NH WIC Program MANUAL FORM - WOMAN

TYPE OF WIC SERVICE PROVIDED ☐ **Recertification** ☐ **Certification** ☐ **Nutrition Follow up**

Date WIC Service Provided:	Is the client physically present? ☐ Yes ☐ No, reason stated:

CLIENT / GROUP DEMOGRAPHICS

Client Name:	Gender	DOB / /	EDD/PG end date: / /

Hispanic/Latino? ☐ Yes ☐ No ☐ Declined	American Indian/Alaskan Native _____ Asian_____ Black or African American _____ White or Caucasian _____ Native Hawaiian or Other Pacific Islander_____

Caregiver Name DOB / /	Alternate Name
Telephone Number (Landline)	Telephone Notes/Message Telephone
Telephone Number (Cell Phone)	Email / Receive appointment reminders ☐ email ☐ text (phone)
Street Address	City / Zip Code
Mailing Address	City / Zip Code

Proof of ID Caregiver	Proof of ID Infant/Child	Proof of Residence	Homeless
Interpreter	Primary Language	Special Needs	Migrant? ☐ Yes ☐No

INCOME INFORMATION

Adjunctive Eligibility ☐ TANF ☐Medicaid ☐ SNAP	_____ # in Household	
Medicaid # ☐ Proof Pending	☐ Zero Income	☐ Self-declared income
Total Income Amount $ ☐ Monthly ☐ Weekly ☐ Twice/Month ☐ Every 2 Weeks ☐ Annually ☐ Multiple Incomes		
Income Source Description:		
☐ Yes Is the applicant a member of a family in which there is a pregnant woman who is receiving or participating in Medicaid? ☐ Yes Is the applicant a member of a family in which there is an infant who is receiving or participating in Medicaid?		
Proof of Income Shown **Staff Signature/Title**		
Other Income Eligibility Information	Rights & Rules Reviewed ☐ Yes ☐ No Rights & Rules provided ☐ Yes ☐ No	

WOMEN CERTIFICATION

1st Prenatal Visit Date	Month Care Began	# of Previous Pregnancies	# of Births	Pregnancy with multiples	Last Pregnancy End Date

How often do you have a drink containing alcohol? (days/weeks)	Current Alcohol Use: # of drinks per day:	Have you ever used an electronic vapor Product? ☐ Yes ☐ No
Current Cigarette Use: ☐ Yes ☐ No # of cigarettes per day:	Smoking Changes During Pregnancy: ☐ no change ☐ increase ☐ decrease ☐ does not smoke ☐ started ☐ stopped ☐ Tried to stop ☐ unknown/refused	Changes in use since you became pregnant? ☐ No change ☐ Stopped ☐ unknown/refused
Does anyone smoke in the house? ☐ Yes ☐ No Does anyone smoke inside your vehicle? ☐ Yes ☐ No		Illegal Drug Use? ☐ Yes ☐ No
		Misuse of prescription drugs ☐ Yes ☐ No Medications prescribed or over the counter?
		Marijuana use in any form ☐ Yes ☐ No

Health care Provider	Infant Feeding History

MEDICAL PROVIDER/MEDICATION SUPPLEMENTS/HEALTH CONCERNS

Average number of vitamins per week in the month before pregnancy		Pregnancy/ Delivery complications
Current medication/ Supplement Use ☐ Vitamins/Minerals ☐ Iron ☐ Folic Acid ☐ Other _____		
Do you have diabetes when you are not pregnant? ☐ Yes ☐ No	Did you develop diabetes during this pregnancy? ☐ Yes ☐ No	Did you develop diabetes during a previous pregnancy? ☐ Yes ☐ No
Do you have high blood pressure or pre high blood pressure (>120/80) when you are not pregnant? ☐ Yes ☐ No	Did you develop high blood pressure or pre high blood pressure (>120/80) during this pregnancy, including pregnancy induced hypertension? ☐ Yes ☐ No	

MEASUREMENTS (Include date of measurement if different from date of visit/certification)

Height	Current Weight	BMI	Pre-Pregnancy Weight	Weeks Gestation (PG only)
Weight at Delivery (BF & PP only)		Total Pregnancy Weight Gain (BF & PP only)		
HGB/HCT (include date)		Notes		

RISK FACTORS- To be completed by WIC CPA

Assigned Risks Notes	
☐ Professional Discretion High Priority**,** include reason	☐ Doctor Diagnosed Medical Conditions (please list)

REFERRALS MADE	**REFERRALTO WIC FROM**
☐ SNAP ☐ TANF ☐ Medicaid ☐ Other	☐ Healthcare provider ☐ Head start ☐ On WIC before ☐ Family/ friend ☐ District Office ☐ Medicaid
BASIC CONTACT COMPLETED. ☐ Yes ☐ No	

CARE PLAN /NUTRITION ED GOALS

Client concerns	Nutrition topics reviewed
Handouts given	Counselor comments
Nutrition Education Goals/ Plan	

To be completed by WIC Staff
BENEFIT PACKAGE _____

Tailored benefit/formula package ☐ No ☐ Yes,
Reason: _____

Special formula	Dx/ Reason for request
Name of HCP requesting formula	Length of issuance
eWIC Card #: **6107 3000** _ _ _ _ _ _ _ _	Caregiver Signature for card:

NEXT APPOINTMENT/CLASS REGISTRATION

Next Appt Type ☐ FUN- low priority in person ☐ FUN- low priority on line education ☐ FUN- high priority with nutritionist ☐ Other: _____ Date/Time	Date participant contacted that benefits are available:
Form Completed By **Print Name:** **Staff Signature**:	Data Entered into StarLINC
Participant Signature:	Date: