach their full potential. Protective factors include diagnosis before 6 years of age; loving, nurturing, and stable home environment during the school years; absence of violence; and involvement in special education and social services.

Adults with FASD

FASDs last a lifetime. Research indicates that adults with FASDs have increased behavioral problems; are perhaps less efficient and more distractible; have more difficulty with paying attention, learning, memory, planning, and analyzing social situations; and feel less confident that they have sufficient resources to cope with their environment. Adults with FASDs have a high rate of psychiatric and personality disorders, problems with drugs and alcohol, and difficulties with the law. They are also less likely to obtain a degree, have stable employment, and live independently. Young adults with PAE have increased risks for mental health problems and secondary disabilities, which impacts their ability to live independently.

Implications for WIC Nutrition Services

When speaking with a biological mother of a child with an FASD, the American Academy of Pediatrics recommends the following:

- Build rapport with the mother and allow her to express her emotions and concerns related to her child's health and the demands of parenting a child with an FASD.
- Reaffirm the parent as a key part of the child's care team.
- Keep all lines of communication and advocacy open as the child's care is coordinated through the medical home.

WIC staff can help parents/caregivers of infants and children with FASD choose steps to improve health by:

- Offering regular monitoring to address underweight/overweight, delayed growth, and nutritional inadequacies.
- Tailoring food packages to meet the needs and preferences of participants.
- Encouraging food choices to improve intake of dairy products, green leafy vegetables, vegetable oils, nuts, eggs and fish.
- Guiding participants in choosing healthy snacks to achieve satiety.
- Helping participants understand and improve age-appropriate feeding skills and behavioral and developmental issues associated with feeding.
- Encouraging physical activity to improve glucose tolerance, muscle and nerve development, and motor coordination.
- Referring to their health care provider to discuss nutritional supplements and any growth and development concerns.
- Providing referrals to early intervention services, infant/child feeding skills, home visiting programs, and parenting programs.
- Referring to their health care provider and WIC breastfeeding specialist for breastfeeding support. These infants may need frequent growth monitoring and re-evaluation of their feeding capacity, so feeding plans will need to be adjusted accordingly.

WIC staff can assist adult participants with FASD as follows (also see *Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Appropriate Feeding Decisions and/or Prepare Food*):

- Provide individualized nutrition education appropriate for the learning level of the participant/caregiver. Be sensitive to the unique learning needs and style of the participant/caregiver, which may mean using food models, posters, and handouts.

- Provide referrals to promote parenting and infant/child feeding skills, including referrals to local home visiting programs, parenting programs, and early intervention services.
- Encourage participants/caregivers to follow the health care provider's plan of care. Coordinate with health care providers as needed.
- Provide individualized food packages tailored to meet the needs of participants.
- Some adults with FASD may be unable to prepare powder or concentrated infant formula. Thus, for the safety of the infant, State WIC Agencies may allow ready-to-feed (RTF) WIC formulas.
- Refer to their health care provider to discuss nutritional supplements for pregnant women.

WIC staff can increase their own knowledge by reading Substance Use and Prevention Manual: Screening, Education and Referral Resource Guide for Local WIC agencies. Available from: https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide.

Fetal Growth Restriction (FGR)

(3361) **Category: PG**

Defined as: Diagnosed condition 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.

A woman identified with fetal growth restriction should have Nutrition Care counseling.

Justification:

Fetal growth restriction (FGR) is usually defined as a fetal weight < 10th percentile for gestational age. It may be diagnosed by a physician using serial measurements of fundal height and abdominal girth and can be confirmed using ultrasonography.

FGR usually leads to birth of an infant that is small for gestational age (SGA). The severely growth restricted infant is at increased risk of fetal and neonatal death as well as polycythemia, and long-term neurocognitive complications. FGR is also associated with increased risk of chronic diseases such as cardiovascular disease in adulthood.

FGR may be caused by congenital anomalies or infections in the fetus or may be associated with maternal height, pre-pregnancy weight, birth interval, and maternal smoking.

Procedure:

Determine if the woman has been diagnosed with Fetal Growth Restriction. Apply to a pregnant woman only.

Participant Focused Counseling:

A pregnant woman diagnosed with FGR can benefit from nutrition counseling to promote optimal nutrient intake, appropriate weight gain, and avoidance of tobacco, alcohol, and drugs.

Food Allergies

(3531) **Categories: ALL**

Defined as: Food allergies are adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food, when diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by participant or caregiver.

Note: This risk only applies to food allergies and should not be assigned to those who have non-immunologic adverse reactions to food.

A participant identified with Food Allergies should have Nutrition Care counseling.

Consider contacting the participant's Specialist RD for participant with multiple complex food allergies before counseling or assigning food package.

Justification:

Food allergies are a significant health concern as they can cause serious illness and life-threatening reactions. Prompt identification and proper treatment of food allergies improves quality of life and nutritional well-being.

Studies of large, nationally representative samples suggest that 5.8% of children (ages 0-17) and 6.2% of adults have a food allergy based on a clinician's diagnosis and/or the severity of reported symptoms. These estimates do not include food intolerances or other non-immunologic reactions to food. Perceived food allergy prevalence in these studies was 19% among adults and 11.4% among children, suggesting that more access to testing and counseling is needed.

Common Food Allergens

Although reactions can occur from the ingestion of any food, a small number of foods are responsible for most food-induced allergic reactions. The foods that most often cause allergic reactions are listed below with their prevalence among all U.S. children and adults:

	Children	Adults
Any food allergy	7.6%	10.8%
Peanuts	2.2%	1.8%
Cow's Milk	1.9%	1.9%
Shellfish	1.3%	2.9%

Tree Nuts	1.2%	1.2%
Eggs	0.9%	0.8%
Fish	0.6%	0.9%
Wheat	0.5%	0.8%
Soy	0.5%	0.6%
Sesame*	0.2%	0.2%

*As of Jan.1, 2023, sesame officially recognized as the 9th major food allergen in the US and required to be identified on food label

Many food allergies appear within the first two years of life. The majority of allergies to cow's milk, eggs, wheat and soy resolve in early childhood. In contrast, allergies to peanuts and tree nuts typically persist into adulthood. Adults may have food allergies from childhood or developing later and continuing through life.

People with an allergy to one food tend to be allergic to similar foods within a food group. For example, all shellfish are closely related; if a person is allergic to one shellfish, there is a strong chance that person is also allergic to other shellfish. The same holds true for tree nuts, such as almonds, cashews, and walnuts.

Food Allergies vs. Non-Immunologic Adverse Reactions to Food

Food allergy reactions occur when the body's immune system responds to a food as if it were a threat. However, not all adverse reactions to food are caused by food allergies. Some are caused by "non-immunologic adverse reactions to food," which includes a wide range of disorders related to the consumption of foods (often referred to as food intolerances, but this term is not preferred). Non-immunologic adverse reactions to food are often misdiagnosed as food allergies because the symptoms can be similar. However, unlike food allergies that trigger an immune response that may result from exposure to even small traces of a food allergen, non-immunologic adverse reactions to food do not involve the immune system and are typically dose-dependent. The National Institute of Allergy and Infectious Disease (NIAID) separates non-immunologic adverse reactions to food into four categories, including Metabolic, Pharmacologic, Toxic, and Idiopathic / Undefined, as follows:

1. **Metabolic** - A reaction is caused by an inability to metabolize a food component. The most common non-immunologic adverse reaction to food is lactose intolerance, caused by a deficiency in the enzyme lactase, which is necessary in the metabolism of lactose, a type of sugar found in dairy products. (For more information see nutrition risk criterion #355, Lactose Intolerance.)

2. **Pharmacologic** - A reaction caused by the consumption of a food or food additive that results in drug-like pharmacologic effects. For example, overconsumption of caffeine can cause undesirable symptoms for some individuals such as nervousness, insomnia, headaches, nausea, and diarrhea.

3. **Toxic** - A reaction caused by a toxin found in a food. For example, consumption of fish in the Scombridae family (e.g., tuna, mackerel, bonito, etc.) can cause scombroid fish poisoning or histamine fish poisoning if the fish contains high levels of histamine.

4. **Idiopathic / Undefined** - There are some reactions for which there has yet to be a defined mechanism for the resulting symptoms. For example, many individuals claim to have a hypersensitivity to monosodium glutamate (MSG), and report a myriad of symptoms including headaches, numbness, dizziness, heart palpitations, chest pain and back pain. However, decades of research have yet to prove a definitive link between these symptoms and the consumption of MSG. Some research suggests that those diagnosed with Irritable Bowel Syndrome (IBS) may have some of their symptoms associated with undefined non-immunologic adverse reactions to food including wheat (e.g., non-celiac wheat sensitivity (NCWS)) and foods high in fermentable oligo-, di-, and mono-saccharides and polyols (FODMAPs).

IgE vs Non-IgE Mediated Allergic Reactions to Foods

There are several types of immune responses to foods, including immunoglobulin E (IgE)-mediated, non-immunoglobulin E (non-IgE)-mediated or mixed.

The most common types of food allergies involve IgE-mediated responses. In an IgE-mediated response, the immune system produces allergen-specific IgE antibodies (sIgE) when a food allergen first enters the body. Upon re-exposure to the food allergen, the sIgE identifies it and quickly initiates the release of chemicals, such as histamine. These chemicals cause various symptoms based on the area of the body in which they were released. These reactions typically occur within minutes up to a couple of hours after ingestion and include symptoms such as urticaria (hives), angioedema (swelling), wheezing, cough, nausea, vomiting, hypotension (low blood pressure) and anaphylaxis.

Food-induced anaphylaxis is the most severe form of IgE-mediated food allergies. It often occurs rapidly, within seconds to a few hours after exposure, and is potentially fatal without proper treatment (often including the use of epinephrine). Food-induced anaphylaxis often affects multiple organ systems and produces many symptoms, including difficulty breathing, swelling and reduced blood pressure. Tree nuts, peanuts, milk, egg, fish, and shellfish are the leading causes of food-induced anaphylaxis. Prompt diagnosis and avoidance of allergens is essential to prevent life-threatening reactions.

Non-IgE-mediated allergic reactions to foods are generally delayed in onset, occurring more than 2 hours after ingestion, are more chronic in nature, and primarily affect the skin and/or gastrointestinal system. Celiac Disease (Risk 3541) is one example of a non-

IgE mediated allergic reaction to food. Other less common examples, which fall under Risk 353: Food Allergies, are found in the table below.

Examples of Non-IgE mediated allergic reactions to foods:

Condition	Brief Description
Food Protein-Induced Enterocolitis Syndrome (FPIES)	FPIES is a gastrointestinal food hypersensitivity that manifests as episodes of severe vomiting and diarrhea. It can lead to acute dehydration, changes in blood pressure and body temperature, pallor, and lethargy. If chronic and undiagnosed, it can cause weight loss or failure to thrive (Risk 1341). FPIES is commonly misdiagnosed initially as a severe stomach illness because the symptoms are so similar. Though any food can trigger FPIES, the most common triggers are cow's milk, soy, rice, and oats. Management involves strict avoidance of the triggering food. Most cases resolve by age 5.
Food Protein-Induced Allergic Proctocolitis (FPIAP)	FPIAP is a food allergy that manifests as bloody stools, typically within the first few weeks of life. The most common food that triggers FPIAP is cow's milk. Symptoms typically resolve with elimination of cow's milk and soy protein. Cases often resolve around 12 months of age
Food Protein-Induced Enteropathy (FPE)	FPE (sometimes referred to as cow's milk-sensitive enteropathy) involves injury to the small intestine when cow's milk is present in the diet. Symptoms typically present as protracted diarrhea within weeks of introducing cow's milk protein and resolve when cow's milk is avoided. Other food proteins, such as soybean, wheat, and egg, can also cause FPE. More than half of infants with FPE also have vomiting and failure to thrive, and some may have malabsorption, abdominal distension and early satiety. Bloody stools are usually absent.

Prevention Theories

In terms of food allergy prevention:

There is no evidence that pregnant or breastfeeding women should restrict any foods to prevent the development of allergies in their offspring.

The American Academy of Pediatrics (AAP) recommends that all infants, including those with a family history of food allergies, be exclusively breastfed until 6 months of age, unless contraindicated for medical reasons, and continue breastfeeding as long as mutually desired by mother and child for two years or more.

There is also no evidence to suggest that exclusive breastfeeding is associated with the prevention of any specific food allergies among breastfed infants.

However, exclusive breastfeeding for the first 3-4 months has been shown to decrease the risk of eczema in the first 2 years of life, a condition which has been associated with the development of food allergies.

Eczema, also referred to as atopic dermatitis (AD), is a common inflammatory skin disorder characterized by recurrent lesions and intense itch.

Eczema affects up to 20% of children and 10% of adults. While it can occur at any age, the typical age of onset is between 3 – 6 months.

Exclusion diets should not be advised in the treatment of children with eczema unless there is a clinical history of IgE-mediated allergic reactions. Unjustified elimination of a specific food can be harmful and lead to loss of tolerance to the food, with high rates of anaphylaxis when reintroduced.

There are currently no published trials that compare the timing of the introduction of allergenic foods on the development of food allergy in exclusively formula-fed versus exclusively breastfed infants.

For infants who cannot be exclusively breastfed, there is not currently a specific formula that is recommended to prevent food allergy.

Past recommendations to feed hydrolyzed formulas or soy formulas to prevent food allergies in high-risk infants who cannot be exclusively breastfed are not supported by current research.

Previous research suggested a benefit of the delayed introduction of highly allergenic foods to high-risk infants and children. However, this advice was modified in 2008 when new research failed to find any benefit regarding the delayed introduction of allergenic foods to at-risk infants and children.

Introducing Allergenic Foods

Additional research has suggested that the early introduction of allergenic foods may help to prevent the development of allergies to the foods offered among both the general population as well as high-risk populations. Currently, the strongest evidence for these recommendations comes from research on peanuts and eggs. As a result, the American Academy of Allergy, Asthma, & Immunology (AAAAI) recommends the introduction of peanut-containing products and egg or egg-containing products to all infants, irrespective of their relative risk of developing peanut allergy, starting around 6 months of life, and not deliberately delaying the introduction of other potentially allergenic foods (cow’s milk, soy, wheat, tree nuts, sesame, fish, shellfish) once the introduction of solid foods has begun.

Do the following two paragraphs contradict each other?--Colleen

Introduction to potentially allergenic foods can occur at home when the infant is developmentally ready for complementary food introduction, in accordance with the family's cultural practice, but not before the infant demonstrates developmental readiness with eating a few other common starter foods. While the AAAAI indicates that in-office allergy screening (such as sIgE and skin prick testing) by healthcare professionals is not required prior to offering potentially allergenic foods, irrespective of relative risk, this remains an option to consider for families that prefer to not introduce allergenic foods at home. Once potentially allergenic foods have been introduced, they should continue to be offered.

WIC staff should encourage WIC families to speak with their healthcare providers (HCP) to discuss their plans for the introduction of potentially allergenic foods, especially those considered to be at risk of developing food allergies. According to a consensus report from the AAAAI and the Canadian Society for Allergy and Clinical Immunology (CSACI), infants should be considered "at increased risk" for developing a food allergy (or an additional food allergy) if they have mild or moderate eczema, a family history of atopy (a genetic tendency to develop allergic diseases such as asthma, allergic rhinitis, and eczema) in either parents, or who have already been diagnosed with at least one food allergy. Infants should be considered "at the highest risk" for developing a food allergy if they have severe eczema.

Management

The only way to manage a food allergy is avoidance.

Food allergies produce anxiety and affect quality of life; however, management strategies can help mitigate these negative outcomes.

HCPs should work closely with families to provide education on food allergen avoidance and emergency management plans that are culturally and age appropriate. This includes education on reading food labels and ingredient lists, communicating allergens with people providing food, and the avoidance of any cross-reactive foods, i.e., similar foods within a food. Emergency management plans are essential for individuals with severe food allergic reactions, such as anaphylaxis. Nutrition counseling and weight and/or growth monitoring is recommended for all individuals with food allergies to ensure a nutritionally adequate diet.

Formula fed infants with a documented allergy to cow's milk protein should be provided with an extensively hydrolyzed protein formula. According to the AAP, soy formulas should not be considered first for infants with a documented allergy to cow's milk protein since approximately 10 to 14% of infants with a cow's milk protein allergy also have a soy protein allergy (43). Infants who are partially breastfed or formula fed, with certain non-IgE mediated allergies, such as FPIES and FPIP, may require extensively hydrolyzed casein or amino acid-based formula. WIC nutritionists should refer infants to their HCP if there is a concern of allergy to a formula and follow recommendations made.

Implications for WIC Nutrition Services

Through participant-centered counseling, WIC staff can assist participants with food allergies in making changes that improve quality of life and promote nutritional well-being while avoiding allergenic foods. Based on the needs and interests of the participant, WIC staff can (as appropriate):

- Refer participants diagnosed with severe asthma, eczema, eosinophilic esophagitis (EoE) and exercise-induced anaphylaxis to ~~an~~ HCP for food allergy evaluation, since food allergies often coexist with these conditions.
- Facilitate and encourage the participant's ongoing follow-up with their HCP for optimal management of the food allergy.
- Promote exclusive breastfeeding until six months of age and continuing as long as mutually desired by mother and child for 2 years or beyond.
- Provide hypoallergenic formula for participants with appropriate medical documentation, as needed.
- Individually tailor food packages to substitute or remove allergenic foods.
- Educate participants on maintaining adequate nutritional intake while avoiding allergenic foods. Surveys suggest that many individuals with food allergies are allergic to multiple foods. Multiple food allergies increase the level of effort required to avoid the triggering foods, as well as the risk of malnutrition. Consider contacting specialist RD for participant with multiple food allergies.
- Monitor weight status and growth patterns of participants.
- Educate participants with food allergies on reading food labels and identifying allergenic foods and ingredients. See resources below:
    - https://www.fda.gov/consumers/consumer-updates/have-food-allergies-read-label Accessed 6/9/25
    - https://www.foodallergy.org/resources/how-read-food-label. Accessed 6/9/25
    - Educate participants with food allergies on planning meals and snacks for outside the home.
    - Refer participants with suspected sensitivity to foods to their HCP for an oral food challenge of allergenic foods, as appropriate.
    - Establish/maintain communication with the participant's HCP.

Foster Care

(9031) **Categories: IBE, IBP, IFF, C-1, C 2-4**

Defined as: entering the foster care system during the previous 6 months or moving from one foster care home to another foster care home during the previous 6 months.

Note: This risk factor must be manually assigned in WOW and a note must be written to document it.

Justification:

Research findings have shown that foster children have a higher frequency of mental and physical problems, often the result of abuse and neglect suffered prior to entry into the foster care system. When compared to other Medicaid-eligible children, foster care children have higher rates of chronic conditions such as asthma, diabetes, and seizure disorders.

Because the foster care system often lacks a comprehensive health component, the social and medical histories of foster children in transition are frequently unknown to the foster care providers applying for WIC benefits for the children.

The nutrition education, referrals, and service coordination provided by WIC will support the foster parent in developing the knowledge and skills to ensure that the foster child receives appropriate nutrition and health care.

Procedure:

Determine that the child has entered into or transferred within foster care during the previous 6 months. Staff using this risk criterion should also evaluate and document other nutritional risks as well as problems that may require follow up or referral to other health care programs. This risk criterion should be used as the sole risk criterion **only** if careful assessment of the applicant's nutritional status indicates that no other risk criteria based on anthropometric, biochemical, medical, or dietary risk criteria can be identified.

This nutritional risk cannot be used for consecutive certifications while the child remains in the same foster home.

Participant Focused Counseling:

The foster care provider can state the feeding practices she can follow to promote optimal growth and development of the child.

Gestational Diabetes

(3021) **Category: PG**

Defined as: Diagnosed by a physician and self-reported by applicant/participant/caregiver. Gestational Diabetes is any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

A pregnant woman identified with Gestational Diabetes should have Nutrition Care counseling.
Best Practice: see participant immediately; if not possible, within 5 days. Provide additional Nutrition Care follow-up in 3 months.

Justification:

Uncontrolled Gestational Diabetes can result in stillbirth, polycythemia, or respiratory distress syndrome. Although rarely seen in GDM, congenital anomalies, neural tube defects, and/or cardiac abnormalities may occur if a woman has GDM in the early first trimester. Women with Gestational Diabetes are at increased risk for pregnancy complications and for Type II diabetes later in life. Diet and physical activity are the cornerstones of treatment. A woman with Gestational Diabetes should be monitored for compliance with diet and to ensure that blood sugar levels are maintained within the acceptable range. Close monitoring by the health care professional is essential.

Procedure:

Determine if the woman has been diagnosed with Gestational Diabetes.

Review collected information about dietary and lifestyle practices.

Participant Focused Counseling:

A woman with Gestational Diabetes can benefit from nutrition counseling that enables her to understand and follow the carbohydrate-controlled meal plan prescribed by her health care professional. Breastfeeding should be strongly encouraged as it is associated with maternal weight loss and reduced insulin resistance for both mother and offspring.

High Maternal Weight Gain

(1331) **Categories: PG, BE/BP, WPP**

Defined as:

Pregnant Women, including adolescents*

- A high rate of weight gain, such that in the 2nd and 3rd trimesters, for singleton pregnancies, a participant gains more weight per week than recommended based on her prepregnancy weight:

Pregnancy Weight Classification	BMI	Total Weight Gain (pounds) per week
Underweight	< 18.5	>1.3
Normal Weight	18.5 to 24.9	>1
Overweight	25 to 29.9	>0.7
Obese	≥ 30	>0.6
Multi-fetal Pregnancies	See Justification for more information	

OR

- High weight gain at any point in pregnancy, such that using an IOM-based weight gain grid, a pregnant woman's weight plots at any point above the top line of the appropriate weight gain range for her weight gain category.

Breastfeeding or Non-Breastfeeding Women, including adolescents* (most recent pregnancy only): a total gestational weight gain exceeding the upper limit of IOM's recommended range based on BMI for singleton pregnancies

Pregnancy Weight Classification	BMI	Total Weight Gain (pounds)
Underweight	< 18.5	>40
Normal Weight	18.5 to 24.9	>35
Overweight	25 to 29.9	>25
Obese	≥ 30	>20
Multi-fetal Pregnancies	See Justification for more information	

Justification:

Women with high maternal weight gain are at increased risk for cesarean delivery and delivering large for gestational age infants that can lead to complications during labor and delivery. There is a strong association between higher maternal weight gain and both postpartum weight retention and subsequent maternal obesity. High maternal weight gain may be associated with glucose abnormalities and gestational hypertension disorders. Childhood obesity is one of the most important long-term health outcomes related to high maternal weight gain. The IOM prenatal weight gain recommendations based on prepregnancy weight status categories are associated with improved maternal and child health outcomes.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines: normal weight women should gain 37-54 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds. For underweight women with multiple fetuses, a consistent rate of weight gain is advisable. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy. Education by the WIC nutritionist should address a steady rate of weight gain that is higher than for singleton pregnancies.

Procedure:

Pregnant Woman: Determine if the pregnant woman has had a weight gain of 7 pounds or more over a one-month period. Use self-reported information or information from the health care professional. Probing may be required to determine the amount of weight gained if a self-report is used.

Breastfeeding or Postpartum Woman: Using data self-reported or from the health care professional, determine if the total weight gain for the most recent pregnancy exceeds the IOM recommended maximum number of pounds, based upon pre-pregnancy weight status.

Participant Focused Counseling: The supplemental foods, nutrition education, and counseling related to the weight gain guidelines provided by the WIC Program may improve maternal weight status and infant outcomes. In addition, WIC nutritionists can play an important role, through nutrition education and physical activity promotion, in assisting postpartum women to achieve and maintain a healthy weight.

***** Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women as well.

High Weight-for-Length (Infants/Children < 24 Months of Age)

(1151) **Categories: IBE, IBP, IFF, C-1**

Defined as: ≥ 97.9 percentile weight-for-length as plotted on the CDC/WHO Birth to 24 months gender specific growth charts.

Justification:

CDC, WHO, and WIC use a cut-off value of ≥ 97.9 percentile weight for length in an infant 0 to ≤24 months. The WIC Program plays an important role in public health efforts to reduce the prevalence of obesity by actively identifying and enrolling infants and young children who may be at risk of overweight/obesity in later childhood or adolescence.

Procedure:

- Obtain current length measured to the nearest 1/8 inch. Record measurement in the participant's record.
- Determine the exact age of the infant or child.
- For an infant or child < 24 months of age who was born at 37 weeks or earlier, adjust the age before plotting, following the procedure in **Table GAA**.
- Plot Weight for Length on the CDC/WHO Birth to < 24 months growth chart. If the plotted point lies at or above the 97.9 percentile, assign the risk criterion.
- Review collected information for possible causes of high weight for length.

Participant Focused Counseling:

When identifying this risk, it is important to communicate with parents/caregivers in a way that is supportive and non-judgmental, and with a careful choice of words that convey an empathetic attitude and minimize embarrassment or harm to a child's self-esteem. The American Medical Association recommends more neutral terms like weight disproportionate to height, excess weight, and high weight for length when communicating with the parent/caregiver.

Educate parents/caregivers on behaviors that can lead to healthy body weight, including:

- Recognizing fullness cues
- Delaying introduction of solids until six months of age
- Offering a variety of nutritious foods of appropriate texture
- Not overly restricting foods
- Comforting the infant/child by holding, reading, or rocking instead of feeding

History of Birth of a Large for Gestational Age (LGA) Infant

(3371) **Categories: PG, BE/BP, WPP**

Defined as: Birth of an infant weighing ≥ 9 pounds (≥ 4000 grams).

Justification:

An infant who is large for gestational age (also known as macrosomia) is at increased risk for fetal and neonatal complications including shoulder dystocia, meconium aspiration, and asphyxia. The incidence of maternal complications is also high.

Women with a previous delivery of an infant weighing ≥ 9 pounds are at an increased risk of giving birth to a large for gestational age infant. LGA may be an indicator of maternal diabetes or a predictor of future diabetes.

Procedure:

Use information provided by the woman or her health care professional to determine if she has delivered a large for gestational age infant. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy
- Review information collected about dietary and lifestyle practices and health conditions such as gestational diabetes that could lead to a large for gestational age infant.

Participant Focused Counseling:

- A pregnant woman with a history of birth of an LGA infant can state the food, physical activity, and lifestyle choices she can make that are associated with a positive pregnancy outcome.
- A non-pregnant woman with a history of delivery of an LGA infant can state the food, physical activity, and lifestyle choices she can make to achieve good health.
- A postpartum woman who expresses interest in losing weight can set a goal for appropriate weight loss and state the food, physical activity, and/or lifestyle choices she can make to achieve her goal.

History of Birth with Nutrition-Related Congenital or Birth Defect

(3391) **Categories: PG, BE/BP, WPP**

Defined as: A woman who has given birth to an infant with a nutrition-related birth defect, such as a neural tube defect.

A woman who has delivered an infant with a nutrition-related birth defect should have Nutrition Care counseling.

Justification:

The single greatest risk criterion for delivery of an infant with a neural tube defect (a defect of the brain and spinal cord) is a personal or family history of such a defect. More than 50 percent of recurrences may be prevented by consuming supplemental folic acid (400 micrograms per day) before conception. Other nutrients, such as vitamin A consumed in excess or zinc consumed inadequately, have been linked to birth defects, such as cleft palate.

Procedure:

Use information provided by the woman or her health care professional to determine if she has delivered an infant with a nutrition-related birth defect. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy

Review information collected about dietary and lifestyle practices for restrictive eating, failure to consume adequate folic acid, or the use of tobacco, alcohol, or drugs that could be linked to birth defects.

Participant Focused Counseling:

A woman who has delivered an infant with a nutrition-related birth defect can state the food and lifestyle choices she can make that are associated with a positive pregnancy outcome, such as:

- Consuming foods rich in folic acid, vitamin A, and zinc
- Avoiding tobacco, alcohol, or drugs

History of Gestational Diabetes

(3031) **Categories: PG, BE/BP, WPP**

Defined as: History of Gestational Diabetes diagnosed by a health professional as self reported by applicant/participant/caregiver. Gestational Diabetes is any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

A woman who has a history of gestational diabetes should have Nutrition Care counseling. Best Practice: initial contact 0-10 days.
Best Practice: A pregnant woman with a history of gestational diabetes should have a Nutrition Care follow-up in 3 months.

Justification:

Uncontrolled Gestational Diabetes can result in respiratory distress syndrome, increased rate of stillbirth and pregnancy complications, and type 2 diabetes later in life. Although rarely seen in GDM, diagnosis in the early first trimester can result in congenital abnormalities and neural tube defects.

Studies have found that the risk factors for subsequent GDM include insulin use in the index pregnancy, obesity, diet composition, physical inactivity, failure to maintain a healthy BMI and weight gain between pregnancies. In addition, if a woman's lipid levels are elevated, a history of GDM is also a risk factor for cardiovascular disorders.

Procedure:
Using information provided by the woman or her health care professional, determine if she has a history of Gestational Diabetes. Apply as follows:

- **Pregnant woman**: any pregnancy
- **Breastfeeding or postpartum woman**: during most recent pregnancy for a woman
- Review collected information about relevant dietary or lifestyle practices.

Participant Focused Counseling:

- Breastfeeding has been shown to lower blood glucose level and to decrease the incidence of type 2 diabetes in women with a history of GDM. Exercise also has a beneficial effect on insulin action by enhancing peripheral tissue glucose uptake. Medical Nutrition Therapy is an essential component in the care of a woman with a history of GDM.
- Diet and physical activity is the cornerstone of treatment.
- A postpartum woman who expresses interest in losing weight can set a goal for appropriate weight loss and state the food, physical activity, and/or lifestyle choices she can make to achieve her goal.

History of Preeclampsia

(3041) **Categories: PG, BE/BP, WPP**

Defined as: Presence of the condition diagnosed by a physician as self-reported by applicant/participant/caregiver. Preeclampsia is defined as pregnancy-induced hypertension (>140mm Hg systolic or 90mm Hg diastolic) with proteinuria developing usually after the twentieth week of gestation. Clinical symptoms of preeclampsia may include: edema, renal failure, and the HELLP (Hemolysis, Elevated Liver enzymes, and Low Platelets) syndrome.

Justification:

Preeclampsia occurs in 3.4% of pregnancies in the United States and is associated with one maternal death per 100,000 live births in developed countries. Worldwide, it leads to the death of over 60,000 women annually.

It is important to note that *postpartum* preeclampsia can also occur, regardless of whether it was present during pregnancy. It is usually diagnosed within 48 hours of delivery but can occur up to 6 weeks postpartum. Thus, women during this period should monitor for preeclampsia symptoms and contact their health care provider immediately if they occur.

Women with a history of preeclampsia are at greater risk for future hypertension (HTN), heart attack, stroke, congestive heart failure, metabolic disease, and postpartum depression; these risks increase with repeated incidence of preeclampsia and with preterm delivery. Because women with a history of preeclampsia are at increased risk for HTN and related conditions, implementing lifestyle changes after delivery to help prevent HTN is crucial. Lifestyle measures to reduce the risk of HTN for women who are not pregnant include the following:

- Have blood pressure checked at least yearly or as recommended by one's health care provider. For those at risk of HTN, regularly monitoring blood pressure is crucial. Blood pressure levels greater than 180/120 mmHg are extremely dangerous and require immediate medical attention.
- Consume a diet consistent with the Dietary Guidelines for Americans or follow the Dietary Approaches to Stop Hypertension (DASH) eating plan. Details regarding the DASH eating plan can be found on the National Heart, Lung, and Blood Institute's website: www.nhlbi.nih.gov/health-topics/dash-eating-plan.
- Engage in regular physical activity.
- Achieve and maintain a healthy weight.
- Limit alcohol and avoid any use of tobacco, marijuana or illegal substances. (See *Maternal Smoking* and *Alcohol or Substance Use*.)

Currently, there is inconclusive scientific evidence on preventative measures for preeclampsia in future pregnancies. However, when dietary calcium is inadequate, research indicates adequate dietary calcium or supplementation (1.5-2 grams/day) may help prevent

preeclampsia. Dietary folate and folic acid supplementation during pregnancy has also been associated with lower risk of preeclampsia.

Breastfeeding
Women who had preeclampsia face a greater risk of HTN later in life and longer breastfeeding duration has been found to reduce this risk. Since women who had preeclampsia during pregnancy have greater incidence of preterm birth, low birth weight, cesarean delivery, exposure to medications not compatible with breastfeeding, and mother/infant separation, staff should plan to provide breastfeeding support to assist mothers in overcoming these potential issues, so women have opportunities to meet their breastfeeding goals.

Women with a history of preeclampsia should be encouraged to breastfeed, unless contraindicated due to a reason not related to preeclampsia. If postpartum women require antihypertensive medications, those that are compatible with breastfeeding should be chosen. The mother should discuss her breastfeeding status and goals with WIC breastfeeding support staff and her health care provider to determine the best infant feeding and medication plan.

Implications for WIC Nutrition Services
The WIC Program provides support to participants with a history of preeclampsia by offering nutritious food that are important components of a diet to help prevent HTN. WIC nutrition staff also offer nutrition education, counseling, and referrals.

In addition, WIC staff can assist participants by:

Pregnant Women with History of Preeclampsia:
- Encouraging prenatal care as soon as possible and to attend all health care appointments.

- Providing information about the symptoms of preeclampsia (sudden weight gain, swelling of face or hands, upper abdominal pain, difficulty breathing, changes in vision (including seeing spots), severe headache, nausea, and/or vomiting) and of the importance of contacting their health care provider immediately if they occur. Also, inform them that preeclampsia can occur postpartum.

- Counseling them on healthy weight gain, prenatal vitamin use, and a nutritious diet, including adequate calcium intake. For women with low calcium intake, refer them to their health care provider to discuss whether a calcium supplement is appropriate. **Please note that a low-sodium diet and/or weight loss is NOT recommended as treatment for HTN *during* pregnancy.**

- Encouraging them to discuss individualized physical activity recommendations with their health care provider.

- Providing information on avoiding any use of alcohol, tobacco, marijuana or illegal substances, as well as offering substance use referrals. The WIC Substance Use Prevention Manual is available for additional guidance and referral resources (https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide).

- Referring to local home visiting programs for health monitoring and support, if available.

- Encourage breastfeeding, which can reduce risk of HTN later in life.

Postpartum Women with History of Preeclampsia:

- Informing them of the symptoms of postpartum preeclampsia and of the importance of contacting their health care provider immediately if they occur.

- Providing breastfeeding promotion and support.

- Check compatibility of medication, if taken, and breastfeeding. Share information with mother. Encourage them to discuss their breastfeeding status and goals with their health care provider, especially if medications are prescribed.

- Encouraging them to attend all health care appointments, including their 4-6 week postpartum visit; to develop a plan for future pregnancies; to discuss health conditions and medication needs with their health care provider; and to have their BMI, blood pressure, lipids, and fasting glucose assessed yearly.

- Counseling them on achieving and maintaining a healthy weight, physical activity, following a diet consistent with the Dietary Guidelines for Americans or the DASH diet.

- Informing them that history of preeclampsia increases their risk of future HTN, cardiovascular disease, and stroke.

- Providing information on avoiding any use of alcohol, tobacco, marijuana or illegal substances, as well as offering substance use referrals. The WIC Substance Use Prevention Manual is available for additional guidance and referral resources (https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide)

- Referring them to their provider to discuss whether a calcium or folic acid supplement is appropriate, if intake of these nutrients seems inadequate.

- Referring to local home visiting programs, if available, for health monitoring and support.

History of Preterm or Early Term Delivery

(3111) **Categories: PG, BE/BP, WPP**

History of preterm and/or early term delivery is defined as follows:
• Preterm: Delivery of an infant born <36 6/7 weeks.

• Early Term: Delivery of an infant born >37 0/7 and <38 6/7 weeks.
Use information provided by the woman or her health care professional to determine if she has delivered a premature infant. Apply as follows:

Pregnant woman: any pregnancy
Breastfeeding or postpartum woman: most recent pregnancy

Justification:

Prior spontaneous preterm delivery is highly associated with recurrence in subsequent pregnancies. A history of one previous preterm birth is associated with a recurrent risk of 17-37%; the risk increases with the number of prior preterm births and decreases with the number of term deliveries

Typically, a pregnancy lasts about 40 weeks. Premature or preterm birth, however, is defined as a birth that occurs between 20 and 37 weeks of pregnancy, according to the American College of Obstetricians and Gynecologists (ACOG. In the past, the period from 3 weeks before until 2 weeks after the estimated date of delivery was considered a “term” pregnancy, with the expectation that a baby would have similar health outcomes if they were born any time during this interval. In 2013, ACOG released a committee opinion that the label “term” should be replaced with the designations *early term* (≥37 0/7 weeks and ≤38 6/7 weeks gestation) and *full term* (≥39 0/7 weeks and ≤40 6/7 weeks gestation) to more accurately describe these groups of infants.

Prematurity affects about 12% of all live births in the U.S., and about 50% of these preterm births were preceded by preterm labor. In 2011, the annual rate of premature births in the United States reached 11.7%, nearly two times the rate in European nations. Preterm births also account for approximately 70% of newborn deaths and 36% of infant deaths.

Despite advances in neonatal care, preterm birth remains a leading cause of infant death in the United States. More infants die from pre-term related problems than any other single cause. Preterm birth strains society’s healthcare resources due to its long-term effects on the health of the newborn. Premature infants may have physical problems that have nutritional implications, including immature sucking, swallowing and immature digestion and absorption of carbohydrates and lipids. Preterm infants are at risk for a

number of illnesses/health conditions that range from minor to severe complications depending on the circumstances. (See risk 1421 *Preterm or Early Term Delivery* for more details.)
Several factors have been found to increase the risk of preterm delivery. Epidemiologic studies have consistently reported low socioeconomic status, nonwhite race, maternal age of ≤ 18 years or ≥ 40 years, and low pre-pregnancy underweight as risk factors. Studies suggest even modest restrictions in maternal nutrition around the time of conception can lead to premature births and long-term adverse health effects for offspring. Other factors associated with a risk of preterm birth may be identified before pregnancy, at conception, or during pregnancy include:

- Low maternal weight gain during pregnancy
- Maternal infections, maternal hypertension, gestational diabetes
- Smoking, indoor pollution
- Maternal stress, teen pregnancy, multiple fetuses
- Sexually transmitted diseases, low psychosocial health status
- Previous or present pregnancy complications
- Lack of perceived social support, poor housing quality

A recent study indicated that maternal obesity is also an independent risk factor for preterm delivery (10). Complications associated with obesity (BMI > 30) prior to conception that increase the risk for preterm delivery include (11):
• Gestational Diabetes Mellitus, hypertension, preeclampsia
• Cesarean Delivery, Clinical/Health/Medical: History of Preterm or Early Term Delivery
• Postpartum weight retention
Additional concerns related to obesity include potential intrapartum, operative, and postoperative complications and difficulties related to anesthesia management. Obese women are also less likely to initiate and sustain breastfeeding

Participant Focused Counseling:

A woman with a history of preterm delivery can state the food or lifestyle choices she can make (such as appropriate weight and avoidance of tobacco, alcohol, and drugs) to lower her risk of preterm delivery.

History of Spontaneous Abortion, Fetal Death, Neonatal Loss

(3211) **Categories: PG, BE/BP, WPP**

Defined as: A spontaneous abortion (miscarriage) that occurs at < 20 weeks gestation, a fetal death (death at ≥ 20 weeks gestation), or a neonatal death (death occurring from birth through the first 28 days of life).

Justification:

Previous fetal and neonatal deaths are strongly associated with preterm low birth weight. There is also an increase in subsequent preterm deliveries in women who have experienced one or more second trimester spontaneous abortions. The extent to which nutritional interventions can decrease the risk for repeat poor pregnancy outcomes depends upon the degree to which poor nutrition was responsible for the poor pregnancy outcomes. The risk for future small for gestational age outcomes is greater for a woman with a history of 2 or more spontaneous abortions (SAB's). SAB's may also be indicators of neural tube defects.

Nutritional deficiencies and excesses have been shown to result in low birth weight and pregnancy loss. Prenatal weight gain is one of the most important correlates of birth weight and fetal growth restriction. All women of childbearing age should be advised to consume 400 micrograms of folic acid daily.

Procedure:

Determine if the woman has a history of miscarriage (SAB) or fetal or neonatal death. Apply as follows:

- **Pregnant woman**: any pregnancy. A pregnant woman must have had ≥ 2 miscarriages to apply this risk factor
- **Breastfeeding woman**: most recent pregnancy with one or more infants still living
- **Postpartum woman**: most recent pregnancy

Participant Focused Counseling:

Review collected information about dietary and lifestyle practices (such as restrictive eating practices, failure to consume 400 micrograms of folic acid daily, or tobacco, alcohol or drug use) that could contribute to poor pregnancy outcome.

Educate on possible nutrition-related causes. Discuss behavior changes the participant is willing to make. Assist participant in setting simple goals to achieve those changes. Refer to behavior change programs (e.g., smoking cessation) as appropriate.

HIV/AIDS

(3524) **Categories: ALL**

Defined as: a chronic virus infection that reduces an individual's ability to fight off infections and diseases. When HIV progresses to AIDS, the immune system becomes extremely weakened and can no longer protect against other infections or opportunistic illnesses that would not harm healthy individuals but can be life-threatening to people infected with HIV.

A participant determined to have HIV/AIDS should have Nutrition Care counseling. If the participant is breastfeeding, the CPA should review the conditions for safe breastfeeding. Best Practice: notify the IBCLC/DBE in case complications arise.

Justification:

The Human Immunodeficiency Virus (HIV) destroys white blood cells found in the immune system, also known as CD4 (cluster of differentiation) or T cells (T lymphocytes).

HIV is transmitted only through blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breastmilk from an HIV-infected person. HIV can lead to Acquired Immunodeficiency Syndrome (AIDS) if left untreated.

Individuals who are aware of their HIV status and are undergoing antiretroviral therapy (ART) to stop the replication of the virus, can typically live decades. Those unaware of their status or who are not on ART can usually remain in this stage up to about ten years before progressing to the AIDS stage.

Getting tested is the only way individuals know they are infected with HIV. The Centers for Disease Control and Prevention (CDC) recommends that all pregnant people get tested early in their pregnancies. An early diagnosis during the prenatal period can reduce the transmission of HIV in babies to less than 1% if the expectant parent receives Active Antiretroviral Therapy (ART) during pregnancy, labor, and delivery, and the baby receives appropriate preventative medication after birth. This treatment also keeps the chance of passing HIV to an infant through breastfeeding to less than 1%, making breastfeeding a viable option.

PrEP (Pre-Exposure Prophylaxis) is a daily pill containing two medicines (tenofovir and emtricitabine), recommended for HIV negative people who are at substantial risk of becoming infected with HIV. PrEP, when taken consistently, reduces HIV transmission by up to 92%.

Participant Focused Counseling:

WIC can improve the management of chronic infectious diseases through WIC foods, nutrition education, counseling, and referrals to community resources that provide support in the long-term management of chronic infectious diseases.

Dietary recommendations depend on the symptoms experienced by the HIV positive participant. A discussion using open-ended questions can determine the participant's symptoms, and openness to exploring dietary approaches to reducing symptoms, using the following options.

A participant with **unintended weight loss or wasting**, may be dealing with

1. Poor food intake due to medication side effects, sore mouth, or mental health issues
2. Altered metabolism due to disease progression
3. Nutrient malabsorption caused by gastrointestinal problems from either the medications or the virus itself.

For these participants, the main goals are to maintain or increase body weight, retain or increase lean body mass, and take in adequate macro- and micro-nutrients.

- These participants usually require a higher protein diet
- They may need a multivitamin supplement, since most are lower in vitamins A, B6, C, and E. **Specific supplements should be recommended only by the health care provider.** Note: Iron supplements leading to iron overload encourage disease progression from HIV to AIDS. In addition, supplements of vitamin A and Zinc can have a negative impact on adults living with HIV/AIDS.

Goals for **asymptomatic participants or those with stable weight** should focus on adequate nutrition to prevent wasting. On recommendation of the health care provider, they can take a multivitamin or mineral supplement.

Although people with HIV are able to manage the disease and live longer with Highly Active Antiretroviral Therapy (HAART), the side effects can cause gastrointestinal problems, lipid disorders, and insulin resistance/glucose intolerance should:

- Reduce total fat and cholesterol
- Increase dietary fiber
- Increase physical activity
- Reduce alcohol consumption
- Reduce consumption of simple sugars

HIV/AIDS and Food Safety

Participants with HIV are more susceptible to food-borne illness due to a weakened immune system. WIC nutritionists should encourage them to:

- Store and prepare foods safely
- Check expiration dates
- Avoid raw or semi raw foods like meat, unpasteurized dairy foods, and soft cheeses.
- Infants born to HIV-positive mothers often are carefully monitored for their HIV status for the first six months of life, and may be referred to WIC as HIV positive, even though their status may not yet be established. Pediatricians may request ready-to-feed or liquid concentrate infant formula, since powdered infant formula is not sterile and may not be microbiologically safe. If requested, liquid concentrate formula is appropriate and allowable for an infant diagnosed as HIV positive.

HIV/AIDS Care and Support

Families that include someone living with HIV often lack the financial and psychosocial support needed to deal with this diagnosis and the social stigma can reduce compliance with medical treatment needed to control the disease. They must get care, stay in care, and adhere to their medical plan. WIC agencies should refer participants to health care services and community resources, including other nutrition assistance programs to improve health outcomes.

The following information summarizes the WIC Nutrition Services that can help improve the health and birth outcomes of participants living with HIV.

NUTRITION AND HEALTH TIPS TO MANAGE HIV/AIDS SYMPTOMS

All Categories

- Use MyPlate as the guide for dietary needs.
- Consult health care providers when using supplements and herbs to avoid adverse reactions or medication interactions that could reduce effectiveness.
- Eat small, frequent meals when gastrointestinal problems are present or persistent.
- Eat soft foods with manageable textures at tolerable temperatures when oral lesions and dental problems are present (i.e. mashed potatoes, scrambled/boiled eggs, bananas, non-citrus juices, puddings, custards, milk, cooked vegetables, rice, oatmeal, non-fizzy drinks, cottage cheese, non-spicy foods).
- Add canned tuna, beans, cheese, peanut butter, dried milk for inexpensive extra protein.

- Add moderate amounts of concentrated sources of calories to diet when needed (e.g., butter, cream cheese, gravies, whole milk, ice cream).
- Consume nutritious, high caloric foods when appetite is normal or has returned.
- Drink adequate water to stay hydrated, replace fluid loss from diarrhea and vomiting, and help medications move through the body.
- Consume foods high in fiber or fiber supplements to slow digestion if foods are moving too quickly through the body.
- Eat yogurt or foods with *Lactobacillus acidophilus* culture to help with bacterial overgrowth resulting from prolonged use of antibiotics.
- Avoid caffeinated beverages to prevent dehydration.
- Avoid or reduce sugar-free foods with sorbitol as diarrhea may be exacerbated.
- Consult with a health care provider about the use of complete oral nutritional supplements to help nutritional status.
- Avoid alcohol and illegal drugs for overall good health and to help protect the liver.
- Use pancreatic enzymes when medically prescribed to help with digestion.
- Prepare and store food safely.
- Avoid expired and moldy foods or foods with rotten spots.
- Participate in weight-bearing exercises to strengthen and maintain bones.
- Refer families affected by HIV to other community resources for food, housing, and medical resources to improve compliance with HIV treatment.

Women

- Advise pregnant individuals who are living with HIV to consume a diet adequate in nutrients, achieve appropriate weight gain, and discuss taking a multivitamin with their health care provider.
- Educate parents living with HIV about infant feeding options. Anyone on antiretroviral therapy, with an undetectable or extremely suppressed viral load has a less than 1% chance of passing HIV to an infant through breastfeeding. Those who have a higher viral load and those who are not on antiretroviral medications have a higher chance of passing HIV to an infant they breastfeed. Use of infant formula or donor milk from a Human Milk Banking Association of North America (HMBANA) milk bank eliminates the risk of HIV transmission through feeding. Parents living with HIV should be encouraged to speak with their physicians about getting started on antiretroviral medications if they currently are not on a regimen, and if on the medication, to continue taking it as directed and keep medical appointments for best chances of sustaining their undetectable viral loads.
- More information about **breastfeeding and HIV** can be found at:
    - https://www.cdc.gov/breastfeeding-special-circumstances/hcp/illnesses-conditions/hiv.html
    -

Infants

- Educate parents/caregivers living with HIV that they can breastfeed if they choose to. Provide factual information regarding chances of passing HIV through breastmilk, depending on the parents' viral load, and the importance of the parent being on antiretroviral medication to achieve and maintain a very suppressed viral load. Educate that if they choose to use donor breastmilk from a HMBANA milk bank or infant formula, it eliminates the chance of passing HIV through feeding.
- Discourage giving pre-chewed food, regardless of HIV status, as the HIV status of the individual who is pre-chewing the food is unknown.
- More information about **infants and HIV** can be found at:
    - https://clinicalinfo.hiv.gov/en/guidelines/perinatal/infant-feeding-individuals-hiv-united-states

Children

- Discourage giving pre-chewed food, regardless of HIV status, as the HIV status of the individual who is pre-chewing the food is unknown.

Hepatitis

(3523) **Categories: ALL**

Defined as: inflammation of the liver.

A participant determined to have Hepatitis should be referred to the CPA for Nutrition Care counseling.

Justification:

Hepatitis is most often caused by viruses, but can also be caused by excessive alcohol intake, toxins, and medicines such as acetaminophen and some other conditions linked to liver inflammation.

Regardless of the type of hepatitis, infected individuals with signs of the infection will typically experience anorexia, nausea, vomiting, diarrhea, jaundice, epigastric pain, tiredness, and weakness, all of which affect one's diet and health. Darker urine and pale stools may also be present. Viral hepatitis is the leading cause of liver cancer and the most frequent need for liver transplants in the United States. Because symptoms of all kinds of hepatitis are the same, diagnosis by laboratory testing or an epidemiologic link to a confirmed case is required.

Procedure:

WIC can improve the management of acute or chronic Hepatitis infections through WIC foods, nutrition education, counseling, and referrals to community resources that provide support in the long-term management of Hepatitis infections.

WIC Nutrition Services for Acute Infectious Hepatitis:

- Encourage sufficient calorie intake to help meet increased nutrition needs.
- Recommend the Dietary Guidelines to ensure healthy eating pattern
- Provide suggestions to address poor appetite
- Provide education on safe food handling and storage practices

WIC Nutrition Services for All Types of Hepatitis:

- Recommend testing to pregnant women and high -risk individuals.
- Encourage abstinence from alcohol.
- Provide information on high calorie, high protein, and moderate fat diets, as recommended by health care provider.
- Discuss high calorie consumption at breakfast to reduce nausea. (Typically, nausea is less common in the morning.)
- Recommend, in consultation with health care provider, consumption of high calorie and protein liquid formula between meals to boost calorie intake.

- Encourage a bland diet with extra fluids depending on the severity of nausea and vomiting.

The chart below summarizes differences in Hepatitis types, and additional WIC Nutrition Services that can help improve the health and outcomes of participants with Hepatitis.

TYPE	TRANSMISSION	PREVENTION/TREATMENT	WIC NUTRITION SERVICES
ACUTE INFECTIONS: Must be present within the past 6 months.			
A	Fecal-oral route Household member Sexual partner Fecal contaminated food/water	70% asymptomatic **Prevention**: Proper hygiene Food safety Vaccination	Encourage vaccine for children, adolescents, high risk adults.Promote BF as safe except with cracked/bleeding nipples. Stop breastfeeding until nipples heal and continue to pump to maintain milk supply. Discourage pre-chewing infant food
E	Uncommon in US. Fecal-oral, usually drinking water. Uncooked/undercooked meat and shellfish Travel to developing countries	No treatment or vaccine; Symptoms usually resolve; Pregnant: 10-30% death rate in 3rd trimester **Prevention:** Clean drinking water and good sanitation Supportive therapy/ hospitalization.	Avoid contaminated water
ACUTE AND CHRONIC INFECTIONS: Acute infections must be present in last 6 months. Chronic infections may last a lifetime			
B	Infected blood, needles, body fluids at work; Asian & Pacific islanders most at risk; Those undergoing dialysis; Those who are HIV infected; Immigrant/refugee status; Sexual intercourse with infected person; Mother to child at birth (both vaginal & Cesarean section births)	Interferon & antiviral drugs **Prevention:** Hepatitis B vaccine;	Encourage vaccine for newborns, adolescents, at risk adults; Promote BF as safe except with cracked/bleeding nipples Stop breastfeeding until nipples heal and continue to pump to maintain milk supply. Discourage pre-chewing infant food

TYPE	TRANSMISSION	PREVENTION/TREATMENT	WIC NUTRITION SERVICES
C	Present in blood & body fluids: Sharing needles; Sexual activity; Transfusion/organ transplant before July 1992; Sharing razor, toothbrush, or nail clippers; Tattoos & piercings from unlicensed facilities Mother to child at birth	No vaccine	Promote BF as safe except with cracked/bleeding nipples. Stop breastfeeding until nipples heal and continue to pump to maintain milk supply.
D	Uncommon in the US. Contracted only when a person has Hepatitis B first. Contact with blood and body fluids; Sexual activity with infected person; Mother to child transmission at delivery; Sharing drug paraphernalia, razors, or toothbrushes; Direct contact with blood of infected person	No vaccine, except Hepatitis B for prevention; Interferon may be helpful	Recommend Hepatitis B vaccine

Homelessness

(8011) **Categories: All**

Defined as: A woman, infant, or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:

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

Procedure:

Determine if the participant is homeless, as defined above.

Review dietary and lifestyle practices.

Participant Focused Counseling:

The goals of nutrition counseling are:

- to assist the homeless participant in making decisions about the selection, storage, and preparation of foods to promote optimal nutritional status.
- To advise and support the caregiver of the homeless participant so she is able to make the best decisions regarding food selection, storage, and preparation, despite living conditions.

Hyperemesis Gravidarum

(3011) **Category: PG**

Defined as: Current diagnosis of Hyperemesis Gravidarum, diagnosed by a physician as self-reported by applicant/participant/caregiver.

Hyperemesis Gravidarum (HG) is defined as severe and persistent nausea and vomiting during pregnancy which may cause more than 5% weight loss and fluid and electrolyte imbalances. This nutrition risk is based on a chronic condition, not single episodes. HG is a clinical diagnosis, made after other causes of nausea and vomiting have been excluded.

A pregnant woman identified with Hyperemesis Gravidarum should have Nutrition Care counseling.

Best Practice: Provide Nutrition Care follow-up in 1-3 months

Justification:

A pregnant woman with Hyperemesis Gravidarum is at risk for weight loss, dehydration, ketonuria, and electrolyte imbalances such as hypokalemia. HG affects approximately 0.3-3.0% of pregnancies and may lead to adverse fetal consequences and hospitalization in some cases. HG is the second most common reason for hospitalization for pregnant women, with preterm labor being the most common.

Risk Factors for HG

Biological, physiological, psychological and sociocultural factors are thought to be influential in HG. Various risk factors include maternal underweight, multiple pregnancy, nulliparity, previous history of HG, trophoblastic disorders, and history of eating disorders. Family history, Helicobacter pylori infection, history of motion sickness and/or migraine headaches are also risk factors for HG.

HG and Adverse Maternal Outcomes

HG can adversely affect maternal outcomes and, if inadequately managed, can lead to malnutrition, dehydration, electrolyte imbalances, thrombosis, and Wernicke's encephalopathy (a very rare but potentially life-threatening complication of HG, caused by thiamine deficiency). Vitamin K deficiency has also been reported with HG and may be implicated in neonatal hemorrhage. Other serious complications include esophageal rupture (caused by severe vomiting), peripheral neuropathy, coagulopathy and Mallory-Weiss syndrome (acute increase in esophageal pressure due to vomiting).

Women with HG in the second trimester are at an increased risk for placental disorders, such as placental abruption. Pregnant women with HG are at an increased risk for any autoimmune disorder, and in extreme cases this may lead to organ damage manifesting as oliguria and abnormal liver function tests. In addition, pregnant women with HG are at increased risk for psychological distress therefore leading to an increased risk for depression and anxiety. Other concerns associated with HG include severe distress, social dysfunction and loss of time from work. Malnourishment may develop over a period of time in women suffering with HG, which may lead to refeeding syndrome (RFS).

HG and Adverse Birth Outcomes
Women with HG have an increased risk of giving birth to low birth weight, small for gestational age, and premature infants, infants at increased risk of colic, irritability, and growth restrictions, and, possibly, an increased risk of psychological disorders and reduced insulin sensitivity.

Procedure:

- Determine if the woman has been diagnosed with and currently has Hyperemesis Gravidarum.
- Review collected information about dietary and lifestyle practices.

Participant Focused Counseling:

WIC nutrition staff can provide the following nutrition services to women with HG:
- Refer to a health care provider for appropriate monitoring and treatments as necessary.
- Provide education on how to recognize symptoms of dehydration such as: increased thirst, dry mouth, low urine output or urine that is darker in color than normal.

Offer suggestions to help with nausea such as:

- Avoid foods and smells that seem to trigger nausea.
- Eat crackers or dry cereal before getting out of bed to curb nausea in the morning.
- Avoid large fluid intakes in the morning. Drink liquids between meals instead of with meals.
- Choose foods carefully. Select foods that are high in carbohydrates or protein, low in fat, and easy to digest. Salty foods are sometimes helpful, as are foods that contain ginger — such as ginger lollipops. Avoid greasy, spicy and fatty foods. Consume foods that settle the stomach and calm the nausea.
- Eat several small meals throughout the day instead of three large meals. Meals should contain more carbohydrates than fat and acid. Protein-rich meals also decrease symptoms. Lighter snacks, including nuts, dairy products, and beans, are recommended.

Hypertension and Prehypertension

(3452) **Categories: PG, BE/BP, WPP, C 3-4**

Defined as: Presence of hypertension or prehypertension diagnosed by a physician as self-reported by applicant/participant/caregiver as follows:

- **Adult hypertension:** consistent readings of ≥140/≥90 mmHg millimeters of mercury
- **Adult prehypertension:** consistent readings of 120-139/80-89 mmHg.
- **Hypertension during childhood** is age-specific and is defined as blood pressure readings greater than the 95th percentile for age, gender, and height on at least three separate occasions. Blood pressure reading between the 90th and 95th percentiles is considered prehypertension.

A participant identified with hypertension or prehypertension should have Nutrition Care counseling.
Best Practice: Provide Nutrition Care follow-up in 3-6 months.

Justification:

Untreated hypertension leads to many degenerative diseases, including congestive heart failure, end-stage renal disease, and peripheral vascular disease.

Hypertensive disorders of pregnancy include Chronic Hypertension, Preeclampsia, Eclampsia, Preeclampsia superimposed on Chronic Hypertension, and Gestational Hypertension.

There is no cure for hypertension; however, lifestyle modifications can prevent high blood pressure and are critical in the management of hypertension and prehypertension.

Children with high blood pressure are more likely to become hypertensive adults. Therefore, they should have their blood pressure checked regularly beginning at the age of three. Blood pressure and overweight status have been suggested as criteria to identify hypertensive children.

Hypertension (HTN), commonly referred to as high blood pressure, occurs when the force of blood against artery walls is high enough that it may eventually cause health problems. Hypertension is measured in terms of both systolic blood pressure (pressure in blood vessels when the heart contracts) and diastolic blood pressure (pressure in blood vessels when the heart rests between contractions). Two main factors in the body increase levels of blood pressure – a higher volume of blood being pumped by the heart and narrower arteries. Untreated HTN leads to many degenerative diseases, including congestive heart failure, end-stage renal

disease, and peripheral vascular disease. People with HTN are often asymptomatic; diagnosis is based on measuring levels of blood pressure.

About 75 million adults in the United States (1 in every 3) have HTN, and about the same number have prehypertension. Unfortunately, only half of adults in the United States with HTN have their blood pressure under control, and HTN leads to at least 410,000 deaths in the United States annually.

Primary HTN has no known cause. **Secondary HTN** can be caused by sleep apnea, kidney problems, diabetes, some tumors, thyroid problems, inflammation, and blood vessel defects. In addition, several medications (e.g., some birth control, cold medicines, decongestants, pain relievers) as well as illegal substances can significantly raise blood pressure.

Risk factors for HTN include the following:

- Age (Risk increases with age.)
- Race/ethnicity (In the United States, people of African descent experience disproportionately higher rates of HTN compared to other races/ethnicities. Causes for this racial disparity in rates of HTN are complex and multifactorial.)
- Family history
- Overweight or obesity (This causes more blood to be pumped by the heart.)
- Physical inactivity (This is associated with a higher heart rate, which increases the force of blood against arteries.)
- Tobacco use (This increases blood pressure during use. Chemicals in tobacco also lead to narrowing of arteries.)
- Second-hand exposure to tobacco smoke
- Excessive sodium intake (This causes fluid retention, which increases blood pressure.)
- Inadequate potassium intake (This causes an excessive amount of sodium in the blood.)
- Excessive alcohol intake (This can damage the heart over time.)
- Stress
- Prehypertension
- Pregnancy
- Male gender

Management of HTN includes lifestyle modifications and medication. In prehypertensive individuals, implementing lifestyle changes can prevent or delay the onset of HTN. In hypertensive individuals, dietary intervention is not only effective in reducing blood pressure but also in delaying or avoiding drug treatment.

Lifestyle changes to manage HTN and prehypertension include the following:

- Have blood pressure checked at least yearly or as recommended by one's health care provider. For those at risk of HTN, regular monitoring of blood pressure is crucial. Blood pressure levels greater than 180/120 mmHg are extremely dangerous and require immediate medical attention.
- Consume a diet consistent with the Dietary Guidelines for Americans or follow the Dietary Approaches to Stop Hypertension (DASH) eating plan. Details regarding the DASH eating plan can be found on the National Heart, Lung, and Blood Institute's website: www.nhlbi.nih.gov/health-topics/dash-eating-plan.
- Engage in regular physical activity.
- Achieve and maintain a healthy weight.
- Limit alcohol and avoid any use of tobacco, marijuana or illegal substances.
- If lifestyle changes alone do not sufficiently reduce blood pressure, medications may be prescribed. These include angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs), calcium channel blockers, and/or diuretics.

Pregnant Women

Hypertension occurs in 6-8% of all pregnancies in the United States. Any HTN during pregnancy can lead to preeclampsia, eclampsia, stroke, pregnancy induction, and/or placental abruption. Because HTN during pregnancy can tighten the mother's blood vessels (including those in the umbilical cord), it can reduce oxygen and nutrients to the infant, potentially causing prematurity, low birth weight, and fetal growth restriction.

Hypertensive disorders of pregnancy are categorized as follows:

Chronic Hypertension during Pregnancy:

Definition: Hypertension is present before pregnancy or is diagnosed before 20 weeks gestation.

- Increases the risk of developing more severe HTN during pregnancy, gestational diabetes, and perinatal mortality. In infants, it may lead to fetal growth restriction and, additionally, exposure to antihypertensive medications may cause fetal growth restriction and malformation.
- Treatment includes frequent, regular monitoring of blood pressure**.** It is typically suggested that women with well-controlled blood pressure who exercised regularly before pregnancy continue moderate physical activity during pregnancy, unless contraindicated. Women should check with their health care provider for individualized guidance.

Preeclampsia:

- **Definition**: Onset of hypertension during pregnancy, typically with proteinuria, and usually after 20 weeks gestation. For some women, proteinuria does not occur; for these women, preeclampsia is diagnosed as hypertension with thrombocytopenia, impaired liver function, renal insufficiency, pulmonary edema, and/or cerebral or visual disturbances.

- The most common type of hypertensive disorder during pregnancy, preeclampsia occurs in 3.4% of pregnancies in the United States and is associated with one maternal death per 100,000 live births in developed countries. Worldwide, it leads to the death of over 60,000 women annually.

- **Risk factors** include history of preeclampsia, chronic HTN, chronic kidney disease, history of thrombocytopenia, in vitro fertilization, diabetes, auto-immune disorders (such as lupus), uterine artery notching, family history of preeclampsia, obesity, polycystic ovarian syndrome, giving birth for the first time, multifetal pregnancy, pregnancy interval greater than 10 years, and being older than 40 years. **Low dietary and serum calcium levels are also associated with preeclampsia**.

- **Clinical signs** include any of the following: proteinuria, low blood platelet count, abnormal kidney or liver function, and fluid in the lungs. Symptoms can include sudden weight gain, swelling of face or hands, upper abdominal pain, difficulty breathing, changes in vision (including seeing spots), severe headache, nausea, and/or vomiting.

- For pregnant women, preeclampsia can lead to pulmonary edema (fluid build-up in the lungs), heart attack, stroke, acute respiratory distress syndrome (difficulty breathing due to fluid leaking into the lungs), coagulopathy (blood unable to clot), severe renal failure, retinal injury, liver rupture, placental abruption, hemolysis (breakdown of red blood cells), cesarean delivery, and/or death. Women with preeclampsia are at greater risk for postpartum depression, future HTN, heart attack, stroke, congestive heart failure, and metabolic disease; these risks increase with repeated incidence of preeclampsia and with preterm delivery. The infant of a woman with preeclampsia is at greater risk for cesarean delivery, preterm birth, low birth weight, small for gestational age, and/or stillbirth. For the children of mothers who had preeclampsia, they are at heightened risk of bronchopulmonary dysplasia (form of chronic lung disease), cerebral palsy, cardiovascular dysfunction, learning disabilities, and lower IQ.

- Currently, there is inconclusive evidence on preventative measures for preeclampsia in future pregnancies. However, **when dietary calcium is inadequate, research indicates adequate dietary calcium or supplementation (1.5-2 grams/day) may help prevent preeclampsia. Dietary folate and folic acid supplementation during pregnancy has also been associated with lower risk of preeclampsia.**

  Treatment for preeclampsia depends on severity and other individual factors. For women with preeclampsia without severe features (hypertension with proteinuria after 20 weeks gestation), the American College of Obstetricians and Gynecologists (ACOG) currently suggests that strict bed rest *not* be routinely prescribed (although there may be situations in which different levels of rest, including bed rest and hospitalization, may be indicated).

For women with severe preeclampsia, treatment should:

- occur in an inpatient setting, and ACOG recommends early delivery of the infant to prevent additional harm to the mother and infant. The only known cure for preeclampsia during pregnancy is the delivery of the infant and placenta.
- It is important to note that *postpartum* preeclampsia can occur, regardless of whether it was present during pregnancy. It is usually diagnosed within 48 hours of delivery but can occur up to 6 weeks postpartum. Thus, women during this period should monitor for preeclampsia symptoms and contact their health care provider immediately if they occur.

Chronic Hypertension with Superimposed Preeclampsia:
Definition: Hypertension is present before pregnancy, and preeclampsia develops during pregnancy. It is classified as either "with severe features" (hypertension with proteinuria before 20 weeks gestation with organ problems) or "without severe features" (hypertension with proteinuria after 20 weeks gestation).

Eclampsia:
Definition: Eclampsia is the presence of new-onset grand mal seizures in a woman with preeclampsia. Eclampsia can occur before, during, or after labor. It may be preceded by severe headaches, blurred vision, sensitivity to light, abdominal pain, hyperreflexia (over-reactive reflexes), and altered mental status.

- Eclampsia is a critical situation and can lead to maternal death. Treatment typically includes parenteral magnesium sulfate in an inpatient setting. Once the mother's condition is stabilized, ACOG recommends the delivery of the infant. Treatment with magnesium sulfate may also be continued after delivery, if needed.
- Please note that due to the critical nature of eclampsia and its treatment in an inpatient setting, women with eclampsia are not encountered within a WIC setting.

Gestational Hypertension:
Definition: Onset of hypertension during pregnancy, usually after 20 weeks gestation, and without proteinuria. It usually resolves after delivery but does increase the risk of developing chronic HTN.
The term "pregnancy-induced hypertension" includes preeclampsia, eclampsia and gestational hypertension. **Please note that a low-sodium diet and/or weight loss is NOT recommended as treatment for HTN *during* pregnancy.**

Breastfeeding
A systematic study done by the Agency for Healthcare Research and Quality found that there is an inverse relationship between duration of breastfeeding and HTN: the longer a woman breastfeeds, the less risk she has for developing HTN. Similarly, women with hypertension should be encouraged to breastfeed, unless contraindicated. If postpartum women require antihypertensive medications, medications should be chosen that are compatible with breastfeeding, if possible. It is thus very important for the mother to discuss her breastfeeding status and goals with her health care provider to determine the best infant feeding and medication plan.

Children

Hypertension among children is a serious condition and may eventually lead to hypertension and chronic disease in adulthood. The definition of HTN is based on the normative distribution of blood pressure in healthy children. In 2017, the American Academy of Pediatrics (AAP) updated their pediatric HTN diagnostic tools to account for the sex, age, and height of the child. For more information about the definition and classification of HTN in children see the AAP *Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents*: https://pediatrics.aappublications.org/content/140/3/e20171904.

Early detection of high blood pressure in children is crucial for preventing future health concerns. Thus, the AAP recommends that blood pressure be measured annually once children are three years old. For children under three years of age, health care providers should measure blood pressure at every visit if the child has a risk factor for developing HTN.

The prevalence of HTN among children and adolescents in the United States is around 3.5%. About 2-4% U.S. children and adolescents experience persistently elevated blood pressure. Higher rates are experienced by boys and among Hispanic and non-Hispanic African American children compared to white children.

For most children with HTN, there is no specific, identifiable cause (thus, it is considered primary HTN). Some children, however, do experience HTN as a direct result of medications, kidney disease, endocrine disorders, or congenital heart defects.

Risk factors for elevated blood pressure and HTN among children include the following:

- Family history of HTN, including maternal HTN during pregnancy
- Overweight and obesity (including high weight-for-length in infants)
- History of prematurity, low birth weight, and/or small for gestational age
- High sodium intake.

Hypertension during childhood has implications for both current and long-term health. Health outcomes of HTN occurring in children may include the following:

- Dyslipidemia and cardiovascular damage
- Learning disabilities, impaired neurocognition and executive functioning
- In adulthood: HTN, metabolic syndrome, and cardiovascular disease.

For the management of HTN in children, the AAP recommends the following lifestyle changes:

- Achieve and maintain a healthy weight-for-length or BMI (body mass index).
- Follow an age-appropriate DASH-type eating plan.
- Participate in moderate to vigorous physical activity at least 3-5 days per week, 30-60 minutes per session.
- Get adequate sleep (more than 7 hours a night).

For more information about HTN among children, please see the Centers for Disease Control and Prevention's website *High Blood Pressure during Childhood and Adolescence* at: https://www.cdc.gov/bloodpressure/youth.htm.

Implications for WIC Nutrition Services
The WIC Program provides support to participants with hypertension/prehypertension by offering fruits, vegetables, whole grains, legumes, low-fat dairy, and fish, which are important components of the DASH eating plan. WIC nutrition staff also offer nutrition education and counseling as well as referrals to smoking cessation and substance use treatment, if needed, which are critical to the management of hypertension/prehypertension. In addition, WIC staff can assist participants by:

For Pregnant Women with Hypertension:
- Asking probing questions to determine the type of hypertension they have been diagnosed with during pregnancy.
- Encouraging them to start prenatal care as soon as possible and to attend all health care appointments. Health status and blood pressure should be monitored frequently by health care provider. The health care provider may also recommend regular self-monitoring of blood pressure.
- Informing them of the symptoms of preeclampsia and of the importance of contacting their health care provider immediately if they occur. Also**, inform them that preeclampsia can occur postpartum.**
- Counseling them on healthy weight gain, prenatal vitamin use, and a nutritious diet, including **adequate calcium intake**. For women with low calcium intake, refer them to their health care provider to discuss whether a calcium supplement is appropriate. Please note that **a low-sodium diet and/or weight loss is NOT recommended as treatment for HTN *during* pregnancy.**
- Encouraging them to discuss individualized physical activity recommendations with their health care provider.
- Informing them that hypertension during pregnancy increases their risk of future HTN, cardiovascular disease, and stroke.
- Providing information on avoiding any use of alcohol, tobacco, marijuana or illegal substances, as well as offering substance use referrals. The WIC Substance Use Prevention Manual is available for additional guidance and referral resources: https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide.
- Referring to local home visiting programs for health monitoring and support, if available.

For Postpartum Women with Hypertension:
- Asking probing questions to determine the type of hypertension they experienced during pregnancy and are now experiencing.
- Informing them of the symptoms of **postpartum preeclampsia** and of the importance of contacting their health care provider immediately if they occur.

- Providing breastfeeding promotion and support, unless contraindicated. Encourage women to discuss their breastfeeding status and goals with their health care provider, especially if medications are prescribed.
- Encouraging them to attend all health care appointments, including their 4-6 week postpartum visit; to develop a plan for future pregnancies; to discuss health conditions and medication needs with their health care provider; and to have their BMI, blood pressure, lipids, and fasting glucose assessed yearly.
- Counseling them on achieving and maintaining a healthy weight, physical activity, following a diet consistent with the Dietary Guidelines for Americans or the DASH diet.
- Providing information on avoiding any use of alcohol, tobacco, marijuana or illegal substances, as well as offering substance use referrals. The WIC Substance Use Prevention Manual is available for additional guidance and referral resources: https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide.
- Referring them to their health care provider to discuss whether a calcium or folic acid supplement is appropriate, if intake of these nutrients seems inadequate.
- Referring to local home visiting programs for health monitoring and support, if available.

For Children with Hypertension:

- Encourage caregivers to take children to all health care appointments.
- Counsel caregivers on: healthy pediatric weight gain and, for children with high weight-for-length or obesity, discuss strategies for achieving and maintaining a healthy weight; age-specific, DASH-type eating habits; and the importance of adequate sleep and physical activity in children.

Late to Prenatal Care

(3341) **Category: PG**

Defined as: Prenatal care beginning after the 1st trimester (after completed week 13 of gestation).

Justification:

Women who do not receive early or adequate prenatal care are more likely to deliver premature, growth retarded, or low birth weight infants. Women with medical or obstetric problems, as well as young adolescents, may need closer management with the frequency of prenatal visits determined by the severity of the identified health problem.

Procedure:

Determine if the woman did not have her first prenatal care visit before she completed 13 weeks of gestation. This risk criterion applies to a pregnant woman only.

A woman who has not contacted a healthcare professional to schedule a prenatal appointment should be given referral information as appropriate.

Participant Focused Counseling:

WIC interventions such as referrals to prenatal care and encouragement to keep scheduled prenatal appointments and to follow the advice of health care professional(s) promotes optimal birth outcomes.

A pregnant woman late to prenatal care can:

- State one or more steps she can take to get early and adequate prenatal care.
- State the food and lifestyle choices she can make that promote a positive pregnancy outcome.

Large for Gestational Age (LGA)

(1531) **Categories: IBE, IBP, IFF**

Defined as: Birth weight of ≥ 9 pounds (≥ 4000 grams). Presence diagnosed by a physician as self-reported by applicant/participant/caregiver.

Justification:

Infant mortality rates are higher among full-term infants who weigh > 9 pounds (> 4000 grams).

LGA is associated with congenital birth defects (especially congenital heart conditions) and developmental and intellectual retardation. LGA may be due to uncontrolled maternal diabetes. It can contribute to childhood obesity that may persist into adult life.

Procedure:

Determine if the infant's birth weight was 9 pounds or greater.

Review collected information to determine if feeding practices are present that could promote a rapid rate of weight gain, such as an early introduction of solid foods.

Participant Focused Counseling:

The caregiver can state the feeding practices she can follow to promote optimal growth and development in her child.

Limited Ability of Caregiver to Make Feeding Decisions

(9021) **Categories: All**

Defined as: A woman (pregnant, breastfeeding, or non-breastfeeding) or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food, including:

- ≤ 17 years of age;
- Mental illness, including diagnosed clinical depression, intellectual disability;
- Physically disabled, limiting food preparation ability; OR
- Currently using or history of misuse of alcohol, use of illegal substances, use of marijuana, or misuse of prescription medications.

Note: This risk factor must be manually assigned in WOW and a note must be written to document it.

Justification:

- The mother or caregiver 17 years of age or younger generally has limited exposure and skills needed to care for and feed a dependent.
- Cognitive limitation in a parent or primary caregiver has been recognized as a risk criterion for Failure to Thrive as well as abuse and neglect.
- The mentally handicapped caregiver may not exhibit the necessary parenting skills to promote beneficial feeding interactions with the infant.
- Maternal mental illnesses such as severe depression and maternal substance abuse are strongly associated with abuse and neglect.
- Physical handicaps such as blindness or para- or quadriplegia may restrict or limit the caregiver's ability to prepare and offer a variety of foods.
- Substance abuse can lead to impaired parental behaviors, compromised caregiving relationship, reduced capacity to prioritize infant/child's needs (including feeding needs) over need for substances, parental difficulty in controlling emotions and anger, reduced likelihood for infants/children to receive adequate medical and dental care, chaotic, higher rates of household financial instability, food and housing insecurity, inconsistent employment, domestic violence, and stress, parental incarceration, increased likelihood of infant/child entering foster care, increased risk of neglect and abuse.

Procedure:

Determine if the woman or the infant/child's primary caregiver has a limited ability to make appropriate feeding decisions and/or prepare food for the reasons stated above.

Participant Focused Counseling:

- Education, referrals and service coordination can aid the mother/caregiver in developing skills, knowledge, and or assistance to properly care for a dependent.
- The goals of nutrition counseling are to provide risk- and age-appropriate information and support that will enable the woman or caregiver with a limited ability to make feeding decisions to improve nutritional status.

WIC staff can:

- Provide individualized nutrition education in an easy-to-understand format.

- Provide referrals to promote parenting and infant/child feeding skills, including referrals to local home visiting programs, parenting programs, and early intervention services.

- Provide referrals to those with substance misuse for professional treatment, referring to community resources for alcohol and substance use support groups, and providing breastfeeding promotion and support to women enrolled in supervised medication-assisted treatment programs.

- Encourage participants/caregivers with mental illnesses, intellectual disabilities, and physical disabilities to follow the health care provider's plan of care. Coordinate with health care providers, as needed.

- Provide individualized food packages, tailored to meet the needs of participants. Some caregivers who have a limited ability to make appropriate feeding decisions/prepare food may be unable to prepare powder or concentrated infant formula. Thus, for the safety of the infant, State WIC Agencies may allow ready-to-feed (RTF) WIC formulas to be issued when it is determined that the caregiver may have difficulty correctly diluting powder or concentrated formulas.

Listeriosis

(3529) **Categories: ALL**

Defined as: infection caused by the bacteria *Listeria monocytogenes* within the past six months. It is most commonly transmitted through contaminated food; however it is also naturally present in the soil, water, and animals, including poultry and cattle.

A participant determined to have Listeriosis should be referred to the CPA for Nutrition Care counseling.

Justification

Listeriosis is especially dangerous due to its ability to grow in cold temperatures, unlike many other pathogens. Common food sources include ready-to-eat deli meats and hot dogs, unpasteurized milk and dairy products, raw sprouts and others. Symptoms include fever, stiff neck, confusion, weakness, vomiting, and diarrhea.

Pregnant women and newborns are at exceptionally high risk for listeriosis. Pregnant women are 10-20 times as likely as the general population to become infected. It can lead to miscarriage, stillbirth, or lifelong health issues for the child.

Participants with weakened immune systems are also at higher risk.

Participant Focused Counseling

Use a conversation with open-ended questions to determine typical food habits and risks for Listeriosis, and possible approaches the participant can take to manage or prevent the infection. Possible options include:

- Prevention by safe food handling and storage
- Recommend alternatives to raw milk and dairy products
- With an existing infection,
    - Get sufficient calories to meet increased nutrient needs using the US Dietary Guidelines
    - Offer suggestions to address poor appetite
- Provide education on safe food handling and storage practices

Low Birth Weight or Very Low Birth Weight

(1411) (1412) **Categories: IBE, IBP, IFF, C-1**

Defined as:

- **LBW:** Infant born with a birth weight ≤5 pounds, 8 ounces (≤2500 grams)
- **VLBW:** Infant born with a birth weight (≤3 pounds, 5 ounces (≤1500 grams)

An infant identified with VLBW should have Nutrition Care counseling.
Best Practice: see participant immediately; if not possible, within 5 days. Provide Nutrition Care follow-up in 1-3 months.

An infant identified with LBW should have Nutrition Care counseling.
Best Practice: provide Nutrition Care follow-up in 3-6 months.

Justification:

LBW is considered the single most important predictor of infant mortality, especially within the first months of life (6). Neonates with LBW have a 20 times greater risk of dying compared to infants of normal birth weight. LBW contributes to a range of poor health outcomes including fetal and neonatal mortality and morbidity, and inhibited growth.

LBW is usually caused by intrauterine growth restriction (IUGR), preterm birth (PTB) or both. Preterm birth (an infant born at fewer than 37 weeks' gestational age) is the most common cause of LBW. In the US, the rates of preterm births have increased from 10% to 12.5% in the past 25 years, likely as a result of higher survival rates due to advances in perinatal medical care.

In the U.S., approximately 1 in 12 infants (8%) is born with LBW. The percentage of LBW infants has increased 4% among all racial groups from 2016-2021 in the U.S. Since 2016, LBW rates increased a total of 1% for non-Hispanic White women, 7% for non-Hispanic Black women and 7.3% for Hispanic women. The rates of LBW among different racial and ethnic groups in the U.S. are:

• 1 in 7 Black infants (14%)

• 1 in 12 Asian infants (8%)

• 1 in 13 Native American or Alaska Native infants (8%)

• 1 in 14 Latin infants (7%)

• 1 in 14 White infants (7%)

Black infants are more than twice as likely to be born with a LBW or to die in their first year of life as White infants. Rates of very low birthweight (VLBW) infants comprise only 1.0% of live births in the U.S. but Black mothers are 2.6 times more likely to have a VLBW infant than White mothers.

The increased likelihood of LBW in Black infants has been associated with mothers who are unmarried, unemployed, lower income, younger, and receive federal government assistance to pay for rent. Yet even with the presence of traditional protective factors such as marriage, education, and being non-smokers, Black women still experience LBW at higher rates than Whites.

Institutional racism (differences in access to resources by race as well as differences in policies, laws and practices that reinforce racial inequity) may explain racial disparities in LBW between Black and White women. Black women are at a higher risk of chronic stress due to adverse social determinants including low socioeconomic status, housing insecurity, and experience racism as a stressor and weathering (discrimination that worsens with age).

Black mothers, when compared to other racial or ethnic groups, have the highest rate of LBW babies despite whether they were born in the U.S. or in another country. However, multiple studies have shown Black infants born to mothers who are immigrants experience LBW at rates similar to infants born to White mothers, suggesting the presence of other factors affecting birth weight for non-immigrant Black mothers.

U.S. born Black women have more exposure to racism as a major stressor that negatively impacts maternal health while foreign born Black women do not report perceiving racism in the same way. In addition, foreign-born Black women may have more positive social determinants such as higher levels of education and income, and access to better health care. This issue is very complex, and continued research is needed focusing on the factors contributing to the inequitable racial gap in LBW.

LBW infants are more likely than infants whose weight is normal to have medical problems that may include:

• **Respiratory:** Respiratory Distress Syndrome (RDS). Infants with RDS do not have a protein called surfactant that keeps small air sacs in an infant's lungs from collapsing. Treatment with surfactant helps these infants breathe more easily. Infants who have RDS also may need oxygen and other medical support to help their lungs work.

• **Neurological:** Intraventricular Hemorrhage (IVH). Bleeding in the brain.

• **Cardiovascular:** Patent ductus arteriosus. Patent ductus arteriosus is when an opening between 2 major blood vessels leading from the heart does not close properly. This can cause extra blood to flow to the lungs. In many infants who have patent ductus arteriosus, the opening closes on its own within a few days after birth. Some infants need medicine or surgery to close the opening.

• **Gastrointestinal**: Necrotizing enterocolitis (NEC) is a gastrointestinal disease that involves infection and inflammation that causes damage and the death of cells in some or all the intestines.

• **Jaundice**: An excess of bilirubin due to the infant's liver not adequately removing it from the bloodstream.

• **Retinopathy of prematurity**: When an infant's retinas do not fully develop in the weeks after birth.

• **Immunological**: Sepsis, pneumonia, or meningitis. In an infant who is born prematurely, the immune system may not be fully developed and may not be able to fight off infection.

When LBW infants become children, they tend to have lower neurodevelopmental scores in the areas of language, cognition, and motor skills compared to term normal birth weight infants. There is also evidence that LBW infants have a higher risk of developing chronic health conditions later in life including:

• Diabetes

• Heart disease

• High blood pressure

• Metabolic syndrome

• Obesity

• Stroke

Nutrition for Infants with LBW and VLBW

The LBW or VLBW infant may begin life with a compromised nutritional status and require a form of nutrition support, (addition of infant formula, special infant formula, tube feeding). Some of these infants, especially ones with VLBW, will need supplemental feedings because they have limited nutrient reserves at birth and are subject to physiological and metabolic stresses that increase their nutrient needs. Providing breastmilk to these infants in the first month of life has been linked to improved growth and development. While infant formula can be used to offer higher amounts of macronutrients than breastmilk, it can be harder to digest

for LBW and VLBW infants. Breastmilk contains beneficial biological components, including immunoglobulins, cytokines, growth factors, hormones, antimicrobial agents, immune cells, stem cells, prebiotic oligosaccharides, and probiotic bacteria. Mother's own milk has been associated with multiple health benefits for LBW and VLBW infants, including lower incidences of necrotizing enterocolitis (NEC), late-onset sepsis, chronic lung disease, retinopathy of prematurity, and neurodevelopmental impairment. Pasteurized donor breastmilk is recommended when mother's own milk is not available or sufficient. LBW infants that are supplemented with fortified pasteurized donor milk have a greater risk of growth failure than those fed mother's own milk.

For VLBW infants, breastmilk often requires fortification with formula in order to meet their nutritional needs. Assistance in early milk expression should be available to mothers within 6 to 8 hours of birth of any VLBW infant because of the need for early and frequent milk expression to maintain milk supply. The use of breastmilk is lower among VLBW infants with non-Hispanic Black mothers, compared with those with non-Hispanic White mothers. Approaches that have been shown to reduce Black and White disparities in breastfeeding in the NICU setting include peer counselor programs and support groups, assistance with breast pump acquisition, and transportation for mothers to visit the hospital.

Implication for WIC Nutrition Services

WIC services can directly support LBW and VLBW infants and their caregivers, as they may have unique feeding difficulties. LBW and VLBW infants may be born preterm so their delivery is often unexpected, and a mother may not have made decisions about how to feed her infant yet. These infants may require additional calories from formula, extra breastfeeding support, and/or special infant formula. WIC can support LBW and VLBW infants and their caregivers through:

• Providing breastfeeding education to mothers. This has been shown to increase breastfeeding intent and decrease maternal anxiety. Education may include information on the health benefits of mother's own milk, the need for early and frequent milk expression, the role of skin-to-skin contact, nonnutritive suckling, direct breastfeeding when physiologically appropriate, and technical information on proper milk handling, storage, and transport.

• Referring to a WIC breastfeeding peer counseling program, if available.

• Promoting and supporting breastfeeding as the normative standard for infant nutrition and providing early and frequent breastfeeding support.

• Recommending the use of a hospital grade electric breast pump for expressing milk if the infant is in the NICU or the infant is unable to breastfeed directly from the breast.

• Providing anticipatory guidance about potential feeding challenges.

• Monitoring the child's growth to ensure healthy weight gain.

• Providing nutrition education for mothers/caregivers and appropriate referrals as necessary for growth, feeding, health, and/or infant developmental issues.

• Discouraging families from direct milk sharing and the purchase of breastmilk from Internet-based sources as both practices are associated with risks of bacterial or viral contamination of non-pasteurized milk and the possibility of exposure to medications, other substances, and unsafe handling practices.

For formula fed infants:

- Assure formulas are mixed correctly.
- Check with the HCP for increased calorie mixing instructions as needed.
- Boil and sterilize water, bottles and parts until the baby is 4 months old. (adjusted age)
- Do not put anything in the bottle except formula or breastmilk.
- Use baby-paced bottle feeding.
- Review hunger and fullness cues.
- Monitor growth to ensure healthy weight gain.
- Provide anticipatory guidance about feeding challenges.

Procedure:

- Determine if the infant or child's birth weight was 5 pounds, 8 ounces or less.
- Review collected information for appropriateness of feeding practices.

Participant Focused Counseling:

The goal of nutrition counseling is to assist and support the caregiver in establishing and maintaining feeding practices that support the optimal growth of the infant.

Low Head Circumference

(1521) **Categories: IBE, IBP, IFF, C-1**

Defined as:

Head circumference less than 2.3rd % when plotted on the CDC/WHO Birth to < 24 months gender specific Head Circumference for Age growth chart. Presence 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.

Justification:

Low head circumference (LHC) is related to a variety of genetic, nutrition, and health factors. While LHC alone does not necessarily indicate abnormal brain development, it may be indicative of future nutrition and health risk, particularly poor neurocognitive abilities. LHC is associated with VLBW, pre-term birth, and socioeconomic status, and is in part related to nutrition factors.

Participant Focused Counseling:

WIC Counselors can assist families in making nutritionally balanced food choices to promote optimal growth and provide referrals to medical providers and other available local resources.

Low Hemoglobin/Hematocrit

(2011) **Categories: All**

Defined as:

Infants and children 9 months of age and older: Hemoglobin ≤ 10.9 g/dl or hematocrit ≤ 32.8%

Women: Cut-off values for hemoglobin or hematocrit that are established by the CDC. (See **Table A**)
A participant who has a hemoglobin value < 10g/dl (or hematocrit < 30%) should have Nutrition Care counseling.
Best Practice: Provide Nutrition Care follow-up in 3-6 months.

A participant with hemoglobin <9g/dl should have Nutrition Care counseling.
Best Practice: See participant immediately; if not possible, within 5 days.

A participant with hemoglobin ≤8g/dl should have test results confirmed by a second test. If confirmed, participant should be referred to their Health Care Provider immediately.

Follow Local Health Department Policy for Participants with Hgb ≤8 g/dl.

Justification:

Hemoglobin and hematocrit reflect the amount of functional iron in the body and are the most frequently used tests to screen for anemia, including iron deficiency anemia (IDA), megaloblastic anemia (folic acid or B-12 deficiency), or sickle cell anemia and thalassemia (inherited) While the hemoglobin test is neither a direct measure of iron status, nor does it distinguish among different types of anemia, it is a useful screening tool for referring a WIC participant to their health care provider for further evaluation.

Iron deficiency anemia is the most common anemia in children and women of childbearing age . Iron is present in all cells in the body and serves several vital functions. Iron:

- Carries oxygen from the lungs to the rest of the body.
- Is involved in the synthesis of hormones.
- Is involved in normal growth and development.

Iron deficiency may be caused by a diet low in iron, insufficient absorption of iron from the diet, or increased iron requirements due to growth, blood loss, or pregnancy.

Groups at risk of iron deficiency anemia include pregnant women, infants and young children, women with heavy menstrual bleeding, frequent blood donation, and people with cancer, gastrointestinal disorders, or heart failure.

Iron deficiency progresses to Iron deficiency anemia when iron stores become so low that hemoglobin production is disrupted.

Iron Deficiency Anemia is associated with GI disturbances, diminished physical work capacity, impaired heat regulation, immune dysfunction, and Helicobacter pylori infection.

Iron in the Diet

Dietary sources of iron come in two major forms: heme and nonheme iron.

Heme iron is well absorbed and found primarily in animal food sources, including red meat, liver, poultry, and fish.

Nonheme iron is not absorbed as well and is found in foods from plants. Dietary sources of nonheme iron include iron-fortified grain products, legumes, fruits, and green leafy vegetables. Because nonheme iron is less bioavailable, the iron requirement for vegetarians is 1.8 times higher.

Additional factors can also affect iron absorption. Consumption of vitamin C-rich foods enhances the absorption of nonheme iron. Consumption of meat, poultry, or fish with a meal increases the absorption of nonheme iron.

Phytates, found in grains and beans, and some polyphenols, such as those found in cereals and legumes, can inhibit nonheme iron absorption. Calcium is linked to a reduction in the absorption of both heme and nonheme iron.

The effects of enhancers and inhibitors on iron absorption are diminished by a typical mixed western diet and do not significantly impact most people's iron status.

Iron Deficiency Anemia in Women

Women of childbearing age require additional iron to make up for:

- blood loss during menstruation
- increased needs during pregnancy
- blood loss at delivery and postpartum
- adolescent pregnancy
- gestational diabetes
- multiparity

(For more information on adolescent pregnancy, gestational diabetes and multiparity see risk #331 *Pregnancy at a Young Age,* risk #302 *Gestational Diabetes,* risk #303 *History of Gestational Diabetes* and risk #335 *Multi-fetal Gestation).*

The strongest predictors of IDA in postpartum women are IDA during pregnancy and high blood loss during delivery.

Pregnant women are at particular risk due to their increased iron needs. Pregnant women need almost twice as much iron as

those who are not pregnant to support increased red blood cell production and the development of the fetus and placenta. The Recommended Dietary Allowance (RDA), the average daily level of intake sufficient to meet the nutrient requirements of nearly all (97%–98%) healthy individuals, for iron in pregnant women **is 27 mg per day.** Based on data from the National Health and Nutrition Examination Survey (NHANES), 2001-2014, the average iron intake from food for pregnant women aged 20 to 40 years was 17.2 mg, well below the RDA. Given the high iron requirements during pregnancy and insufficient intake from foods, iron supplementation is often recommended during pregnancy. Based on data from NHANES, 1999-2010, 16.3% of pregnant women 12-49 years old in the United States had Iron Deficiency, including 2.6 with Iron Deficiency Anemia. Data also showed that Iron Deficiency was more prevalent in:

- women in the second or third trimester
- Mexican American pregnant women
- non-Hispanic black pregnant women
- women with parity greater than or equal to 2

In addition to high iron needs, women often under consume iron putting this group further at risk for IDA (2)

IDA during pregnancy increases the risk of maternal death and is associated with several negative fetal and maternal outcomes. Maternal IDA Increases an infant's risk for:

- low birth weight
- premature birth
- death
- impaired cognitive and behavioral development

A long history of studies supported the belief that the fetus is protected from any impact of maternal iron status, however, a better understanding of regulation of iron physiology and neonatal iron status is challenging this assumption. Newer literature indicates fetal iron stores may be compromised when maternal iron stores are suboptimal, linking IDA during pregnancy with IDA in infants.

Iron Deficiency Anemia in Infants and Children

Infants and children are at risk for ID and IDA given their high iron requirements to support their rapid growth. The prevalence of anemia and possibly ID and IDA in infants and children has declined since the 1970s in the U.S., and many attribute this decline to the fortification of infant formula and cereal and the establishment of the WIC program. Based on data from the 2007-2010 NHANES, 7.1% of children aged 1-5 were iron deficient and 1.1% had IDA. The rates were higher in 1- to 2-year-olds at 13.5% and 2.7%

respectively. **Based on CDC recommendations, WIC regulations require a hematological test to screen for anemia during the following timeframes for infants and children:**

- **Infants: 9 to 12 months of age.**
- **Children 1-2 years: One blood test is required between 12 to 24 months of age, ideally 6 months after the infant screen (around 15 to 18 months of age).**
- **Children 2 to 5 years: Once every 12 months for children 2-5 years of age whose blood results were within normal range at their last certification.**

Iron is essential for normal neurodevelopment of infants and children. Numerous studies have linked IDA in infants and children to later cognitive, motor, and behavior effects. Cognitive deficits and the impact of IDA can be long lasting and may be irreversible, even with treatment. It has been difficult to establish a causal relationship between IDA and these deficits due to confounding variables and difficulty designing and executing the large-scale studies needed to demonstrate a direct link. IDA can also increase susceptibility to lead poisoning by increasing intestinal lead absorption.

While all infants and children are at risk of IDA due to their rapid growth, additional factors can place infants and children at higher risk. The table below outlines risk factors for IDA in infants and children:

Risk Factor	Additional Information
History of Prematurity*	Preterm infants miss out on the rapid accumulation of iron that occurs in the last trimester of pregnancy, are born with lower iron stores and are at risk of depleting their iron stores earlier than full term infants
History of low birth weight or small for gestational age †	Low birth weight and small for gestational age infants are more likely to have lower iron stores that are unable to support the catch-up growth often seen in these infants
Exclusive breastfeeding beyond 4 months of age without supplemental iron	While the iron breast milk contains is highly bioavailable, it is very limited. Full-term infants usually have adequate iron stores for 4 to 6 months but become at risk of developing iron deficiency at 6 to 9 months, unless they obtain adequate iron from complementary foods, iron-fortified formula, or iron supplementation

Dietary habits linked with inadequate iron intake	The following dietary habits may increase an infant or child's risk for inadequate iron intake: use of non-iron fortified formula, introduction of cow's milk in the first year of life, weaning to whole milk or complementary foods that do not include iron-fortified cereals or foods naturally rich in iron
Maternal IDA	Infants born to mothers with IDA during pregnancy may be born with lower iron stores and are more likely to develop IDA as infants and children
Feeding problems, poor growth, and inadequate nutrition‡	These challenges, which are often seen in infants with special care needs, are considered risk factors
Demographic factors	Low socioeconomic status and having parents who are migrant workers or recent immigrants are also associated with increased risk

* For more information on prematurity see Risk #142 *Preterm or Early Term Delivery.*

† For more information on low birth weight or small for gestation see Risk #141 *Low Birth Weight and Very Low Birth Weight* and Risk #151 *Small for Gestational Age.*

‡ For more information on special care needs see Risk #362 *Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat.*

Implications for WIC Nutrition Services

The WIC food package is designed to include foods that contain specific nutrients to improve the health status of program participants, address inadequate intakes, and, ultimately, prevent nutrient deficiencies such as ID and IDA. Nutrition education combined with the WIC food package can help decrease the likelihood that an individual would develop IDA.

For individuals who currently have low Hgb or Hct, WIC staff can:

- Refer participants to their health care provider for more thorough testing as appropriate. Only a health care provider can diagnose anemia and determine the specific type and cause.

- Reinforce treatment plans, such as iron supplementation, provided by the health care provider, and refer participants to health care providers for medical follow-up care.
- Per State policy, provide follow up testing/referrals at future appointments.
- Discuss lead testing with participant or parent/caregiver and refer to appropriate resources if needed.
- Reiterate infant feeding guidance such as providing iron-fortified infant formula for infants not breastfed or partially breastfed for the first year of life and offering iron-rich or iron fortified complementary foods around 6 months of age.
- For breastfed infants, refer to healthcare provider to determine if iron supplementation is needed before 6 months of age, see:
    - to https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/diet- and-micronutrients/iron.html
- Encourage consumption of iron-rich foods (with an emphasis on the foods in the WIC food package): Lentils and beans, fortified cereals, red meats, fish, and poultry, for more information, see:
    - https://ods.od.nih.gov/factsheets/Iron-HealthProfessional/#h3
- Encourage consumption of foods rich in Vitamin C to aid in iron absorption: Citrus fruits, tomatoes, and other fruits and vegetables, for more information see:
    - http://ods.od.nih.gov/factsheets/VitaminC-HealthProfessional/

Procedure:

Obtain a blood hemoglobin or hematocrit test result.

Infants and Children:

- An infant must be tested between 9 and 12 months of age.
- A child must be tested once, between 12 and 24 months of age (ideally at 15 to 18 months of age or 6 months after the infant's test), then annually, between 24 and 60 months, provided the test result is above the cut-off value or at a 6 month interval if the test result is equal to or below the cut-off value.
- Compare the result to the cut-off value. If the hemoglobin is ≤ 10.9 g/dl or hematocrit ≤ 32.8%, assign the risk criterion.

Low Maternal Weight Gain

(1311) **Category: PG**

Defined as: A pregnant woman's weight gain is below the minimum recommended for the completed week of gestation.

A woman who is both underweight and has low maternal weight gain should have Nutrition Care counseling.

Justification:

In the short term, low maternal weight gain in the second and third trimesters is associated with an increased risk of small for gestational age (SGA) infants, especially in underweight and normal weight women, failure to initiate breastfeeding, and preterm birth among underweight, and to a lesser extent, normal weight women.

In the long term, poor maternal nutrition during pregnancy can have permanent, detrimental effects on the child's health in later years, including increased risk for obesity, impaired glucose tolerance, and cardiovascular disease. This most likely results from suboptimal maternal nutrition that affects fetal organ development.

Inadequate gestational weight gain is most prevalent among Asian, Hispanic, and black mothers. Hispanic, black, and women who identified as "other" regarding race gain significantly less weight than white women after adjusting for pre-pregnancy BMI, age, parity, and education. Black and Hispanic women compared to white women are more likely to have inadequate weight gain as opposed to excessive gestational weight gain. Research shows that black women in the U.S. are more likely to gain less than the recommended amount of weight during pregnancy and more likely to lose weight during pregnancy compared to white women

Weight Loss during Pregnancy

Weight loss during pregnancy can result in SGA infants, stillbirth, and neonatal death (8). In addition, surviving children are at risk for poor growth and infection during infancy. Common causes of unintended weight loss during pregnancy include food insecurity, substance misuse, housing insecurity, infection, food-borne illness, and symptoms associated with pregnancy such as hyperemesis gravidarum (9). Please refer to Risk - *Hyperemesis Gravidarum* for additional information.

Weight Loss during Pregnancy in Obese Women

The recommended amount of weight gain in obese women during pregnancy remains controversial. Research demonstrates that it may be beneficial for the mother, and not harmful for the infant, to lose weight during pregnancy. The benefits of weight loss among obese pregnant women include decreased rates of cesarean delivery, large-for-gestational-age infants, and postpartum weight

retention. As a result, some scientists are now suggesting that the NASEM recommendations for weight gain in obese pregnant women be re-evaluated.

Although controversy remains regarding weight loss during pregnancy among obese women, if a pregnant woman was obese prior to pregnancy, she should follow the advice of her health care provider regarding weight recommendations. For WIC nutrition risk assignments, WIC staff should follow the NASEM recommendations.

The recommended rate of weight gain for women with singleton pregnancies is based on pre-pregnancy weight status. The total recommended weight gain is as follows:

- **Underweight status** (BMI <18.5): 28 to 40 pounds
- **Normal weight status** (BMI 18.5-24.9): 25 to 35 pounds*
- **Overweight status** (BMI 25.0-29.9): 15 to 25 pounds*
- **Obese status** (BMI ≥ 30.0): at least 11-20 pounds*

***Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women also.

For normal weight women pregnant with twins, total recommended weight gain is 37-54 pounds; overweight women, 31-50 pounds; and obese women, 25-42 pounds. Weight gain should be 4-6 pounds in the 1st trimester and about 1.5 pounds per week during the 2nd and 3rd trimesters. For triplet pregnancies, overall gain should be about 50 pounds with a steady gain of about 1.5 pounds per week. For underweight women with multiple fetuses, a consistent weight gain of 1.5 pounds per week during the second and third trimesters is associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy.

Procedure:

Use **Table I-P** for the assessment.

- Obtain current height and weight measurements.
- Obtain pre-pregnancy weight (self report or from health care professional).
- Record height and weight measurements in the woman's record.
- Use **Table W** to determine pre-pregnancy weight status.
- Subtract the woman's pre-pregnancy weight from her current weight to determine the number of pounds gained.
- Determine the last completed week of gestation when height and weight measurements were taken.
- Using **Table I-P**, locate the completed week of gestation in the left-hand column. Read across the columns to locate the woman's pre-pregnancy weight status.

- If she has gained equal to or less than the number of pounds in the column, she has low maternal weight gain.

Note: Do not evaluate this risk criterion for a woman pregnant with twins, triplets, or more.

Participant Focused Counseling:

Review collected information about dietary or lifestyle practices or medical conditions that could explain low maternal weight gain.

Tailor nutrition education for pregnant woman to ensure she receives nutrition support that is relevant to her concerns and lifestyle factors. Assist pregnant women by carefully assessing the health status, dietary intake, and concerns of the woman in a participant-centered manner to find out possible factors contributing to low weight gain.

May Not Meet Dietary Guidelines

(4011) **Categories: PG, BE/BP, WPP, C 2-4**

Defined as: Women and children age 2 and older, who meet the eligibility requirements of category, income, and residency may be presumed to be at nutritional risk based on Failure to meet the Dietary Guidelines for Americans (consuming fewer than the recommended number of servings from one or more of the basic food groups, based on energy needs).

Justification:

Research has found that less than one percent of all women and children age 2-5 meet the recommendations for all food groups. Furthermore, members of low-income households are less likely to meet recommendations than more affluent ones.

According to the Institute of Medicine, “evidence exists to conclude that nearly all low-income women in the childbearing years, and children age 2 and older are at dietary risk, vulnerable to nutrition insults, and may benefit from WIC services.”

By presuming dietary risk, “WIC retains its potential for preventing and correcting nutrition-related problems.”

Procedure:

This risk factor may be assigned only to women and children age 2 and older for whom a complete nutrition assessment has been performed and for whom no other risk is identified.

Participant Focused Counseling:

Anticipatory guidance is the focus of the session.

- Guide participant in choosing healthy foods and age appropriate physical activities.
- Reinforce positive lifestyle behaviors.
- Discuss nutrition-related topics of interest to participant, such as food shopping, meal preparation, feeding relationships, and family meals.
- Refer as appropriate to the Supplemental Nutrition Assistance Program (SNAP), community food banks, and other available nutrition assistance programs.

Medical Condition, Nutrition Related

(3411-3621) **Categories: All**

Defined as: Any condition listed below that has been 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.

Participants identified with one of these risk criteria should have Nutrition Care counseling.

Procedure:

Use collected information to determine that the participant has a diagnosed medical condition listed below. The condition must currently affect nutritional status.

Section 246.7(i)(6) of the WIC Program regulations requires that the State Agency ensure that appropriate documentation is included in the applicant's WIC record to substantiate the nutrition risk condition(s) used to certify the applicant, and to validate conformance with the definition of the nutrition risk condition(s). When a self-report of a medical diagnosis is given, the CPA or CPPA must validate the presence of the condition by asking the following questions:

- Is this condition current and being treated by a health care professional?
- Is this condition being controlled by diet or medication or both?
- What dietary instructions have been prescribed?
- What medication has been prescribed?

The name and contact information for the medical professional should be obtained to allow communication and verification, if necessary. When determined appropriate, a consent form for release of confidential information may be completed and signed by the applicant/participant or caregiver in order to allow collection of pertinent medical or diet information to support the nutrition risk determination, and to assist the CPA in supporting the nutritional plan of care for the participant.

Expanded background material on each of the following conditions can be found in the Nutrition Care Manual.

	Explanation:
Asthma, moderate persistent or severe persistent (3601)	Asthma must be diagnosed as *moderate persistent* or *severe persistent* that requires the daily use of an inhaled anti-inflammatory agent or an oral corticosteroid.
Bronchitis Present in the last 6 months. (3526)	An acute infection that occurs when the airways in the lungs swell and produce mucus, resulting in a cough. It typically occurs after a chest cold and is usually caused by a virus. Since bronchitis is rarely caused by bacteria, antibiotics are not needed or recommended, and can harm both children and adults. Bronchitis typically resolves on its own in two weeks, but cough may last 8 weeks. Pain relievers should be appropriate for the age of the child. Only acetaminophen should be used for infants under 6 months of age. Prevention rests on good hygiene, updated immunizations, and not smoking.
Cancer (3471)	Nutritional status at the time of diagnosis is associated with outcome of treatment. The type of cancer and the stage of disease progression determine the type of medical treatment and nutrition management.
Cardiorespiratory diseases (3604)	Cardiorespiratory diseases affect normal physiological processes and can be accompanied by growth failure, failure to thrive, and malnutrition due to low calorie intake and hypermetabolism.
Cardiovascular Disease (CVD) **(3603)**	CVD (heart disease) is an umbrella term for several types of heart conditions that cause a decrease flow of blood to the heart which can result in a heart attack and is the leading cause of death among women. Risk factors for CVD include diabetes, smoking, obesity and overweight, physical inactivity, high blood pressure, and high cholesterol. Women-specific risk factors for CVD are pregnancy and pregnancy-related complications, including preeclampsia, preterm delivery, gestational diabetes, and polycystic ovary syndrome. People with CVD benefit from physical activity and a healthy diet including high fiber foods, and a diet low in sodium, saturated fat, sugar, and alcohol.

Celiac disease **(or Celiac Sprue; Gluten Enteropathy; Non-tropical Sprue)** (3541)	Inflammatory condition of the small intestine precipitated by the ingestion of gluten, a protein in wheat, rye, some oats, and barley in individuals with genetic predisposition. Eating gluten-containing foods can lead to diarrhea, weight loss, and malabsorption of other nutrients, and damage to the small intestine. Lifelong strict avoidance of these grains is essential. Nutrition counseling can help these participants meet their nutrient needs and help in compliance.
Cerebral palsy (3485)	Oral motor dysfunction is associated with cerebral palsy (CP). Infants and children often have poor growth due to eating impairment (difficulty spoon feeding, biting, chewing, sucking, cup drinking, swallowing.) Texture modification, increased calories and nutrients, and referral to feeding clinics are often required.
Cleft lip or palate (3492)	Severe cleft lip or palate often cause difficulty with chewing, sucking, and swallowing even after extensive repairs. Nutrition care may be needed for adequate growth, development, and health maintenance.
Congenital Hyperthyroidism (3444)	Excessive thyroid hormone levels at birth, either **transient** (due to maternal Grave's disease), which is treated with antithyroid drugs and subsides within several weeks, or **persistent** (due to genetic mutation).
Congenital Hypothyroidism (3443)	Congenital hypothyroidism due to maternal iodine deficiency is the leading cause of preventable mental retardation. Unless treated within 18 days after birth, the mental retardation will be irreversible.
Crohn's disease (3423)	Weight loss, growth impairment, and malnutrition are prevalent. Nutrition care is essential.
Cystic fibrosis (3602)	Cystic fibrosis is a genetic disorder that affects the cells that produce mucus, sweat, and digestive fluids. Despite progress, life expectancy is limited to 35-40 years. People with CF often face malnutrition, poor growth, frequent respiratory infections, breathing problems, and chronic lung disease. Due to the impact of CF on pancreatic enzymes, the digestion and absorption of protein and fats are impaired. Most people with CF take pancreatic enzymes and fat-soluble vitamins A, D, E and K. The focus of nutrition therapy is to ensure adequate intake through a personalized plan designed by a specialist RD. **Best Practice: Contact Cystic Fibrosis Center and/or the participant's Specialist RD before counseling and assigning food package,**

Developmental, Sensory, or Mental Disability (3621)	Infants and children are at risk for nutritional problems. Pregnant and postpartum women may have chewing and swallowing problems that limit intake and increase malnutrition risk. Nutrition education , referrals, and service coordination are important early interventions. **Consider contacting the participant's Specialist RD before counseling and assigning food package.**
Diabetes Mellitus (3431)	Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action, or both. Control of diabetes through diet, exercise, and/or medication can reduce the degree of organ damage that occurs over time. Dietary guidelines for diabetes management vary depending upon the type of diabetes.
Down Syndrome (3497)	Hereditary or congenital condition at birth that causes a physical or metabolic abnormality. The current condition must alter nutritional status metabolically, mechanically, or both. Special attention to nutrition may be required to achieve adequate growth and/or to maintain health.
Epilepsy (3481)	People with epilepsy are at nutrition risk due to prolonged anticonvulsant therapy, inadequate growth, and physical injuries from seizures. Children on a ketogenic diet require growth monitoring, and increased energy and protein while maintaining ketogenic status. Women on antiepileptic drugs are at higher risk for infants with neural tube defects and may require folic acid supplementation.
Gall Bladder Disease (3421)	Includes gallstones, or obstructing bile duct causing pain and cramps, and inflammation of the gallbladder caused by bile duct obstruction. Since lipids stimulate gallbladder contraction, a low-fat diet with 25% to 30% of total calories as fat is recommended. Greater fat restriction is not recommended. Supplementation with fat soluble vitamins may be needed.
Gastrointestinal anomalies (3493)	Hereditary or congenital condition at birth that causes a physical or metabolic abnormality. The current condition must alter nutritional status metabolically, mechanically, or both. Special attention to nutrition may be required to achieve adequate growth and/or to maintain health. The goals of nutrition counseling vary depending upon the disorder.
Gastroesophageal Reflux Disease (GERD) (3429)	GERD is irritation and inflammation of the esophagus due to reflux of gastric acid into the esophagus. Nutrition Care for adults includes avoiding eating for 3 hours before going to bed, and avoiding fatty foods, coffee, and alcoholic beverages.

Hyperthyroidism (3442)	Excessive thyroid hormone production (known as Grave's disease) causes increased energy expenditure and weight loss with increased appetite. Normal weight is usually regained after medical treatment. Monitor weight status and diet adequacy.
Hypothyroidism (3441)	Thyroid gland makes inadequate thyroid hormone, sometimes due to inadequate iodine intake during pregnancy and lactation, causing infants with irreversible brain damage and maternal complications such as anemia, preeclampsia, miscarriage, premature delivery, and postpartum thyroid disease. Encourage iodine sufficiency, including 150 mcg iodine supplement. Monitor weight status.
Inborn Errors of Metabolism (3511)	Includes but not limited to Phenylketonuria (PKU); Maple Syrup Urine Disease (MSUD); Galactosemia; Homocystinuria; Tyrosinemia; Histidinemia; urea cycle disorders; Glutaric Aciduria; Methylmalonic Acidemia; Glycogen Storage Disease; galactokinase deficiency; fructoaldolase deficiency; Propionic Acidemia; or Hypermethioninemia. Appropriate dietary management may include the use of special formulas. **Contact appropriate metabolic dietitian before assigning formula or food package:** Children's National Medical Center in DC--202-476-6287 Johns Hopkins--410-955-3071 University of Maryland Hospital--410-328-3335
Juvenile Idiopathic Arthritis (3606)	IA is an umbrella term for all forms of childhood arthritis. Children with JIA face nutrition problems due to chronic inflammation, drug side effects, and/or functional problems like jaw joint stiffness which lead to lower BMI and smaller height. There is no prescribed diet for JIA, but omega-3 fatty acids from salmon, sardines, mackerel, herring, and tuna (and to a lesser degree ground flax, flaxseed oil, walnuts, and green leafy vegetables) may help reduce inflammation. They also help prevent heart disease. Monitor growth and encourage adequate caloric intake.
Lactose intolerance (3551)	Documentation should indicate that the ingestion of dairy products causes the following GI disturbances: nausea, diarrhea, abdominal bloating, and/or cramps and that the avoidance of dairy products eliminates them. Nutrition counseling can offer strategies for avoiding symptoms while consuming dairy products or to obtain nutrients such as calcium from alternate sources when dairy products or foods containing dairy products must be avoided. Secondary lactase deficiency results from small bowel injury and resolves when primary problem is resolved. Usually in infants. Congenital lactase deficiency is a rare disorder of a few infants that presents with intractable diarrhea when human milk or formula is introduced. Developmental lactase deficiency is relative lactase deficiency among pre-term infants <34 weeks gestation. May benefit from lactase supplemented feedings or lactose-reduced formula.

Lupus Erythematosus Systemic Lupus Erythematosus (SLE) (3605)	Lupus (SLE) is a chronic inflammatory and autoimmune disease affecting multiple organ systems including skin, joints, heart, and central nervous system. The most common symptoms are fatigue, loss of appetite and weight, and skin lesions (butterfly rash on face). It is most common among women of childbearing age (15-44 years). While safe and healthy pregnancies and healthy babies are possible, they are considered high risk pregnancies because of problems that arise during the pregnancy including kidney inflammation, gestational diabetes, and preeclampsia, with fetal complications like miscarriage, preterm birth, and intrauterine growth restriction. Diet quality is important due to higher risk of CVD (obesity, hypertension and dyslipidemias), low bone mineral density, and vitamin D deficiency. A low calorie diet high in nutrient-rich foods and mono and polyunsaturated fatty acids may help control inflammation. Vitamins A, B-6, C, D, and E, dietary fiber and limited protein and sodium may reduce comorbidities and flares.

Multiple sclerosis (3482)	Individuals with MS may have chewing and swallowing problems requiring food texture changes. Obesity and malnutrition frequently occur due to immobility and steroid and antidepressant use.
Muscular dystrophy (3491)	A familial disease characterized by progressive muscle wasting and atrophy. Rapid functional changes can result in children gaining weight too rapidly. Focus nutrition education on healthy foods for a balanced diet while limiting simple sugars and fat.
Neural tube defects (3483)	Limited mobility or paralysis, hydrocephalus, limited feeding skills, and genitourinary problems put children with neural tube defects at increased risk of abnormal growth and development. Ambulatory disability, atrophy of the lower extremities, and short stature place NTDs-affected children at high risk for increased BMI. Monitor for growth and appropriate feeding practices.
Pancreatitis (3427)	Reduced secretion of pancreatic enzymes leads to malabsorption, and tissue necrosis can occur. A high carbohydrate, low-fat, low protein diet may be helpful.
Parasitic infections (3522)	Parasites are organisms that live on or in a host and survive by getting their food at the detriment of the host. Pregnant women and children are most at risk from certain parasites. Toxoplasmosis, from uncooked meat or from soil, is the leading cause of death from foodborne illness in the US. Other frequent parasites include Giardia, Cryptosporidium, lice, and pinworms. Risk of parasitic infections are reduced by wearing gloves when contacting soil and covering sand boxes when not in use. Good hygiene and proper food handling and storage are preventive.
Parkinson's Disease (3484)	Some participants with Parkinson's disease required protein redistribution diets to increase efficacy of medication. Monitor weight for adequate maternal weight gain.
Peptic Ulcer (3425)	Focus of treatment is elimination of Helicobacter pylori infection with antibiotic and proton pump inhibitor therapy. Dietary advice is to avoid alcohol, coffee, chocolate, and some spices.
Pneumonia (3528)	An infection of the lungs caused by viruses, bacteria, or fungi severe enough to affect nutritional status. The infectious disease must be present within the past 6 months. Chronic, prolonged, or repeated infections adversely affect nutritional status through increased nutrient requirements as well as through decreased ability to take in or utilize nutrients. Children younger than 5 years of age are at especially high risk of pneumonia. When contracted during pregnancy, pneumonia causes increased negative outcomes including low birth weight, pre-term birth, and respiratory failure for the mother. Effective vaccinations are available for bacterial and viral pneumonia. Regular hand washing and disinfecting of frequently touched surfaces are also effective for prevention.

Polycystic Ovary Syndrome (PCOS) **(3607)**	PCOS is a hormonal disorder common among women of reproductive age. Most women with PCOS produce excess male sex hormones and have many small cysts of their ovaries. The cause is unknown but insulin resistance may play a role, along with a genetic component. Excess male hormones may prevent ovulation, irregular menstrual periods, leading to difficulty conceiving. Half of all women with PCOS are overweight, and are more likely to develop type 2 diabetes, high blood pressure, heart and blood vessel problems, uterine cancer, and metabolic syndrome. Weight loss is the primary therapy for PCOS. WIC Nutrition Care should focus on diet and physical activity to promote weight loss and coordination with HCP treatment.
Post Bariatric Surgery (3420)	Surgery to promote weight loss in morbid obesity presents risks for nutritional deficiencies, requiring daily nutritional supplements and eating nutritionally dense foods. **Consider contacting the participant's Specialist RD for current supplements and eating plan before counseling and assigning food package.**
Postpartum thyroiditis (3445)	Postpartum thyroiditis can be either transient or permanent dysfunction occurring in the first year after delivery. Often resolution is spontaneous.
Pre-diabetes (3631)	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. Individuals are at relatively high risk for the development of type 2 diabetes and cardiovascular disease (CVD). Dietary recommendations include monitoring calories, reduced carbohydrate intake, high fiber consumption, and increased physical activity.
Renal disease (3461)	Any renal disease including pyelonephritis and persistent proteinuria but excluding urinary tract infections involving the bladder. A pregnant woman with renal disease may develop a preeclampsia-like syndrome and the growth of her fetus may be limited. Women with chronic renal disease often have proteinuria and may develop azotemia. **Contact the participant's Specialist RD before counseling and assigning food package**
Short bowel syndrome (3426)	SBS is the result of extensive small bowel resection in infants or adults. Supplementation with fat soluble vitamins and vitamin B12 may be needed. The pediatric client's nutritional status must be assessed, and growth closely monitored.
Sickle cell anemia (not trait) (3496)	An inherited disorder that can affect every organ of the body. Good nutrition with adequate calories, iron, folate, vitamin E and vitamin C with good hydration are key to minimize complications. **Hemoglobin tests are not required if health care provider submits diagnosis, since hemoglobin will always be low. HCP hemoglobin records should be provided when possible. A note should be entered into the record.**

Thalassemia (3494)	Hereditary or congenital condition at birth that causes a physical or metabolic abnormality. The current condition must alter nutritional status metabolically, mechanically, or both. Special attention to nutrition may be required to achieve adequate growth and/or to maintain health. **Hemoglobin tests are not required if health care provider submits diagnosis, since hemoglobin will always be low. HCP hemoglobin records should be provided when possible. A note should be entered into the record.**
Tuberculosis (3527)	A disease caused by the growth of pathogenic microorganisms in the body severe enough to affect nutritional status. The infectious disease must be present within the past 6 months. Chronic, prolonged, or repeated infections adversely affect nutritional status through increased nutrient requirements as well as through decreased ability to take in or utilize nutrients.
Ulcerative colitis (3428)	Gastrointestinal disorders increase nutritional risk in a number of ways, including restricted food intake, abnormal deglutition, impaired digestion of food in the intestinal lumen, generalized or specific nutrient malabsorption, or excessive gastrointestinal losses of endogenous fluids and nutrients. Frequent loss of nutrients through vomiting, diarrhea, malabsorption, or infections can result in malnourishment and lowered disease resistance. Nutrition management plays a prominent role in the treatment of gastrointestinal disorders.

Meningitis

(3521) **Categories: ALL**

Defined as: inflammation of the protective membranes of the brain and spinal cord known as meninges.

A participant determined to have Meningitis should be referred to the CPA for Nutrition Care counseling.

Justification:

Meningitis is typically caused by an infection of the fluid surrounding the brain and spinal cord. Most commonly meningitis is caused by a bacterial or viral infection, but it can also result as a response to physical injury, cancer, or certain drugs. Meningitis is severe, and treatment differs depending on the cause, so it is important to have a correct diagnosis of the agent responsible for the disease.

Bacterial Meningitis:
While most people with meningitis recover, bacterial meningitis is usually severe, and can result in serious complications, including brain damage, hearing loss, or learning disabilities.

The causes of bacterial meningitis vary by age group, and include variants of Streptococcus, Listeria, Neisseria, Haemophilus, and E. coli. In addition, ***Cronobactor*** may cause meningitis in infants in the first two months of life but is very rare (about 4-6 infections per year). *Cronobactor* infections have been associated with use of powdered infant formula. The recommendation for prevention is to follow the manufacturer's preparation instructions.

Meningitis symptoms include sudden onset of fever, headache, and stiff neck. Other symptoms include nausea, vomiting, sensitivity to light, and confusion. Diagnosis must be confirmed through laboratory testing of blood or cerebrospinal fluid. Bacterial meningitis is effectively treated with antibiotics, but it is important to begin treatment as early as possible. The most effective prevention is vaccination, as well as properly preparing and refrigerating foods, and avoiding certain foods.

Viral Meningitis:
Viral meningitis is the most common type, and it is often less severe than the bacterial type. Children younger than five and people with weakened immune systems are at higher risk of developing the disease, with infants younger than one month old and those with weakened immune systems more likely to develop severe illness.

Laboratory tests are required to confirm the illness, which usually resolves without treatment in 7-10 days. However, those with meningitis caused by the herpes virus or influenza may benefit from antiviral medication.
Risk can be reduced by the following:

- Washing hands with soap and water, especially after changing diapers, using the toilet, or coughing or blowing your nose
- Avoiding touching faces with unwashed hands.
- Avoiding close contact with infected people.
- Cleaning and disinfecting household surfaces that are frequently touched.
- Staying home when sick.
- Having children vaccinated against other viruses that can cause meningitis, including measles, mumps, chicken pox, and flu.

Participant Focused Counseling
Through open-ended questions, determine the symptoms the participant faces. Based on the symptoms, discuss the options the participant is willing to take, as follows:

- Encourage adequate calories and healthy foods to meet the elevated needs of the participant during the infection and recovery.
- Discuss suggestions to address poor appetite.
- Offer education on good hygiene practices, and proper food preparation and storage techniques.
- Encourage vaccinations for both bacteria and viruses known to cause meningitis.
- Review instructions for preparation of powdered formula. Use “teach back” for assurance that participant understands formula preparation to protect the infant.

Mental Illnesses

(3611) **Categories: PG, BE/BP, WPP, C 2-4**

Defined as: The presence of a mental illness that is diagnosed, documented, or reported by a physician, or someone working under a physician's orders, mental health provider or as self-reported by an applicant, participant, or caregiver. Mental illnesses where the current condition, or treatment for the condition may affect nutritional status include but are not limited to Depression, Anxiety Disorders, Post-Traumatic Stress Disorder (PTSD), Personality Disorders, Bipolar Disorder, Schizophrenia, and Attention-Deficit/Hyperactivity Disorder (ADHD).

A participant identified with mental illness should have Nutrition Care counseling.

Best Practice: Provide Nutrition Care follow-up in 3-6 months.

Justification:

In 2019, the prevalence of any mental illness in U.S. adults was 20.6%--one fifth of the adult population. Mental illness can vary from mild to severe. The highest prevalence of mental illness occurs in:

- Young adults aged 18-25
- Females
- People of two or more races
- LGBTQ adults

Prevalence of severe mental illness in US adults was 5.2%. Severe mental illness results in serious functional impairment which substantially interferes with or limits one or more major life activities including, but not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating sleeping, walking, standing, speaking, breathing, lifting, learning, reading, concentrating, and working, according to the US Department of Labor.

People with severe mental illness often have difficulty maintaining a healthy diet, even when guidance is provided. Unintended changes in total body weight (5% in the past month, or 10% in the past six months) and medications that alter appetite or intake, nutrient absorption, or the metabolism of nutrients may signal the need for additional referrals and indicate that the mental illness is more serious.

The **prenatal and postnatal periods** are a common time for the relapse of mental illnesses such as depression, bipolar disorder, and anxiety disorders since women may choose not to take their medications while pregnant or breastfeeding. Suicide remains a

leading cause of mortality in the postpartum period and accounts for 20% of maternal deaths in the first year after birth. Mental illnesses during pregnancy have been associated with adverse perinatal outcomes, including placental abnormalities, small-for-gestational- age fetuses, fetal distress, preterm delivery, adverse neurodevelopmental outcomes, and disordered attachment. Pregnant women with untreated mental illness are also more likely to smoke, use alcohol and drugs, have less prenatal care, and have poor nutrition.

Children whose parents have a mental illness are at risk for developing social, emotional, and behavioral problems. They are more likely to have an inconsistent and unpredictable family environment which can place the child at risk for poverty, living in a single parent home, hostile behavior by a parent, and having a parent with a substance use disorder.

Mental illnesses or serious emotional disturbances also occur in **children**. Symptoms in children are observed as serious changes in the way they typically learn, behave, or handle their emotions, which cause distress and problems getting through the day. The diagnosis is often made in the school years or sometimes earlier. Symptoms of mental illnesses often change as a child grows. Mental illnesses can also interfere with a child's healthy development, causing problems that can continue into adulthood. The most common mental illnesses that are diagnosed in childhood are attention-deficit/hyperactivity disorder (ADHD), anxiety, and behavior disorders.

Poverty affects mental health in many ways including increased financial stress, chronic and acute stressful life events, inadequate nutrition, and lead exposure. It can also affect parental relationship stress, result in a low-stimulation home environment, and child abuse and neglect. Poverty in childhood is associated with depressive and anxiety disorders, and higher rates of almost every psychiatric illness in adulthood. Poverty in adulthood is linked to depressive disorders, anxiety disorders, and suicide.

Treatment

Treatment for any mental illness can be complex and depends on the severity of the symptoms. Mental illnesses are most commonly treated with psychotherapy and medication. Certain medications such as antidepressants, antipsychotics, anticonvulsants, or stimulants can influence body weight and appetite. Individuals who are prescribed antipsychotics often have weight gain that may result in additional health issues, reduced quality of life, and poor compliance with taking the medication as prescribed.

Mental Illnesses and Nutrition

Nutrition supports mental health by maintaining the structure and function of the nerve cells and brain chemicals. The production of nerve chemicals or neurotransmitters requires certain nutrients including **amino acids, zinc, copper, magnesium, iron, iodine, selenium, and B vitamins**. If the intake of these nutrients is low, it can affect the production of neurotransmitters and therefore mental health. While vitamin D is usually associated with bone health it

is also important for the brain. Research has associated **vitamin D** deficiency with mood disorders, dementia, and an increased risk for depression.

Essential fatty acids (EFA) are also crucial nutrients that may support mental health. They are the building blocks for nerve tissue and transmitting nerve signals. When EFA are out of balance or consumed in insufficient amounts, biochemical malfunctions such as incomplete or inaccurate nerve signals can impact physical and mental health.

Some patients with mental illnesses can be deficient in some vitamins, minerals, and nutrients. These commonly include, **B6, B9, B12, omega-3 and omega-6 fatty acids, magnesium, vitamin D, and zinc**. Evidence suggests that in some cases, when these deficiencies are returned to normal, changes in mood and behavior can be achieved.

Common Mental Illnesses

Depression (3611)

Depression has varied symptoms, most commonly feelings of sadness or a marked loss of interest or pleasure in activities. Other symptoms include **appetite changes resulting in unintended weight loss or gain**, insomnia or oversleeping, loss of energy or increased fatigue, restlessness or irritability, feelings of worthlessness or inappropriate guilt, and difficulty thinking, concentrating, or making decisions. Depression affects 6.7% U.S. adults in any given year and 16.6% will experience depression at some time in their life. The prevalence of depression among females is 60% higher than males. Of those adults diagnosed with depression, 63.8% had severe impairment. Although depression can occur at any age, it usually first appears in the late teens to mid-twenties. Depression is now recognized in children and adolescents and tends to present as irritability, rather than low mood. There is no definite known cause of depression but contributing factors include genetics, nutrition, environmental stressors, hormonal disruptions, and changes in brain chemistry. Approximately one-third of people who have depression do not respond well to the available treatments.

<u>Prenatal Depression</u>

Sadness, anxiety, and fatigue are the most common symptoms of prenatal depression. Pregnant women with depression are less likely to follow their prenatal medical plan, have **inadequate or excessive weight gain**, and are more likely to smoke or abuse substances. Pregnant women with untreated depression have more birth complications, preeclampsia, preterm delivery, and infants of low birth weight with impaired social, cognitive, and emotional development. Women of color and women from lower socioeconomic groups have greater rates of prenatal depression.

About 6-8% of US women may use antidepressants while pregnant. Currently there are no recommended medications for treating prenatal depression, and there are some concerns about the effects on fetal and infant health. Prenatal women with depression should discuss the benefits and risks of antidepressant therapy with their health care provider.

Depression in Pregnant Adolescents

Pregnant adolescents have significant risk for depression. They exhibit depressed mood, but more frequently have **changes in appetite, weight**, and insomnia rather than loss of interest and poor concentration compared to older adults. Up to 20% of pregnant adolescents with depression attempt suicide.

Postpartum Depression

Postpartum depression (PPD) is one of the most common complications following pregnancy and has many adverse outcomes for both mother and baby, including maternal morbidity and mortality, higher infanticide, less maternal-infant attachment, shorter breastfeeding duration, and impaired parenting behaviors. PPD risk factors include genetics, history of mental illness, physical, psychological, or sexual abuse, discrimination, and immigration.

Breastfeeding and Depression

Women with PPD are less likely to breastfeed and are more likely to stop breastfeeding early. They have fewer positive interactions with their infants and worse perception about their baby's behavior. Cortisol in the mother's system can reduce the milk supply. Breastfeeding problems can make the participant feel overwhelmed and increase depression. If she stops breastfeeding, the abrupt drop in oxytocin can make depression more severe.

Successful breastfeeding can decrease loneliness and emptiness common to PPD. Oxytocin released during breastfeeding can help the participant feel calmer and more relaxed. SSRIs and SSNIs in breastmilk used to treat PPD show negligible risk to the infant. A participant with PPD who wants to breastfeed should talk to her health care provider about acceptable medications.

Anxiety Disorders (3612)

Anxiety disorders are the most common mental illness in adults in the US. They include general anxiety disorder, panic disorder, and several phobia-related disorders. All share an increase in emotional, physical, and neurological symptoms triggered by specific

situations or circumstances. Risk factors include genetic and environmental components and exposure to stressful events, an adverse childhood experience, and a history of family mental illness.

Anxiety during pregnancy can have adverse effects on both the birthing person and the baby including impaired fetal development, complications of labor, and altered mental development of the newborn. Anxiety disorders are usually treated with psychotherapy and medications. Pregnant participants with anxiety disorders should work closely with their health care providers to establish and adjust suitable medications.

Post-Traumatic Stress Disorder (PTSD) (3613)

PTSD is a psychiatric disorder that occurs in people who have experienced or witnessed a traumatic, shocking, scary, or dangerous event. People with PTSD have intense or disturbing thoughts and feelings related to their trauma that last after the traumatic event has ended. To be considered PTSD, the symptoms must last more than a month and be severe enough to interfere with relationships or work. It can occur at any age, with women more likely than men to be affected. Rape is the most common trigger of PTSD, with childhood sexual abuse a strong predictor of developing PTSD in one's lifetime. About 3% of pregnant women and 4% of postpartum women have PTSD. Risk factors associated with postpartum PTSD include negative birth experiences, operative birth, history of mental health problems, and lack of support. Postpartum PTSD is associated with lower birth weights and lower rates of breastfeeding. Psychotherapy, medication (usually antidepressants), or a combination is used to treat PTSD.

Obsessive-Compulsive Disorder (OCD) (3614)

OCD is a chronic and long-lasting disorder where a person has uncontrollable, recurring thoughts *(obsessions)* and/or behaviors *(compulsions)* that they repeat over and over. Compulsions like hand washing, cleaning, or checking things can interfere with daily life. OCD affects 1% of the US population, men and women equally. Risk factors include genetics, childhood trauma, and brain abnormalities. OCD is usually treated with cognitive behavioral therapy, medications, or both, depending on severity. SSRIs are the first-line medication, especially during the perinatal period, given their safety record.

Personality Disorders (3615)

Personality disorders, including obsessive-compulsive personality disorder (OCPD), (different from OCD) are an "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture," according to the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Behaviors are pervasive and inflexible, often resulting in distress and impairment. The person's way of thinking, feeling, and behaving is different from society's expectations and causes

problems functioning. There is no medication specifically used to treat personality disorders, but psychotherapy can be effective. Some medications can be used under the care of a psychiatrist to treat some symptoms.

Bipolar Disorders (3616)

Bipolar disorder (aka manic-depressive disorder) is a mental illness that causes changes in a person's mood that affects daily life. Mood shifts are manic (elevated or agitated) or depressive (sad and hopeless). During depressive episodes, 25-50% attempt suicide. Episodes can be mixed, and moods can last from days to weeks and vary in intensity. People with bipolar disorders are more likely to have other mental illnesses like anxiety, eating disorders, substance use issues or chronic medical conditions such as diabetes, obesity, or heart disease. The exact cause of bipolar disorders is not known, but genetics, hormones, and an imbalance in brain chemistry are believed to play a role. Bipolar disorders also tend to run in families with the average age of onset being 25 years old.

Medications are the treatment of choice for bipolar disorders with mood stabilizers like antiseizure medications with lithium being used the most commonly. These medications are believed to affect the chemical imbalances in the brain . **Lithium and sodium are similar in chemical bonding, so it is necessary for those taking lithium to have a stable, moderate intake of salt to keep lithium levels steady**. Simple information based on the **Dietary Approaches to Stop Hypertension (DASH)** diet could be useful to those taking lithium. Mood stabilizers may also cause other side effects that could affect a person's nutritional status including **weight gain, increased thirst, nausea, vomiting, and diarrhea.**

The postpartum period is a vulnerable time for illness relapse in bipolar women. Women with bipolar disorder who discontinued their medication during pregnancy had a significantly higher risk of relapsing during the postpartum period (approximately 65% vs 25%) than those who remained taking their medication. The effect of lithium use on a breastfed baby is not as well studied. Lithium is excreted in human milk. Both the American Academy of Pediatrics and the National Library of Medicine (LactMed) provide guidelines for lithium use during breastfeeding but when lithium therapy is continued during the perinatal period it requires close monitoring of the breastfeeding dyad. Infant monitoring includes checking for over-sedation, restlessness, hydration status, and changes in growth and development.

Schizophrenia (3617)

Schizophrenia can be severely disabling if not treated. It is characterized by delusions, hallucinations, disorganized speech and behavior, and other symptoms that cause social or occupational dysfunction. Schizophrenia affects 1% of the U.S. population, occurring equally in men and women but tends to be diagnosed earlier in males (late teens/early twenties) than in females (twenties or thirties). Genetics is estimated to be responsible for 80% of schizophrenia cases. People with schizophrenia also have higher mortality rates due to **higher rates of heart disease, liver disease, and**

diabetes, which appear to be more related to fat metabolism than dietary fat intake, due to altered metabolism. Patients with schizophrenia have three times the visceral fat compared to those with equal total body fat. They also have **reduced energy needs** due to the antipsychotic medications frequently used to treat schizophrenia. Antipsychotic medications **increase appetite**, with weight gain as much as 25-60 pounds over the first few years.

People with schizophrenia have a lifetime risk of having a serious drug or alcohol problem (47% vs 16% for the general population). High rates of substance use are associated with poor medical compliance, clinical decline, violence, and suicide.

Women with schizophrenia have increased rates of stillbirths and neonatal deaths, which may be due to the illness, other medical conditions, lifestyle factors, or social issues. **Pregnant women with schizophrenia who take antipsychotics are more likely to be obese, smoke, use alcohol, drugs, other medications, and have pre-existing diabetes and hypertension. Antipsychotics may increase the risk of gestational diabetes mellitus (GDM), obesity, and gestational hypertension,** leading to adverse maternal and neonatal outcomes like fetal growth abnormalities, preterm birth, and congenital malformations. Since most antipsychotics are sedating for adults, it is recommended that breastfed infants are monitored for sedation as some cases in infants have been reported.

Attention-Deficit/Hyperactivity Disorder (ADHD) (3618)

Attention-deficit/hyperactivity disorder (ADHD) is a persistent pattern of inattention (wandering off task, losing focus, and disorganization) and/or hyperactivity (moving constantly, excessively fidgeting, tapping, or talking) or impulsivity (hasty acts that occur without thought and may have a high potential for harm) that interferes with functioning or development. ADHD is most often identified during elementary school years when the inattention becomes more prominent and impairing. In most individuals with ADHD, symptoms of motoric hyperactivity become less obvious in adolescence and adulthood, but difficulties with restlessness, inattention, poor planning, and impulsivity persist. Severe impairment is more likely when diagnosed at or before four years of age. About 10% of US children have been diagnosed with ADHD with nearly 2/3 of those having another behavioral diagnosis. Male children are two times as likely to have ADHD compared to female children. It is estimated that 2.5% of adults have ADHD. Many adults do not even realize that they have ADHD. Adults with undiagnosed ADHD may have a history of problems at school, work, or with relationships. In adults, hyperactivity may manifest as extreme restlessness or wearing others out with their activity. Impulsive behaviors may manifest as social intrusiveness (e.g., interrupting others excessively) and/or as making important decisions without consideration of long-term consequences (e.g., taking a job without adequate information). In the U.S., Black and Hispanic population rates of ADHD tend to be lower than for White populations suggesting that culturally appropriate practices are relevant in assessing ADHD.

The causes of ADHD are not understood but genetics play a role. Other risk factors include premature delivery, low birth weight, alcohol, drugs, or tobacco use during pregnancy, environmental exposure to lead or pesticides at a young age, or brain injury. Standard treatment for ADHD includes both behavior therapy and stimulant medication, which reduces appetite and weight gain. Stimulants work by increasing the brain chemicals dopamine and norepinephrine, which play essential roles in thinking and attention.

Long-term use has resulted **in lower adult height and bone mineralization** for some. Nutrition treatment should focus on **eating before taking medications** so they do not affect appetite. Children who need to gain weight can be offered **calorie dense foods** with appropriate meal timing. Bribes or coercion are not effective. While the research on diet and its impact on ADHD remains inconclusive, most researchers agree that treatment should include **decreasing processed foods, increasing foods high in omega-3 fatty acids, and assuring appropriate weight gain and growth**.

ADHD medications are being more commonly prescribed during pregnancy because untreated ADHD can result in risk-taking behavior, placing the mother and fetus in danger. There is evidence adequate treatment of ADHD may decrease substance use in the mother.

However, there is also research that shows the stimulant methylphenidate is associated with an increased risk of low Apgar score at delivery that is not seen in untreated women with ADHD. Infants may also have neonatal withdrawal syndrome after being exposed to methylphenidate. The data is limited regarding the safety of ADHD medications during pregnancy and lactation, but it currently does not suggest a link between methylphenidate and congenital malformations.

WIC Nutrition Services Recommendations for Mental Illnesses	
All types of Mental Illnesses	• Make referrals (or encourage continued visits) to the primary health care provider and/or other appropriate mental health and social service programs to initiate and/or maintain treatment. • Reinforce and support the treatments and therapies prescribed by the participant's health care provider. • When appropriate, encourage regular, healthy meals and snacks that are simple and easy to prepare. • Encourage carbohydrate sources from whole grains, vegetables, and fruits to aid in maintaining stable blood sugar levels. Rapid increases in blood glucose can result in an increase in the release of insulin, which in turn raises adrenaline and cortisol which can cause changes in behavior and mood. • Encourage oily fish such as salmon, sardines, and tuna which are high in eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) as the essential Omega-3 fatty acids contribute to overall brain function and may offer some benefit for mental health condition such as depression, anxiety, and bipolar disorder). • Because a person with a mental illness may experience significant distress in social, work, or other settings, WIC professionals should seek to understand how symptom severity impacts eating and physical activity. Value Enhanced Nutrition Assessment (VENA) techniques can be used to provide participant centered education and goal setting for these individuals. Goal setting should consider the level of impairment in major life activities and be cognizant of the participant's needs and barriers. • Assess for unintended changes in weight. • Assess current medications and possible drug nutrient interactions.
Depression	• Encourage food choices such as fruits, vegetables, olive oil, whole grains, low- fat dairy, and nutrient dense animal and plant protein sources (e.g., lean meats, poultry, and eggs; seafood; nuts and seeds) as part of a healthy dietary pattern. • Encourage regular physical activity after consulting healthcare provider. • Educate about prevalence, risks, and signs of postpartum depression. • Provide breastfeeding education, assessment, and support (e.g., peer counseling) to women with existing depression in the perinatal period.
Anxiety Disorders	• Support gradual behavioral changes. • Encourage practices that promote mindfulness which may be helpful with anxiety. • Recommend maintaining well-balanced meals and routine mealtimes.
PTSD and OCD	• Support gradual behavioral changes.

Personality Disorders	• Support a flexible variety of food choices (provide the participant options to give them the freedom to choose). • Encourage flexible eating times if possible.
Bipolar Disorders	• Encourage regular simple meals and snacks that may help maintain blood sugar levels. • Assess for consistent fluid and salt intake. If taking lithium, education on following the Dietary Guidelines for Americans or the DASH diet may be appropriate. • Encourage social and physical activity.

Stigma, prejudice, and discrimination against people with mental illness can cause people to avoid or delay treatment. Individuals with mental illness can have negative attitudes, including internalized shame, about their own condition (i.e., self-stigma). The strong family values of emotional restraint and avoiding shame in some Asian cultures, may be contrary to seeking professional help for mental illness. In addition, some African American communities distrust the mental healthcare system. Stigma not only directly affects individuals with mental illness but also the friends and family of those who seek treatment. The National Alliance on Mental Illness (NAMI) offers some suggestions about what we can do to help reduce the stigma of mental illness:

- Talk openly about mental health.
- Educate yourself and others about mental health so you can respond to misperceptions or negative comments by sharing accurate facts.
- Be conscious of language that is used to discuss mental health. For information see: What to Say - Tips for Talking About Mental Illnesses (makeitok.org)
- Encourage equality between physical and mental illness – normalize mental health treatment, just like other health care treatment.
- Show compassion for those with mental illness.

Participant Centered Counseling

Using the nutrition guidance in the chart above, and the need to speak openly about mental health, Participant Centered Counseling is an ideal approach to help participants determine what small steps they can take to improve their mental health by using their WIC foods to stabilize blood glucose, support appropriate physical activity, and improve their mood and self-efficacy. When engaging with WIC participants with a mental illness, use open ended questions to learn what the participant is already doing to manage their condition, when/where they have been successful, where they are struggling, and ask permission to share ideas that have worked for others.

- Explore any nutrition and physical activity recommended by their health care provider.
- Invite the participant to discuss their achievements and shortfalls trying to follow the HCPs recommendations.
- Have participants share their favorite foods and preparation methods.
- Learn about the participant's kitchen skills, abilities, frustrations, and limitations.
- Find out what foods the participant refuses to eat.
- Help the participant find enjoyable substitutes to fill their nutrient gaps.
- Help the participant plan to make small gradual changes that support health, without overwhelming or setting them up for failure.

Additional Resources and Information

Brochures and Fact Sheets on mental disorders by topic from the National Institute of Mental Health:
https://www.nimh.nih.gov/health/publications/index.shtml
Overview of medications used to treat mental disorders:
https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml
Treatment Options for ADHD in Children and Teens: A Review of Research for Parents and Caregivers
https://www.ncbi.nlm.nih.gov/books/NBK99163/
National Suicide Prevention Lifeline:
988 or 1-800-273-8255 or 988
https://suicidepreventionlifeline.org/
National Maternal Health Hotline:
1-833-9-HELP4MOMS
National Maternal Mental Health Hotline | MCHB (hrsa.gov)

Migrant Farm Worker; Migrant Farm Worker Status

(8021) **Categories: All**

Defined as: Categorically eligible women, infants, and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

Justification:

Data on the health and/or nutritional status of migrants indicate significantly higher rates of infant mortality, malnutrition, and parasitic disease (among migrant children) than among the general U.S. population. Migrancy has been stipulated as a condition that predisposes persons to inadequate nutritional patterns or nutrition-related medical conditions.

Procedure:

- Determine if the participant is a migrant farm worker (or dependent).
- Review dietary and lifestyle practices.

Participant Focused Counseling:

The goals of nutrition counseling are to assist the migrant farm worker (or dependent) in making decisions about the selection, storage, and preparation of foods to promote optimal nutritional status.

- Review WIC foods appropriate for the participant(s).
- Review safe handling food practices.
- Referrals and service coordination with other programs may also be appropriate.

Mother in WIC or WIC-Eligible While Pregnant

(7011) **Categories: IBE, IBP, IFF**

Defined as: An infant under 6 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 pregnancy with a priority I risk.

Justification:

WIC participation during pregnancy is associated with improved pregnancy outcomes. An infant whose nutritional status has been maintained through WIC services during gestation and early infancy may decline in nutritional status without these services and return to a state of elevated risk for nutrition-related health problems.

An infant whose mother was at nutritional risk during pregnancy but did not receive WIC benefits may also be thought of as at risk for morbidity and mortality in the infancy period.

WIC participation during infancy is associated with lower infant mortality, decreased anemia, and improvements in head circumference, length, and weight.

Procedure:

Use mother's WOW record as documentation of her participation while pregnant.

Documentation of the nutritional risk of the mother who did not participate in WIC while pregnant must be written as a note in the infant's WOW record. Priority I risk criteria are detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions.

Participant Focused Counseling:

- Promote breastfeeding.
- Review feeding practices that promote optimal growth and development of the infant.
- Provide appropriate WIC brochures.

Multi-fetal Gestation

(3341) **Categories: PG, BE, BP, WPP**

Defined as: More than one fetus in the current pregnancy for a pregnant woman or the most recent pregnancy for a breastfeeding or postpartum woman.

A woman pregnant with multiple fetuses should have Nutrition Care counseling.
Best Practice: Provide Nutrition Care follow-up in 3 months.

Justification:

Multi-fetal gestations are associated with low birth weight, fetal growth restriction, placental and cord abnormalities, preeclampsia, anemia, shorter gestation, and an increased risk of infant mortality.

Pregnant or breastfeeding women with twins have a greater requirement for all nutrients than women with only one infant. Postpartum, non-breastfeeding women who deliver twins are at greater nutritional risk than women who deliver one infant.

For twin gestations, the 2009 IOM recommendations provide provisional guidelines: normal weight women should gain 37-54 pounds; overweight women, 31-50 pounds, and obese women, 25-42 pounds. There was insufficient information to develop even provisional guidelines for underweight women with multiple fetuses. A consistent rate of weight gain is advisable. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low birth weight deliveries in twin pregnancy. In triplet pregnancies, the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy. Education by the WIC nutritionist should address a steady rate of weight gain that is higher than for singleton pregnancies.

Procedure:
Determine if the woman is or was pregnant with 2 or more fetuses. Apply as follows:

- **Pregnant woman**: current pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy

Participant Focused Counseling:
Review collected information about dietary and lifestyle practices. A woman pregnant with multiple fetuses, the woman who delivered more than one infant, or the mother breastfeeding more than one infant can state the food and lifestyle choices she can make that promote a positive pregnancy outcome.

Neonatal Abstinence Syndrome

(3831) **Categories: IBE, IBP, IFF**

Definition: Neonatal abstinence syndrome (NAS) is a drug withdrawal syndrome that occurs among drug-exposed (primarily opioid-exposed) infants as a result of the mother's use of drugs during pregnancy. NAS is a combination of physiologic and neurologic symptoms that can be identified immediately after birth and can last up to 6 months after birth.

A participant diagnosed with Neonatal Abstinence Syndrome should have Nutrition Care counseling. First contact immediately, if not possible, within 5 days. Best Practice: CPA follow up in 2-3 months.

Refer a breastfeeding infant with a breastfeeding complication diagnosed with Neonatal Abstinence Syndrome to the IBCLC/DBE. See procedure under Breastfeeding Complication risk for Infant.

Justification:

Neonatal abstinence syndrome occurs when an infant is born dependent on prescription or illicit drugs the mother was taking during pregnancy. NAS is a combination of withdrawal symptoms that involve multiple bodily systems. It is most commonly associated with chronic opioid exposure during fetal development; however, can also result from chronic intrauterine exposure to other substances including benzodiazepines, barbiturates, selective serotonin reuptake inhibitors and ethanol. Although these non-opioid substances can lead to NAS, these infants typically respond well to non-pharmacological methods of intervention.

Withdrawal in the newborn varies based on the type of substance, dose, and timing of exposure. Opioid is a general term for a variety of illicit and prescription drugs that decrease pain. Prescription opioid pain relievers include oxycodone, hydrocodone, codeine, morphine, and fentanyl. Opioids are water soluble and are, therefore, able to move easily across the placenta to the infant. This transfer of opioids increases as gestational age increases.

Participants who take any form of opioid, including prescription opioids as directed for chronic pain, can become addicted. Due to the risk of the transmission of infectious diseases such as HIV and Hepatitis C, women who become pregnant while using illicit opioids, such as heroin, are often put on opioid maintenance therapy. Opioid maintenance therapy involves the prescribed use of either methadone or buprenorphine. These prescribed opioids can still lead to NAS; however, since they are not injected, they decrease the risk of the mother contracting blood-borne infectious diseases. Opioid maintenance therapy can also help protect the fetus from repeated opioid withdrawal in utero.

Infants born with NAS are often premature, have low birth weights, and are growth restricted. In addition to exposure to substances in utero, additional factors, including social, nutritional, physical, and mental health problems can also contribute to the health status

of the infant. An increased risk of birth defects such as spina bifida, hydrocephaly, glaucoma, gastroschisis, and heart defects are associated with early pregnancy opioid use.

Neonatal Abstinence Syndrome Symptoms

Symptoms of NAS generally involve the central nervous system, autonomic nervous system, and the gastrointestinal tract. The severity of the infant's symptoms is commonly assessed using the Modified Finnegan Score Sheet. The Modified Finnegan Score Sheet consists of 21 symptoms that are associated with NAS. Following the determination of a baseline score, infants are assessed every 4 hours unless the severity of the symptoms requires more frequent monitoring.

The following list includes symptoms associated with NAS:

- Loud, high-pitched crying, sweating, yawning
- Sleep disturbances, feeding difficulties, poor weight gain
- Excessive sucking, regurgitation, diarrhea

Neonatal Abstinence Syndrome Treatment

Infants with NAS typically have longer hospital stays, serious complications, and costly treatment. The first treatment option for infants with NAS is to manage symptoms without medication by rooming in with the mother, encouraging skin-to-skin contact, swaddling, having a calm environment, avoiding overstimulation, and supporting breastfeeding. Infants who are at risk for NAS and who room-in with their mothers are not only at a lower risk of needing pharmacological treatment for NAS, but they also have a shortened hospital stay. If withdrawal is severe or if the initial treatment is not successful in managing symptoms, medications such as morphine, methadone, phenobarbital or clonidine may be used. An infant given these medications may have side effects that could include: slow or shallow breathing, slow heart rate, difficulty waking-up, excessive sleepiness, constipation, and fewer wet diapers.

Nutritional Considerations for Neonatal Abstinence Syndrome

The timing and type of feedings play an important role in the management of NAS symptoms. Infants with NAS may have impaired feeding behaviors such as excessive sucking, regurgitation, diarrhea and poor feeding that is characterized by fussiness, crying, and sleepiness. Infants with NAS have higher caloric requirements due to their energy expenditure. This combined with the impaired feeding behaviors may result in difficulty with weight gain. The American Academy of Pediatrics (AAP) recommends breastfeeding if not contraindicated. The AAP also recommends that infants with NAS be fed frequent small volumes of human milk or high calorie formula, as needed, in a quiet and calm environment, to aid the infant in tolerating feedings and improving digestion and to allow for adequate growth.

The Academy of Breastfeeding Medicine recommends breastfeeding for women who are on a prescribed stable dose of methadone maintenance because the concentrations of methadone in human milk are low. Studies have indicated that, although the amount of methadone in human milk is dependent on the mother's dose, the methadone transferred in human milk averages less than 2.8% of the maternal dose. Breastfeeding has been found to provide protection against the development of NAS symptoms and lessen the severity of symptoms, which would decrease the need for pharmacological intervention for the infant. The amount of methadone that is in human milk is small and therefore, it is thought that breastfeeding, and not the methadone in human milk, is responsible for its protective impact against NAS. Gradual weaning, when mutually desired by the mother and infant, is recommended for breastfeeding women who are being treated for opioid addiction. Gradual weaning (rather than an abrupt stop to breastfeeding) decreases the risk of the infant developing NAS.

Implications for WIC Nutrition Services

NAS can be a difficult subject to talk about with WIC participants due to the stigma of addiction. In the WIC clinic, caregivers may not be forthcoming with the infant's diagnosis of NAS and an addiction history of the mother may not be available at the initial assessment. WIC staff can assist caregivers by:

- Educating to recognize infant hunger cues.
- Reviewing feeding frequency and/or formula type and amount to help manage gastrointestinal symptoms of NAS.
- Providing growth monitoring to assess adequate weight gain.
- Encouraging supportive interventions to include:
    - Skin-to-skin contact
    - Swaddling
    - Quiet environment with little stimulation
- Encouraging breastfeeding unless medically contraindicated.
- Providing referrals for support services such as drug and alcohol counseling, parenting support, and medical evaluations.
- Encouraging mothers who are on medication-assisted therapy (e.g., methadone or buprenorphine) and who are breastfeeding, to speak with their health care provider if they have questions about the timing and dose of their medication.
- Educating mothers who are on medication-assisted therapy and who are breastfeeding on the importance of gradual weaning when mutually desired by the mother and infant

Nicotine and Tobacco Use

(3711) **Categories: All**

Defined as: Any use of products that contain nicotine and/or tobacco to include but not limited to cigarettes, pipes, cigars, electronic nicotine delivery systems (e-cigarettes, vaping devices), hookahs, smokeless tobacco (chewing tobacco, snuff, dissolvables), or nicotine replacement therapies (gums, patches).

Justification:

Tobacco products contain a variety of harmful chemicals. Tobacco use can lead to serious illnesses, including cancers, lung disease, and heart disease. Nicotine, one of the chemicals in tobacco, is highly addictive and associated with additional health risks. During pregnancy, the use of nicotine and/or tobacco products is harmful to both the mother and fetus, with potential consequences including low birth weight or even miscarriage. Nicotine can be found in breastmilk, therefore, using nicotine products may impact breastfed infants. Women, infants, and children living in a smoking environment also face adverse health outcomes.

Tobacco Smoking

Tobacco smoke contains over 7,000 chemicals that cause immediate damage to the body. According to the CDC, cigarette smoking kills more than 480,000 Americans annually, and remains the single largest preventable cause of death and disease in the United States.

According to 2018 CDC data, 14.1% of adult women in the US use tobacco products. In 2016, one in fourteen women who gave birth smoked cigarettes during pregnancy. Women most likely to smoke during pregnancy were aged 20-24, identified as non-Hispanic American Indian or Alaska Native, high school education or less. CDC data from 2014 show that women receiving WIC benefits were more likely to smoke before and during pregnancy than women who did not receive WIC benefits. There is no CDC data that reports on the incidence of smoking among breastfeeding women.

Electronic Nicotine Delivery Systems (ENDS)

Vapes, vaporizers, vape pens, hookah pens, electronic cigarettes (e-cigarettes or e-cigs), and e-pipes are some of the many terms used to describe electronic nicotine delivery systems (ENDS). ENDS are noncombustible tobacco products used to smoke or “vape” a solution that often contains nicotine. The solution, or “e-liquid”, is heated to create an aerosol that the user inhales. An individual’s level of exposure to nicotine varies with the product. Exhaled ENDS vapor contains chemicals that can cause cancer, harm the fetus, and pollute indoor air.

Data from the CDC’s 2015 Pregnancy Risk Assessment Monitoring System (PRAMS) for Oklahoma and Texas indicated that maternal use of ENDS was 10% before pregnancy and 7% around the time of conception. Reported reasons for ENDS use around

the time of pregnancy included curiosity, the perception that ENDS might help with quitting or reducing smoking, and the perception of reduced harm to the mother when compared to cigarette smoking.

The CDC has stated that ENDS use is not safe for pregnant women. Continual innovation makes health risk assessments difficult, and more research is needed to understand ENDS' safety, health effects, and cessation efficacy. Women who are pregnant or trying to become pregnant should consult with their health care provider on the risks that ENDS pose for both maternal and neonatal health.

Nutrition

The research on tobacco use and its impact on nutritional status has focused on cigarette smoking. Cigarette smoking causes a generalized upward shift in hemoglobin concentration and hematocrit, which lowers the effectiveness of anemia screening tools. Therefore, pregnant women who smoke may require additional iron supplementation even if their hemoglobin/hematocrit results show they are not anemic. Smoking also increases oxidative stress and affects metabolism. **Vitamin C is the only micronutrient with a Dietary Reference Intake (DRI) specific to individuals who smoke, with the recommendation of consuming an additional 35 mg per day compared to those who do not.** Research indicates that those who smoke have lower concentrations of certain nutrients (i.e., B-carotene, vitamin B-12, vitamin B-6 and folic acid), but due to the observational nature of the research, the exact cause remains unclear. Additional research is needed to determine smoking's effect on micronutrients and if additional DRI recommendations for other micronutrients are needed for those who smoke.

Smoking Cessation

Around 50% of women who smoked during the three months before they conceived quit during pregnancy, often because they are highly motivated to protect their babies. About 50% of them returned to smoking after the baby was born.

Research has shown that both dosage (number of cigarettes smoked in a day) and timing of maternal smoking (during particular trimesters) are associated with neonatal birth weight. **Women who stopped smoking before their third trimester gave birth to infants with similar weights to those infants who were never exposed to smoking.** Therefore, efforts for smoking cessation should not only be made in the early stages of pregnancy but should continue throughout pregnancy with an emphasis on the health benefits for the infant if smoking stops before the third trimester.

Little research has been conducted to prove the effectiveness and safety of Nicotine Replacement Therapy (NRT) for pregnant or postpartum women who engage in NRT. The optimal cessation intervention for a pregnant tobacco user is behavioral, as the safety and efficacy of neonatal nicotine exposure while using NRT has not been established. If a behavioral smoking cessation intervention alone is unsuccessful, the American College of Obstetricians and Gynecologists recommends that NRT only be considered in conjunction with a behavioral intervention and with close monitoring by a health care provider.

ENDS are often marketed as smoking cessation devices. However, due to the differences between products it is difficult for health organizations and researchers to determine how effective all ENDS are for helping people to quit smoking. The FDA does not approve of using ENDS to help people quit smoking.

Breastfeeding

In 2001, the American Academy of Pediatrics removed nicotine from its list of contraindicated substances during breastfeeding, indicating that the benefits of breastfeeding while smoking outweigh the alternative of smoking and formula feeding. Therefore, maternal use of nicotine and tobacco should not prohibit a mother from breastfeeding her child. Breastfeeding while smoking may help reduce some of the harmful effects of prenatal smoking on infants, including acute respiratory illness and asthma. However, women who smoke cigarettes are less likely to initiate breastfeeding than those who do not, possibly revealing that there is a psychosocial factor responsible for lower rates of breastfeeding among women who smoke cigarettes. This is an opportunity for WIC staff to inform participants of the health benefits and to encourage them to breastfeed despite their use of tobacco.

Nicotine has been found to have multiple effects on breastmilk. Nicotine can transfer to an infant through breastmilk. Nicotine lowers prolactin levels, which has been associated with reduced breastmilk supply and reduced milk fat content. Additional changes in milk composition and flavor due to maternal smoking may contribute to an infant's early weaning from breastmilk.

Smoking in the presence of an infant or child can expose them to secondhand smoke, which has negative health outcomes. If a woman chooses to continue her nicotine and tobacco use while breastfeeding, she should not do it in the presence of the infant. Additionally, it is recommended that a breastfeeding woman who uses nicotine should first breastfeed her infant and then use the product. This timing will help minimize the amount of nicotine in her breastmilk the next time she breastfeeds.

Implications for WIC Nutrition Services

WIC staff can provide the following nutrition services to women who use nicotine and/or tobacco:

- Provide a safe and supportive environment when discussing nicotine and/or tobacco use. For more information on techniques for delivering effective messages, please see: *WIC Substance Use Prevention* resource, Chapter 6: https://wicworks.fns.usda.gov/resources/wic-substance-use-prevention-guide
- Consider all potential nicotine and/or tobacco delivery methods participants may be using.
- Explain the importance of eliminating or reducing the amount of tobacco and/or nicotine use, especially before the third trimester if pregnant.
- Explain that ENDS have variable amounts of nicotine and are not safer alternatives to cigarettes.
- Encourage fruit and vegetables that are high in vitamin C intake to achieve adequate antioxidant and vitamin C consumption.
- Highlight WIC foods, especially 100% juice that are good sources of vitamin C and other important nutrients.
- Encourage high iron fruits and vegetables. If the participant is taking an iron supplement, provide recommendations for minimizing gastro-intestinal side effects and foods that can improve iron bioavailability. For more information, please see: https://ods.od.nih.gov/factsheets/Iron-HealthProfessional/.
- Refer to their health care provider to discuss the health implications of using NRT while pregnant or breastfeeding.

Offer the following suggestions to minimize secondhand smoke exposure to the infant:

- Avoid smoking in an infant's presence.
- Smoke outside.
- Ask other smokers to avoid smoking around the infant or other children.
- Have smoke-free rules for the car and home.
- Change clothes and wash hands after smoking and prior to handling the infant.
- Refer to a state quitline (1-800-QUIT-NOW), text-based program (text QUIT to 47848), or a local in-person smoking cessation program.

WIC staff can provide the following nutrition services to breastfeeding women who use nicotine and/or tobacco:

- Provide breastfeeding promotion and support and inform participants of the health benefits of human milk for infants of mothers who smoke.
- Utilize the participant-focused WIC Breastfeeding Support website topic articles that can be found at: https://wicbreastfeeding.fns.usda.gov/breastfeeding-and-alcohol-drugs-and-smoking.
- Recommend mothers to refrain from smoking/vaping until right after a feeding so that nicotine level will have time to decrease before the next feeding.
- Counsel women who use NRT to time its use for after breastfeeding and to not use at night.
- Provide anticipatory guidance about the possible effect of nicotine on breastmilk supply.
- Refer to the *Maryland WIC Breastfeeding Kardex* for information about smoking and breastfeeding women.

Nutrient Deficiency or Disease

(3411) **Categories: ALL**

Defined as: Presence of any currently treated or untreated nutrient deficiency or disease, diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. These include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beriberi, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Xerophthalmia, and Iron Deficiency.

A participant identified with a nutrient deficiency disease should have Nutrition Care counseling.

Justification

Nutrient deficiencies or diseases can be the result of poor nutritional intake, chronic health conditions, acute health conditions, medications, altered nutrient metabolism, or a combination of these factors, and can impact the levels of both macronutrients and micronutrients in the body. They can lead to alterations in energy metabolism, immune function, cognitive function, bone formation, and/or muscle function, as well as growth and development if the deficiency is present during fetal development and early childhood. Frequency of nutrient deficiencies vary by age, gender, and/or race and ethnicity. For certain segments of the population, nutrient deficiencies may be as high as one third of the population.

Macronutrient deficiencies include deficiencies in protein, fat, and/or calories, and can lead to stunting, pronounced wasting or a disproportionately large abdomen. Marasmus is a disease of severe wasting due to a prolonged inadequate intake of protein, carbohydrate, and fat. Kwashiorkor is a disease that results from a prolonged inadequate intake of protein. Essential fatty acid deficiencies, which would include omega-3 fatty acid deficiency, are thought to be rare among the general population. Signs of an essential fatty acid deficiency may include a dry scaly rash, decreased growth in infants and children, lowered immune response, and impaired wound healing.

Micronutrient deficiencies include deficiencies in vitamins and minerals. The most common nutrient deficiencies in the United States population were vitamin B6, iron, vitamin D, vitamin C, and vitamin B12.

Pregnant Women

A significant proportion of women who participate in WIC have inadequate nutrient intakes of vitamin E (96-100%). Additionally, greater than 50% of pregnant women participants reported inadequate intakes of iron and between 10-50% reported inadequate intakes of magnesium, folate, zinc, vitamin A, vitamin C, and vitamin B6. Micronutrient deficiencies during pregnancy are not only a concern for the mother but are a risk for certain birth defects due to inadequate levels B vitamins, vitamin K, magnesium, copper, and zinc. Iodine deficiency during pregnancy can lead to irreversible adverse effects on fetal growth and development. Research suggests that over half of pregnant women have insufficient intakes of iodine. Because intake patterns of pregnant women can

exclude or limit specific food groups, it is not uncommon to have multiple nutrient deficiencies during pregnancy. For example, iron deficiency usually does not occur alone, but it often occurs in conjunction with other vitamin and mineral deficiencies.

Breastfeeding and Postpartum Women

Among those breastfeeding women more than 50% had inadequate intakes of vitamin A, and 10-50% had inadequate intakes of magnesium, zinc, vitamin C, vitamin B6, folate, copper, and calcium. Over 50% of non-breastfeeding postpartum women had inadequate intakes of magnesium, vitamin A, and calcium, while 10-50% had inadequate intakes of vitamin C, folate, copper, zinc, thiamin, vitamin B6, vitamin B12, iron, and riboflavin.

Infants

Formula fed infants had a choline intake below the AI; however, other vitamins and minerals were adequate. Intakes of vitamin D, iron, and zinc among breastfed infants can be of concern if appropriate complementary foods and/or vitamin and mineral supplements are not provided to the infant. At least 10% of breastfed infants between 6 and 12 months of age had inadequate intakes of iron and zinc. Vitamin D in human milk is usually low. Therefore, the American Academy of Pediatrics (AAP) recommends all infants who take less than 32 ounces of formula a day be given a vitamin D supplement of 400 IU daily. Additionally, infants who are born to mothers who are vitamin D deficient are more likely to be deficient themselves.

Children

For children participating in the WIC program, the prevalence of inadequate intakes of nutrients was found to be less than 5% for each nutrient, except vitamin E, which was found to be inadequate in the diets of 34.9% of children between 2 and 5 years of age (5). Additionally, it has been estimated that one in four children does not meet the RDA for iron, and one in ten does not meet the RDA for calcium.

NOTE: Individuals with nutrient deficiency diseases, or who are concerned that they may have a nutrient deficiency disease, should be followed by their medical provider (especially if supplements are required for treatment) because overdoses of some nutrients are possible.

Participants Most Likely to Have Nutrient Deficiencies or Disease: Participants

- experiencing food insecurity, homelessness,
- with a short interpregnancy interval,
- who have recently left their previous country of residence,
- with a gastrointestinal disease that can limit absorption of nutrients (i.e. celiac disease or Crohn’s disease) or individuals with a history of gastrointestinal surgery (including gastric bypass) are at risk for vitamin B12 deficiency,

- with other medical conditions that influence nutrient status (i.e. cystic fibrosis, renal disease, genetic disorders),
- on medications that interact with the absorption or excretion of certain vitamins and minerals,
- with substance use disorders are more likely to have deficiencies due to poor intake and/or the effects of the substance,
- who have high intakes of alcohol are at greater risk of developing a magnesium deficiency,
- who smoke are more likely to have a vitamin C deficiency due to oxidative stress.

Participant Focused Counseling:

The WIC food package is designed to include foods that contain specific nutrients to improve the health status of program participants, address inadequate intakes, and, ultimately, prevent nutrient deficiencies. Nutrition education combined with the WIC food package can help decrease the likelihood that an individual would develop a nutrient deficiency or disease.

For individuals who currently have a nutrient deficiency or disease, WIC staff can:

- Encourage improved intake of whole grains, legumes, dairy, lean protein, fruits, and vegetables.
- Emphasize appropriate portion size and variety to avoid nutrient to nutrient interaction. (For example, excessive calcium intake inhibits the absorption of iron.)
- Provide education on foods that contain the specific nutrient(s) of concern.
- Provide education on preparing foods that are part of the WIC food package.
- Refer individuals who report food insecurity to appropriate resources in the community like the Supplemental Nutrition Assistance Program (SNAP) and/or food pantries.
- Reinforce the medical and dietary treatment plans provided by the medical provider and refer participants to medical providers for medical follow-up care.
- Refer individuals who smoke to tobacco cessation programs.

Nutrition Practice – Child

(4251) **Categories: C-1, C 2-4**

Defined as: Routine feeding practices that may result in impaired nutrient status, disease, or health problems. Specific practices are shown below.

Justification: Inappropriate nutrition practices may lead to poor nutritional status in children.

INAPPROPRIATE FEEDING PRACTICE	JUSTIFICATION
Feeding inappropriate beverages as the primary milk source, such as: ● Reduced fat (2%), lowfat (1%), or fat free (skim) milk before 2 years of age, unless overweight or obesity is a concern for a specific child. ● Rice or soy-based beverages that are inadequately fortified. ● Goat's milk, sheep's milk, or imitation or substitute milk inadequately fortified.	Children under age 2 who drink milk reduced in fat content may not receive adequate fat or calories in the diet and may be at risk for poor growth. Reduction in dietary fat intake is not recommended until after the age of 2.
Feeding any sugar containing beverages, such as Kool-Aid, punch, sodas, tea or sports drinks.	Abundant epidemiological evidence shows that sugar-especially sucrose-is the major dietary factor affecting the prevalence and progression of dental caries. Consumption of foods and beverages high in fermentable carbohydrates, such as sucrose, increases the risk of early childhood tooth decay. Excessive intake of nutrient-poor, high calorie foods by children between 13 and < 24 months of age can reduce the appetite for other foods, especially those high in iron. Fewer nutrients are available to support growth needs.
Using nursing bottles, cups, or pacifiers improperly, such as: ● Using a nursing bottle to feed any beverage other than breastmilk or formula. ● Putting the toddler to bed with the bottle. ● Using a nursing bottle beyond 14 months of age. ● Allowing unrestricted use of a bottle or cup.	Inappropriate use of nursing bottles, cups, or pacifiers increase the risk for tooth decay, earaches, and choking. Pediatric dentists recommend that parents be encouraged to have infants drink from a cup as they approach their first birthday, and that infants are weaned from the bottle by 12-14 months of age.
Using feeding practices that disregard the developmental stage of the child, such as: ● Not recognizing or disregarding the child's cues for hunger and fullness. ● Forcing the child to eat certain foods or to "eat everything on	The interactions between caregiver and child during feeding (referred to as the feeding relationship) affect a child's ability to progress in eating skills and to consume a nutritionally adequate diet. A dysfunctional relationship, characterized by a caregiver misinterpreting, ignoring, or overruling the innate

the plate" or sit at the table for more than 30 minutes to finish eating. ● Using dessert or other "special" foods as a reward or bribe. ● Feeding foods inappropriate in consistency, size, or shape that could cause choking. ● Not allowing the child to learn to self-feed; routinely forcing the child to finish eating by taking over feeding. ● Restricting meals and snacks (less than 3 meals and 2 nutritious snacks per day). ● Severely limiting the child's food intake, such as feeding the child only the foods that the caregiver likes or never offering a variety of foods because she thinks the child will not eat them. An entire food group is not offered (such as no Milk group foods) and there is no medical reason to do so.	capability of the child to regulate food intake based on hunger and satiety can result in poor dietary intake, poor growth, and future problems with regulation of food intake.
Feeding a diet very low in calories and/or essential nutrients, such as a vegan or macrobiotic or other highly restrictive diet.	Highly restrictive diets prevent adequate intake of calories and nutrients, interfere with growth and development, and may lead to other adverse physiological effects. A vegan diet is the consumption of plant origin foods (no meat, poultry, fish, eggs, milk, cheese or other dairy products). While a vegan diet may offer health benefits, lack of planning can result in an inadequate intake of calories, protein, vitamins B-12 and D, calcium, iron, and zinc. Such a diet requires attention to planning.
Feeding foods that could be contaminated with harmful bacteria or toxins, such as: ● Feeding unpasteurized juice, milk, or cheese. ● Feeding deli or processed meats or hotdogs without further cooking them. ● Feeding raw or undercooked meat, fish, shellfish, poultry, or eggs. ● Feeding raw vegetable sprouts. ● Feeding local fish or seafood listed on the MDE advisory as DO NOT EAT.	Unpasteurized juice or dairy products and undercooked meats may contain pathogens that cause serious, potentially fatal foodborne illness. Raw vegetable sprouts can cause Salmonella or E. coli 0157.
Feeding dietary supplements that are inappropriate and/or excessive, such as: ● Giving any vitamin, mineral, or herbal supplement (unless prescribed by health care provider).	The use of non-prescribed or non-recommended dietary supplements, including single or multivitamins or minerals or the use of herbal remedies including teas may result in toxicity and harmful nutrient interactions.

• Giving a child's multivitamin supplement inappropriately (does not follow directions on the label). • Giving any herbal remedy or herbal tea such as chamomile, comfrey, sassafras, or senna.	Teas with potentially harmful effects on children include licorice, comfrey leaves, sassafras, senna, buckhorn bark, cinnamon, wormwood, woodruff, valerian, foxglove, poke root, poke weed, periwinkle, nutmeg, catnip, hydrangea, juniper, Mormon tea, thorn apple, yohimbe bark, lobelia, oleander, Mate, kola nut or gotu kola, and chamomile.
Routinely not providing essential dietary supplements. • Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride. • Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride. • Not providing 400 IU of vitamin D if a child consumes less than 1 liter (1 quart) of vitamin D fortified milk or formula. Since 1 quart is above the recommendation for pre-school children, most children will require a supplement.	Fluoride decreases the susceptibility of teeth to dental caries. Once fluoride is an integral part of the tooth structure, teeth become stronger and more resistant to decay. It is recommended that when the water supply contains less than 0.3 parts per million (ppm) of fluoride, children between the ages of 12 and < 36 months of age consume 0.25 milligrams of fluoride daily and children 36 to 72 months of age consume 0.50 milligrams of fluoride daily. When the water supply contains 0.3 - 0.6 ppm fluoride, children 36 to 72 months of age should take 0.25 milligrams of fluoride daily.

Participant Focused Counseling:

Based on the participant's willingness to explore change, review the risks related to the feeding practice, the benefits of change, and steps participant is willing to take to change the potentially harmful practices.

Nutrition Practice – Infant

(4111) **Categories: IBE, IBP, IFF**

Defined as: Routine feeding practices that may result in impaired nutrient status, disease, or health problems. Specific practices are listed below.

Justification: Inappropriate nutrition practices may lead to poor nutritional status in infants.

INAPPROPRIATE FEEDING PRACTICE	JUSTIFICATION
• Routinely limiting the frequency of nursing of the exclusively breastfed infant to less than 8 times in a 24-hour period if the infant is <2 months of age • Scheduled feeding is used instead of demand feeding. **Refer the infant to the breastfeeding specialist.**	The American Academy of Pediatrics and others advocate breastfeeding as the preferred method of infant feeding during the first 12 months of life. Frequent breastfeeding is critical to establish and maintain an adequate milk supply for the infant. Inadequate frequency of breastfeeding can lead to lactation failure in the mother and dehydration and poor weight gain in the infant.
Using a substitute for breastmilk or FDA-approved iron-fortified formula as the primary nutrient source. Examples include: • Low iron formula without iron supplementation of FDA-approved mixture of low-iron and iron-fortified formulas • Cow, goat, or sheep milk • Evaporated or sweetened-condensed milk • Soy or rice-based beverages • Other beverages such as non-dairy creamer or homemade concoctions	For non-breastfed infants, iron-fortified infant formula is recommended. Use of a low iron formula may deplete the infant's iron stores, leading to anemia and poor growth. Cow, goat, or sheep milk, imitation milks, and substitute milks do not contain nutrients (such as iron or folic acid) in appropriate amounts for infants. The protein is more difficult to digest and can lead to blood loss and anemia.
Over- or under-dilution of formula by: • Not following manufacturer's mixing instructions to stretch formula • Not following specific prescription instructions	Over Dilution of formula can lead to poor growth, Failure to Thrive, or water intoxication (that can be fatal). Under Dilution of formula concentrates calories and protein and increases the renal solute load in the kidneys. Overweight, dehydration, and metabolic acidosis can occur.
Using nursing bottles or cups inappropriately, such as: • Using the bottle to feed fruit juice, fruit drinks, soda, gelatin water, chicken broth, corn syrup or sugar solutions, tea, or diluted cereal or other solid foods.	Inappropriate uses of a nursing bottle, such as feeding sugar-sweetened beverages may displace nutrients supplied by breastmilk or formula. Feeding foods like cereal in a bottle may displace nutrients provided by breastmilk or formula and may

• Allowing the Infant to fall asleep or be put to bed with the bottle at naps or bedtime. • Allowing the infant to use the bottle or cup without restriction (used as a pacifier). • Propping the bottle when feeding. • Allowing an infant to carry around and drink throughout the day from a covered or training cup.	lead to choking. Allowing the infant to fall asleep with the bottle or propping the bottle when feeding the infant may result in Early Childhood Caries, ear infections, and choking.
Lack of sanitation in the preparation, handling, or storage of infant formula or expressed breastmilk, such as: • Bottles, nipples, or equipment for breastmilk or formula preparation are not properly washed and rinsed. • Formula, bottles, nipples, or equipment for formula or breastmilk are not sterilized before the infant is 4 months of age. • Formula is not prepared and/or stored by manufacturer's OR health care provider's instructions. • The breast pump is not cleaned per manufacturer's instruction. • Well, cistern, or spring water that has not been tested and certified as pathogen-free by a certified testing agency such as a health department is used to prepare formula or is fed to the infant. • There is no stove, refrigerator, freezer, or sink in the home or the equipment is not working. • The infant is fed formula or expressed breastmilk left from a prior feeding. • The infant is fed breastmilk or prepared formula held at room temperature for more than one hour. • The infant is fed prepared formula held in the refrigerator longer than 24 hours (if made from powder) or 48 hours (if made from concentrate). • Freshly expressed unrefrigerated human milk is added to frozen human milk • Freshly pumped chilled human milk is added to frozen human milk in an amount that is greater than the amount of frozen human milk. • The infant is fed breastmilk that has been previously frozen, thawed and then held in the refrigerator for over 24 hours	Prepared infant formula or expressed breastmilk is perishable and must be handled and stored properly to be safe for consumption. Lack of sanitation may cause a gastrointestinal infection.

before feeding, ● Human milk is thawed/heated in a microwave. ● Thawed human milk is refrozen. ● Feeding donor human milk received directly from another person or through the internet	
Offering complementary foods (solids, table, or family foods) that are inappropriate in type, timing or feeding methods, such as: ● Feeding sugar or corn syrup in any beverage or putting it on a pacifier. ● Feeding any food other than breastmilk or formula before 6 months of age.	Before 6 months of age, the infant's gastric and enzymatic secretions and digestive and renal capacity are low, making digestion of solid foods inefficient and potentially harmful. Nutrients supplied by breastmilk or iron-fortified formula may be displaced. Developmentally, the infant is not ready to accept solids. The extrusion reflex is strong, resulting in foods being pushed out of the mouth. Offering sugar-sweetened beverages or excessive amounts of juice may prevent consumption of essential nutrients from breastmilk, formula, or other more appropriate foods. After 6 months of age, complementary foods are gradually added to supplement the nutrients and calories provided by breastmilk or iron-fortified formula.
Feeding a very nutritionally inadequate diet such as: ● Not allowing the infant to consume any more food than the caregiver initially provides. ● Following a strict vegan or macrobiotic diet. ● Other diets very low in calories and/or essential nutrients.	Highly restrictive diets prevent adequate intake of calories and nutrients, interfere with growth and development, and may lead to other adverse physiological effects. An infant held to a rigid feeding schedule may be underfed or overfed. Caregivers insensitive to signs of hunger and satiety or who exert control over feeding may inappropriately restrict or encourage excessive intake.
Using feeding practices that disregard the developmental stage of the infant, such as: ● Not recognizing or disregarding the infant's cues for hunger or fullness (putting the infant on a strict feeding schedule instead of feeding on demand) or forcing an infant to eat a certain type or amount of food. ● Feeding foods that could cause choking, such as potato or other snack chips, hot dogs, raw vegetables, raw hard fruits, or large pieces of meat. ● Feeding food in a bottle or syringe-nipple feeder and not by spoon.	A critical developmental period exists in which the infant learns progressively how to accept, manipulate, and swallow solid foods. Between the ages of 6 and 7 months, the infant develops the ability to self-feed finger foods that are easily chewed and swallowed. Foods that are inappropriate in size, shape, or consistency may cause choking and result in asphyxiation.

• Not supporting the infant's growing need for independence with self-feeding (only spoon feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils.) • Not advancing the textures of foods (puree; mashed; chopped; tiny pieces of foods) according to the infant's developmental readiness.	
Feeding foods that could be contaminated with harmful bacteria or toxins, such as: • Honey or unpasteurized fruit or vegetable juice • Undercooked or raw meat, fish, shellfish, poultry, or eggs • Local fish or seafood listed on the MDE advisory as DO NOT EAT. • Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese' • Raw vegetable sprouts (alfalfa, clover, bean, and radish) • Deli meats, hot dogs, and processed meat unless heated to steaming	Honey in any form may contain spores of *Clostridium botulinum*, which if consumed by an infant, may create a deadly toxin inside the gastrointestinal tract and lead to death. Unpasteurized juice and undercooked meats may contain pathogens that cause serious, potentially fatal foodborne illness.
Feeding dietary supplements that are inappropriate and/or excessive, such as: • Feeding any vitamin or mineral supplement (unless prescribed by health care professional. • Feeding any herbal remedy or herbal tea such as chamomile, comfrey, or senna. • Feeding "gripe" water.	The use of unprescribed dietary supplements, including single or multivitamins or minerals or the use of herbal remedies including teas may result in toxicity and harmful nutrient interactions.
Not giving a dietary supplement recognized as essential by national public health policy, such as: • Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride. • Infants who are exclusively breastfed, or are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D.	Fluoride decreases the susceptibility of teeth to dental caries. Once fluoride is an integral part of the tooth structure, teeth become stronger and more resistant to decay. It is recommended that when the water supply contains less than 0.3 parts per million (ppm) of fluoride, infants 6 months of age and older consume 0.25 milligrams of fluoride daily.

Nutrition Practice – Woman

(4271) **Categories: PG, BE, BP, WPP**

Defined as: Routine use of nutrition practices that may result in impaired nutrient status, disease, or health problems. Specific practices are listed 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: • Single or multiple vitamins; • Mineral supplements; and • Herbal or botanical supplements/remedies/teas. • Cannabidiol (CBD), for Pregnant and Breastfeeding women only (Products labeled as CBD with any form of THC should be a risk with 372)
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.	• Low-calorie diet. • Strict vegan diet; and • Any other diet restricting calories and/or essential nutrients.
427.4 Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.	• Consumption of less than 27 mg of iron as a supplement daily by pregnant woman. • Consumption of less than 150 mcg of supplemental iodine per day by pregnant and breastfeeding women.

	• Consumption of less than 400-800 mcg of folic acid from supplements daily by all WIC women categories.
427.5 Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms	Potentially harmful foods: • Seafood: Any raw or undercooked fish, or shellfish, or food containing raw or undercooked seafood, e.g., sashimi, found in some sushi or ceviche; Refrigerated smoked fish; Partially cooked seafood, such as shrimp and crab • Raw or undercooked meat or poultry. • Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot. • Pâtés: Unpasteurized, refrigerated pâté or meat spreads. • Deli Salads: Deli Salads prepared without preservatives in a deli-type store or restaurant. • Unpasteurized milk or foods containing unpasteurized milk. • Soft cheeses made with unpasteurized milk such as feta, Brie, Camembert, blue- veined cheeses and Mexican style cheeses such as queso blanco or queso fresco. • Eggs: Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings (Caesar), cookie and cake batters, sauces, and beverages such as unpasteurized eggnog. • Raw sprouts (alfalfa, bean, clover, radish, microgreens); • Unpasteurized fruit or vegetable juices; or unwashed fruits and vegetables.

Consuming dietary supplements with potentially harmful consequences.

(427.1) Categories: PG, BE, BP

Justification:

Pregnant and breastfeeding women taking inappropriate or excessive amounts of dietary supplements, such as single or multivitamins or minerals, herbal supplements, teas, or cannabidiol (CBD) are at risk for adverse effects such as harmful nutrient interactions, toxicity, and possible birth defects. These substances can cross the placenta and may harm the fetus. ~~T~~

Most nutrient toxicities occur through excessive supplementation. Vitamins A, B-6 and the minerals iron and selenium can be micronutrients that are consumed in excess during pregnancy and breastfeeding. They may also be present in breast milk and have a negative impact on the infant.

Vitamin A: critical during periods of rapid growth and cell development, but excess during pregnancy can cause birth defects, especially in the first 60 days after conception.

Vitamin B6: sometimes taken by pregnant women to reduce nausea and vomiting in doses of 10-25 mg three to four times a day. The effectiveness of this remains unproven but these amounts remain under the tolerable Upper Limit (UL). Doses of 50–510 mg per day taken during the first trimester have not been associated with adverse fetal outcomes, however the UL is set at 100 mg per day.

Iron: The UL in the U.S. for iron is 45 mg per day and is based on the reported side effects of gastrointestinal discomfort, nausea, and constipation at levels of 40–50 mg per day. These are common complaints in pregnant women and iron supplementation may exacerbate discomfort.

Selenium: potentially consumed in excess during pregnancy. It acts as an antioxidant and is important in reproduction but there are no recommendations for supplementation during pregnancy. Excess selenium intake could be of concern if women eat locally from areas where the selenium content in the soil is high or consume large amounts of Brazil nuts. There are no known cases of selenium toxicity during pregnancy or breastfeeding in the U.S.

Micronutrients	Pregnancy RDA	Breastfeeding RDA	Tolerable Upper Intake Level
Vitamin A	770 mcg	1,300 mcg	3,000 mcg
B6	1.9 mg	2 mg	100 mg
Iron	27 mg	9 mg	45 mg
Selenium	60 mcg	70 mcg	400 mcg

Herbal and Dietary Supplements

Pregnant and breastfeeding women should be cautious about using herbal and dietary supplements because safety, purity, and effectiveness are not guaranteed because they are not regulated by the Food and Drug Administration (FDA), and because potency can differ between and among batches and brands.

Many people falsely believe that herbs are safe because they are natural. Some herbs can be harmful to the rapidly growing fetus by interfering with cell growth and division during this rapid process. Herbs can have different strength depending on the form used. Teas contain the least compounds, while tinctures, which are alcohol extracts, have the highest concentration and they contain alcohol. **Raspberry and blackberry leaf teas** can cause hypoglycemia in women with gestational diabetes. Other herbs can cause uterine contractions and bleeding and are contraindicated in pregnancy including **oregano tea**, **avocado leaf tea, cat's claw, sage tea**, and large amounts of **parsley or celery seeds**. Regular **chamomile** consumption during the third trimester is associated with a higher risk of pre-term delivery and lower birth weight. **Ginger** should be limited to 1,000 mg/day during pregnancy for nausea and vomiting due to possible uterine stimulating effects**. Fennel and peppermint** tea used during pregnancy may have toxic contaminants.

Pregnant women should discuss the use of herbal teas and supplements with their health care provider prior to use.

Cannabidiol (CBD): The cannabis plant, commonly known as marijuana, contains more than 100 chemical compounds that share a common structure known as cannabinoids. The most common is the psychoactive compound tetrahydrocannabinol (THC). The second is CBD which does not produce the typical effects of marijuana. All cannabinoids, including CBD, readily cross the placental

barrier. CBD has been shown to help reduce inflammation, anxiety, pain, and seizures. However, CBD products are not regulated by the Food and Drug Administration (FDA) and the FDA has approved only one CBD prescription drug to treat a rare form of epilepsy. Studies of CBD products showed that only 31% were accurately labeled in regard to CBD levels. Other studies showed the presence of potentially hazardous chemicals such as toxins or THC. Potential side effects of CBD include drug interactions, liver abnormalities, diarrhea, fatigue, vomiting, and sleepiness.

Increasing numbers of pregnant women use it for pain, insomnia, anxiety, or nausea. Though there are very few studies on the use of CBD during pregnancy, some have shown CBD use may include placental changes, an effect on the functionality of the uterine lining, and inducing preterm labor. More plentiful animal studies have shown harm to developing fetuses.

CBD has been found in breast milk after maternal marijuana use, whether by smoking or eating, but does not appear to be present after just CBD use. There does remain a concern about CBD products containing unlabeled THC and other contaminants such as pesticides, heavy metals, bacteria, and fungus. Currently, the FDA strongly advises against the use of CBD in any form during pregnancy or while breastfeeding.

427.1 References - Supplements/Herbs

• Over-the-counter medicine, supplements and herbal products during pregnancy (marchofdimes.org)

https://www.marchofdimes.org/find-support/topics/pregnancy/what-to-know-about-supplements-herbs-and-medicines-pregnancy

• Vitamin and Mineral Supplement Fact Sheets (nih.gov)

https://ods.od.nih.gov/factsheets/list-VitaminsMinerals/

• Dietary Supplements | FDA

https://www.fda.gov/food/dietary-supplements

Consuming a diet very low in calories and/or essential nutrients

(427.2) Categories: PG, BE, BP

A participant determined to be eating a very low calorie diet should be referred to the CPA for Nutrition Care counseling

Justification:

Calories: During pregnancy, the maternal diet must provide enough energy for the mother's usual requirements and those of the growing fetus. Extra energy is required for the synthesis of new and existing tissues in the second and third trimesters. Restrictive diets may increase the risk of low birth weight, birth defects, suboptimal fetal development, and chronic health problems in their children. Restrictive diets are of special concern for the pregnant adolescent, since her additional growth needs compete with the developing fetus and the physiological changes of pregnancy.

Macronutrients: Pregnant women should avoid a diet that severely restricts any macronutrient. Examples include: the **ketogenic diet** which lacks carbohydrates, the **Paleo diet** which limits dairy, and any diet that consists of an excess of saturated fats. Fad diets may be especially harmful during pregnancy because of the resulting nutrient imbalance and consequent nutrient deficiencies or possible ketosis from lack of carbohydrates. Infants of mothers on a low-carbohydrate diet may be prone to gaining weight in childhood. An extreme intake of protein has been associated with low-birth-weight infants. The Paleo diet promotes consumption of excess saturated fats and restricts the consumption of dairy-based foods, which may contribute to deficiencies in calcium and vitamin D.

Vegan Diets: strict veganism can have a low content of essential micronutrients such as iron, zinc, vitamin B 12, vitamin D, omega-3 fatty acids, calcium, and iodine. The most common nutrient deficiencies in vegans are vitamins D and B12, and are best met for vegans with supplements, since few plant foods are fortified with vitamin D, and they eat no animal products which are the source of vitamin B12.

The breastmilk of a vegan mother can be severely deficient in vitamin B12, which if not treated, could cause growth failure and permanent damage to the infant's nervous system. Breastfeeding women who follow a strict vegan diet should have their infant's vitamin B12 levels monitored.

Pregnant and breastfeeding vegan women should be encouraged to take an individual B12 supplement that is dissolved on the tongue to increase absorption. However, both pregnant and breastfeeding women following a vegan dietary pattern should consult

with their healthcare provider to determine whether supplementation of vitamin D, vitamin B12 (and what form), and/or other nutrients such as iron, choline, zinc, iodine, or essential fatty acids are necessary.

Weight Loss Surgery: Although pre-pregnancy weight loss from bariatric surgery may improve the chances of getting pregnant and decrease the risk of gestational diabetes and hypertension, it has the potential for deficiencies in nutrients essential for healthy fetal development. The nutrients that need to be replaced depend on which bariatric surgery was performed and the nutritional status of the pregnant woman, but the most common deficiencies include vitamins D, folate, B12, B1, and A and the minerals iron and calcium.

Women who have had **gastric band** surgeries may have more difficulty eating enough while **gastric bypass** procedures tend to cause malabsorption problems. Common nutrient deficiencies can be exacerbated by morning sickness or hyperemesis, GERD, and abdominal bloating.

The American College of Obstetricians and Gynecologists recommends delaying pregnancy for 18 months after bariatric surgery. A more individualized approach is to delay pregnancy until a woman's weight has been stable for 2 years.

However, this does not always happen, and many women become pregnant with nutrient deficiencies. Pregnant women may also be unwilling to gain the recommended weight after losing weight post-surgery.

Women who have had bariatric surgery have higher risks of fetal growth restriction, preterm births, higher rates of miscarriage and neonatal mortality after surgery. **Malabsorptive procedures (bypass**) are associated with a significant increase in Small for Gestational Age (SGA) whereas restrictive procedures (banding) are not. This could be related to malnutrition, since many vitamins and minerals are absorbed in the small intestine which is bypassed by the surgery. Women of reproductive age undergoing bariatric surgery are a high-risk group and require specialized preconception and antenatal nutritional support to achieve the best outcomes for both mothers and babies as bariatric surgeries increase. Women who become pregnant following bariatric procedures should have laboratory screening for nutritional deficiencies every trimester.

427.2 References - Highly Restrictive Eating/Nutrient Malabsorption

• https://www.eatright.org/

• Weight-loss (Bariatric) Surgery | NIDDK (nih.gov)

https://www.niddk.nih.gov/health-information/weight-management/bariatric-surgery

Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.

(427.4) : PG, BE, BP, WPP

Justification:

Most healthcare providers recommend women who are pregnant or planning to become pregnant take a daily prenatal vitamin and mineral supplement in addition to consuming a healthy dietary pattern. This may be especially important to meet folic acid, iron, and iodine needs during pregnancy and iodine needs during breastfeeding.

Iron: The Recommended Dietary Allowance (RDA) for iron substantially increases during pregnancy from 18 mg per day to 27 mg per day. Iron is a key nutrient that supports fetal development. t is used by the body to make the extra blood that the pregnant woman and fetus need during pregnancy. This increased amount of iron is found in most prenatal vitamins.

Iron deficient anemia (IDA) is more common in economically and socially disadvantaged people and may independently contribute to problems in pregnancy and early childhood development. About 33% of low-income pregnant women in the U.S. have IDA in their third trimester which is associated with increased low birth weight, preterm delivery, and fetal and infant death. Maternal effects include fatigue, light-headedness, and low prenatal weight gain. IDA in the first and second trimesters is associated with increased maternal morbidity.

Iron needs for women who are breastfeeding differ from those who are pregnant. For adult women who are breastfeeding, before menstruation returns, iron needs fall to 9 mg/day and then return to pre-pregnancy levels once menstruation resumes. If breastfeeding women continue to take their prenatal vitamins, they may exceed their needs for iron. Women who are breastfeeding should not exceed the UL of 45 mg of iron per day. Breastfeeding women should seek guidance from a healthcare provider regarding the appropriate level of iron supplementation based on their unique needs as more than half of breastfeeding women continue to use prenatal supplements.

Folic acid is the synthetic form of folate, a water-soluble B vitamin. Folate occurs naturally in foods such as dark green leafy vegetables, legumes, and oranges and is fortified in enriched grains (i.e., bread, pasta, rice, and cereal). Most women do not receive the recommended daily allowance of folate from diet alone. Adequate folic acid intake is particularly important prior to conception and during the first trimester to help prevent neural tube defects (NTDs). NTDs are major birth defects of the brain and spine that occur early in pregnancy due to improper closure of the embryonic neural tube, which may lead to a range of disabilities or death. The most common NTDs are anencephaly (underdeveloped brain and incomplete skull) and spina bifida (incomplete closing of the spinal cord) as well as miscarriages, preterm births, orofacial clefts, and congenital heart defects. Natural folate is less bioavailable and has not been shown to lower the risk of NTDs as synthetic folic acid. The RDA for folate is higher during pregnancy and breastfeeding than all other life stages. The United States Preventative Services Task Force (USPSTF) recommends that all women who are planning or

capable of pregnancy take a daily supplement containing 400 to 800 mcg of folic acid, along with the folate in food. The critical period for supplementation is at least 1 month before pregnancy and during the first 12 weeks of pregnancy. Most prenatal supplements sold in the United States contain folic acid. Supplementation with folic acid during preconception and early pregnancy is critical and can prevent 40–80% of neural tube defects. The UL for women who are pregnant, or breastfeeding is 1,000 mcg of folic acid.

Iodine is an essential nutrient required for the synthesis of thyroid hormone, which is responsible for regulating growth, development, and metabolism. Iodine requirements increase substantially during pregnancy and breastfeeding. The RDA for iodine during pregnancy is 220 mcg and 290 mcg during breastfeeding. If iodine requirements are not met during these periods, the production of thyroid hormones may decrease and be inadequate for maternal, fetal, and infant needs. Inadequate iodine intake during pregnancy and breastfeeding could be detrimental to the growth and development of the baby's brain. Severe iodine deficiency during pregnancy and the neonatal period is associated with many adverse effects, including miscarriage, stillbirth, neonatal mortality, growth retardation and decreased IQ. Even subclinical hypothyroidism can double the risk of miscarriage and neonatal death. Adequate iodine levels in breastmilk are essential for the proper neurodevelopment of infants. The American Thyroid Association recommends that pregnant and breastfeeding women receive 150 mcg per day of supplemental iodine to meet the increased iodine needs during pregnancy and breastfeeding. Many prenatal supplements do not contain iodine. Pregnant and breastfeeding women should discuss the need for supplemental iodine in their prenatal vitamin with their health care provider to ensure they are receiving an adequate amount.

The following is a table showing the RDA and UL for iron, folate and iodine during pregnancy and lactation:

Micronutrient	Pregnancy RDA	Breastfeeding RDA	Tolerable Upper Intake Level (UL)
Iron	27 mg	9 mg	45 mg
Folate	600 mcg	500 mcg	1,000 mcg
Iodine	220 mcg	290 mcg	1,100 mcg

427.4 Inadequate vitamin/mineral supplementation

• General Information About NTDs, Folic Acid, and Folate | CDC https://www.cdc.gov/folic-acid/about/index.html

• Recommendation: Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication

Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.

(427.5) PG

Justification:

The CDC estimates that each year 1 in 6 people in the U.S. will get sick from a foodborne illness caused by pathogenic microorganisms (bacteria, viruses, and parasites) and their toxins and chemical contamination. Pregnant women and their fetuses are more susceptible to foodborne illnesses a pregnant woman's immune system is weakened while the fetus's immune system is still developing, making it harder to fight off certain harmful foodborne microorganisms. Therefore, it is important that they avoid foods with a high risk of infection. For this reason, the Dietary Guidelines for Americans and government agencies such as the Centers for Disease Control and Prevention, the USDA Food Safety and Inspection Service, and the Food and Drug Administration advise pregnant women and other high-risk individuals not to consume unpasteurized (raw) juice or milk, raw sprouts, and some soft cheeses made from unpasteurized milk. During pregnancy, women should only eat foods containing seafood, meats, poultry, or eggs that have been cooked to recommended safe minimum internal temperatures.

Pregnant women are 10 times more likely to get ***Listeria***, the bacteria that causes Listeriosis, than other U.S. adults. *Listeria* is a soilborne bacteria that grows in cool, moist environments. Infection occurs from eating contaminated foods including unpasteurized (raw) juice or milk, raw sprouts, or some soft cheeses made from unpasteurized milk. Deli and luncheon meats and hot dogs should be reheated to steaming hot or 165°F to kill *Listeria*. Listeriosis during pregnancy can cause miscarriage, stillbirth, or a preterm delivery. Infections are more likely in the third trimester (96%) than the first, but the consequences are more severe with the earlier infections.

Salmonella, *Campylobacter jejuni*, *E. coli,* and Toxoplasmosis are other foodborne pathogens that are of concern for pregnant women.

Salmonella is more likely to cause an infection in the mother rather than the fetus. *Salmonella* infections occur from eating contaminated foods such as raw or undercooked eggs, unpasteurized milk, raw or undercooked seafood or meat or unwashed fruits and vegetables. Symptoms include vomiting, diarrhea, abdominal pain and flu-like aliments.

Campylobacter *infections* are caused by consuming raw or undercooked poultry or another food that has been contaminated by raw or undercooked poultry. *Campylobacter* can cross the placenta and infect the fetus causing miscarriage, stillbirth, or preterm labor.

E. coli can affect pregnant women when they consume contaminated food or water, or unpasteurized milk. The symptoms can vary with each person but often include severe stomach cramps, diarrhea, vomiting, and sometimes a fever. If pregnant women are exposed to *E. coli*, dehydration is the main risk.

Toxoplasmosis is caused by a parasite (*Toxoplasma gondii)* that infects more than 40 million people in the U.S. A woman can become infected with Toxoplasmosis by eating unpasteurized milk, raw vegetables, undercooked meat (especially pork, lamb, and venison), shellfish, and food contaminated with knives and cutting boards that have been in contact with raw meat or shellfish. Infection can also be caused by drinking contaminated water, and after accidental ingestion of the parasite when in contact with cat feces. The risk of infection is higher during pregnancy and can lead to severe neurological damage, injury to various organs, miscarriage, premature birth, or stillbirth. Informing pregnant women and postpartum mothers about food safety issues through trained health professionals is crucial for the consistency of messages and increasing food safety awareness among vulnerable consumer groups.

427.5 References – Food Borne Illnesses

- Food Safety | Food Safety | CDC https://www.cdc.gov/food-safety/index.html
- Safe Food Handling | FDA https://www.fda.gov/food/buy-store-serve-safe-food/safe-food-handling
- http://www.foodsafety.gov https://www.foodsafety.gov/
- https://www.fightbac.org/ https://fightbac.org/
- fightbac.org/kids/ https://fightbac.org/kids/
- People at Risk: Pregnant Women | FoodSafety.gov https://www.foodsafety.gov/people-at-risk/pregnant-women
- Food Safety For Pregnant Women, Their Unborn Babies, and Children Under Five (fda.gov) https://www.fda.gov/food/people-risk-foodborne-illness/food-safety-pregnant-women-and-their-unborn-babies

• What Is Foodborne Illness? Food Safety for Moms to Be | FDA

https://www.fda.gov/food/people-risk-foodborne-illness/food-safety-moms-be

• Listeria Monocytogenes | Food Safety and Inspection Service (usda.gov)

http://www.fsis.usda.gov/food-safety/foodborne-illness-and-disease/illnesses-and-pathogens/listeria

• About Toxoplasmosis | Toxoplasmosis | CDC https://www.cdc.gov/toxoplasmosis/about/index.html

• E. coli (Escherichia coli) | E. coli | CDC https://www.cdc.gov/ecoli/about/index.html

• Campylobacter (Campylobacteriosis) | Campylobacter | CDC https://www.cdc.gov/campylobacter/about/index.html

Participant Focused Counseling:

When a woman is identified with a nutrition practice risk factor, review the risks related to the practice, and the benefits of change. Determine her willingness to explore change and discuss the steps the participant is willing to take to change the potentially harmful practices.

Obese (Child)

(1131) **Categories: C 2-4**

Defined as: BMI/age ≥ 95th percentile on CDC growth chart for a child 2 to 5 years of age.

Justification:

The rapid rise in the prevalence of obesity in children is one of the most important public health issues in the United States today.

Research on BMI and body fatness shows that the majority of children with BMI/age at or above the 95th percentile have high adiposity, and an increased risk for future adverse health outcomes and/or developmental diseases.

The causes are complex. Both genetic and environmental factors contribute to obesity risk.

Obesity can result from excessive energy intake, decreased calorie expenditure, or impaired regulation of energy metabolism. Having a Body Mass Index (BMI) for age at the 95th percentile or higher identifies children with a greater likelihood of being overweight as adolescents and adults.

It is recommended that an obese child undergo a medical assessment and careful evaluation to identify any underlying health risks or secondary complications.

Overweight in early childhood may signify problematic feeding practices such as excessive consumption of high calorie foods and beverages or family behaviors such as too many hours spent watching television. Such practices, if continued, may contribute to diet and inactivity-related health risks in adulthood.

Procedure:

- Obtain current height measured to the nearest 1/8 inch and weight measured to the nearest 4 ounces. Record measurements in the participant's record.
- Calculate BMI using the procedure found in **Table BMI.1**. Plot the BMI value on the BMI/age growth chart.
- If the plotted point is at or greater than the 95th percentile, assign the risk criterion.
- Review collected information for routine dietary practices that could promote a faster rate of weight gain, such as drinking milk and other beverages from a baby bottle; excessive snacking (more than 3 snacks per day); or forcing the child to eat. Inquire about usual activity and television watching.

Participant Focused Counseling:

Do not use the medical term “obese” when discussing the child’s weight with the caregiver. Frame the Participant Focused Counseling discussion to make achieving the child’s optimal growth a shared goal of the WIC program and the parents/caregivers. Make clear that BMI/age ≥95th percentile is a medical condition that can be addressed.

- Educate parents/caregivers on behaviors that can lead to healthy body weight, including:
    - Recognizing fullness cues
    - Offering a variety of nutritious foods;
    - Not overly restricting foods;
    - Offering the child foods lower in fat, such as 1% or fat free milk and low-fat cheese, or selecting beans as well as peanut butter;
    - Comforting the child by holding, reading, or rocking instead of feeding;
    - Being active as a family;
    - Reducing screen and electronics time.
- Discuss the behavior changes parents/caregivers are willing to address.
- Discuss strategies that might work for the family.
- If parents/caregivers are willing, help them set a simple, measurable goal.
- Enter the goal in WOW.

Oral Health Conditions

(3811) **Categories: All**

Defined as: Diagnosis of oral health conditions by a physician or a health care professional working under the orders of a physician or adequate documentation by the CPA or CPPA.

- **Women and Children**: includes, but not limited to tooth decay, periodontal disease, tooth loss and/or ineffectively replaced teeth that impair the ability to ingest food in adequate quantity or quality.
- **Pregnant woman:** includes gingivitis of pregnancy.
- **Infants and Children**: includes the presence of Early Childhood Caries (baby bottle tooth decay) or smooth surface decay of the maxillary anterior teeth or the primary molars.

Justification:

Missing more than seven teeth in adults seriously affects the ability to chew foods and can restrict food intake, resulting in a diet that is poor in nutritional quality. Diet quality tends to decline as dental impairment increases, including decreases in vitamin A, fiber, calcium, and other nutrients because hard-to-chew nutritious foods like fruits and vegetables decline, while high calorie, high fat processed foods increase.

Periodontal infection is a significant risk criterion for preeclampsia, can result in placental-fetal exposure and, when coupled with a fetal inflammatory response, can lead to preterm delivery. Periodontal disease and caries may also increase the woman's risk of atherosclerosis, rheumatoid arthritis and diabetes.

There is evidence that gingivitis of pregnancy results from end tissue deficiency of folic acid that will respond to folic acid supplementation as well as plaque removal.

Early childhood caries result from inappropriate feeding practices, especially frequent sugar consumption. Healthful dietary and oral hygiene practices can prevent the loss of primary teeth, and potential speech problems.

Children with special health care needs (including prematurity and intrauterine malnutrition, GERD, failure to thrive and other weight gain and growth problems, craniofacial malformations, compromised immune function, and Down syndrome) can increase the risk of oral health problems and can also make the overall effects of poor oral health more severe.

Referral to dental services should be made as appropriate.

Procedure: Determine the presence of oral health conditions in the woman, infant, or child. Self-reported information is acceptable. The presence of obvious dental decay or tooth loss may also be documented by observation by WIC staff. Review collected information about dietary practices that may increase the risk of dental problems.

Participant Focused Counseling:
With **woman** with oral health conditions, discuss:

- Dietary and oral health practices that lower risk of dental problems including use of fluoride toothpaste and rinsing nightly with alcohol-free, over-the-counter mouth rinse with 0.05% sodium fluoride.
- Preparing easy-to-chew foods, as needed

With **caregiver** of an infant or child with oral health conditions, discuss:

- Feeding practices that promote optimal oral health, such as reducing frequency of sugary food and drink; weaning directly from bottle to open cup by 12 months of age; not propping baby bottle, and, if necessary, giving only water in bottle at bedtime

- Oral health strategies that reduce cavity risk, such as daily oral hygiene appropriate for age, routine dental checkups, and not sharing cups or utensils between adult and child.

- Use of fluorides for the prevention and control of caries is documented to be both safe and highly effective, including using tiny amounts of fluoride toothpaste as soon as teeth erupt. Parents and caregivers may have questions and concerns about fluoride content in water supplies and in infant formula. Fluoridated water can be found in communities that supplement tap water with fluoride and it may also be found in well water. The CDC's My Water's Fluoride website: https://nccd.cdc.gov/doh_mwf/ allows consumers in currently participating States to learn the fluoride status of their water system.

- Emphasize non cariogenic vs high cariogenic foods, using the chart below:

Noncariogenic Foods	Low Cariogenic Foods	High Cariogenic Foods
Cheese, cottage cheese, plain yogurt	Flavored milk	Breakfast bars, granola bars
Chicken, eggs, unflavored cow's milk	Fresh fruits	Cake, cookies, candies**
Popcorn, nuts and seeds*	Whole grain products	Doughnuts, pretzels, soda crackers
Seltzer, flavored club soda		Raisins and other dried fruit
Vegetables		Sweetened drinks, including fruit juice
		Sweetened dry cereal
*choking hazard for infants and toddlers		**Sticky candy and/or slowly eaten candy are extremely cariogenic

Adapted from: Faine, MP. Nutrition and oral health. In: Proceedings of Promoting Oral Health of Children with Neurodevelopmental Disabilities and Other Special Health Care Needs. May 4-5, 2001. Seattle, WA.

Overweight (Woman)

(1111) **Categories: PG, BE/BP, WPP**

Defined as:

1. **Pregnant Woman:** Pre-pregnancy Body Mass Index (BMI) ≥ 25.0*.
2. **Postpartum or Breastfeeding (less than 6 months postpartum) Woman:** Pre-pregnancy Body Mass Index (BMI) ≥ 25.0*.
3. **Breastfeeding (6 months or more postpartum) Woman:** Current Body Mass Index (BMI) ≥ 25.0*.

*Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women as well.

Justification:

Maternal overweight and obesity are associated with higher rates of cesarean delivery, gestational diabetes mellitus, preeclampsia, and other pregnancy-induced hypertensive disorders, as well as postpartum anemia. Several studies have established an association between obesity and increased risk for hypertension, dyslipidemia, diabetes mellitus, cholelithiasis, coronary heart disease, osteoarthritis, sleep apnea, stroke and certain cancers.
Since obesity can result from the over-consumption of excess calories from foods lacking in other nutrients, the obese woman may be malnourished.

Procedure:

Pregnant Woman:

- Use **Table W** for the procedure. Measure height to the nearest 1/8 inch. If the height fraction is between 1/8 and 3/8 of an inch, round down to the nearest whole number. If it is between 5/8 and 7/8 of an inch, round up to the nearest whole number.
- Obtain pre-pregnancy weight (self-report or from health care professional). Using the woman's current height and pre-pregnancy weight, determine her weight status according to **Table W**. Record height and weight measurements in the woman's record.

Breastfeeding or Postpartum Woman:

- For a postpartum or breastfeeding woman (**less than 6 months postpartum**) use current height and pre-pregnancy weight to determine weight status according to **Table W**.
- For a breastfeeding woman (**6 months or more postpartum)** use current height and weight measured to the nearest 4 ounces to determine weight status according to **Table W**. Record height and weight measurements in the woman's record.
- Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks, fluid shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Prepregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the prepregnancy weight. In most cases, therefore, prepregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery.
- Review collected information about dietary and lifestyle practices or medical conditions that could lead to being overweight .

Participant Focused Counseling:

When a woman is determined to be overweight, review the related risks, and the benefits of change. Determine her willingness to explore change and discuss the steps the participant is willing to take to change to improve her weight status.

Overweight/At Risk of Overweight (Infant, Child)

(1141) **Categories: IBE, IBP, IFF, C 1-4**

Defined as:

- **Overweight:** BMI/age ≥ 85th to less than the 95th percentile on CDC growth chart for a child 2 to 5 years of age.
- **At risk of overweight:** an infant whose biological mother was obese at the time of conception, or any infant or child whose biological mother or father is obese.

Justification:

Increasingly, attention is being focused on the need for comprehensive strategies that focus on preventing overweight/obesity and a sedentary lifestyle for all ages. Scientific evidence suggests that the presence of obesity in a parent greatly increases the risk of overweight in preschoolers, even when no other obvious signs of increasing body mass are present.

Procedure: Child 2 to 5 years of age:

1. Obtain current height measured to the nearest 1/8 inch and weight measured to the nearest 4 ounces. Record measurements in the participant's record.
2. Calculate BMI using the procedure in **Table BMI.1**. Plot the BMI value on the BMI/Age growth chart.
3. If the plotted point is between the 85th to below the 95th percentiles, assign the risk criterion.
4. Review collected information for routine dietary practices that could promote a faster rate of weight gain, such as drinking milk and other beverages from a baby bottle; excessive snacking (more than 3 snacks per day); or forcing the child to eat. Inquire about usual activity and television watching.

Procedure: Infant or Child ≤ 24 months of age:

- If infant is less than one year of age, ask biological mother for her height and weight at the time of conception. **Or**
- If the child is over one year of age, ask the biological mother for her height and weight. If mother is pregnant or has had a baby in the past six months, ask for her preconception height and weight. **Or**
- If the biological father is present at the certification, ask for his height and weight. If biological mother or father provides height and weight information, use **Table BMI.2** to calculate BMI ≥30.
- Parents are not required to give their height and weight information.

Participant Focused Counseling:

Do not use the medical term “overweight” when discussing the child’s weight with the caregiver. Frame the Participant Focused Counseling discussion to make achieving the child’s optimal growth a shared goal of the WIC program and the parents/caregivers.

Make clear that BMI/age between the ≥85th percentile and the 95th percentile is a medical condition that can be addressed.

- Educate parents/caregivers on behaviors that can lead to healthy body weight, including:
  - Recognizing fullness cues;
  - Offering a variety of nutritious foods;
  - Not overly restricting foods;
  - Offering the child foods lower in fat, such as 1% or fat free milk and low fat cheese, or selecting beans as well as peanut butter;
  - Comforting a child by holding, reading, or rocking instead of feeding;
  - Being active as a family;
  - Reducing screen and electronics time.
- Discuss the behavior changes parents/caregivers are willing to address.
- Discuss strategies that might work for the family.
- If parents/caregivers are willing, help them set a simple, measurable goal.
- Enter the goal in WOW.

Pica Practice

(425.9) Category: ALL

Defined as: Self-reported by applicant/participant/caregiver. Routine ingestion of nonfood items (Pica).

A participant identified with Pica practice should have Nutrition Care counseling. Give Lead and Pica brochures.

Justification: Pica is the compulsive eating of nonnutritive substances and can have serious medical implications. Non-food items usually include dirt, raw starch, and ice. Other items may include paper, uncooked rice, baking soda, baby powder, burnt matches, cigarette ashes, or coffee grounds.

Pica is common in pregnancy affecting 14-44% of women in the U.S. Pica is not limited to any race, culture, socio-economic group, or geographic area. It occurs in all areas of the world but is most common in Africa (Pregnant women in Ghana, where pica is common, indicated that most of them who consume non-food items do so to satisfy a craving or because they like the smell or taste. Some of the risk factors associated with pica include stress, cultural factors, low socioeconomic status, and an underlying mental illness. The cause of pica is not understood but some of the theories include that it relieves nausea and vomiting, or that it provides an essential nutrient that the woman is deficient in, most often iron or zinc. However, neither of these theories have been supported by research. It is more likely that malnutrition is the result of pica when nonfood items replace essential nutrients in the diet.

Large intakes of non-food items can be harmful to a woman's nutritional status. Substances like dirt may contain toxins like heavy metals (such as lead, cadmium, and arsenic), parasites, or other pathogens. Excessive consumption of dirt may also lead to intestinal obstructions or perforations. An emerging theory for the explanation of pica is that it serves useful immune functions by the ingested microorganisms stimulating the inborn immune system, resulting in less of a response to allergens and antigens. Eating dirt may be a means by which the gut diversifies its microorganism flora.

However, pica during pregnancy can have negative consequences on the fetus. There have been case reports of intrauterine toxicity, lead poisoning that has caused long-term neurological disability and delayed childhood motor functions.

The strength of the craving can be intense and has been compared to that for tobacco or alcohol. Recommending stopping pica often fails since the craving is so strong, but allowing the woman to smell the dirt and trading its consumption for a burned tortilla, toast or jicama may sometimes work.

Pica has also been seen in children with obsessive-compulsive disorders, mental retardation, and sickle cell disease. Complications of this disorder include: iron-deficiency anemia, lead poisoning, intestinal obstruction, acute toxicity from soil contaminants, and infestations of parasitic worms.

Procedure:
During the nutrition assessment, establish that the woman or child frequently eats non-food items.

Participant Focused Counseling:

- Through open-ended questions, determine what nonfood items the participant eats.
- Ask what participant knows about the risks related to pica.
- Ask permission to share the known risks.
- Determine if the participant has had a blood lead test if child, pregnant, or breastfeeding.
- Share Pica handout and Lead handout.
- Suggest participant complete the lead risk review, then discuss with health care provider.
- Explore nutrition practices that help prevent lead absorption:
    - Evenly spaced meals throughout the day.
    - Foods high in calcium: milk, cheese, yogurt
    - Foods high in iron: lean meat, fish, poultry, eggs, peas and beans
    - Foods high in vitamin C: oranges and citrus fruit, berries and melons, dark green leafy vegetables, and potatoes.

- **427.3 References - Non-Food Ingestion**
- Pica | National Eating Disorders Association https://www.nationaleatingdisorders.org/
- Pica Cravings During Pregnancy | American Pregnancy Association
- https://americanpregnancy.org/healthy-pregnancy/is-it-safe/unusual-cravings-pica/

Possibility of Regression

(5011) **Categories: ALL**

Defined as: A participant previously certified as eligible for the Program may be considered to be at nutritional risk in the next certification period if the CPA or CPPA determines there is a possibility of regression in nutritional status without the benefits that the WIC Program provides.

Possibility of Regression may be used one time only following a certification period.

Justification:

On occasion, a participant's nutritional status or dietary practices may be improved such that s/he rises above the cut-off value of the initial risk condition by the end of the certification period. This occurs most frequently with those conditions that contain specific cutoffs or thresholds, such as anemia or inappropriate growth. Removal of such individuals from WIC can result in a situation where the recently improved nutritional status deteriorates quickly, so that s/he re-enters the Program at equal or greater nutritional risk than before. WIC Program regulations permit State agencies to certify previously certified individuals who do not currently demonstrate a nutrition risk condition if they may regress to one or more previously identified risk conditions because they no longer receive WIC benefits. This provision may be used only once following a certification period. Such participants shall not be considered to be at nutrition risk based on the possibility of regression for consecutive certification periods.

Procedure:

Competent Professional Authorities and other certifying staff should keep in mind that every nutrition risk condition does not necessarily lead itself to the possibility of regression. For example, gestational diabetes or gingivitis of pregnancy are not conditions to which a new mother could regress, since they are directly associated with pregnancy, and the breastfeeding or non-breastfeeding women cannot regress to being pregnant if she is no longer receiving WIC benefits.

When recertifying a participant, if no other risk criterion can be found, Possibility of Regression may be used as a risk criterion for risks such as, but not limited to

- Underweight
- Overweight (child age 2 and older, only)
- Risk for Overweight (child age 2 and older, only)
- Low Hemoglobin/Hematocrit
- Elevated Blood Lead
- Dental Problems
- Failure to Thrive
- Nutrition Practice Nutrition-related Medical Condition

Participant Focused Counseling:

WIC staff can:

- Review and congratulate participant/caregiver on steps taken to achieve the improvement.
- Ask what behaviors should be continued to maintain the improvement.
- Invite participant/caregiver to share ideas on additional steps she might take to make even greater improvements.
- Ask what, if any, ideas or suggestions she might want from the certifier.

Pregnancy at a Young Age

(3311) **Categories: PG, BE/BP, WPP**

Defined as: Conception occurs on or before 20 years of age.

Justification:

Pregnancy in women under the age of 20 is associated with anemia, eclampsia, postpartum depression, maternal death, low birth weight, preterm delivery and stillbirth. Adolescent/teen pregnancy is associated with lower socioeconomic and education status and increased health care costs. As the adolescent mother has not yet completed her own growth, there may be suboptimal nutrient levels available to support both her growth and that of the fetus.

Studies indicate that there is competition for nutrients between the still growing adolescent mother and her rapidly developing fetus which is also known as 'nutrient partitioning'. This may result in compromised growth and development of the mother and/or fetus.

Mother at Increased Risk of:	Infant at Increased Risk of"
Repeat teen pregnancy	Low or very low birth weight
Sexually transmitted disease	Congenital malformations
Anemia	Sudden Unexplained Infant Death (SUID)
Caesarian delivery	Low Apgar score
Lack of early prenatal care	Prematurity
Preeclampsia	Developmental delays
Substance misuse	Behavior disorders
Not completing high school	
Socioeconomic disadvantage	
Depression (compared to adults)	

Nutritional Impact

Adolescence is a period of rapid growth and development and increased nutritional needs. Pregnancy further increases energy and nutrient demands. Nutritional surveys across the lifespan indicate that adolescents have the highest nutritional deficiencies due largely to unhealthy eating. A systematic review reported that the nutrient intakes of pregnant adolescents appeared to be low in several nutrients (discussed below) which are vital for fetal growth and development during pregnancy.

Iron
Iron deficiency anemia is one of the most common nutrient deficiencies during pregnancy, and it is amplified for pregnant adolescents. According to the Centers for Disease Control and Prevention (CDC) non-pregnant females 12 to 19 years of age, 9-11% had iron deficiency, and 2-3% had iron deficiency anemia. Compared to pregnant adult women, pregnant adolescents have higher iron requirements as adolescents experience rapid expansion of blood volume due to normal adolescent growth. The CDC recommends supplements of 15-30 mg per day of iron for most women during pregnancy. However, pregnant adolescents who are diagnosed with iron deficiency are often prescribed doses of iron as high as 60-120 mg/day. The risk of iron deficiency increases further with each additional pregnancy due to the demand of normal growth, pregnancy, and the inability to replace blood loss experienced in childbirth.

Calcium
In a pregnant adolescent, the maternal diet needs to contain enough calcium to mineralize two skeletons, as an adolescent is still in the process of attaining peak bone mass and continued skeletal growth. Low calcium intake in adolescents is associated with low bone density and increased later risk of osteoporosis for the mother. The Recommended Daily Allowance (RDA) for calcium for adolescents is 1300 mg per day; however, studies indicate that 800 mg per day is the average for 12-19 year old females Although the RDA for calcium does not increase during pregnancy, if an adolescent has inadequate calcium intake during pregnancy it can lead to negative consequences for both the mother and infant, including increased risk of maternal hypertension and preeclampsia.

Folate
During pregnancy, folic acid is needed for cell division; during lactation it is required for the synthesis and secretion of milk. If the dietary supply of folate is low, circulating levels begin to decline during the fifth month of pregnancy and continue to decline until several weeks after delivery, and may result in intrauterine growth restriction, congenital anomalies, or spontaneous abortion. Although prenatal vitamins contain folic acid, vitamin adherence has been reported to be low among adolescents. Smoking and alcohol use both lower red blood cell folate concentrations.

Vitamin B12
Vitamin B12 is essential for normal neurological function and red blood cell formation during pregnancy. Low levels of vitamin B12, especially in pregnant adolescents, may lead to spontaneous abortion, pregnancy loss, intrauterine growth restriction, low birthweight (<2500 g), and neural tube defects. Folate supplementation may mask the adverse effects of low vitamin B12. Therefore, along with adequate supplementation of folate, pregnant adolescents should have their vitamin B12 status monitored. Vitamin B12 is mainly found in animal sources (meat and dairy products), therefore pregnant teens who follow strict vegetarian/vegan diets or have other diet restrictions are at risk of deficiency. Some studies have indicated that daily maternal supplementation with 50 µg of daily oral vitamin B12 during pregnancy and early lactation significantly improved maternal plasma and breastmilk measures of vitamin B12 status, as well as multiple measures of infant vitamin B12 status.

Zinc
Zinc is important before pregnancy for reproductive health and immune function. It also plays a vital role during embryo development, fetal growth, and lactation, increasing the zinc requirement during pregnancy and lactation. Pregnant adolescents are vulnerable to developing zinc deficiency. Additionally, low iron intake is linked with inhibition of zinc absorption. Therefore, health care providers may advise pregnant adolescents to take both a zinc and iron supplement. Zinc supplementation may have a modest effect on reducing the risk of preterm birth.

Weight Gain during Teen Pregnancy
The National Academies of Sciences, Engineering and Medicine guidelines recommend maternal weight gain of between 11-40 lbs. during pregnancy based on pre-pregnancy body mass index (BMI). There are no specific/separate weight gain recommendations for teen pregnancy. The risk of preterm delivery and low birthweight delivery decreases with adequate weight gain in pregnancy. Studies indicate that pregnant adolescents who have similar pregnancy weight gains as adult counterparts and deliver low birthweight infants may have experienced weight gains attributed to normal adolescent growth and development rather than appropriate pregnancy weight gains.

Psychosocial Impact
Pregnancy may lead to increased psychological stress for the adolescent and may increase the risk of postpartum depression and long-term depression. Psychological and emotional stress may be related to additional perinatal and economic responsibilities, adjustment in lifestyle, and changes in the family dynamic. The impact of any stress may continue into adulthood or be lifelong. Studies suggest that adolescents who stay in school to age 18 are less likely to give birth than those who leave school with less than 12 years of education. Interventions that may help adolescent mothers stay in school are more likely to complete high school during pregnancy and postpartum. Strong school connections, family assistance, or commitment in completing educational goals may also reduce multiparity in adolescents.

Implications for WIC Nutrition Services
WIC staff can provide the following nutrition services to women $\leq$ 20 years of age:

- Educate on how the WIC food package helps to provide important nutrients needed during pregnancy and how to incorporate WIC foods into their total diet to get a balanced diet.
- Promote the mom-focused WIC Breastfeeding Support website to learn more about breastfeeding.
- Encourage:
  - Adequate prenatal care.
  - Consumption of prenatal vitamins, as recommended by their health care provider.
  - Consumption of adequate amounts of iron, zinc, and calcium-rich foods in order to meet the recommended intake.

- Advise that the pregnant adolescents speak with their healthcare providers to ensure that their folate and vitamin B12 levels are within recommended range.
- Discuss infant feeding plans and provide information to support breastfeeding goals, as appropriate.

Participant Focused Counseling:

- Review collected information to identify lifestyle or dietary practices that may prevent adequate and appropriate food intake.
- For the **adolescent mother who is breastfeeding**, assess knowledge and skills for breastfeeding success.
- Review the related risks, and the benefits of change.
- Determine her willingness to explore change.
- Discuss the steps the participant is willing to take to change/ improve her nutritional status.
- Review strategies for making the change.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.

Pregnant Woman Currently Breastfeeding

(3381) **Category: PG**

Defined as: A breastfeeding woman who is now pregnant.

This risk factor must be manually assigned in WOW and a note must be written to document it.

CPA can provide nutrition care counseling. Refer to IBCLC/DBE if breastfeeding high risk intervention is needed.

Justification:

Breastfeeding during pregnancy can influence the mother's ability to meet the nutrient needs of her growing fetus and breastfed infant. Pregnancy hormones generally cause the expectant mother's breastmilk volume to decline and composition to change. If the mother conceived while her nursing infant was solely or predominantly breastfed, the infant could fail to receive adequate nutrition. Nipple tenderness could become a problem. Oxytocin released during breastfeeding might trigger uterine contractions and premature labor, and this is a concern especially if the pregnant participant is at risk for premature labor.

Procedure:

- Determine if the pregnant woman is breastfeeding another child.
- A woman who is pregnant and breastfeeding an infant or child should be advised to let her healthcare provider know that she is currently breastfeeding. For low-risk pregnancies, this is typically not a concern. If this is a high-risk pregnancy or the individual is already at risk for premature labor, her healthcare provider might advise her to discontinue breastfeeding. It is important that she talk with her health care professional to learn the signs of premature labor.
- The breastfed infant of a pregnant woman who is breastfeeding should be assessed for adequate growth.

Participant Focused Counseling:

- Review collected information to identify lifestyle or dietary practices that may prevent adequate and appropriate food intake.
- Discuss the steps the participant is willing to take to ensure her nutritional status.
- Review strategies for making the change.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.

Preterm or Early Term Delivery

(1421) **Categories: IBE, IBP, IFF, C-1**

Defined as:
Preterm and early term delivery are defined as follows:

- Preterm: Delivery of an infant born ≤36 6/7 weeks gestation.
- Early Term: Delivery of an infant born ≥37 0/7 and ≤38 6/7 weeks gestation.

An infant identified as preterm or early term should have Nutrition Care counseling.

Justification:

Prematurity affects about 12% of all live births in the U.S., and about 50% of these preterm births were preceded by preterm labor. In 2011, the annual rate of premature births in the United States reached 11.7%, nearly two times the rate in European nations. Preterm births also account for approximately 70% of newborn deaths and 36% of infant deaths.
Factors that increase the risk of preterm delivery include low socioeconomic status, nonwhite race, maternal age of ≤ 18 years or ≥ 40 years, low pre-pregnancy weight, history of prior preterm births, low weight gain during pregnancy, maternal obesity, hypertension, diabetes, or sexually transmitted diseases

Despite advances in neonatal care, preterm birth remains a leading cause of infant death in the United States. Preterm infants may have health problems because their organs did not have enough time to develop in the womb. Babies that are born too early may have a number of health conditions, including:

- Low or very low birth weight
- Increased caloric needs
- Feeding difficulties due to a lack of reflexes for sucking and swallowing
- Immature digestion and impaired absorption of carbohydrates and lipids
- Breathing problems like chronic lung disease/ bronchopulmonary dysplasia and apnea
- Cerebral palsy, an impairment of the brain that controls movement and muscle tone
- Developmental delay and poorer cognitive function
- Vision problems like retinopathy of prematurity (ROP), which may cause blindness
- Behavioral problems and psychiatric disorders
- Increased risk for necrotizing enterocolitis (NEC) due to their immature gastrointestinal systems

• Increased risk for Sudden Infant Death Syndrome (SIDS)

• Temperature control problems.

• Heart problems, Hypoglycemia, Hearing problems, anemia and jaundice

• Immature immune systems, which may result in infections.

The Benefits of Breastfeeding

Preterm infants often need special medical care in a neonatal intensive care unit (NICU) and may need to stay there for days or even months. Breastfeeding is recommended as the normative standard for infant feeding and nutrition for all infants, especially preterm babies. Breastfeeding preterm infants has been associated with positive health outcomes for these infants, including:

• Improved motor maturity and cognitive ability

• Reduced risk of NEC

• Reduced risk of ROP and retinal detachment

Additionally, mothers of preterm infants produce milk that is designed to meet the baby's particular nutritional needs during the first few weeks of life. It is higher in protein and minerals, such as salt, and contains different types of fat that are easier to digest and absorb compared to fats in the milk of mothers of full term babies. The fat in human milk also helps to enhance the development of the baby's brain and neurologic tissues, which is especially important for premature infants.

Human milk is also easier for babies to digest than infant formula and avoids exposing the baby's immature intestinal lining to the cow's milk proteins found in premature infant formula. Preterm infants who are breastfed are less likely to develop intestinal infections than babies who are formula fed, and the colostrum produced in the first few days contains high concentrations of antibodies that will help the baby fight infection.

Breastfeeding preterm infants, especially if they are in the NICU, may present unique challenges for breastfeeding dyads. These mothers will benefit from extra breastfeeding support due to the delay of direct breastfeeding, reliance on breast pumps, and the stress of having a sick newborn. Even if the baby cannot breastfeed directly from the breast at first, the mother can be encouraged to express her milk to ensure that her supply is maintained. Supportive care for infants in the NICU may include the use of a feeding tube. Expressed human milk can be passed through the tube, therefore, it is important for the mother to discuss her feeding decisions with her baby's doctor. Preterm infants sometimes need additional calories and nutrients to facilitate adequate growth, and in such cases a human milk fortifier may be prescribed by a health care provider.

Preterm infants who are not breastfed may require the use of a formula higher in calories and nutrients to support their growth. According to the American Academy of Pediatrics (AAP), soy formulas are typically not recommended for low birth weight preterm infants, as their use may result in less weight gain and lower serum albumin and phosphorus levels than cow's milk-based formulas.

In addition to breastfeeding, skin-to-skin care or kangaroo care (holding your baby naked or in just a diaper on your bare chest), can help preterm infants breathe better, gain weight, keep their body at the right temperature, and prepare them for breastfeeding. All caregivers can provide skin-to-skin care, not just the mother.

Late Preterm Birth

Infants born at 34 0/7 through 36 6/7 weeks gestation, called late preterm infants, are sometimes mistaken for term infants since their size and weight may be similar. However, caregivers, health care providers, nutritionists, and lactation consultants must be aware that these babies are physiologically and metabolically immature. In addition to the health conditions previously mentioned for preterm infants, it is important to be aware that late preterm babies have an increased risk of morbidity and mortality which is often related to feeding problems. Due to their immaturity, late preterm infants may have more challenges with breastfeeding because they tire easily and have less stamina, which results in greater difficulty with latching, sucking, and swallowing. Mothers of late preterm infants will benefit greatly from timely lactation assessment and support since feeding difficulties, slow weight gain, failure to thrive, hypoglycemia, and jaundice are very common in these babies.

Growth Patterns

Preterm infants have different patterns of growth compared to term infants. Plotting the growth of preterm infants using their adjusted gestational age is an essential component of care until they reach 24 to 36 months of age. (See the *Clarification* section for more information on how to determine adjusted gestational age.) Most preterm infants, however, show catch-up growth in weight, length, and head circumference after their initial postnatal growth failure. If catch-up growth occurs, it usually starts early in the first months of life and is often achieved within the first years of life.
The effects of preterm birth can continue beyond infancy. Children who were born prematurely are at an increased risk for the following:

- Neurodevelopmental problems
- Intellectual/cognitive impairments, which can lead to learning disabilities and the need for special education services
- Motor problems
- Feeding difficulties such as problems with chewing and swallowing, late development of feeding skills, food refusal, eating behavior problems, and poor appetite
- Emotional problems such as anxiety and depression
- Behavioral concerns such as attention problems and hyperactivity

Procedure:

All preterm infants and children (up to 2 years of age) who have reached the equivalent age of 40 weeks gestation, shall be assessed for growth using the Centers for Disease Control and Prevention (CDC) Birth to 24 Months gender specific growth charts adjusting for gestational age as follows:

1. Document the infant/child's gestational age (at delivery) in weeks. (Mother/caregiver can self-report, or referral information from the medical provider may be used.)
2. Subtract the child's gestational age in weeks from 40 weeks (gestational age of term infant) to determine the adjustment for prematurity in weeks.
3. 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, 2011. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2011, clinic visit, his chronological postnatal age is 12 weeks. What is his gestation-adjusted age?

30 = gestational 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.
Note: Preterm infants (< 36 6/7 weeks gestation) who have not reached the equivalent age of 40 weeks gestation may be assessed for growth using a growth chart for low birth weight (LBW) or very low birth weight (VLBW) infants (e.g., Infant Health and Development Program [IHDP]) consistent with the protocols of the local medical community in which the WIC clinic operates. The CDC does not recommend the use of the CDC Growth Charts for preterm infants who have not reached the equivalent age of 40 weeks gestation.

Participant Focused Counseling:

- The goals of nutrition counseling are to assist and support the caregiver in establishing and maintaining feeding practices that support the optimal growth of the infant.
- The caregiver may need to be advised that timetables for feeding solid foods may not apply to a premature infant. She should be advised to consult with her infant's health care professional regarding when to offer solid food.
- Review collected information for appropriateness of feeding practices.

Recent Major Surgery, Physical Trauma, Burns

(3529) **Categories: ALL**

Defined as: major surgery (including cesarean sections), physical trauma or burns severe enough to compromise nutritional status. Any occurrence:

- Within the past two (≤ 2) months may be self-reported.
- 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.

A participant determined to have had a recent major surgery, physical trauma, or burns should be referred to the CPA for Nutrition Care counseling.

C-section is not usually designated as high risk

Justification:

The body's response to injuries increases nutrient requirements needed for recovery and can lead to malnutrition. These changes increase calorie and protein needs, as well as many vitamins, minerals, fatty acids, and amino acids.

Proper wound healing is critical in recovery. Even after a wound is closed, metabolic rate and need for additional nutrition can remain high.

Factors that can prevent proper wound healing or can increase the time needed for a wound to heal include: malnutrition prior to the event, infections, diabetes, poor blood flow, obesity, age, heavy alcohol use, stress, medications, and smoking.

Because healing is complex and affected by many factors, there is no set recovery time based only on the type and severity of injury. For some it could take a couple of weeks, for others it may take months.

Major Surgery and Wound Healing

Major surgeries are those that involve a risk to the life of the individual and include operations on organs within the body. Removal of a portion of the large or small intestine, heart surgery, and bariatric surgery are examples.

Cesarean sections are considered a major surgery, and therefore, require additional assessment and education in the WIC clinic. In the US, the rate of cesarean delivery rose from about 20% to about 30% for singleton births in 2011. Reasons for cesarean delivery include multiple pregnancy, failure of labor to progress, medical concerns for the infant, problems with the placenta, a large infant, breech position, maternal infections, and medical conditions in the mother (diabetes, high blood pressure).

Physical Trauma

Physical trauma can include fractures, wounds, hospitalization from blunt force trauma, penetrating trauma, and trauma from surgery. Physical trauma can also result from domestic or child abuse, with additional acute or ongoing psychological and emotional trauma that result in poor appetite, poor food choices, and using food for coping.

Burns

Burns can be caused by heat (including hot surfaces, fires, and hot liquids), chemicals, electricity, sunlight, or nuclear radiation. A first-degree burn only affects the outer layer of the skin (epidermis). A second-degree burn damages the epidermis, and the dermis (the layer beneath). Third-degree burns damage the epidermis, dermis, and the tissue under the skin.

Burns are also classified by the size of the area burned, known as Percent Total Body Surface Area or TBSA. The larger the area of the burn, the greater the risk for infection and fluid loss. Inhalation burns occur inside an individual's lungs and internal organs.

Implications for WIC Nutrition Services

Most surgeries, physical traumas, and burns are unexpected. The education and supplemental food that WIC provides can help ensure that the individual is in good nutritional health prior to the surgery, physical trauma, or burn. Following the event, the individual will be at increased nutritional risk until the injury has completely healed.

WIC staff can improve outcomes by:

- Reviewing nutritional intake to assure that vitamins and minerals meet the RDAs (unless the amounts that exceed the RDAs are recommended by their health care provider).
- Reviewing calorie and protein intake to be sure they preserve lean muscle mass and body weight.
- Recommending the participant to discuss a multivitamin supplement with the health care provider when diet cannot meet the RDAs for vitamins and minerals.
- Referring to community resources for smoking cessation, support groups, food assistance, and safe living environments (in cases of physical abuse).
- Referring to a lactation specialist if women experience difficulty breastfeeding following a cesarean section.

Recipient of Abuse

(9011) **Categories: All**

Defined as: an individual who has experienced physical, sexual, emotional, economic, or psychological maltreatment that may frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, and/or wound the individual.

The experience of abuse may be self-reported by the individual, an individual's family member, or reported by a social worker, healthcare provider, or other appropriate personnel. Types of abuse relevant to the WIC population include, but are not limited to, the following:

- **Domestic violence**: abuse committed by a current or former family or household member or intimate partner.
- **Intimate partner violence** (IPV): a form of domestic violence committed by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner) that may include physical violence, sexual violence, stalking, and/or psychological aggression (including coercive tactics).
- **Child abuse and/or neglect**: any act or failure to act that results in harm to a child or puts a child at risk of harm. Child abuse may be physical (including shaken baby syndrome), sexual, or emotional abuse or neglect of an infant or child under the age of 18 by a parent, caretaker, or other person in a custodial role (such as a religious leader, coach, or teacher).

An employee of a local department who, in the course of employment, receives a report of suspected child abuse or neglect communicated formally or informally to the employee, or who otherwise has reason to suspect that child abuse or neglect has occurred, shall immediately report the information to the Child Protective Services unit within the local department for prompt investigation.

Justification:
Abuse is a serious public health problem with numerous individual and societal consequences. Women and children who experience abuse often suffer from immediate and long-term physical and emotional health consequences. Although abuse is prevalent, it is underreported because recipients are financially dependent on the abuser, or fear future abuse, stigmatization, and shame. Screening and evaluation for abuse is inconsistent in the medical community.

Impact on Maternal Health

Data from the 2015 National Intimate Partner and Sexual Violence Survey (NISVS) say about 1 in 3 US women experienced contact sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime. The highest rates of IPV are generally experienced by women between the ages of 18 to 34 and nearly three quarters of all women recipients of IPV first experienced IPV before the age of 25. According to the NISVS, some ethnic minorities are disproportionately affected by IPV.

Lifetime prevalence of IPV among women of various ethnicities:

- Multi-Racial, Non-Hispanic – 57%
- American Indian/Alaska Natives, Non-Hispanic 48%
- Black, Non-Hispanic 45%
- White, Non-Hispanic 37%
- Hispanic 34%
- Asian or Pacific Islander 18%

Higher rates of IPV are experienced by immigrant women, women with disabilities, LGBTQ women, women veterans, and women with substance use disorders.

Intimate Partner Violence during the perinatal period is more common than other maternal health conditions like preeclampsia or placenta previa, but it receives considerably less attention. Most studies found that 3-9% of women experience abuse during pregnancy, rising to 12% after delivery. Studies focusing on low-income women suggest up to 50% experience abuse. Women using WIC services are more likely than other low-income women to experience abuse.

Women who experience abuse are at greater risk of:

- Chronic pain, like fibromyalgia, joint disorders, facial and back pain.
- Cardiovascular problems like hypertension.
- Gastrointestinal disorders, like stomach ulcers, appetite loss, abdominal pain, digestive problems.
- Neurological problems, like severe headaches, vision and hearing problems, memory loss, traumatic brain injury.
- Participating in risky health behaviors like smoking, alcohol, and substance use, putting them at greater risk for unintended pregnancies and sexually transmitted infections.
- Inadequate prenatal care, or not getting care until the third trimester.
- Being overweight or underweight, not gaining enough weight if 35 years or older, and gaining too much weight if 20-34 years old.
- Suffering mental health issues, including depressive symptoms and PTSD.

Despite the detrimental effects of IPV, it is often under-reported and not commonly evaluated during pregnancy. The US Department of Health and Human Services and the American College of Obstetrics and Gynecologists recommend that physicians screen all women for IPV during obstetric care, beginning at the first prenatal visit, at least once per trimester, and at the postpartum checkup.

Impact on Infant Health

IPV experienced by the mother can have severe impacts on neonatal health, putting the infant at higher risk of low birth weight (LBW), preterm birth (PTB), or being born small for gestational age (SGA). IPV has also been shown to contribute to increased likelihood of spontaneous abortion, fetal loss, and neonatal death. These complications may be caused by several mechanisms, including blunt physical trauma to the mother, negative maternal coping behaviors (e.g., smoking, drug use, or alcohol use), inadequate maternal nutrition, isolation, limited access to prenatal care, and elevated physical or psychological stress levels.

Ending the domestic violence can have a positive influence on infant weight gain.
Babies who are SGA are at an increased risk of early childhood developmental and behavioral problems and of developing coronary heart disease, stroke, non-insulin-dependent diabetes mellitus, adiposity, and metabolic syndrome in adulthood.

Shaken Baby Syndrome (SBS) or Abusive Head Trauma (AHT) is the leading cause of physical child abuse death in the United States. Babies from birth to 1 year, especially babies ages 2 to 4 months, are at greatest risk of injury from shaking because they cry more frequently and are easier to shake than older children. Factors that increase the likelihood of SBS are having unrealistic expectations about child development and child-rearing, having been abused or neglected as a child, being a victim or witness to domestic violence, and being a single parent.

Breastfeeding

Limited studies concluded that IPV exposure appears to associate negatively with breastfeeding outcomes, including decreased breastfeeding initiation, early cessation of exclusive breastfeeding, and shortened duration of exclusive breastfeeding. However, high-quality research remains limited. Because exposure to IPV is not a strong predictor of breastfeeding outcomes based on existing literature, WIC staff should provide breastfeeding support to help participants meet their individual breastfeeding goals.

Impact on Child Health

There are many forms of abuse and neglect. Per the CDC, the most common forms are:

- **Physical abuse** – the intentional use of physical force that can result in physical injury. Examples include hitting, kicking, shaking, burning, or other shows of force against a child.

- **Sexual abuse** – involves pressuring or forcing a child to engage in sexual acts. It includes behaviors such as fondling, penetration, and exposing a child to other sexual activities.
- **Emotional abuse** – refers to behaviors that harm a child's self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threatening.
- **Neglect** – the failure to meet a child's basic physical and emotional needs. These needs include housing, food, clothing, education, and access to medical care.

According to data from National Survey of Children's Exposure to Violence, approximately 1 in 7 U.S. children (0 – 17 years old) experienced child abuse and/or neglect in the reported year. Children with low socioeconomic status face abuse and neglect five times more often than higher status families.

According to the National Child Abuse and Neglect Data System, 75% of the 3.4 million child and abuse neglect referrals in 2011 were classified as neglect, with the majority of children being under 3 years old.

Neglect can affect children for their lifetime depending when, how often, and how severely it occurs. Abused children often have moderate to severe malnutrition because food is withheld, leading to compromised nutrition and failure to thrive (FTT). Even when not abused themselves, children who witness aggression or IPV can suffer symptoms of post-traumatic stress disorder, like bed-wetting or nightmares, allergies, asthma, gastrointestinal problems, headaches, and the flu. Abused children can have physical injuries like cuts, bruises, broken bones, and emotional and psychological problems.

Child abuse and neglect are considered adverse childhood experiences (ACEs). ACEs can have negative, lifelong effects on health, including disruption to healthy brain development, affecting social development, and compromising the immune system. Research shows that exposures to ACEs increases the risks of injury, sexually transmitted infections, including HIV, mental health problems, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases such as cancer, type 2 diabetes, heart disease, and suicide. Child abuse and neglect are just a portion of potential ACEs that can occur in childhood.

Procedure, Woman:

Homicide is the leading cause of pregnancy-associated death in Maryland. The majority were intimate partner homicides.

- Discreetly place intimate partner violence posters and shoe cards in WIC ladies' rooms, not waiting rooms where they can be viewed by abusing partners.
- Ask all WIC participants the WOW question concerning fear for personal or child safety.
- Assure confidentiality.
- Ask in a private place when partner is present.
- If the answer is positive, educate on the dangers of partner violence, and offer discreet help.
- If in imminent danger, offer to make the phone call to connect the participant to the local domestic violence service provider before

she leaves the WIC clinic, or connect with the Maryland Network Against Domestic Violence: https://mnadv.org/ which provides comprehensive domestic violence services in each county.
- If the participant is not ready to act, offer discreet information for follow up, such as getting a shoe card from the ladies room, or calling the National Domestic Violence Hotline: 1-800-799-SAFE (7233).

Procedure, Infant or Child:

Maryland law requires that:

- An individual who has reason to believe that a child has been abused or neglected shall immediately notify a local law enforcement agency or a local department.
- An employee of a local department who, in the course of employment, receives a report of suspected child abuse or neglect communicated formally or informally to the employee or who otherwise has reason to suspect that child abuse or neglect has occurred, shall immediately report the information to the Child Protective Services unit within the local department for prompt investigation.

Implications for WIC Services

WIC staff can provide the following nutrition services to participants who experience abuse:

- Provide a safe and supportive environment for participants who may be experiencing or have experienced abuse.
- Encourage pregnant women to attend all prenatal appointments with their health care provider and explain the importance of early and adequate prenatal care.
- Offer tailored breastfeeding support catered to the participant's specific needs and concerns.
- Encourage parents to attend local parenting classes or parent training programs.
- Refer the participant to their family case manager, if available, and/or to services and resources in their community that provide support to victims of abuse.
- Refer participants to national resources such as:
    - National Domestic Violence Hotline: 1-800-799-SAFE (7233). This hotline is staffed with trained counselors 24 hours a day and provides callers with crisis counselors, safety planning and assistance in finding resources, such as shelter. A secure, confidential online chat option is also available.
    - Directory of Crime Victim Services. This website provides a directory of programs and organizations that can help victims of crime.

- Rape, Abuse and Incest National Network (RAINN): 1-800-656-HOPE (4673). This national hotline provides counseling and assistance to victims of sexual violence and their families and friends from trained counselors who are available 24 hours a day.
- National Clearinghouse for the Defense of Battered Women (NCDBW): 1-800-903- 0111 ext. 3. This national organization provides technical assistance to abused women facing charges related to their abuse.
- Childhelp National Child Abuse Hotline: 1-800-4-A-CHILD (1-800-422-4453). This hotline offers information to parents seeking help for child abuse, individuals who suspect child abuse is occurring and those needing prevention tips. Professional counselors are available to provide support and referrals to emergency and social services. Their website also lists Child Protective Services in each state.

Participant Focused Counseling:

- Assess the level of danger to the participant/child with open-ended questions.
- Educate about the risks of intimate partner violence.
- Offer to provide information or make the necessary contact with a domestic violence support network.

Short Interpregnancy Interval

(3321) **Categories: PG, BE/BP, WPP**

Defined as: An interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy.

Note: this risk is specific to live births and does not include miscarriage or stillbirth in the calculation.

Justification

Adverse maternal and infant health outcomes have been associated with short interpregnancy intervals. An interval of 18-24 months has been associated with the lowest risk.

Outcomes associated with short IPI have included perinatal and neonatal complications such as preterm birth, low birth weight, small for gestational age, birth defects, and autism.

Findings from a small pilot study found coordination of primary health care and social support services reduced adverse pregnancy outcomes and the average number of pregnancies conceived within 18 months among low income women who previously delivered a very low birth weight baby.

A 2007 US survey found that, among childbearing age women, those aged 18-24 years were least aware of the need for folic acid prior to pregnancy and least likely to report daily use of supplements containing folic acid. Only 17% of women age 18-24 years were likely to hear about folic acid from their health care provider.

Referral for family planning services may be appropriate.

Procedure:

Apply as follows:

- **Pregnant woman**: current pregnancy
- **Breastfeeding or postpartum woman**: most recent pregnancy
  - Determine if the woman has been pregnant and had a live birth before.
  - Determine the time interval between the 2 pregnancies:
  - Obtain the date when her most recent baby was born. For a pregnant woman, the date will be for the birth preceding this current pregnancy. For a breastfeeding or postpartum woman, the date will be for the birth that preceded her most recent pregnancy.

- Obtain the date of the last menstrual period prior to this current pregnancy for a pregnant woman. Obtain the date of the last menstrual period for the most recent pregnancy for a breastfeeding or postpartum woman.
- Estimate the date of conception as occurring on the 14th day following the first day of the last menstrual period.
- Subtract the date of the last live birth from the date of conception. The difference is the time interval between the 2 pregnancies.

Participant Focused Counseling:

Through open ended questions and discussion, determine the participant's concerns and interest in:

- Health care referrals for family planning, early prenatal care, and folic acid supplementation.
  WIC can help to reduce the risk of adverse pregnancy outcomes by:
  - Encouraging postpartum women and their partners to meet with their health care provider to discuss developing a reproductive plan and birth spacing as appropriate.
  - Encouraging folic acid supplementation.
  - Encouraging healthful eating by following the Dietary Guidelines for Americans.
- Education:
  - Given that half of all pregnancies nationwide are unintended, the above areas have the potential to improve health outcomes for women, infants, and children,
  - Discuss the topics of interest or concern to the participant using the WIC Guide to a Healthy New Mom, including her interest in easy ways to use her WIC foods.

Short Stature/At Risk of Short Stature

(1211) **Categories: IBE, IBP, IFF, C 1- 4**

Defined as:

- Length/age ≤ 5th percentile, CDC/ WHO growth chart Birth to ≤ 24 months, or
- Stature/Age ≤ 10th percentile, CDC growth chart 2 to 5 years of age.

Explanation:

- CDC uses the cut off value of ≤ 2.3 percentile length for age to define **short stature** in an infant or child from Birth to < 24 months and ≤ 5th percentile for a child 2 to 5 years.
- CDC uses ≤ 5th percentile to define **at risk of short stature** in an infant or child from Birth to < 24 months, and > 5th percentile to ≤ 10th percentile for a child 2 to 5 years.

Justification:

Short stature may be an indicator of chronic undernutrition related to the lack of total calories and to a poor quality of diet that is low in nutrients such as protein, zinc, vitamin A, and calcium. Short stature may also result from disease conditions such as endocrine disturbances or from congenital conditions such as Fetal Alcohol Syndrome. Participation in WIC is associated with improved growth in height (as well as weight).

Procedure:

- Obtain current length or height measured to the nearest 1/8 inch. Record measurement in the participant's record.
- Determine the exact age of the infant or child. When plotting on the 2 to 5 years CDC growth chart, round the child's age to the nearest whole month.
- For an infant or child < 24 months of age who was born at 37 weeks or earlier, adjust the age before plotting, following the procedure in **Table GAA**.
- Plot Length for Age on the CDC/WHO 0 to < 24 months growth chart. If the plotted point lies at or below the 5th percentile, assign the risk criterion.
- Plot Stature for Age on the CDC 2 to 5 years growth chart. If the plotted point lies at or below the 10th percentile, assign the risk criterion.
- Review collected information for possible causes of short stature. Inquire about the parent's height.

Participant Focused Counseling:

- Review collected information to identify feeding or dietary practices that may prevent adequate and appropriate food choices for the infant/child.
- Discuss the steps the participant is willing to take to ensure the child's nutritional status.
- Review strategies for making the improvements.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.

Slowed/Faltering Growth Pattern

(1135) **Categories: IBE, IBP, IFF**

Defined as:

- Infants Birth to 2 weeks: Excessive weight loss after birth, ≥ 7% birth weight loss
- Infants 2 weeks to 6 months of Age: Any weight loss, using 2 separate measurements taken at least 8 weeks apart

An infant determined to have slowed/faltering growth pattern should have Nutrition Care counseling, and, if breastfeeding, be referred to the IBCLC/DBE.

Justification:

Growth faltering is a growth rate below what is appropriate for an infant's age and sex. It can affect length, weight, and head circumference, resulting in values lower than expected. Growth faltering may include **weight faltering** (a drop in weight-for-age) or **slowed growth** where both weight and length growth are slower than expected, for example, a drop in weight after a minor illness. (Note: what appears to be growth faltering could be due to a measurement or plotting error.)

Normal Growth Patterns

Understanding normal infant growth is important, because infants gain weight differently depending on how they are fed.

Breastfed infants gain weight rapidly during the first three or four months of life, then the rate of growth slows.

Formula fed infants, by comparison, grow more slowly for the first three or four months, then weight gain escalates.

The normal decrease in the breastfed infant's rate of growth is sometimes misunderstood as inadequate milk supply, leading to early introduction of solid foods or inappropriate and unnecessary formula feeding.

Normal infant growth is:

- steady and predictable and demonstrates health and nutritional status. The overwhelming majority of infants have no growth problems.
- pulsating, happening in spurts, with periods of slow or no measurable growth.
- adjustable to genetic potential, with catch-up and catch-down periods
- seasonal, with length velocities faster during spring and summer, and stagnant over other months

Excessive Weight Loss after Birth

Almost all normal infants lose weight after birth, but the amount of weight loss varies. It is usual for breastfed infants to lose up to 7% of birth weight, while formula fed infants lose about 5% of birth weight. Healthy infants typically regain their birth weight within 8-10

days after birth. However, if a breastfed infant loses 7% of birth weight in the first 72 hours after birth, the mother-infant dyad should be evaluated, and any problems resolved immediately. At this time, early screening and lactation support can reduce the newborn's risk of dehydration and failure to thrive

Weight loss of up to 10% of birth weight is the maximum acceptable loss for newborn infants. Any additional loss is a potential emergency. Contributing factors include:

- Hospital practices like epidurals, pacifier use, low or non-nutritive feedings, or strict feeding schedules.
- Maternal factors such as retained placenta, number of children, anxiety, and poor maternal knowledge.
- Infant factors such as birth weight, gestational age, gender, and feeding method
- For breastfed infants, poor positioning, latch and/or milk transfer

Any Weight Loss 2 Weeks to 6 Months

Although infants begin to grow more slowly from 3 to 18 months of age, they should not lose weight after 2 weeks of age. Any such weight loss requires follow up.

Growth faltering can be caused by

- Inadequate calorie intake, malabsorption, or increased metabolic needs
- Dehydration, feeding problems, malnutrition, or growth failure
- Milk protein allergy or gastrointestinal reflux
- Lead poisoning, HIV, Celiac disease, cystic fibrosis, congenital heart disease, or inborn errors of metabolism
- Neglect

Procedure:

If growth faltering is suspected, consider the following:

- Rule out
    - maternal neglect, maternal depression, or emotional deprivation
    - inadequate calorie intake due to inappropriate formula mixing, breastfeeding problems, or early introduction of solid foods,
- Monitor growth monthly and use two separate weight measurements at least 8 weeks apart as data markers.

Screening for Slow or Faltering Growth Pattern

Changes in growth can be the first sign of a pathological condition regardless of its cause.

Recognition of poor growth in early life can identify infants who may be at risk for growth faltering. Early intervention can prevent growth retardation, which may be irreversible when it occurs early in life. Intervention can also prevent long-term consequences such

as short stature, poor learning ability, low adult wages, and when paired with later weight gain, increased risk for nutrition-related chronic diseases.

Screening for slow or faltering growth is a preventive health measure which requires careful growth monitoring and critical thinking skills. Although one measure of weight-for-age may cause concern, it does not show growth faltering. Screening should use multiple growth indicators, including risk for underweight, short stature, failure to thrive, and low head circumference (when available). These may be warning signs of the need for early intervention.

In many situations, poor growth will likely be caused by a combination of factors, which require a combination of intervention strategies for successful health outcomes. Environmental health factors to consider include:

- Adequate nutrition and nutrient dense foods including a history of human milk or formula feeding
- Appropriate introduction of complementary foods
- Maternal conditions that can affect lactation: mastitis, prolonged labor, C-section, hypo- or hyperthyroidism, diabetes, low birth weight, prepregnancy BMI > 27, pregnancy-induced hypertension, flat/inverted nipples, vitamin B12 deficiency
- Mealtime routine and eating/feeding behavior
- Growth faltering in light of familial growth patterns
- Neglect
- Lack of social support
- Adverse social and psychological environment
- Depressed or poor mental abilities of parent/caregiver
- Lack of parental education and nutrition knowledge

Participant Focused Counseling:

- Provide early postpartum breastfeeding support to minimize dehydration and/or failure to thrive
- Refer to IBCLC/DBE for latch and other assistance
- Use “tell me how you know your baby is hungry/full” to explore knowledge and practice. Review baby behavior hunger and satiety cues and division of responsibility as needed.
- Explore feeding schedule (including both breastfeeding and formula feeding) and discuss adjustments if necessary.
- Review formula mixing technique, if applicable, using, “Tell me how you mix the formula.” Review correct mixing technique, if necessary, and follow with teach back to assure improved understanding and knowledge.
- Discuss mom’s food package to be sure it meets her needs. Adjust if needed. Discuss ways mom might improve her own calorie intake.
- Review accuracy of weight, length, and head circumference (if available) measurements.
- Refer to allied health professionals such as physician, early childhood intervention, social services, and home visiting programs as appropriate

Small for Gestational Age (SGA)

(1511) **Categories: IBE, IBP, IFF, C-1**

Defined as: Diagnosis by a physician as self-reported by applicant/participant/caregiver or someone working under physician's orders.

An infant who is Small for Gestational Age should have Nutrition Care counseling.

An infant who is Small for Gestational Age and Low Birth Weight should have follow-up Nutrition Care in 3-6 months.

Justification:

Fetal growth restriction can lead to an infant who is born small for gestational age (SGA) at birth.

SGA infants often have congenital abnormalities, a slower physical growth and, possibly, slower mental development. These effects may persist into childhood. SGA infants are at a higher risk of mortality.

Procedure:

- Determine if the infant has been diagnosed as small for gestational age.
- Review collected information for appropriateness of feeding practices.

Participant Focused Counseling: The goal of nutrition counseling is to support the caregiver in establishing and maintaining feeding practices that promote the growth and development of the infant. Where appropriate, encourage follow up with or refer to health care professionals, those infants and children who do not attain a normal growth pattern.

Transfer

(5021, 5023, 5024, 5025) **Categories: All**

Defined as: Person with a current and valid Verification of Certification (VOC) document from another WIC State or local agency.

Justification:

According to federal regulations, once a WIC participant has been determined to be eligible for program benefits by a local agency, the service delivery area into which the participant moves is obligated to honor the terms of participation. The VOC is valid through the end of the current certification, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or if the certification period extends beyond the receiving agency's certification period for that category and shall be accepted as proof of eligibility for Program benefits.

Transferring participants should receive the food package offered in the receiving State agency according to their category and nutritional needs. The receiving agency should explain any differences in the authorized supplemental foods. Participants who are eligible to receive WIC formula (infant formula, exempt infant formula, or WIC-eligible nutritionals) in Food Package III must have one or more qualifying conditions, as determined by a health care professional licensed to write medical prescriptions under State law in the area from which they are moving.

Procedure:

Obtain and review the VOC. The VOC is valid through the end of the current certification period, even if the participant does not meet the receiving agency's nutritional risk, priority or income criteria, or the certification period extends beyond the receiving agency's certification period for that category, and shall be accepted as proof of eligibility for Program benefits. This criterion should be used **only** when the VOC document does not reflect a specific nutrition risk condition at the time of transfer **or** if the participant was initially certified based on a nutrition risk condition not in use by the Maryland WIC Program. The VOC is valid until the certification period expires and shall be considered as proof of eligibility for program benefits. If the local agency receiving the VOC has a waiting list for participants, the transferring participant shall be placed on the list ahead of all other waiting applicants.

Underweight (Woman)

(1011) **Categories: PG, BE/BP, WPP**

Defined as:

- **Pregnant woman:** prepregnancy Body Mass Index (BMI) <18.5*
- **Postpartum or breastfeeding woman (< 6 months postpartum):** prepregnancy or current BMI < 18.5*
- **Breastfeeding woman (6 months or more postpartum)**: Current Body Mass Index (BMI) < 18.5*.
  *Based on 2009 IOM Guidelines, the BMI weight categories used for adult women will be used for pregnant adolescent women as well.

A woman who is underweight and has low maternal weight gain should have Nutrition Care counseling. Best Practice: follow up in 3 months.

Justification:

Underweight women who become pregnant are at a higher risk for delivery of a low birth weight baby, fetal growth restriction, and perinatal mortality. Pre-pregnancy underweight is also associated with complications such as Cesarean delivery.

Being underweight may indicate poor nutritional status, inadequate food consumption, environmental stress, lifestyle habits, and/or an underlying medical condition.

Procedure:

Pregnant Woman:

- Use **Table W** for the procedure. Measure height to the nearest 1/8 inch. If the height fraction is between 1/8 and 3/8 of an inch, round down to the nearest whole number. If it is between 5/8 and 7/8 of an inch, round up to the nearest whole number.
- Obtain pre-pregnancy weight (self-report or from health care professional). Using the woman's current height and pre-pregnancy weight, determine her weight status according to **Table W**. Record height and weight measurements in the woman's record.

Breastfeeding or Postpartum Woman:

- For a postpartum or breastfeeding woman (less than 6 months postpartum) use current height and pre-pregnancy weight or current weight measured to the nearest 4 ounces to determine weight status according to **Table W**.
- For a breastfeeding woman 6 months or more postpartum, use current height and weight measured to the nearest 4 ounces to determine weight status according to **Table W**. Record height and weight measurements in the woman's record.
- Weight during the early postpartum period, when most WIC certifications occur, is very unstable. During the first 4-6 weeks, fluid

shifts and tissue changes cause fluctuations in weight. After 6 weeks, weight loss varies among women. Prepregnancy weight, amount of weight gain during pregnancy, race, age, parity and lactation all influence the rate of postpartum weight loss. By 6 months postpartum, body weight is more stable and should be close to the prepregnancy weight. In most cases, therefore, prepregnancy weight is a better indicator of weight status than postpartum weight in the first 6 months after delivery.

- The **one exception** is the woman with a BMI of <18.5 during the immediate 6 months after delivery. Underweight, at this stage, may indicate inadequate weight gain during pregnancy, depression, an eating disorder, or disease, all of which need to be addressed.

Participant Focused Counseling:

- Review collected information to identify lifestyle or dietary practices that may prevent adequate and appropriate food intake.
- Discuss the steps the participant is willing to take to ensure her nutritional status.
- Review strategies for making the change.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.

Underweight/At Risk of Underweight (Child)

(1031) **Categories: IBE/IBP, IFF, C 1- 4**

Defined as:

- Weight for Length ≤ 5th percentile, CDC/WHO growth chart Birth to ≤ 24 months, **or**
- BMI/Age ≤ 10th percentile, CDC growth chart 2 to 5 years of age.

Specifically:
Underweight: CDC, WHO, and WIC use a cut-off value of

- ≤ 2.3 percentile weight for length in an infant Birth to ≤ 24 months, **or**
- ≤ 5th percentile BMI/Age for a child age 2 to 5 years.

At risk of underweight: WIC uses the cutoff value of

- > 2.3 and ≤ 5th percentile Wt/lgth for an infant/child, Birth to ≤ 24 months **and**
- > 5 and ≤10th percentile BMI/age for a child age 2 to 5 years**.**

An infant or child, Birth to 24 months with a Weight for length at or below the 2.3 percentile should have Nutrition Care counseling, with a Nutrition Care follow-up in 3 months.

A child 2 to 5 years of age with a BMI/age below the 5th percentile, should have Nutrition Care counseling, with a Nutrition Care follow-up in 3-6 months.

Justification:

While progress along the lower percentiles may represent normal growth for some children, it may also be an indicator of inadequate calorie and nutrient intake.

Procedure:

- Obtain current length or height measured to the nearest 1/8 inch. Obtain current weight measured to the nearest 1 ounce for infants and children < 24 months of age and to the nearest 4 ounces for children ≥ 24 months of age. Record measurements in the participant's record.

- For an infant or child less than 24 months of age whose length is measured in recumbent position, plot weight for length on the gender-specific CDC/WHO growth chart Birth to ≤ 24 months. For a child 2 years of age and older whose height is measured standing up, compute BMI using the procedure in **Table BMI.1**. Plot the BMI value on the CDC BMI/age growth chart for 2-5 year-olds.
- For an infant or child < 24 months of age who was born at 37 weeks or earlier, adjust the age before plotting, following the procedure in **Table GAA**.
- If the plotted percentile is less than or equal to the 5th percentile, assign the risk criterion.
- Review collected information for possible causes of underweight, such as not offering 3 meals and 2 snacks per day or restricting food intake.

Participant Focused Counseling:

- Review collected information to identify feeding or dietary practices that may prevent adequate and appropriate food choices for the infant/child.
- Discuss the steps the participant is willing to take to ensure the child's nutritional status.
- Review strategies for making the improvements.
- If willing, help her set a simple, measurable goal.
- Enter the goal in WOW.

Tables and Lists

Table A Low Hemoglobin/Hematocrit Cut-off Values for Women

	Hemoglobin or hematocrit value is less than or equal to:							
	Cigarettes per day							
	Non Smoker		1 to 19		20 to 39		40+	
Category	**Hgb**	**Hct**	**Hgb**	**Hct**	**Hgb**	**Hct**	**Hgb**	**Hct**
Pregnant through 13 weeks	10.9	32.9	11.2	33.9	11.4	34.4	11.6	34.9
Pregnant 14 through 26 weeks	10.4	31.9	10.7	32.9	10.9	33.4	11.1	33.9
Pregnant 27 through 40 weeks	10.9	32.9	11.2	33.9	11.4	34.4	11.6	34.9
Breastfeeding or Postpartum 12 to < 15 years	11.7	35.6	12.0	36.6	12.2	37.1	12.4	37.6
Breastfeeding or Postpartum 15 to < 18 years	11.9	35.8	12.2	36.8	12.4	37.3	12.6	37.8
Breastfeeding or Postpartum 18 + years	11.9	35.6	12.2	36.6	12.4	37.1	12.6	37.6

Table W Weight Status of Pregnant, Breastfeeding and Postpartum Women

Procedure: Measure and record the woman's height. If the height fraction is between 1/8 and 3/8 of an inch, round down to the nearest whole number. If it is between 5/8 and 7/8 of an inch, round up to the nearest whole number.

To evaluate Underweight:

- If the woman is **pregnant or less than 6 months postpartum**, use either:
  - her pre-pregnancy weight (self-report or from health care professional) or
  - a current weight measured to the nearest 4 ounces.
- If she is a **breastfeeding woman 6 months or more postpartum**, use her current weight measured to the nearest 4 ounces.
- Record weight measurements in the WIC record.

To evaluate Overweight:

- If the woman is **pregnant or less than 6 months postpartum**, use her pre-pregnancy weight (self-report or from health care professional).
- If she is a **breastfeeding woman 6 months or more postpartum**, use her current weight measured to the nearest 4 ounces.
- Record weight measurements in the WIC record.

On **Table W**, which follows:

- Locate height in the left column on the following chart.
- Read across the weight columns until you find where her weight falls.
- Her weight status is indicated at the top of the column.
- She has a risk criterion if she is underweight, overweight, or obese.

Table W Weight Status of Pregnant, Breastfeeding, and Postpartum Women

Height is:		Underweight (BMI < 18.5)	Normal Weight (BMI 18.5-24.9)			Overweight (BMI 25.0-29.9)			Obese (BMI ≥ 30.0)
Ft. &in.	In.	Weight (in pounds) is:							
4' 8"	56"	≤ 82 1/4	82 1/2	-	111 1/4	111 1/2	-	133 1/2	≥ 133 3/4
4' 8 1/2"	56-1/2"	≤ 83 3/4	84	-	113 1/4	113 1/2	-	135 3/4	≥ 136
4' 9"	57"	≤ 85 1/4	85 1/2	-	115 1/4	115 1/2	-	138 1/4	≥ 138 1/2
4' 9 1/2 "	57-1/2"	≤ 86 3/4	87	-	117 1/4	117 1/2	-	140 3/4	≥ 141
4'10"	58"	≤ 88 1/4	88 1/2	-	119 1/4	119 1/2	-	143 1/4	≥ 143 1/2
4' 10 1/2"	58-1/2"	≤ 89 3/4	90	-	121 1/4	121 1/2	-	145 3/4	≥ 146
4'11"	59"	≤ 91 1/4	91 1/2	-	123 1/2	123 3/4	-	148 1/4	≥ 148 1/2
4' 11 1/2"	59-1/2"	≤ 92 3/4	93	-	125 1/2	125 3/4	-	150 3/4	≥ 151
5' 0"	60"	≤ 94 1/4	94 1/2	-	127 3/4	128	-	153 1/4	≥ 153 1/2
5' 1/2"	60-1/2"	≤ 96	96 1/4	-	129 3/4	130	-	155 3/4	≥ 156
5' 1"	61"	≤ 97 1/2	97 3/4	-	132	132 1/4	-	158 1/2	≥ 158 3/4
5' 1-1/2"	61-1/2"	≤ 99 1/4	99 1/2	-	134	134 1/4	-	161	≥ 161 1/4
5' 2"	62"	≤ 100 3/4	101	-	136 1/4	136 1/2	-	163 1/4	≥ 163 3/4
5' 2-1/2"	62-1/2"	≤ 102 1/2	102 3/4	-	138 1/2	138 3/4	-	166 1/4	≥ 166 1/2
5' 3"	63"	≤ 104	104 1/4	-	140 3/4	141	-	169	≥ 169 1/4
5' 3-1/2"	63-1/2"	≤ 105 3/4	106	-	143	143 1/4	-	171 3/4	≥ 172
5' 4"	64"	≤ 107 1/4	107 1/2	-	145 1/4	145 1/2	-	174 1/4	≥ 174 1/2

Table W	Weight Status of Pregnant, Breastfeeding and Postpartum Women, continued									
Height is:		Underweight (BMI < 18.5)	Normal Weight (BMI 18.5-24.9)			Overweight (BMI 25.0-29.9)			Obese (BMI ≥ 30.0)
Ft. & in.	In.	Weight (in pounds) is:							
5' 4-1/2"	64-1/2"	≤ 109	109 1/4	-	147 1/2	147 3/4	-	177	≥ 177 1/4
5' 5"	65"	≤ 110 3/4	111	-	149 3/4	150	-	179 3/4	≥ 180
5' 5-1/2"	65-1/2"	≤ 112 1/2	112 3/4	-	152	152 1/4	-	182 3/4	≥ 183
5' 6"	66"	≤ 114 1/4	114 1/2	-	154 1/2	154 3/4	-	185 1/2	≥ 185 3/4
5' 6-1/2"	66-1/2"	≤ 116	116 1/4	-	156 3/4	157	-	188 1/4	≥ 188 1/2
5' 7"	67"	≤ 117 3/4	118	-	159 1/4	159 1/2	-	191	≥ 191 1/4
5' 7-1/2"	67-1/2"	≤ 119 1/2	119 3/4	-	161 1/2	161 3/4	-	194	≥ 194 1/4
5' 8"	68"	≤ 121 1/4	121 1/2	-	164	164 1/4	-	196 3/4	≥ 197
5' 8-1/2"	68-1/2"	≤ 123	123 1/4	-	166 1/2	166 3/4	-	199 3/4	≥ 200
5' 9"	69"	≤ 124 3/4	125	-	168 3/4	169	-	202 3/4	≥ 203
5' 9-1/2"	69-1/2"	≤ 126 3/4	127	-	171 1/4	171 1/2	-	205 3/4	≥ 206
5' 10"	70"	≤ 128 1/2	128 3/4	-	173 3/4	174	-	208 1/2	≥ 208 3/4
5" 10-1/2"	70-1/2"	≤ 130 1/4	130 1/2	-	176 1/4	176 1/2	-	211 1/2	≥ 211 3/4
5' 11"	71"	≤ 132 1/4	132 1/2	-	178 3/4	179	-	214 3/4	≥ 215
5' 11-1/2"	71-1/2"	≤ 134	134 1/4	-	181 1/4	181 1/2	-	217 3/4	≥ 218
6' 0"	72"	≤ 136	136 1/4	-	183 3/4	184	-	220 3/4	≥ 221
6' -1/2"	72-1/2"	≤ 137 3/4	138	-	186 1/2	186 3/4	-	223 3/4	≥ 224
6' 1"	73"	≤ 139 3/4	140	-	189	189 1/4	-	227	≥ 227 1/4
6' 1-1/2"	73-1/2"	≤ 141 3/4	142	-	191 1/2	191 3/4	-	230	≥ 230 1/4

Table I-P Low Maternal Weight Gain

Procedure:

- Determine pre-pregnancy weight status by using **Table W**.
- Subtract the pre-pregnancy weight from the current weight to determine the pounds gained.
- Determine the last completed week of gestation.
- Locate the week of gestation in the left column of the table below.
- Move across the columns to the woman's pre-pregnancy weight status.
- If she has gained equal to or less than the number of pounds in the box, she has the risk criterion, Low Maternal Weight Gain.

Note: Do not evaluate this risk criterion for a woman pregnant with twins, triplets, or more.

Table I-P Low Maternal Weight Gain

Completed Week of Gestation	Underweight pounds:	Normal Weight pounds:	Overweight/ Obese pounds:	Completed Week of Gestation	Underweight pounds:	Normal Weight pounds:	Overweight/ Obese pounds:
1	N/A	N/A	N/A	21	11 1/2	9 1/2	5 1/2
2	1/4	1/4	N/A	22	12 1/2	10 1/2	6
3	1/2	1/2	1/4	23	13 1/4	11 1/4	6 1/2
4	1	3/4	1/2	24	14	12	7
5	1 3/4	1 1/4	1/2	25	14 3/4	12 3/4	7 1/2
6	2	1 1/2	3/4	26	15 3/4	13 1/2	8
7	2 1/2	1 3/4	3/4	27	16 3/4	15	8 3/4
8	2 3/4	2	1	28	17 1/2	15 1/4	9
9	3 1/4	2 1/4	1	29	18 1/2	15 3/4	9 1/2
10	3 1/2	2 1/2	1 1/4	30	19 1/4	16 3/4	10
11	4	2 3/4	1 1/2	31	20	17 1/2	10 1/2
12	4 1/2	3	1 1/2	32	21	18 1/2	11
13	4 3/4	3 1/4	1 3/4	33	21 3/4	19	11 1/2
14	5 1/2	4 1/4	2 1/4	34	22 3/4	19 3/4	11 3/4
15	6 1/2	4 3/4	2 3/4	35	23 1/2	20 3/4	12 1/4
16	7 1/2	5 1/2	3 1/4	36	24 1/2	21 1/2	12 3/4
17	8	6 1/2	3 1/2	37	25	22 1/4	13 1/4
18	8 3/4	7 1/4	4	38	26 1/4	23	13 3/4
19	9 3/4	8	4 1/2	39	26 3/4	24	14 1/4
20	10 3/4	8 3/4	5	40	27 3/4	24 3/4	14 3/4

Table BMI.1: Calculation of Body Mass Index

Body Mass Index (or BMI) is a comparison of a person's weight against height using a simple equation:

BMI = Weight / Height / Height · 703

Weight is measured to the nearest quarter pound (4 ounces) and height to the nearest 1/8 inch. These fractions must be converted to decimals for use in the BMI equation. The table below shows how to convert the fractions to decimals. If you use an electronic scale that displays weight in tenths of a pound, use the displayed weight value, such as 31.1 pounds, etc.

Fraction:			Decimal:
1/8		=	.125
1/4	(2/8)	=	.25
3/8		=	.375
1/2	(4/8)	=	.5
5/8		=	.625
3/4	(6/8)	=	.75
7/8		=	.875

Example:	Measured weight is 31 1/4 pounds. Use 31.25 pounds in the equation.
Example:	Measured height is 37 4/8 inches. Use 37.5 in the equation.

Interpretation of BMI/age

The BMI value you obtain must be plotted on a CDC gender specific growth chart: BMI/age for Children 2 to 5 years old. Compare the plotted point on the growth chart to the cutoff values below to determine if a child 2 years of age or older has a risk criterion.

Underweight/At risk of underweight	≤ 10th percentile, BMI/Age
At Risk of Overweight	Infant or child whose biological parent has a self-reported BMI ≥ 30
Overweight	≥ 85th to less than the 95th percentile
Obese	≥ 95th percentile

Table BMI.2:

Abbreviated Body Mass Index (BMI) Table (Self-reported by mother or father) *

Height	eight in inches	Weight (lbs) equal to 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
5' 12"	72	221
6' 1"	73	227
6' 2"	74	233
6' 3"	75	240
This table may be used to determine parental (male or female) obesity (BMI > 30)		

Table GAA: Calculation of Gestation-Adjusted Age for Infants Born at 37 Weeks or Earlier

All infants and children less than 2 years of age, born at 37 weeks gestation or earlier require gestational age adjustment prior to plotting a growth chart. ([1])

Procedure:

- Obtain the infant or child's gestational age in weeks. The caregiver can self-report this information or it can be provided by the infant's health care professional.
- Subtract the gestational age in weeks from 40 weeks to determine the adjustment for prematurity.
- Subtract the adjustment for prematurity from the infant or child's chronological age in weeks to determine the gestation-adjusted age.
- Use the gestation-adjusted age to plot weight for age and length for age on the CDC/WHO growth chart Birth to > 24 months.

Note: The infant must reach 40 weeks gestation-adjusted age in order to plot the CDC growth chart 2 to 5 years. Do not plot measurements on the growth chart if the infant has not yet reached 40 weeks gestation-adjusted age.

[1]FNS Policy Memorandum 98-09, Revision 7, Guidelines for Growth Charts and Gestational Age Adjustment for Low Birth Weight and Very Low Birth Weight Infants.

Frequently Asked Questions

Q. A pregnant woman tells me that she used to smoke cigarettes but has now stopped. Can I assign the risk criterion *Maternal Smoking*?
A. No. The woman must still smoke at the time of her certification.

Q. Should I tell a breastfeeding woman who is now pregnant to stop breastfeeding her baby?
A. No. Refer a pregnant woman who is breastfeeding another child during her pregnancy to the breastfeeding specialist in your local agency. Advise her to inform her health care professional that she is still breastfeeding if she has not already done so.

Q. How do I know if my community water supply contains fluoride in order to determine adequacy of fluoride intake?
A. Your local agency should contact the local water utility to find out if the water supplied to the community contains fluoride.

Q. A caregiver told me that she gave her 8 month old baby some potato chips as finger foods but was told to stop, so she no longer gives them to the baby. Can I assign the risk criterion, *Nutrition Practice - Infant*?
A. No. The feeding practice must be current.

Q. Several of the risk criteria specify "routinely." Does this mean every day?
A. Not necessarily. "Routine" is defined as a feeding, dietary, or lifestyle practice that currently occurs on more than one occasion. For example, if a pregnant woman tells you she has a beer "once in a while," she is still drinking alcohol while pregnant. This is not every day, but it is routine. The practice can harm her unborn baby. Assign the risk criterion *Alcohol or Illegal Drug Use* and counsel her to stop drinking while she is pregnant.

Q. What if I am not sure that I can use a risk criterion for a participant?
A. Do not guess. If you are a CPPA, talk to a CPA about the risk criterion before you use it. If you are a CPA, talk with one of the State WIC nutritionists. If you are unsure that a risk criterion exists, **do not assign** the risk criterion.

Q. When I certify a postpartum woman and she tells me that she delivered at 42 weeks gestation, should I add extra pounds to table H?
A. No. The maximum number of pounds she should gain during pregnancy is based upon 40 weeks gestation only.

Q. Can I use verbal information that is not found on the Nutrition History to assign a risk criterion?
A. If the information provides documentation of a risk criterion that we use in the Maryland WIC Program, you may use it to assign the risk. However, you must write a note that documents the risk criterion and its source in the participant's WOW record.

Q. Should I assign the risk criterion, *Nutrition Practice – Child*, for a child born prematurely, but still on the bottle after 14 months of age?
A. Depending upon the child's degree of prematurity, the health care professional may recommend that the caregiver postpone weaning to a cup, so that weaning may not be achieved by 14 months of age. Do not apply the risk criterion in this case. If you are a CPPA, you may wish to discuss interpretations of this risk criterion with a CPA.

Q. If a mother has been told by her health care professional to concentrate the calories in the formula by adding less water than the label specifies, can I assign *Nutrition Practice - Infant*?
A. No. If the health care professional advised the mother to follow special directions when making formula, do not assign the risk criterion.

Q. If a pregnant woman's estimated date of delivery (EDD) is different from the EDD calculated from her last menstrual period date, how do I determine date of conception?
A. If the EDD has been determined by a sonogram, use the EDD stated by the woman.

Q. If a pregnant woman does not know how many weeks pregnant she was when she went for her first prenatal care visit, how can I evaluate Late to Prenatal Care?
A. If the woman knows the date that she went, you can calculate the number of weeks of gestation at the time of the visit by using a gestation wheel. You will need the date of her last menstrual period and the date she went for prenatal care.

Q. How can I apply the risk criterion *Fetal Death ≥ 20 weeks* or *Neonatal Loss* to a breastfeeding woman? Her baby is living.
A. True. This risk criterion only applies to a breastfeeding woman who was pregnant with multiple fetuses (twins or more) and lost one of the infants due to miscarriage or death at birth or during the first 28 days of life. She is breastfeeding the infant who survived.

Q. Can I use a gestation wheel that is different from the one the State WIC Office provides?
A. Not for certifying WIC participants. There are differences in gestation wheels. To consistently apply risk criteria to WIC participants in the State of Maryland, you must use the wheel provided by the State.

Q. When I use Table H, do I need to know the woman's pre-pregnancy weight to determine if she gained more weight than the cut-off value?
A. Yes. In order to evaluate high weight gain in a breastfeeding or postpartum woman, you must know her pre-pregnancy weight status.

Q. Why can't I evaluate either *Low Maternal Weight Gain* or *High Maternal Weight Gain* for a woman pregnant with twins or who recently delivered twins?
A. Because there are no scientifically derived cutoff values to accurately assess the weight gain of a woman who is pregnant with twins, triplets, or more, USDA has chosen to not allow *Low Maternal Weight Gain* or *High Maternal Weight Gain* to be assigned to these women. However, USDA does encourage WIC staff to discuss weight gain recommendations with women who are pregnant with twins or triplets. Refer to the risk criterion *Multi-fetal Gestation* for information about the recommended weight gain for women pregnant with twins or triplets.

Q. Is Low Birth Weight the same thing as Small for Gestational Age (SGA)?
A. No. Low birth weight is usually associated with Prematurity. The infant was likely growing at a normal rate as a fetus but was born early or preterm. A Small for Gestational Age infant is one born full term, but the infant's birth weight is below what would be expected at 40 weeks. The infant's growth as a fetus did not progress in a normal manner. There may be different feeding issues for a low birth weight versus a Small for Gestational Age infant.

Risks Chart: Nutrition Risk Criteria.

Best Practice for high-risk participants: Initial Contact with CPA while in clinic. If not possible, all high-risk participants must have initial contact with CPA within 30 days. Best Practice for Higher Risk participants is designated 0-5 days or 0-10 days.

KEY: NC=Nutrition Care (high risk) **BF**=Refer to DBE **M**=Manually assign risk **X**=Lower risk **Best**= Best Practice

RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
Alcohol and Substance Use	PG = Any amount; BE/BP/WPP: ≥ 2 drinks/day All = drugs, any amount. **Best**: CPA standard initial contact, then follow up 3-6 months.	NC	NC BF	NC BF	NC					
BF Complications/potential – Woman/Infant	Review 2.31A for high/low risk details **Best**: Initial contact 0-5 days	NC or BF	NC or BF	NC or BF		NC or BF	NC or BF			
BF Infant of Woman at Nutritional Risk						NC	NC			
BF Mother of Infant at Nutritional Risk	Review 2.31A for high/low risk details	BF NC	BF NC	BF NC						
Complementary Feeding Process	Assign only if no other risk found. Documented complete nutrition assessment required. Applies 4 to 23 months					X	X	X	X	
Depression	**Best**: CPA standard initial contact, then follow up 3-6 months	NC	NC	NC	NC					
Drug Nutrient Interaction	**Best:** consider contacting participant's Specialist RD before counseling & assigning food package	NC	NC	NC	NC	NC	NC	NC	NC	NC

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RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
Eating Disorders	**Best:** CPA standard initial contact then, follow up 3-6 months. Consider contacting participant's Specialist RD.	NC	NC	NC	NC					
Elevated Blood Lead (Provide Screening Tool for any NO or Don't Know answer)	Women & Infants ≥5 mcg/dl Children ≥3.5 mcg/dl **Best:** CPA initial contact 0-5 days CPA follow up in one month	NC	NC	NC	NC	NC	NC	NC	NC	NC
Failure to Thrive	**Best**: CPA initial contact 0-5 days, CPA follow up 1-3 months					NC BF	NC BF	NC	NC	NC
Fetal Alcohol Spectrum Disorder	**Best:** CPA initial contact 0-5 days, then **Best**: CPA follow up 3-6 months					NC	NC	NC	NC	NC
Fetal Growth Restriction		NC								
Food Allergies	Consider contacting participant's Specialist RD for participant with multiple complex food allergies before assigning food package.	NC	NC	NC	NC	NC	NC	NC	NC	NC
Foster Care	Entered into/transferred in last 6 months					M	M	M	M	M
Gestational Diabetes	**Best**: CPA initial contact 0-5 days. CPA follow up 3 months.	NC								
High Maternal Weight Gain		X	X	X	X					

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RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
High Weight for Length	≥ 97.9 percentile on Birth to 24 months growth chart. For <37 wks gestation, correct age using Table GAA before plotting growth chart.					X	X	X	X	
History of Birth of a Large for Gestational Age Infant ≥ 9 pounds	PG = any pregnancy BE/BP/WPP = Any prior pregnancy	X	X	X	X					
History of Birth w/ Nutrition Related Congenital/ Birth Defect	Neural Tube Defect; Cleft Palate. PG = any pregnancy. BE/BP/WPP = Any prior pregnancy	NC	NC	NC	NC					
History of Gestational Diabetes	PG = any pregnancy. **Best**: CPA initial contact 0-10 days. CPA follow up 3 months BE/BP/WPP = most recent pregnancy	NC	NC	NC	NC					
History of Preeclampsia	PG = any pregnancy BE/BP/WPP = Any prior pregnancy	X	X	X	X					
History of Preterm or Early Term Delivery	PG = any pregnancy BE/BP/WPP = Most recent pregnancy	X	X	X	X					
History of Spontaneous Abortion PG: 2 or more @ <20 wks; Fetal Death (≥ 20 wks)		X	X	X	X					

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RISK	CUT OFF VALUE/EXPLANATION	PG	BE	BP	WPP	IBE	IBP	IFF	C1	C2-4
HIV\AIDS	Best: If ppt is breastfeeding, alert DBE in case other complications arise, but does not require BF high risk counseling	NC	NC	NC	NC	NC	NC	NC	NC	NC
Hepatitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
Homelessness		X	X	X	X	X	X	X	X	X
Hyperemesis Gravidarum	**Best:** CPA standard initial contact then follow up 1-3 months	NC								
Hypertension / Prehypertension (Woman)	Prehypertension = BP 130/80 – 139/89 mm Hg Hypertension = Systolic ≥ 140, Diastolic ≥ 90mmHg **Best:** CPA standard initial contact then follow up 3-6 months	NC	NC	NC	NC					
Hypertension / Prehypertension Child Age 3+	Hypertension: > 95th % for age, gender, height on ≥3 occasions Prehypertension = BP 90-95%									NC
Late to Prenatal Care	Prenatal care beginning after completed week 13 of gestation	X								
Large for Gestational Age	Birth weight ≥ 9 pounds					X	X	X		
Limited Ability of Caregiver to Make Feeding Decisions	Mother/caregiver ≤ 17 years, physical/mental disability, drug use	M	M	M	M	M	M	M	M	M
Listeriosis		NC	NC	NC	NC	NC	NC	NC	NC	NC

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RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
Low Birth Weight/ Very Low Birth Weight	LBW: Infant born ≤ 5 pounds, 8 ounces. <2500 g **Best:** CPA initial contact then follow up 3-6 months VLBW: Infant born <3 pounds, 5 ounces. <1500 g **Best:** Initial CPA contact 0- 5 days. CPA follow up 1-3 months.					NC BF	NC BF	NC	NC	NC
Low Head Circumference	HC ≤ 2.3% on Birth to 24 months growth chart					X	X	X	X	
Low Hemoglobin/Hematocrit: Infant/child ≥ 9 months	Hgb ≤ 10.9/Hct ≤32.8.					X	X	X	X	X
Low Hemoglobin/Hematocrit: Woman	Normal risk level values vary based on several factors. To determine use Table A in Attachment 2.31A	X	X	X	X					
Low Hemoglobin/Hematocrit: Woman/child ≥ 9 months	Hgb < 10/Hct < 30 **Best:** Initial CPA contact 0- 5 days CPA follow up 1-3 months	NC	NC	NC	NC	NC	NC	NC	NC	NC
Low Hgb/Hematocrit: Woman/child >9 months	≤ 9 g/dl **Best:** CPA initial contact 0-5 days. CPA follow up 3-6 months	NC	NC	NC	NC	NC	NC	NC	NC	NC

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RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
Low Hgb/Hematocrit: Woman/child >9 months	≤ 8 g/dl Repeat test to confirm. **Refer to HCP immediately, and follow local health department policy.**	NC	NC	NC	NC	NC	NC	NC	NC	NC
Low Maternal Weight Gain	Use Table IP in Attachment 2.31.A (A women with underweight **and** low maternal weight gain = NC) *	X* *NC								
Maternal Weight Loss	Wt loss below pre-pregnancy wt through week 13; loss of ≥ 2 lbs, weeks 14-40	X								
May Not Meet Dietary Guidelines	Only if no other risks. Document complete nutritional assessment.	X	X	X	X					X
Medical Condition, Nutrition Related:										
● Asthma, moderate or severe persistent	With short stature or obesity	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Asthma, moderate or severe persistent	Diagnosed, requires daily use of inhaled anti-inflammatory agent or oral corticosteroid	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Bronchiolitis						x	x	x	x	x
● Cancer		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Cardiorespiratory Diseases		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Cardiovascular Disease		NC	NC	NC	NC					

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RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
● Celiac Disease		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Cerebral Palsy		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Cleft Lip or Palate						NC	NC	NC	NC	NC
● Cleft Lip or Palate	After 18 months of age and appropriate repairs					X	X	X	X	X
● Congenital Hyperthyroidism						NC	NC	NC		
● Congenital Hypothyroidism						NC	NC	NC		
● Crohn's Disease		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Cystic Fibrosis	Contact participant's specialist RD	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Developmental, Sensory, or Motor Disability	Consider contacting participant's specialist RD	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Diabetes Mellitus	Hyperglycemia resulting from defects in insulin secretion, insulin action, or both	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Down Syndrome		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Epilepsy		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Gall Bladder Disease	Gallstones, bile duct obstruction	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Gastrointestinal Anomalies		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Gastroesophageal Reflux Disease	(GERD)	NC	NC	NC	NC	NC	NC	NC	NC	NC

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RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
● Heart Disease		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Hepatitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Hyperthyroidism		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Hypothyroidism		NC	NC BF	NC BF	NC	NC	NC	NC	NC	NC
● Inborn Errors of Metabolism	Contact Metabolic Dietitian BEFORE assigning food package: Children's National Medical Center, Washington, D.C.: 1-202-476-6287 Johns Hopkins: 410-955-3071 University of Maryland Hospital: 410-328-3335	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Juvenile Ideopathic Arthritis		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Lactose Intolerance		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Lupus Erythematosus		NC	NC	NC	NC					
● Multiple Sclerosis		NC	NC	NC	NC					
● Muscular Dystrophy		NC	NC	NC	NC	NC	NC	NC	NC	NC

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RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
● Neural Tube Defects (spina bifida)		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Pancreatitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Parasitic Infections		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Parkinson's Disease		NC	NC	NC	NC					
● Peptic Ulcer		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Pneumonia		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Polycystic Ovary Syndrome (PCOS)		NC	NC	NC	NC					
● Post Bariatric Surgery	Contact participant's specialist RD	NC	NC	NC	NC					
● Postpartum Thyroiditis			NC	NC	NC					
● Pre-Diabetes	Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT): hyperglycemia that does not meet diagnostic criteria for Diabetes	NC	NC	NC	NC					
● Renal Disease	Contact participant's Specialist RD	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Short Bowel Syndrome		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Sickle Cell Anemia (not trait)	Invasive hemoglobin test may be waived	NC	NC	NC	NC	NC	NC	NC	NC	NC
● Thalassemia Major	Invasive hemoglobin test may be waived	NC	NC	NC	NC	NC	NC	NC	NC	NC

KEY: **NC**=Nutrition Care (high risk) **BF**=Refer to DBE **M**=Manually assign risk **X**=Lower risk **Best**= Best Practice										
RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
● Tuberculosis		NC	NC	NC	NC	NC	NC	NC	NC	NC
● Ulcerative Colitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
Meningitis		NC	NC	NC	NC	NC	NC	NC	NC	NC
Mental Illnesses: Anxiety Disorders, PTSD, OCD, Personality Disorder, Bipolar Disorder, Schizophrenia, ADHD	**Best:** CPA standard initial contact then follow up 3-6 months	NC	NC	NC	NC					NC
Migrant Farm Worker Status		X	X	X	X	X	X	X	X	X
Mother in WIC while Pregnant or Eligible with Priority 1 Risk	< 6 months of age only					X	X	X		
Multi-Fetal Gestation	Pregnant with twins, triplets, or more. **Best:** CPA standard initial contact then follow up 3 months.	NC	NC	NC	NC					
Neonatal Abstinence Syndrome						NC BF	NC BF	NC		
Nicotine and Tobacco Use	Includes any tobacco smoking, Electronic Nicotine Delivery Systems, patch. Second-hand smoke for infants & children	X	X	X	X	X	X	X	X	X
Nutrient Deficiency or Disease	Consider contacting participant's Specialist RD	NC	NC	NC	NC	NC	NC	NC	NC	NC

KEY: **NC**=Nutrition Care (high risk) **BF**=Refer to DBE **M**=Manually assign risk **X**=Lower risk **Best**= Best Practice										
RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
Nutrition Practices, Child	See risk in Attachment 2.31A: some require manual entry								X	X
Nutrition Practices, Infant	See risk in Attachment 2.31A: some require manual entry					X	X	X		
Nutrition Practices, Woman	See risk in Attachment 2.31A: some require manual entry	X	X	X	X					
Obese	BMI/Age ≥ 95th % CDC growth chart Age 2 to 5									X
Oral Health Conditions		X	X	X	X	X	X	X	X	X
Overweight	Use Table W in Attachment 2.31A PG: Prepregnancy BMI ≥ 25.0 Postpartum/BF < 6 months: Prepreg BMI ≥ 25.0 Postpartum/BF ≥ 6 months: Current BMI ≥ 25.0	X	X	X	X					
Overweight/Risk of Overweight	Overweight: BMI/Age ≥ 85 to < 95% CDD 2 to 5 yrs Risk Overweight: Infant/Child whose biological parent is obese					X	X	X	X	X
Pica	Give lead and pica brochures.	NC	NC	NC	NC	NC	NC	NC	NC	NC

KEY: **NC**=Nutrition Care (high risk) **BF**=Refer to DBE **M**=Manually assign risk **X**=Lower risk **Best**= Best Practice										
RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
Possibility of Regression									X	X
Pregnancy at a Young Age	Age ≤ 20 at date of conception	X	X	X	X					
Pregnant Woman Currently Breastfeeding	Refer to BF specialist	M/ BF NC								
Preterm or Early Term Delivery	**Preterm**: Delivery of an infant born ≤36 6/7 weeks gestation. **Early Term**: Delivery of an infant born ≥37 0/7 and ≤38 6/7 weeks gestation.					NC BF	NC BF	NC	NC	NC
Recent Major Surgery, Physical Trauma, Burns	C-section is not usually designated as high risk	NC	NC	NC	NC	NC	NC	NC	NC	NC
Recipient of Abuse	**Suspected child abuse**/neglect must be reported immediately. Follow Local Agency, local health department guidance.	X	X	X	X	X	X	X	X	X
Short Interpregnancy Interval	Interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy.	X	X	X	X					
Short Stature/Risk of Short Stature	Length/Age ≤ 5 %, WHO chart, Birth to 2 years Stature/Age ≤ 10th %, CDC chart, 2 to 5 years					X	X	X	X	X

KEY: NC=Nutrition Care (high risk) **BF**=Refer to DBE **M**=Manually assign risk **X**=Lower risk **Best**= Best Practice										
RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
	Use Table GAA in Attachment 2.31A if also premature									
Slowed/Faltering Growth	Birth to 2 weeks: Loss of ≥ 7% of birth weight.2 weeks to 6 months of age: Any weight loss.					NC BF	NC BF	NC		
Small for Gestational Age (SGA)	Must be diagnosed. Small for gestational age plus low birth weight **Best:** CPA standard initial contact then follow up 3-6 months.					NC	NC	NC	NC	
Transfer		X	X	X	X	X	X	X	X	X
Underweight (Woman)	Pregnant: prepregnancy BMI < 18.5 Postpartum/BF woman (< 6 months postpartum): prepregnancy or current BMI < 18.5 Breastfeeding woman (≥ 6 months postpartum) Current BMI < 18.5	X	X	X	X					
Underweight (Woman) with Low Maternal Weight Gain	As above, with low maternal weight gain. **Best:** CPA standard initial contact then follow up in 3 months	NC	NC	NC	NC					

KEY: NC=Nutrition Care (high risk) **BF**=Refer to DBE **M**=Manually assign risk **X**=Lower risk **Best**= Best Practice										
RISK	**CUT OFF VALUE/EXPLANATION**	**PG**	**BE**	**BP**	**WPP**	**IBE**	**IBP**	**IFF**	**C1**	**C2-4**
Underweight/Risk of Underweight (Infant/Child)	Underweight: ≤ 2.3 % Birth to 24 months. **Best:** CPA standard initial contact then follow up in 3 months. <u>≤ 5 % BMI/Age 2 to 5 years = NC*. CPA initial contact, then CPA follow up 3-6 months</u> Risk of Underweight: > 2.3 to ≤ 5 % birth to 24 mo. > 5 to ≤ 10 % 2 to 5 years	—	—	—	—	NC BF — X	NC BF — X	NC — X	NC — X	NC — X

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.32
Effective Date: December 18, 1991
Revised Date: June 27, 2024

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Weight and Height Measurement Requirement

A. Policy

Measurements for weight and height/length are used to assess growth, determine nutritional risk, prescribe the most accurate food package, and provide nutrition education. It is therefore critical that these measurements be current and accurate.

Local agencies shall only use equipment that is in accordance with Policy and Procedure 7.62 *Equipment for Performing Weight and Height Measurements.*

Local agencies shall obtain weight and height/length measurements for each applicant at the time of certification/recertification. Best practice is that height and weight measurements are also obtained at a *mid-certification* however, mid-certification measurements may be pended to a future appointment if it is a hardship to the participant.

Referral measurements from a health care provider are allowed within the following parameters:

- Measurements may not be older than 60 days prior to the appointment;
- Measurements for weight and height/length were taken on the same date;
- Measurements must be within the participant's category (i.e., a pregnant applicant's weight must be taken during the pregnancy);
- For the initial infant certification, referral measurements are only allowed when the infant is not present in accordance with *P&P 2.16 Physical Presence Requirement.*

B. Procedure

The local agency shall:

1. Measure the weight and length of the infant at the initial certification appointment. If an infant is not present at the time of certification, in accordance with Policy and Procedure 2.16 *Physical Presence Requirement*, measurements may be obtained from the health care

provider.

2. Measure the weight and height/length of the child or woman applicant at certification or recertification or obtain measurements taken by the applicant's health care provider within 60 days prior to the certification date.

3. Measure the weight and height/length of the infant, child or woman at mid-certification or obtain measurements from the health care provider. If the participant is not present, measurements may be pended to a future appointment.

4. Follow the procedures described in Attachment 2.32A to collect weight and height/length measurements.

5. Enter the weight and height/length measurements and the **date that they were taken** in the Medical Screen of the management information system.

6. Document any special notations, if needed, related to the measurements entered such as Uncooperative Child, Other Medical Provider, Disability/Cast, VOC, etc., in the Comment field of the Medical Screen of the management information system.

7. Interpret weight and height/length data using growth charts, prenatal weight grids, and any identified risk factors.

8. Consider relevant assessment information before deciding upon the intervention. Refer to Policy and Procedure 2.31A *Nutritional Risk Criteria, Guidelines for Interpretation.*

Attachments: 2.32A Procedures to collect weight and height/length measurements

References:
1. 7 CFR 246.7 (e)(1)
2. COMAR 10.54.01.08
3. WIC Nutrition Services Standards, Standards 6 and 7
4. Value Enhanced Nutrition Assessment (VENA) Updated Guidance 2020
5. PL 111-296 The Healthy Hunger-Free Kids Act of 2010

Revisions:

October 2011	Updated the tools referred to in B.1.g Changed 4 ounces to 1 ounce in measuring weight of a woman or older child in attachment 2.32A
May 2012	Revised B.1.c to allow local agencies to accept data for anthropometric measurements taken by the applicant's health care provider within 60 (instead of 30) days prior to the certification date

October 2012	Added “and mid-certification” to 1.b. and 1.c. Added Reference #6. Deleted references to WOW. Corrected name of Attachment 2.31A and deleted reference to an outdated video. Clarified language in and changed references to CDC Birth to 36-month growth charts to WHO Birth to 24 months growth charts in 2.32A.
October 2013	added language B.1.c.ii about documenting measurements received from another medical source. Had previously been on Policy 2.02
October 2014	Attachment 2.32A Clarified where to order manual cert materials, added language on converting 16th’s and rounding decimals
Nov 2021	Allow for infant measurements to be provided by the healthcare provider if the infant is exempted from physical presence. Added ruler image to 2.32A to help with conversion to 16th’s and rounding.
June 2024	Updated 2.32A to allow for children under 2 that can stand alone to be weighed on an electronic standing scale

Procedures to Collect Weight and Height or Length Measurements

Weight of an Infant or Child Under 2 Years of Age:

A recumbent/seated pediatric beam balance scale or electronic scale shall be used for infants/children unable to stand on their own. A standing beam balance or electronic scale can be used if the child can stand on their own.[1]

1. Cover the scale tray with table paper.
2. Zero-balance the beam balance scale. For an electronic scale, set the scale to zero.
3. The infant must wear a dry diaper only. The child should wear light indoor clothing, no shoes, and have a dry diaper.
4. Place the child in the center of the tray. The infant should be on her back. The child can sit.
5. Check that the child or caregiver is not touching the scale and that the caregiver is not holding onto the child.
6. If using a beam balance scale, move the weights until the indicator is centered.
7. Read the weight value to the nearest one (1) ounce.
8. Remove the infant or child from the scale.
9. If using a beam balance scale, return all weights to zero.
10. Record the weight in pounds and ounces in the Medical screen.

Weight of a Woman or Child 2 Years of Age and Older:

A*n adult beam balance scale or electronic scale shall be used.*[1]

1. The applicant should wear light indoor clothing. Shoes should be removed.
2. Zero-balance the beam balance scale. Set the electronic scale to zero.
3. Ask the applicant to stand in the middle of the platform. Arms should rest at the sides of the body.
4. Check that the applicant is not holding onto the scale.
5. If using a beam balance scale, move the weights until the indicator is centered.
6. Read the weight value to the nearest ounce.
7. Ask the applicant to step off the scale.
8. If using a beam balance scale, return all weights to zero.
9. Record the weight in pounds and ounces in the Medical screen.

1 Refer to P & P 7.62, Equipment for Performing Weight and Height Measurements.

Length of an Infant or Child Under 2 Years of Age:

A length board shall be used.[1]

1. Place a sheet of table paper on the length board.
2. The infant or child may be in light indoor clothing with no shoes or socks.
3. Place the child on his back on the board. The top of his head must touch the headpiece.
4. Ask the caregiver to help by holding the child's head firmly against the headpiece. The caregiver can cup her hands over the child's ears.
5. Check that the child's head and body lie in a straight line and that his eyes look up. There should be space between the chin and the chest.
6. Place one hand over both legs, just above the knees and firmly push both legs down, straightening them against the board.
7. Check that the child's head is still firmly against the headpiece.
8. Slide the foot piece firmly against both heels. Both feet should be flat against the foot piece and toes should point up.
9. Read the length value to the nearest 1/8 inch.
10. Slide the foot piece back. Remove the child from the length board.
11. Record the length in inches and eighths of an inch in the Medical screen.

Height of a Woman or Child 2 Years of Age and Older:

A stadiometer shall be used.[1]

1. Remove shoes, excess clothing* and hair ornaments. Undo braids or ponytails.
2. Ask the applicant to stand with feet slightly apart and to position heels, buttocks, and shoulder blades against the wall or stadiometer.
3. Check that the applicant's knees are straight, head is erect, and eyes look straight ahead. Arms should rest at the sides of the body.
4. Gently lower the headpiece until it rests on the top of the head. Check that the applicant's head is not tilted up or down.
5. Hold the headpiece firmly. Ask the applicant to step away from the wall.
6. Read the height value to the nearest 1/8 inch.
7. Record the height in inches and eighths of an inch in the Medical screen.

***** Very thick socks or very long pants could affect the height measurement of a young child.

If the Child Does Not Cooperate with the Measurement

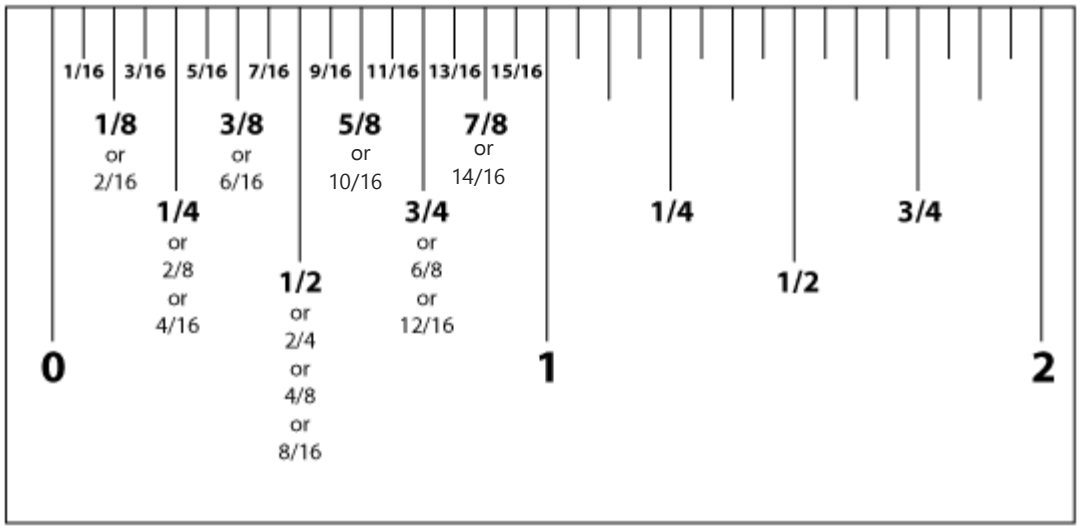
If an infant or child will not cooperate with the measurement, the accuracy of the weight and height measurements may be affected. Enter "Uncooperative" in the Comments field in the Anthropometric Data grid in the Medical screen.

1 Refer to P & P 7.62, Equipment for Performing Weight and Height Measurements.

If You Need to Round or Convert the Measurement

Heights and lengths need to be converted to 8th's. Use the image below for help with conversion.

If the 16th of an inch measurement doesn't line up with an 8th of an inch, then round to the nearest 8th of an inch using the standard rules for rounding; if less than ½ inch round down; if more than ½ inch round up. For example, 25 9/16 inch would round up to 25 5/8 inch.



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Weights that are obtained from digital scales that measure pounds and or ounces in decimals will be entered into the management information system as follows:

1. Pounds measured in decimals will be entered into the pound column of the Anthropometric Data grid in the Medical screen. No ounces are entered in the ounce column. Tab off the pound column and the management information system (MIS) will convert the pounds entered as a decimal into pounds and ounces and display the values in the appropriate columns. For example, if the digital weight is 14.6 pounds, enter 14.6 in the pound column and press Tab; the MIS will convert the measurement to 14 pounds and 10 ounces.

2. Ounces measured in decimals must be rounded before the value is entered in the management evaluation system. Less than .5 round down, .5 and above round up.

Tools for training staff on how to collect weight, height and length data and to interpret the results are available from the Training Center:

☐ Training module, Weight and Height Measurements

The following tools must be used to assess weight and height (or length) risk factors when performing manual certifications. These tools can be ordered by calling the Training Center.

☐ Precise Plot

☐ Gestation Wheel

☐ WHO growth charts, Birth to 24 Months, Boys and Girls

☐ CDC growth charts, 2 to 5 Years, Boys and Girls

Policy and Procedure Number: 2.33
Effective Date: December 18, 1991
Revised Date: November 19, 2025

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Hemoglobin Test Requirement**

A. Policy

A single test to screen for iron deficiency/iron deficiency anemia shall be performed and/or documented at the time of certification for applicants with no other nutritional risk factor present. For applicants with at least one qualifying risk factor, such tests may be delayed to within 90 days of the date of certification. The test may be performed by the local agency or obtained from the applicant's health care provider, as long as there is no cost to the applicant.

The results of the test shall be used to determine nutritional risk, prescribe the most appropriate food package, and provide nutrition education. An applicant with a hemoglobin value < 10.0 g/dL shall be referred for Nutrition Care Counseling (Policy & Procedure 5.03 *Participants at High Nutritional Risk*). An applicant with a hemoglobin value ≤ 8.0 g/dL shall be immediately referred to their Health Care Provider.

All clinics performing standard hemoglobin testing are to follow the State and OSHA regulations for precautions against transmission of bloodborne pathogens and other communicable diseases. OSHA bloodborne pathogen training is mandatory for employees initially and on an annual basis.

B. Procedure

1. The local agency staff shall:

a. Obtain a hemoglobin or hematocrit test result from applicants and participants according to the schedule below:

Pregnant Woman	• Once, as soon as possible within the current pregnancy.

Breastfeeding Woman	• Once, following the termination of pregnancy, ideally performed 4 to 6 weeks postpartum. • At the mid-certification visit, if the previous postpartum test meets the cut-off value for “Low Hemoglobin/Hematocrit.”
Postpartum Woman	• Once, following the termination of pregnancy, ideally performed 4 to 6 weeks postpartum.
Infant	• Once, between the ages of 9 and 12 months.
Child	• Once, between the ages of 12 and 24 months, ideally at 15 to 18 months of age, or 6 months after the infant’s blood test. • Annually, between the ages of 24 and 60 months at the time of certification. • At a 6 month interval, if the previous test result meets the cut-off value for “Low Hemoglobin/Hematocrit.”

If a hemoglobin test for an infant is delayed until 12 months of age, that test shall count as the infant test. Another test shall be scheduled at least 6 months later but before 24 months of age, ideally at 18 months of age, and shall count as the child test.

b. Ensure when performing the test, that equipment is properly used and maintained and that federal and state regulations regarding laboratory testing are followed. Refer to Policy and Procedure 7.64 *Laboratory Requirements for Performing Blood Tests* for additional information.

c. Confirm test results ≤ 8.0 g/dL with a second test for quality assurance of the test value. Staff shall document confirmation of the test value in the management information system. Applicants/participants with confirmed results of ≤ 8.0 g/dL shall be immediately referred to their Health Care Provider.

Local agencies may, at their discretion, mandate a second test for quality assurance for values < 10.0 g/dL. Applicants/participants with hemoglobin values <10.0 g/dL shall be referred for Nutrition Care Counseling.

d. Document the test result and the date that the test was taken in the Medical Screen of the applicant/participant’s record. If a second

hemoglobin test was conducted for quality assurance, record the higher of the two values and indicate in the comment column “value confirmed”.

Documentation from a non-WIC medical source shall be entered as a comment on the participant’s medical screen in the management information system with the date that the test was performed entered in the date field.

e. Accept referral bloodwork data as long as the referral data:
   i. Is reflective of a woman applicant’s category; and
   ii. Conforms to the anemia screening schedule for infants and children in B.1.a.

If the referral data is not reflective of the woman applicant’s category or does not meet the screening schedule, then a test would need to be performed within 90 days of their certification date.

2. For infants ≥9 months of age and any other applicant category; a single standard hemoglobin test may be performed in the local agency following the procedures described in Attachment 2.33A. A second test may be performed in order to provide follow-up or when deemed necessary to provide quality assurance of the test value.

3. For children ≥ 22 pounds or any woman applicant, a single non-invasive hemoglobin test may be performed in the local agency following the procedures described in Attachment 2.33B. A second non-invasive test, or a standard test, may be performed in order to provide follow-up or when deemed necessary to provide quality assurance of the test value.

   If non-invasive hemoglobin testing is attempted but is unsuccessful, the local agency may do a standard hemoglobin test or pend the test for up to 90 days.

4. Hemoglobin testing may be delayed if an applicant has had or will have a test performed by their health care provider that meets the criteria in B.1.e. The local agency must have a procedure to ensure that the test result is obtained within 90 days of the date of certification. Such a procedure may include monthly issuance of food benefits. The local agency must make every effort to obtain the test result.

   Should the participant fail to provide the test result, despite efforts by the local agency to obtain it, the participant is <u>not</u> to be terminated from the Program. The local agency must document in the participant’s record, the attempts made to obtain the result and why these attempts failed. Local agency bloodwork collection procedures shall be monitored during management evaluations.

5. The standard hemoglobin test requirement may be waived by the local agency if:

   a. The applicant's religious beliefs won't allow them to have blood drawn. A statement of the applicant's refusal must be included in their record.

   b. An applicant has a medical condition (such as hemophilia or osteogenesis imperfecta "fragile bones") in which the procedure for obtaining the blood sample could cause harm, or sickle cell anemia or thalassemia, in which the participant will always have low hemoglobin that cannot be addressed by diet. Documentation from the applicant's health care provider is required and must be included in the participant's record.

   Applicants who meet the criteria in 5a or b shall be encouraged to complete non-invasive hemoglobin testing when qualified. If non-invasive testing may not be completed, WIC staff should attempt to obtain hemoglobin data from the applicant's health care provider.

Attachments: 2.33A Standard Hemoglobin Testing Procedure

2.33 B Non-invasive Hemoglobin Testing Procedure

References:

1. 7 CFR 256.7(e)(1)(B) Hematological test for anemia
2. 7CFR246.14 (c)(2)(i) allowable costs
3. FNS Policy Memorandum 92-10, Bloodwork Protocols
4. FNS Policy Memorandum 2001-2 (SFP 01-041) WIC Bloodwork Requirements
5. SFP 09-046 WIC Hematological Data Requirements: Clarification
6. SFP 11-010 Allowable Medical Equipment – New Testing Device
7. WIC Nutrition Services Standards, Standard 6

Revisions:

10/2008	Renamed document from 2.07 to 2.33 and created attachment A
10/2011	Updated reference in B.1.e
10/2012	Added reference to mid-certification in A. Policy and B. Procedure
10/2013	Added clarifying language to B.1.d
10/2015	Updated acceptable medical conditions which result in waiving blood test requirement
11/2019	Added mandatory referral for level ≤8.0; included non-invasive hemoglobin test procedures; added Attachment B
10/2020	Removed our criteria that a child be ≥ 2 years of age for non-invasive testing and updated attachment B accordingly.
11/2021	Corrections to 2.33B added not to use on PG>36 weeks gestation or postpartum <4 weeks.
11/2025	Removed "Check the date on the bottle to be sure it has not expired." From Attachment 2.33A

Standard Hemoglobin Testing Procedure

Staff performing the hemoglobin test shall follow standard precautions to avoid accidental contamination from viruses such as the Human Immunodeficiency Virus (HIV) or Hepatitis B. Newly hired staff shall attend a blood borne pathogens training[1] prior to handling blood. Existing staff shall attend a blood borne pathogens refresher training on an annual basis.

Procedure for performing the hemoglobin screen using the HemoCue Hemoglobin Analyzer

1. Ask the applicant to sit in a chair. If a child, ask the caregiver to hold the child in her lap. Explain why and how the hemoglobin screen is done using correct terminology.

2. Assemble the hemoglobin test supplies on a clean paper towel placed on the work surface:
   - 70% isopropyl alcohol pad
   - lancet (adult or child as appropriate)
   - microcuvette[2]
   - gauze or another dry absorbent pad
   - bandage (may be partially opened)

3. Put on a new pair of disposable gloves; check that there are no holes or tears.

4. Select the puncture site. Use the middle or ring finger (with rings removed) for adults and older children. The big toe or side of the heel may be used for an infant or young child.

5. Prepare the hand for puncture. The hand should be warm and relaxed to obtain an adequate blood flow. Keep the hand extended down to help blood flow.

6. Clean the puncture site with the alcohol pad. Wipe it dry with a clean gauze pad.

7. Press the finger from the top knuckle towards the tip to stimulate blood flow. You may press and release (mimic a heartbeat) but do not “milk” the finger. While maintaining pressure, puncture the **side** of the fingertip with the lancet.

8. Discard the used lancet in the puncture-proof container.

9. Wipe away the first 2-3 drops of blood with a dry gauze pad. Continue to apply pressure until another drop of blood forms. The blood sample must be large enough to fill the microcuvette completely.

10. Holding the square end of the microcuvette, touch the middle of the blood drop with the long pointed edge. Allow the microcuvette to completely fill up with blood in one continuous step. If not completely filled, you must get a new microcuvette and try again. Do not attempt to “top off” the first microcuvette.

11. Apply gauze to the puncture site after filling the microcuvette. Ask the participant or caregiver to hold the gauze and apply gentle pressure against the puncture site. Advise elevating the hand to help stop the bleeding.

[1] This training is to be provided by authorized local health department or medical clinic staff.

[2] Handle microcuvettes with care. Remove only the number of microcuvettes to use immediately. Close the lid and keep the container closed.

12. Remove excess blood from the microcuvette by gently touching both of the flat sides of the filled microcuvette on a dry gauze pad or tissue. Wipe the microcuvette as if spreading butter.

13. Inspect the microcuvette to be sure there are no air bubbles in the middle of the sample.

14. Place the microcuvette into the microcuvette holder and gently slide the holder into the HemoCue machine.

15. Place a bandage on the participant's finger.

16. Read the result that appears in the HemoCue window.

17. Remove the microcuvette from the cuvette holder and discard it in the puncture-proof container. Remove and discard gloves and other waste in the appropriate waste container. Wash hands.

18. Record the hemoglobin result in the Bloodwork Data grid in the Medical Screen of the applicant's record.

19. Interpret the test results. If the risk factor *Low Hemoglobin/Low Hematocrit* is identified, provide and document nutrition education in the participant's record in the management information system. Provide and document any referrals for nutrition care counseling or to the health care provider as applicable.

20. At the end of each day, clean the blood test equipment and area where the blood test is performed. Use gloves when cleaning. Follow local agency procedures.

21. If a blood spill occurs during testing, use the approved cleaning agent to clean the area. Cleanup should take place as soon as possible. Use gloves and paper towels and dispose of them in the proper container.

22. Never eat, drink, or store food or beverages or store stickers or other items where the blood test is performed.

Tools for training staff on how to perform the blood test and interpret the test results are available in the Training Module in the management information system.

Non-Invasive Hemoglobin (Pronto®) Screening Requirements

To determine if the applicant is eligible for non-invasive testing they must:

- Be ≥ 22 pounds
- Be able to sit still for up to 2 minutes
- Have warm hands or ability to warm hands
- If pregnant, be <36 weeks gestation
- If postpartum, be >4 weeks postpartum

Applicants that do not meet the criteria for non-invasive testing may have a Hemocue hemoglobin test completed or have testing delayed for up to 90 days.

Procedure for performing the non-invasive hemoglobin screen using the Masimo Pronto® Device

Masimo recommends cleaning the device, sensor, and cable every morning and at the end of every day to ensure the equipment is clean. Busy clinics may need to clean more frequently. Clean the equipment with either a 70% isopropyl alcohol pad, a pre-moistened cloth with a mild detergent, or a hospital grade cleaning “wet wipe”. Do not spray cleaning liquids directly onto the Pronto especially the speaker area. Do not allow liquids to enter the interior of the device. After cleaning, allow the equipment to air dry before use.

1. Assemble the non-invasive hemoglobin screening supplies:
    - Adult and pediatric sensors
    - Sensor sizing guide
    - 70% isopropyl alcohol pad
    - Gauze or another dry absorbent pad

2. Ask the applicant to sit in a chair. If a child, the caregiver may hold the child in her lap. Explain why and how the hemoglobin screen is done using correct terminology.

3. For adults, determine which sensor should be used. Use the sensor sizing guide attached to the sensor, insert middle or ring finger of hand (non-dominant hand without rings preferred), into the hole. If the cuticle of the fingernail goes past the guide, the pediatric sensor should be used for testing.

    For children, the pediatric sensor should be used with placement on the middle or ring finger (the thumb or big toe can be used if needed).

4. Prepare the finger (or toe for children) for testing. The hand should be warm and relaxed, placed on a flat surface or cupped in staff’s hand, positioned below heart.

5. Before applying sensor, clean the finger/toe with an alcohol pad. Dry with gauze or allow to air dry prior to placing in the sensor.

6. Ensure the testing device is away from ambient light (direct sunlight) and at least 6 inches away from other electronic devices. Turn on the device. The green number indicates how many tests are left in the sensor.

7. Place the finger (or thumb/toe for smaller children) into the sensor with the fleshy part on the detector, nail on top with red emitter light. The tip of the finger should touch the raised digit stop inside the sensor. The cable of the probe should be rested going up the hand.

8. Ask the applicant to sit still while the machine is working. Build rapport with the client while waiting.

9. The first number to appear is the Perfusion Index (PI) number, which is an indication of the pulse strength where the sensor is located. If this number is less than 1.0 the test will most likely not be successful without intervention. The operator may need to remove the sensor and reposition it, try a different site, or attempt to warm the site to improve circulation and increase the PI. If the PI remains below 1.0, do a hemoglobin test using the Hemocue machine or delay the test for up to 90 days.

10. If the PI number is 1.0 or higher, wait approximately 60 seconds for an audible tone before pressing the SpHb button to display reading. If no reading is displayed the operator may need to reposition the sensor, try a different site, warm the site to improve circulation and perform a retest, do a hemoglobin screen using the Hemocue machine, or delay the test for up to 90 days.

11. Record the hemoglobin result in the Bloodwork Data grid in the Medical Screen of the applicant's record.

12. Interpret the test results. If the risk factor *Low Hemoglobin/Low Hematocrit* is identified, provide and document nutrition education in the participant's record in the management information system. Provide and document any referrals for nutrition care counseling or to the health care provider as applicable.

At the end of each day, wipe the device, the sensor, and the cable clean. Do not spray cleaning liquids directly onto the Pronto device, especially the speaker area. Allow to air dry before the next use.

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.34
Effective Date: October 1, 1996
Revised Date: July 1, 2020

SECTION:	**ELIGIBILITY AND CERTIFICATION**
SUBJECT:	**Nutrition and Health Information Requirement**

A. Policy

Local agencies shall obtain, document, and interpret nutrition and health information for each applicant in order to determine nutritional risk, provide nutrition education and referral information, and prescribe the most appropriate food package.

B. Procedure

1. **When collecting and evaluating nutrition and health information from applicants, the local agency shall:**

   a. Enter relevant information into each applicant/participant's record, using the Medical and Nutrition History screens in the management information system in order to identify and document nutrition and health-related risk factors.

   b. Information must be entered/updated at each certification, recertification and mid-certification visit. When new risk information becomes available between WIC appointments, such as a new medical diagnosis, the information should be entered into the participant's record, and risks should be reassigned.

   c. Interpret relevant information to provide the most appropriate intervention for the participant that is based upon identified risk factors and participant concerns.

Attachment:
2.34A Provision of Nutrition Services

References:

1. 7 CFR 246.7(e)
2. COMAR 10.54.01.06 C (2)
3. WIC Policy Memorandum 98-09, Revision 9
4. WIC Nutrition Services Standards, Standard 7
5. SFP 06-056 Value Enhanced Nutrition Assessment (VENA) – WIC Nutrition Assessment Policy

Revisions:

10/11 Deleted reference to old training module.

10/12 Changed age for nutrition history forms to Birth to 3 months and 4 to 12 months. Clarified when information is entered/updated. Added participant focused language. Attachment 2.34A: Changed wording of #13. Attachment 2.34B: Changed wording of #8 and #9. Attachment 2.34C: Changed wording of #7. Attachment 2.34D: Changed wording of #10.

10/15 Removed references to paper versions of forms. Removed 2.34A, 2.34B, 2.34C, 2.34D.

02/19 Added Attachment 2.34A: Edited 2.38A to include certification and mid-certification and renamed as 2.34A. Removed b. Child 1 to 2 years old. Renamed c. as b. Child 1 to 4 years old. Renamed d. as c. Breastfeeding Woman. Added d. Pregnant Woman with steps 1 to 8.

07/20 Added information on reassigning risk factors if new risk information becomes available between WIC appointments.

Provision of Nutrition Services

WIC certifiers shall provide nutrition services during certification and mid-certification visits for each participant category as follows:

a. Infant

1) Review contact information.
2) Update amount of breastfeeding, even if same as previous visit (if applicable).
3) Update breastfeeding questions on introduction of supplemental foods (if applicable).
4) If breastfeeding status has changed, update breastfeeding status and introduction of supplemental foods questions and reason breastfeeding ended (if applicable), change participant category and food package per policy.
5) Review medical history thoroughly; complete and make changes as necessary. If there are no changes, click the *No Changes* checkbox.
6) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
7) Complete bloodwork (if required per Policy and Procedure 2.33).
8) Update immunization record.
9) Complete nutrition history. During an MCV, click the *New* checkbox. All new answers are required.
10) Assess risk factors.
11) Review growth chart.
12) Complete nutrition education based on risk factors and participant interest. Document nutrition education.
13) Make required referrals and others as needed.

b. Child 1 to 4 years old

1) Review contact information.
2) Update amount of breastfeeding, even if same as previous visit (if applicable).
3) Update breastfeeding questions on introduction of supplemental foods (if not completed).
4) If breastfeeding status has changed, update breastfeeding status and reason breastfeeding ended questions (if applicable).
5) Complete medical history:
    a) Begin with: “Tell me about any recent illnesses or changes to your child’s health or dental health since you were here last.”
    b) Ask the physically active play question.
    c) Make any necessary changes. If there are no changes, click the *No Changes* checkbox.
6) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
7) Complete bloodwork (if required per Policy and Procedure 2.33).

8) Update immunization record if less than 2 years of age.
9) Review nutrition history:
    a) Begin with: “Tell me about meal times,” or “Tell me how your child is eating.”
    b) Make any necessary changes. If there are no changes, click the *No Changes* checkbox.
10) Assess risk factors.
11) Review growth chart.
12) Complete nutrition education based on risk factors and participant Interest. Document nutrition education.
13) Make required referrals and others as needed.

c. Breastfeeding Woman

1) Begin with: “How’s breastfeeding going?” or “What questions or concerns about breastfeeding do you have at this time?”
2) Review medical history:
    a) Begin with: “Tell me about any changes to your physical or emotional health since your last WIC visit.”
    b) Ask physical activity question.
    c) Make any necessary changes. If there are no changes, click the *No Changes* checkbox.
3) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
4) Complete bloodwork (if required per Policy and Procedure 2.33).
5) Review nutrition history:
    a) Begin with: “Tell me about any changes you’ve made in what you’re eating or drinking.”
    b) Make any necessary changes. If there are no changes, click the *No Changes* checkbox.
5) Assess risk factors.
6) Review weight status.
7) Complete nutrition education based on risk factors and participant interest. Document nutrition education.
8) Make required referrals and others as needed.

d. Pregnant Woman

1) Review contact information.
2) Review medical history:
    a) Begin with: “Tell me about any changes to your physical or emotional health since your last WIC visit.”
    b) Ask physical activity question.
    c) Make any necessary changes. If there are no changes, click the *No Changes* checkbox.
3) Complete anthropometrics. (Refer to Policy and Procedure 2.32).
4) Complete bloodwork (if required per Policy and Procedure 2.33).

5) Review nutrition history:
    a) Begin with: “Tell me about any changes you’ve made in what you’re eating or drinking.”
    b) Make any necessary changes. If there are no changes, click the *No* Changes checkbox.
6) Assess risk factors.
7) Review weight status.
8) Complete nutrition education based on risk factors and participant interest. Document nutrition education.
9) Make required referrals and others as needed.

Policy and Procedure 2.34B has been removed.

October 2013

Policy and Procedure 2.34C has been removed.

October 2013

Policy and Procedure 2.34D has been removed.

October 2013

Policy and Procedure 2.35 has been removed.

October 2013

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.36
Effective Date: October 1, 2011
Revised Date: June 7, 2017

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Certification of Participants in Hospitals

A. Policy

WIC certification services may be provided in the hospital to individuals receiving maternity or postpartum services when the WIC clinic is within a hospital or there is a signed agreement between the local WIC agency and the hospital. The purpose of performing hospital certifications is:

1. To provide WIC Program services including eligibility determination, breastfeeding promotion and support, nutrition education, health and social service referrals, a food instrument and benefits for supplemental foods as appropriate to pregnant women, breastfeeding and non-breastfeeding postpartum women, and/or their newborn infants at the earliest possible date.

2. To provide outreach to potential WIC participants to promote awareness of WIC Program services and eligibility requirements.

B. Procedure

1. When certifying a pregnant woman who will be delivering at a hospital where the local agency performs certifications, the certifier shall inform the woman that she and her newborn infant may be able to be certified while she is in the hospital and encourage her to bring her proof of identity, proof of residence, and proof of income or adjunct eligibility to the hospital.

2. Hospital certifications may be performed by a Competent Professional Authority (CPA) or Competent Paraprofessional Authority (CPPA).

3. Potential or current WIC participants who live outside the service area of the local agency providing hospital certifications shall not be given a hospital

certification. Those who are potentially WIC-eligible shall be given the WIC outreach brochure and encouraged to call the appropriate local agency (one that is convenient to where she lives or works) as soon as possible for a certification appointment.

4. All Maryland WIC policies and procedures related to providing certifications in clinics shall be followed in performing hospital certifications.

5. All client information shall be collected and maintained in a confidential manner.

6. A hospital identification bracelet may be used and appropriately documented in the Notes section of the participant's record as proof of identity. (Refer to Policy and Procedure 2.23.)

7. Hospital records may be used for proof of residence and to obtain adjunct eligibility information (such as an applicant's Medical Assistance number) if access to the records has been granted to the WIC certifier through an agreement between the local agency and the hospital. The certifier shall verify and appropriately document an applicant's or an applicant's family member's current participation in a qualifying program for adjunctive eligibility. (Refer to Policy and Procedure 2.05.)

8. All applicable nutrition risks shall be identified and documented in the management information system. If the WIC certifier has the hospital's permission to access the hospital record, information may be obtained from it. The date for weight, height/length, and hemoglobin/hematocrit measurements shall be recorded as the date when the measurements were actually performed, not the date they were obtained from the medical record. Hemoglobin or hematocrit measurements for postpartum women must have been performed during the postpartum period. If a hemoglobin or hematocrit test result cannot be obtained, the measurement may be performed (ideally between 4 to 6 weeks postpartum) and/or documented within 90 days of the date of certification, if the applicant has a least one qualifying risk factor. (Refer to Policy and Procedures 2.32 and 2.33.)

9. Nutrition education and breastfeeding support shall be provided and documented for each participant as appropriate to the participant's risks,

needs, and interests identified and prioritized during the nutrition risk assessment. (Refer to Policy and Procedures 5.01 and 5.09.)

10. The food package shall be tailored to the participant's needs and preferences and its content explained to the participant. The Authorized Foods List and Using your Maryland eWIC Card shall also be explained to the participant. (Refer to Policy and Procedures 3.01, 5.09, and 4.10.)

11. CPPAs who are performing hospital certifications shall fax medical documentation for exempt infant formulas, medical foods, soy beverages, and tofu to a Competent Professional Authority (CPA) for approval prior to issuance. (Refer to Policy and Procedures 3.02 and 3.03.)

12. All laptops and printers shall be secured to a cart when being transported to and used in patient rooms. They shall be stored in a locked room designated for this purpose in the hospital unless they are returned to the WIC clinic each day.

13. The following is recommended best practice for follow-up of breastfeeding infants. All breastfeeding infants certified in the hospital shall be given a follow-up appointment within one month. During this visit, assistance with breastfeeding should be provided, weight and length measurements taken, participant category changes and food package adjustments made, and breast pumps issued as appropriate.

Attachments:

References:

Revisions:

10/2012	Deleted references to WOW, Minor language change/clarification in B.6
6/2017	Updated language in policy to reflect eWIC terminology

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.37
Effective Date: October 1, 2012
Revised Date: June 7, 2017

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Use of Volunteers in the WIC Program

A. Policy

Local WIC agencies may choose to use volunteers to stretch resources and increase the quality and quantity of services provided to WIC participants. Volunteers may assist with a variety of tasks ranging from administrative support to nutrition education activities, depending on the qualifications of the volunteer. Volunteers shall be given orientation as to the importance of maintaining the confidential nature of participant information. They shall sign a confidentiality statement and they shall not be allowed access to the management information system.

B. Procedure

1. The job duties of volunteers shall be restricted to activities not involving access to applicant/participant information in WOW.

    a. Examples of appropriate volunteer activities include:

        1) <u>Administrative</u>

            a) Copying materials
            b) Stuffing envelopes with appointment notices

        2) <u>General</u>

            a) Sanitizing toys

            b) Assisting with group education sessions by greeting participants/directing their flow

c) Assisting with language interpretation
d) Leading activities with children such as interactive play, reading or storytelling in waiting area – if appropriately trained to work safely with children, as per local agency health department/sponsoring agency policy

3) Outreach

a) Assisting with outreach at health fairs
b) Conducting customer satisfaction surveys in person or over the phone

4) Nutrition education/breastfeeding promotion and support

a) Creating posters, displays, bulletin boards, educational/resource materials – *if qualified and supervised*
b) Assisting with cooking demos and food tasting
c) Providing group nutrition education – *if qualified and supervised*
d) Setting up/breaking down for group education sessions or breastfeeding showers
e) Special projects such as grocery store tours – *if qualified and supervised*

b. Examples of inappropriate volunteer activities include:

1) Answering the telephone
2) Calling participants to re-schedule missed appointments
3) Performing anthropometric/biochemical measurements
4) Individual nutrition or breastfeeding counseling

2. Volunteers are subject to the same confidentiality restrictions as WIC employees (refer to Policy and Procedure 7.70). During orientation of volunteers, specific confidentiality requirements governing the WIC Program shall be discussed and the volunteer shall sign an agreement stating that they:

a. Understand the policy and procedures of the Program regarding confidentiality, and
b. Agree to keep applicant/participant information confidential.

3. Volunteers shall not drive local agency vehicles.

4. Local agencies shall adhere to any additional policies and procedures pertaining to use of volunteers that are required by their health department or sponsoring agency.

5. Dietetic Interns (other than Maryland WIC employees who are participating in the Virginia/Maryland WIC Dietetic Internship Program):

   Local agencies may provide dietetic interns from area or distance internship programs with WIC experience as part of their community nutrition rotation. The primary objective of a dietetic intern's WIC experience is exposure to aspects of WIC as a community nutrition program such as eligibility determination, participant benefits, funding, federal regulations, and the emphasis on participant-focused counseling and breastfeeding promotion and support. Like volunteers, interns are subject to the same confidentiality restrictions as WIC employees. Their orientation shall include discussion of the importance of maintaining the confidential nature of applicant/participant information, they shall sign a confidentiality statement, and they shall not be allowed access to the management information system. Appropriate activities for an intern include observing the certification process, individual counseling sessions, and group education sessions. Actual provision of individual counseling/group education or performance of anthropometric/biochemical measurements by the interns is permissible if supervised by a Competent Professional Authority (CPA) who is present at the time the service is provided or performed.

Attachments:

References:

Revisions:

1/2017	Removed preparing ID folders for the day under examples of administrative activities. Removed distributing/collecting health history forms or surveys under examples of General activities. Changed

	reference to check pickup to group education sessions.
6/2017	Removed all references to checks

Policy and Procedure 2.38
has been merged into Policy and Procedure 2.10.

August 2018

Policy and Procedure 2.38A
has been removed.

August 2018

Policy and Procedure 2.38B
has been removed.

August 2018

Policy and Procedure 2.38C
has been removed.

August 2018

Policy and Procedure 2.38D
has been removed.

August 2018

MARYLAND DEPARTMENT OF HEALTH
WIC PROGRAM
POLICY AND PROCEDURE MANUAL

Policy and Procedure Number: 2.39
Effective Date: November 18, 2019
Revised Date: November 19, 2025

SECTION: ELIGIBILITY AND CERTIFICATION

SUBJECT: Participant Referrals

A. Policy

Local Agencies shall provide all adult WIC Program applicants, participants, and all caretakers of infants and children with information on health related and public assistance programs, and when appropriate, shall refer applicants and participants to such programs.

Local Agencies shall:

1. Refer participants to required health and social services programs if the participant does not receive such services;
2. Refer participants to other health and social services programs as individual needs are identified;
3. Document referrals in the Client Referrals section of the management information system;
4. Perform an annual review of local provider referral information within the management information system and print materials.
5. Review MD Benefits Referrals under Scheduling Tasks or Scheduler tab and assess and process as needed.

B. Procedure

At each certification and recertification, the Local Agency shall:

1. Assess an applicant/participant's use of health and social service programs.

2. Provide each adult applicant/participant and all caretakers of infants and children with written or verbal referral to the following services, if they are not currently receiving such services:
    a. Medical Assistance;
    b. Temporary Cash Assistance;

c. Food Supplement Program;
d. Resources for counseling on alcohol, drug, and substance abuse.

3. If the participant's medical and nutrition assessment deems it necessary, provide the participant with a referral to the following services:
    a. Nutrition Care Counseling for participants with a high nutrition risk (refer to Policy and Procedure 2.31A and 5.03);
    b. Breastfeeding counseling with a Breastfeeding Specialist for participants with a high breastfeeding risk (refer to Policy and Procedure 2.31A and 5.09); and
    c. The participant's Health Care Provider, if
        i. The participant's hemoglobin test result is less than or equal to 8.0 g/dL (refer to Policy and Procedure 2.33);
        ii. It cannot be determined that a blood lead test has been performed (refer to Policy and Procedure 2.28); and
        iii. The participant is not up to date on their immunizations (refer to Policy and Procedure 2.27).

4. Based upon the participant's needs, staff shall offer information on, and as applicable, offer a referral to additional services.

5. Local Agency staff shall document all referrals offered in the Client Referrals section of the management information system.

6. All written referrals provided to participants may be disseminated either through use of the management information system or print materials developed or procured by the local agency.
    a. Client Referrals section of the management information system, if utilized, Local Agencies shall keep the Local Provider information up to date. This information shall be reviewed at least once every state fiscal year, and updated as necessary, using the Admin Module of the management information system. This information shall include:
        i. Name of the program or service
        ii. Phone number
        iii. Other pertinent information, as applicable
    b. Locally developed or procured print materials with referral information shall be reviewed for accuracy at least once every state fiscal year by the Local Agency. Print materials shall include information on the following health and social service programs:
        i. Medical Assistance;
        ii. Temporary Cash Assistance;

iii. Food Supplement Program;
iv. Alcohol, drug, and substance abuse counseling and treatment; and
v. Immunizations.

7. **MDBenefits**
   a. At least once daily staff shall check the MDBenefits Referral Screen which can be accessed by:
      i. Selecting Scheduler > MDBenefits from the File Menu Bar OR
      ii. Selecting Scheduling Tasks > MDBenefits from the Side Menu panel.
   b. Staff shall review the applicant record on the screen and assess whether the applicant should be Precerted or is a Dual Enrollment and record should be removed.
   c. A minimum of one attempt to contact shall be made prior to permanent removal of the referral.

Attachment(s):

References: 7 CFR 246.7(a)
7 CFR 246.7(b)(1)
7 CFR 246.11(a)(3)
WIC Nutrition Services Standards 2013, Standard 11
WIC Policy Memo #2001-7 Immunization Screening and Referral in WIC

Revisions:
11/2025 Added section 7 on MDBenefits