Chapter 6C
Certification/Participation-Nutrition Assessment

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Nutrition Assessment and Plan of Care

The nutrition assessment process determines an individual's nutrition status, including nutrition eligibility for WIC, and provides the framework for developing an individual's plan of nutrition care.

- **Frequency of Nutrition Assessment**
  A nutrition assessment must be completed and a plan of nutrition care developed for each applicant/participant at each certification and at the following intervals**:**

  - Infants must receive a nutrition assessment five to seven months after birth.
  - Breastfeeding postpartum women must receive a nutrition assessment five to seven months after delivery.
  - Children must receive a nutrition assessment at mid-certification, i.e., five to seven months after certification.

- **Sources of Nutrition Assessment Information**
  Information required for the nutrition assessment may be collected from a variety of sources including the applicant/participant/parent/guardian/caretaker (i.e., self-report), the local agency, a private health care practice, and/or any other type of health care facility.

  Regardless of the source, the information must be documented in the individual's health record in the Crossroads system. Written information obtained from outside the local agency must be scanned and saved in the applicant's/participant's record in the Crossroads system. The information received may be documented from various sources such as the "WIC Program Exchange of Information" form (refer to Attachment 1), "WIC Program Medical Documentation" form (refer to Attachment 2), physician's prescription form, and written correspondence (e.g., memo, letter, discharge summary).

  Information obtained from the applicant/participant/parent/guardian/caretaker is collected through an interview process. To facilitate this process, staff may choose to use a questionnaire the client voluntarily completes prior to the nutrition assessment interview. Client-completed questionnaires are not required to be retained.

- **Categories of Nutrition Assessment Information**
  To complete a nutrition assessment, staff must collect information in each of the following categories.

  - **Anthropometric Information.** This information is collected to assess growth and physical development of infants and children and prenatal weight gain and weight status of women. Refer to Section 2 for more guidance on requirements for anthropometric data collection. The information is documented under the Anthro/Lab quick link in the Crossroads system.

- **Biochemical Information.** This information is collected to assess blood serum indicators of nutrition risk, such as iron status and lead levels. Refer to Section 3 for details about requirements for biochemical data collection. The information is documented under the Anthro/Lab quick link in the Crossroads system.

- **Breastfeeding Status.** This information is collected to assess breastfeeding history, current infant feeding practices, healthcare provider recommendations, breastfeeding goals and any concerns or challenges.

- **Clinical/Health History/Disease Status.** This information is collected to assess medical and clinical indicators of nutrition risk, health history and disease status. Health and disease conditions are evaluated for nutrition-related consequences. The information is documented under the Health Information quick link in the Crossroads system. Clinical information that is assessed includes but is not limited to:
  - pregnant and postpartum women: pregnancy-related conditions, history of pregnancies and birth outcomes, presence of medical conditions, use of substances (tobacco, alcohol, drugs), use of medications (e.g., prescription, over-the-counter, herbal supplements), oral health status, and depression.
    Note: Local agencies must maintain a current list of local health and mental health resources for referral for diagnosis and treatment of maternal depression.
  - infants and children: presence of medical conditions, use of medications (e.g., prescription, over-the-counter, herbal supplements), immunization status and oral health status. Refer to Section 6 for information on immunization screening requirements in WIC.

- **Dietary and Physical Activity Behaviors.** This information is collected to assess dietary and physical activity behaviors which may be indicative of nutrition risk. Behaviors that are assessed include but are not limited to usual eating or feeding pattern, fruit and vegetable consumption, type of milk/beverages consumed, frequency of physical activity, and amount of TV time. The information is documented under the Dietary & Health and Eco-Social quick links in the Crossroads system.

- **Eco-social Information**. This information includes eco-social behaviors and conditions which may indicate nutrition risk. Eco-social information that is assessed includes but is not limited to household composition, food security, working appliances for food preparation and source of drinking water, homelessness, and migrancy status. The information is documented under the Family Demographics, Family Assessment and Eco-Social quick links in the Crossroads system.

■ Establishing Nutrition Risk Eligibility for WIC

Staff must identify all applicable WIC nutrition risk criteria for each participant at each certification/subsequent certification. Refer to Attachment 2: "WIC Nutrition Risk Criteria" for a list of all risk factors used to determine nutrition eligibility. The Assigned Risk Factors quick link lists the system-identified risk factors and allows the CPA to add additional nutrition risk codes based on the interview, observation and assessment performed.

- **Summarizing the Participant's Nutrition Status**
  Staff must organize, integrate, and synthesize the information gathered during the nutrition assessment process in the creation of the Care Plan.

  - **Summary of Nutrition Status/Assessment.** Staff must write a brief statement in the Nutrition Assessment container that summarizes the findings of the nutrition assessment, including problems and potential problems. The container is located under the Care Plan, Care Plan Summary quick link in the Crossroads system.

- **Developing the Care Plan**
  Based on the summary of nutrition problems and potential problems, staff must work with the participant to establish a nutrition plan of care. Consideration must be given to the participant/parent/guardian/caretaker education, understanding of nutrition principles, beliefs, skills, cultural practices, family and social environment resources, access to food and health care services, and stage of readiness to make changes in behaviors for her/himself or her/his family. The required components of a nutrition plan of care are:

  - **Goals.** A goal is intended to be a specific change a client is willing to make to improve a nutrition or physical activity habit or behavior. They generally are one or two actions the participant/parent/guardian/caretaker establishes or agrees to, that he/she will do to achieve the desired health outcome(s). The goals are documented in the Crossroads system under the Care Plan, Maintain Goals quick link. Goals can be Family Goals and/or Individual Goals and should be relevant, achievable, measurable, and realistic.

  - **Nutrition education.** Nutrition education should be related to the goals and any required nutrition education. Nutrition education is documented in the Crossroads system under the Care Plan, Nutrition Education quick link. Refer to Chapter 5 for information on required nutrition education topics.

  - **Breastfeeding support.** Breastfeeding support should address the participant's breastfeeding goals, current breastfeeding practices, and any identified breastfeeding concerns or challenges. This may include counseling on breastfeeding techniques or strategies. The issuance of a breast pump and/or breastfeeding aid should be related to the participant's breastfeeding goals, identified breastfeeding issues, and/or health needs.

  - **Referrals.** Referrals to other health, welfare and social services should be made to help meet additional needs, assist in improving health and achieving positive health outcomes. Referrals should also be related to the goals, identified nutrition problems/potential problems and health needs, and documented in the participant's record. Referrals are documented in the Crossroads system under the Care Plan, Referral Program quick link when the program to which the participant is being referred can be chosen from the screen. Otherwise, the referral must be documented as a note in the Nutrition Assessment section on the Care Plan Summary screen.
    Note: To update information about any programs or services accessible on the Referral Program screen, the local agency should contact their Regional Nutrition Consultant and provide information about the changes needed.

- **Required referrals.** WIC staff must provide written information at certifications or subsequent certifications to adult participants and adult individuals applying for the NC WIC Program for themselves or on behalf of others about the Medicaid Program. The information should include income limits according to family size if they have a family income that appears to be below the monthly income limit and are not currently receiving Medicaid. Additional information about Medicaid can be found at: https://medicaid.ncdhhs.gov/.

- **WIC food package.** The food package prescribed should reflect the participant's nutritional needs and cultural practices.

- **Follow-up.** Follow-up should include a specific timeframe and purpose/action and should be related to the goals, referrals, and health needs.

■ **Documenting the Nutrition Assessment and Care Plan**

Staff are required to document the nutrition assessment and care plan in the client's health record in the Crossroads system.

The primary purpose of documentation is to ensure continuity of care by communicating information among health care providers about a participant's nutrition status. Another purpose of documentation is to serve as a legal record of services provided. Documentation must be clear in the Crossroads system. Use abbreviations consistent with the local agency's approved abbreviation list. Errors must be corrected using an additional entry in the care plan in the Nutrition Assessment area beginning with the text "Additional data or correction to data entered on [date of previous entry]." These documentation practices are critical should the record ever be needed for a legal procedure/action.

Anthropometric Data Collection

Anthropometric data collection is used to assess health and nutritional status. The information correlates with identification of all nutrition risk codes for a participant and the alignment of associated program services.

Staff must comply with Program policies for the type of anthropometric data that is collected, when data is collected, the type of medical equipment used, and procedures staff use to weigh and measure individuals.

■ **Anthropometric Data Requirements**

Both weight and height/length must be collected at each certification for all participant categories. This information may be obtained through weighing and measuring at the time of certification, from documentation in the Crossroads system, or through written referral information from a health care provider. Anthropometric data used for certification must not be more than 60 days old at the time of certification.

The following additional requirements apply:

For Pregnant women	▪ Weight and height data must be collected during pregnancy. ▪ At least two weights must be collected during pregnancy and documented in the Crossroads system appropriate for the woman's pre-pregnancy BMI.* *Note: Only one weight is required if the woman is certified at 37 weeks or greater gestation.*
For Postpartum and Breastfeeding women	▪ Weight and height data must be collected after pregnancy. ▪ Pre-pregnancy weight must be collected or determined.* ▪ Pregnancy outcome and gestational age; as appropriate, birth weight and birth length for delivered infant. ▪ Weight and height data must be collected at the mid-year assessment of postpartum breastfeeding women.
For Infants and Children	▪ Gestational age, birth weight and birth length collected for all infants and children up to 24 months of age. ▪ The expected rate of weight gain must be determined for: - infants and children with a recent history of poor growth (e.g., inadequate weight gain, a decrease in weight-for-age, a decrease in length/height-for-age within the past year) and - any infant or child for whom the clinician determines it necessary, ▪ Parental BMI must be assessed for: - Infants: at the initial or 5-7 month nutrition assessment - Children 12-24 months of age: initial nutrition assessment (i.e. they were not certified for WIC as infants), and - any child for whom the clinician determines it necessary.

* Pre-pregnancy weight may be obtained through participant self-report, documentation in the Crossroads system, or written referral information from a health care provider. In cases

when a woman's pre-pregnancy weight cannot initially be determined through any of these methods, it is required to obtain a pre-pregnancy weight. Staff should ask the participant probing questions related to her weight prior to pregnancy compared to her current weight (e*.g., How do you think your weight has changed since you became pregnant?; How has your appetite changed since you became pregnant?; How do your clothes fit now compared to before you became pregnant?, etc.)* and come to a mutual decision with the participant to identify a pre-pregnancy weight. As always, staff should use their professional judgment.

■ **Anthropometric Medical Equipment**
Medical equipment (i.e., scales and measuring boards) used by local agency staff to obtain anthropometric data is subject to specific purchasing requirements, must meet certain specifications, and must be routinely maintained to assure accurate measurements. Refer to Chapter 12 for additional guidance pertaining to purchasing medical equipment.

- **Specifications for Medical Equipment**
  - **Scales (weight).** There are two types of scales, double beam balance and digital. A double beam balance scale has both a main and a fine weight, adjusts manually; has engraved beam graduations, has a tare (zero) adjustment, and has a precise heavy-duty lever system with heat-treated pivots (no spring system). A digital scale has a load cell(s) and a digital read-out. For both types of pediatric scales**,** the weighing tray and surface should be able to be sanitized.
    Specifications for both beam balance and digital scales are:
    - Infant scales: a minimum increment of 10 grams or ½ ounce and a maximum weight of at least 20 kilograms or 40 pounds
    - Adult scales: a minimum increment of 100 grams or ¼ pound
  - **Infantometers and Stadiometers (length/height)**
    - Infant Board (Infantometer). These boards should be constructed to resist warping and have surfaces that can be sanitized. They should have a moveable foot board and a fixed right-angle head-board. Length should be indicated by fixed and measured increments on the board.
    - Adult Board (Stadiometer). These boards should have a moveable right-angle head-board which indicates the height using fixed, measured increments. Wall-mounted boards must be installed on a stationary wall (e.g., not on a door) and in such a manner to avoid base-board molding and/or carpeted floors which can impact the measurement accuracy.
    - Minimum Specifications.
      Infantometer and Stadiometer minimum increments: 0.1 centimeter or 1/8 inch
      Stadiometer minimum height: 190.5 centimeters or 75 inches.

- **Maintenance of Clinic Scales.** Scales used to obtain anthropometric data must be "zero adjusted", tested for accuracy, and calibrated when found to be inaccurate.
  - **Zero adjustment** of balance beam scales should be done after each measurement and each time the scales are moved. Digital scales make this adjustment automatically.
  - **Testing for accuracy** of scales must be done annually. This can be accomplished by requesting services in writing to the North Carolina Department of Agriculture. The request should include a contact person at the local agency, when the service is

needed and the site/location of each clinic scale that needs to be tested. An inspector will contact the local agency to provide this service free of charge.

North Carolina Department of Agriculture
Standards Division, Measurement Section
Mail Service Center 1050
Raleigh, NC 27699-1050

Local agency staff must retain the receipt from this testing. Any rejected scales which do not meet the testing standards must be removed from service immediately.

- **Calibration of scales** is required only when the result of the annual accuracy testing of scales indicates that it is necessary. This can be accomplished by contacting a medical equipment company or scale technician in your area or the medical equipment manufacturer. The North Carolina Department of Agriculture does not provide this service.

■ **Procedures for Weighing and Measuring**

Staff who weigh and measure individuals must be trained and must follow standard procedures. For standard procedures that must be used when weighing and measuring, refer to Attachment 3. Ensure the established area is designed to maintain the rights of applicants or participants in a manner that does not compromise privacy, dignity and confidentiality. Refer to Chapter 16 for information related to confidentiality.

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Bloodwork Requirements

WIC requires that a hemoglobin (hgb.) or hematocrit (hct.) be completed to screen for iron deficiency anemia. To meet this requirement, WIC Programs should align their efforts with the Centers for Disease Control and Prevention (CDC) guidelines for bloodwork testing of infants, children, and pregnant and postpartum women. The flexibility of these guidelines allows WIC to coordinate with other health programs serving WIC applicants/participants and to minimize repetitive, costly and invasive blood testing procedures. Results of tests performed outside the agency may be used or WIC agencies may perform the bloodwork test themselves at no charge to the applicant/participant.

- **Minimum Requirements**
  The bloodwork requirements for WIC *(which are based on CDC guidelines)* are summarized in the following table.

Participant Category / Age at Certification	Blood work Requirements
WOMEN	
Pregnant	Bloodwork must be performed at the earliest opportunity **during** current pregnancy.
Postpartum non-breastfeeding	Bloodwork must be performed **after** pregnancy ends (ideally 4-6 weeks after pregnancy ends).
Postpartum breastfeeding: *Delivery to 6 months postpartum*	Bloodwork must be performed **after** delivery (ideally 4-6 weeks after delivery).
Postpartum breastfeeding: *6 months to 12 months postpartum*	Additional bloodwork is **not** required if performed since delivery (*and results are available to the WIC Program.)* Otherwise, bloodwork is required.
INFANTS / CHILDREN	
less than 9 months of age	Bloodwork is not required.
9 months through 23 months of age	Bloodwork must be performed between 9-12 months of age** **and again** 6 months later (ideally around 15-18 months of age). *** A blood test performed before 9 months of age may be appropriate on a case-by-case basis (e.g., preterm, early term or low birth weight infant not fed iron-fortified formula).*
24 months to 60 months of age	Bloodwork is required annually beginning at 24 months of age unless the previous test indicates a hemoglobin less than 11.1 g/dL or a hematocrit less than 33%. When hemoglobin is less than 11.1 g/dL s or a hematocrit is less than 33%, a blood test must be performed at 6-month intervals until the hemoglobin is equal to or greater than 11.1 g/dL or the hematocrit is equal to or greater than 33%.

- **Timing of the Bloodwork**
  There is considerable flexibility in the schedule for blood tests used for WIC certifications. Depending on the situation, blood tests may be performed prior to; the same day as; or up to 90 days after the date of certification.

  - The result of a blood test performed **prior to the date of certification** may be used for women when the result reflects the woman applicant's category, meaning the test must have been taken for a pregnant woman during pregnancy and for a postpartum or breastfeeding woman after the end of her pregnancy; or for infants and children, conforms to the anemia screening schedule as outlined in the previous table.

  - The result of a blood test performed on the **same day as certification** may be used for any participant.

  - For pregnant, postpartum breastfeeding and postpartum non-breastfeeding women, and for children; the hematological test may be **deferred for up to 90 days after the date of certification** when the individual has at least one qualifying nutritional risk factor present at the time of certification.

    If no qualifying risk factor is identified at certification, then a hematological test for anemia (hgb/hct) must be performed or obtained from referral sources to complete the eligibility determination. The one exception to this requirement is pregnant women who are certified with temporary eligibility (nutrition risk criterion 503) since these women may be certified for up to 60 days without an evaluation of nutrition risk. Refer to Section 6 for more information on temporary eligibility of pregnant women.
    NOTE: Nutrition risk criteria 401or 428 may not be used unless bloodwork is completed.

    Staff must make every effort to collect bloodwork that has been deferred for up to 90 days after the date of certification. If the participant/parent/guardian/caretaker does not provide the bloodwork information or have the bloodwork performed by the local agency, staff should not withhold Program benefits or terminate the participant from the Program.

- **Medical Exceptions to Bloodwork Requirements**
  Hemoglobin/hematocrit tests are not required if an individual has a medical condition (e.g., hemophilia, fragile bones, a serious skin disease) for which the procedure of collecting a blood sample could cause harm to the applicant/participant. Others for whom the test is not required include individuals for whom the test could cause unnecessary physical burden if they were required to visit the local WIC agency to provide a blood sample (e.g., they are medically confined to bed).

  In cases where a medical condition precludes obtaining a blood test, scan and save the physician’s documentation of the medical condition in the Crossroads system. If the medical condition is treatable, obtain the physician’s documentation of the medical condition at each certification. If the medical condition is lifelong, then document the situation only once. Local agency staff should make every effort to obtain referral medical data, including hematocrit/ hemoglobin data, from the individual’s health care provider.

- **Refusal to have Bloodwork Completed**
  For whatever reason, including religious reasons, the participant/parent/guardian/caretaker may refuse to provide test results or to allow the local agency to do the blood test. When this situation occurs, staff should certify the individual and document in Crossroads that the participant/parent/guardian/ caretaker refused to provide results or to allow the blood test. Staff must document refusal to have bloodwork completed in the Crossroads system at each recertification.
  NOTE: The nutrition risk criteria 401 or 428 may not be used unless bloodwork is completed.

- **Documentation of Bloodwork**
  Staff must document the actual date of the blood test, the test results, and the source of measures in the Crossroads system.

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Breastfeeding Status

As part of the comprehensive nutrition assessment for every participant, the CPA gathers breastfeeding status information by collecting feeding intentions, factors that may influence meeting these goals, current and historical feeding practices, and any healthcare provider recommendations.

Breastfeeding Status Data

At a minimum, feeding information must be collected for every participant at the time of certification. Based on participant category, additional breastfeeding assessment may be required mid-year, when changes in breastfeeding status are reported, or if a participant requests a food package change.

Documentation of actual feeding practices is recorded in the applicable Health Information or Dietary & Health quick links in Crossroads. Any relevant details not captured in these fields should be recorded in the participant's care plan.

Minimum Requirements

To support an integrated nutrition plan of care, breastfeeding status information should be collected through participant interviews and healthcare providers as appropriate. At a minimum, this includes the following information:

Participant Category	Breastfeeding Status Requirements
Pregnant Woman	▪ Breastfeeding intention, considering: – Intensity: exclusive, partial, or minimal – Duration – Method: direct breastfeeding, pumping, or combination ▪ Current or previous breastfeeding experience, considering: – Intensity, duration, method and reason for discontinuation with each child (if applicable) – Confidence in ability to breastfeed and meet personal feeding goals ▪ Perceived or potential barriers, considering: – Personal/Physical limitations such as pain, milk supply concerns, etc. – Psychosocial barriers such as return to work or school, lack of support, external pressure to wean ▪ Healthcare & medical factors: – Healthcare provider recommendations related to breastfeeding ▪ Rationale if recommendations differ from standard breastfeeding guidelines – Current or planned medications
Breastfeeding Woman/Infant or Child	▪ Current feeding practices, including: – Average number of breastfeeding sessions in 24 hours – Method – If supplementing:

Participant Category	Breastfeeding Status Requirements
	▪ Type of supplement ▪ Average amount in 24 hours ▪ Method of supplementation (spoon, bottle, SNS, etc.) – Feeding patterns (cue-based, scheduled, long gaps, cluster feeding, supplementing after each feed) – Infant intake indicators (voids & stool diapers, stool characteristics [early days], infant temperament, growth/weight gain) ▪ Breastfeeding experience & self-efficacy – Anticipated changes to current breastfeeding status – Confidence in ability to breastfeed and meet goals – Identification of supportive resources (e.g. Peer Counselor, healthcare provider, family, friends, etc.) – Use of a breastfeeding aid or accessory ▪ Perceived or potential barriers, including: – Personal/Physical limitations such as pain, milk supply concerns, etc. – Psychosocial barriers such as return to work or school, lack of support, external pressure to wean – Use, need, or request for breastfeeding aids, accessories, or infant formula in response to a reported breastfeeding issue ▪ Healthcare & medical factors – Healthcare provider recommendations related breastfeeding ▪ Rationale if recommendations differ from standard breastfeeding guidelines – Current or planned medications *Note: If a breastfeeding woman was not certified during her pregnancy, the CPA should use professional judgment to collect the relevant breastfeeding-related information outlined under the Pregnant Woman category, as appropriate, to ensure a complete and thorough nutrition assessment.*
Postpartum Woman/Infant	▪ Whether breastfeeding was initiated – If yes, duration of breastfeeding and reason for discontinuation.

Staff Who May Determine Nutrition Eligibility for WIC

Nutrition eligibility for the WIC Program must be determined by a competent professional authority.

- **Competent Professional Authority (CPA)**
  A competent professional authority is an individual on staff at a local agency authorized to determine nutritional risk eligibility and prescribe supplemental foods for the WIC Program. A CPA may be a nutritionist, registered dietitian (RD), dietetic technician registered (DTR), registered nurse (RN), nurse practitioner (NP), physician assistant (PA), or physician (MD). A CPA shall determine if a person is at nutritional risk and eligible for the WIC Program through a comprehensive nutrition assessment. Refer to Section 1 for information on nutrition assessment and care plan.

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Temporary Eligibility for Pregnant Women

A pregnant woman who meets the eligibility requirements for identity, residency, and income may be certified temporarily without an evaluation of nutrition risk for a period up to 60 days and receive up to one month worth of food benefits.

- **Documentation of Temporary Eligibility**
  To document "temporary eligibility" of a pregnant woman, a CPA should use the nutrition risk criterion code 503, "Temporary Eligibility for Pregnant Women". This criterion must be documented in the participant's record in the Crossroads system.

  NOTE: The CPA must complete the starred/required fields on the follow-up visit to complete the certification in Crossroads on the Family Assessment, Anthro/Lab and Health Information screens then navigate to the Certification Summary screen and select Complete Assessment.

- **Issuance of Food Benefits**
  Pregnant women certified as temporarily eligible may receive up to one month of food benefits at the time of certification. Additional food benefits must not be issued until the nutrition assessment (which includes the determination of nutrition eligibility) has been completed. To prevent an interruption of food benefits, staff should schedule an appointment within 30 days of the certification with a Competent Professional Authority (CPA) to complete the nutrition assessment, develop a plan of nutrition care, and provide nutrition education.

- **Nutrition Assessment and Continuation of Program Benefits**
  Pregnant women, who are considered temporarily eligible, should have a nutrition assessment completed. The assessment would ideally be completed within 30 days, but must be completed within 60 days, of the date of certification, to identify nutrition risk criteria. If the nutrition assessment is not completed within 60 days of the date of certification, the woman's application expires. The woman may subsequently reapply for Program benefits and may participate in the Program if found to be residentially, categorically, and income eligible and at nutritional risk.

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Immunization Screening and Referral

The immunization status of infants/children participating in the WIC Program must be determined at initial and subsequent WIC certification visits up to 24 months of age and at the infant mid-year nutrition assessment visit. Infants and children not up-to-date on immunizations at any one of these visits must be referred for immunization services.

To facilitate meeting this requirement, the parent/guardian/caretaker should be asked to bring immunization documentation to each of their infant's/child's WIC certification visits up to 24 months of age.

Immunization Screening

The purpose of immunization screening is to identify children under age two who are at risk for under-immunization.

- **Documented Immunization Record:** To determine immunization status, use a documented record on which actual vaccination dates are recorded. This documentation can be:
  - a paper source such as a client's immunization record (from the primary health care provider) or client's health record, or
  - a computerized record such as the North Carolina Immunization Registry (NCIR) or some other computerized data system.

- **Minimum Screening Requirements:** At a minimum, immunization screening for WIC participants is based on the number of doses of DTaP vaccines the infant/child has received in relation to their age as follows:

By 3 months of age, received 1 dose of DTaP
By 5 months of age, received 2 doses of DTaP
By 7 months of age, received 3 doses of DTaP
By 19 months of age, received 4 doses of DTaP

Immunization status of the DTaP vaccine (diphtheria and tetanus toxoids and acellular pertussis) is used because it is an indicator or predictor of overall immunization status. The Centers for Disease Control (CDC) Recommended Childhood and Adolescent Immunization Schedule recommends doses of this vaccine be given at 2 months, 4 months, 6 months and 18 months.

Immunization Referrals

- **Not Up-To-Date on Immunizations.** If the result of the immunization screening indicates the infant/child is not up-to-date on immunizations:
  - provide information on the recommended immunization schedule appropriate to the current age of the infant/child; and
  - refer infant/child for immunization services according to the local agency protocol.

- **Unknown Immunization Status.** If the immunization status cannot be determined due to lack of information:
  - provide information on the recommended immunization schedule appropriate to the current age of the infant/child;
  - refer infant/child for immunization services according to local agency protocol; and
  - request the parent/guardian/caretaker bring the immunization record to the next certification visit.

Documentation Requirements

Staff must document in the Crossroads system when immunization status is not-up-to-date or is unknown and when referrals to immunization services are made.

Note: Activities related to immunization screening, referral, and documentation in addition to those described in this section are NOT required by the WIC Program. Examples of "extra" activities include but are not limited to: requesting immunization records from health care providers, filing or recording immunization data in the client's agency medical record, making copies of immunization data, screening children older than 24 months of age, and entering historical immunization data into the NCIR.

Local Agency Protocol

Each local agency must have a written protocol which:

- identifies staff responsible for:
  - screening immunization status of infants/children participating in WIC and
  - documenting immunization status in the Crossroads system as up-to-date, not-up-to-date or unknown and when referrals to immunization services are made.

- defines:
  - where children not up-to-date on immunizations will be referred and
  - what to do when a documented immunization record is not available.

WIC's Role in Lead Testing and Referral

In North Carolina, universal blood lead testing at 12 months and again at 24 months of age (or at first contact between 25 and 72 months, if the child has not been previously tested) is encouraged.

Children who participate in Health Check, Health Choice or WIC are encouraged to receive a blood lead test at 12 and 24 months from their health care provider. When children 18-30 months old present for WIC certification, WIC staff should assess whether a blood lead test has been performed by the child's health care provider. If a blood lead test has not been performed or blood lead tests are not available, the child should be referred to the agency's blood lead coordinator or to the child's health care provider, depending on the agency's protocol.

If lead test results are available, the data can be documented on the Anthro/Lab screen in the Crossroads system.

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WIC Program Exchange of Information (DHHS 3492)

PURPOSE: To facilitate the exchange of information necessary for WIC certification between a health care provider and the local WIC Program.

GENERAL INSTRUCTIONS: WIC Program staff should complete the appropriate side of the form (infants/children or women) with the following information and forward it to the individual's health care provider (e.g., faxed, mailed, or given to the individual to take to the health care provider).

- **WIC Agency Name, Address, & Phone Number** of local WIC Program where person receives program services.
- **Patient Name & DOB (date of birth)** of individual being certified for WIC.
- **Client's Signature with Date** authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

DISTRIBUTION: Scan and maintain a copy of the WIC Program Exchange of Information form in the Crossroads system. Send a copy to the referring health care provider if requested.

DISPOSITION: This form may be destroyed in accordance with the Records Retention and Disposition Schedule for Local Health Departments. Refer to Chapter 13 for additional information.

REORDER INFORMATION: Additional copies of this form (DHHS 3492) may be ordered from CNSS using the Community Nutrition Services Requisition Form on the NC WIC Program website.

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North Carolina Department of Health and Human Services
Division of Child and Family Well-Being
Community Nutrition Services Section / WIC Program

RETURN COMPLETED FORM TO LOCAL AGENCY:

WIC PROGRAM EXCHANGE OF INFORMATION: Infants and Children

Name of Client: _____ **Date of Birth:** _____

I authorize the exchange of the information below between the WIC Program and my child's Health Care Provider.
Autorizo el intercambio de la siguiente información entre el programa WIC y el proveedor de atención médica de mi hijo.

Parent's/Caretaker's Signature/Firma: _____ Date/Fecha: _____

The following information is to be completed by the Health Care Provider.

1. Client is insured through (check one): ❒ Medicaid ❒ Other ❒ No health insurance
2. Document if client is ≤ 24 months of age: Birth Weight _____ Birth Length _____ Weeks Gestation _____
3. Enter date and results of most recent measurements / tests:
   Date: _____ Weight: _____
   Date: _____ Recumbent Length: _____ or Standing Height: _____
   Date: _____ Hemoglobin: _____ or Hematocrit: _____
   Date: _____ Blood Lead: _____ or ❒ Results not yet available
4. Immunization status (check one): ❒ Up-to-Date ❒ Not Up-to-Date
5. Medical conditions and medications:

6. Special instructions for nutritional support or feeding:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❒ Yes ❒ No

Completed by: _____ **Date:** _____ **Phone No.:** _____
Signature/Title

SUMMARY OF NUTRITION SERVICES (*to be completed by the WIC Program Staff)*

Completed by: _____ **Date:** _____ **Phone No.:** _____
Signature/Title

The North Carolina WIC Program operates in all 100 counties in North Carolina.
For more information, go to https://www.ncdhhs.gov/ncwic or contact your local WIC Program.
This institution is an equal opportunity provider.

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being
Community Nutrition Services Section / WIC Program

RETURN COMPLETED FORM TO LOCAL AGENCY:

WIC PROGRAM EXCHANGE OF INFORMATION: Women

Name of Client: _____ **Date of Birth:** _____

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.
Autorizo el intercambio de la siguiente información entre el programa WIC y mi proveedor de atención médica.

Parent's/Caretaker's Signature/Firma: _____ Date/Fecha: _____

The following information is to be completed by the Health Care Provider.

1. Actual or expected date of delivery: _____
2. Pre-pregnancy weight (if available): _____
3. Enter date and results of ***most recent*** measurements / tests:

   Date: _____ Weight: _____

   Date: _____ Height: _____

   Date: _____ Hemoglobin: _____ or Hematocrit: _____

4. Obstetric history:

5. Medical conditions and medications:

6. Special instructions for nutritional support or feeding:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❒ Yes ❒ No

Completed by: _____ **Date:** _____ **Phone No.** _____
Signature/Title

SUMMARY OF NUTRITION SERVICES (*to be completed by the WIC Program Staff)*

Completed by: _____ **Date:** _____ **Phone No.:** _____
Signature/Title

The North Carolina WIC Program operates in all 100 counties in North Carolina.
For more information, go to https://www.ncdhhs.gov/ncwic or contact your local WIC Program.
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RISK CODE	PRIORITY	CRITERION

PREGNANT WOMAN

ANTHROPOMETRIC CRITERIA

101	I	**UNDERWEIGHT (Women):** Pre-Pregnancy Body Mass Index (BMI) < 18.5
111	I	**OVERWEIGHT (Women):** Pre-Pregnancy Body Mass Index (BMI) ≥ 25.0
131	I	**LOW MATERNAL WEIGHT GAIN:** • A low rate of weight gain such that in the 2nd and 3rd trimesters, for singleton pregnancies: - Underweight (BMI < 18.5) prior to pregnancy with weight gain < 1 lb. per week - Normal weight (BMI 18.5-24.9) prior to pregnancy with weight gain < 0.8 lb. per week - Overweight (BMI 25.0-29.9) prior to pregnancy with weight gain < 0.5 lb. per week - Obese (BMI > 30.0) prior to pregnancy with weight gain < 0.4 lbs. per week • Low weight gain at any point in this pregnancy, such that using a National Academies of Sciences, Medicine, and Engineering (NASEM – formerly known as the Institute of Medicine)-based weight gain grid, a pregnant woman's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective pre-pregnancy weight category as follows: - Underweight (BMI < 18.5) total weight gain range 28 – 40 lb. - Normal weight (BMI 18.5-24.9) total weight gain 25 – 35 lb. - Overweight (BMI 25.0-29.9) total weight gain 15 – 25 lb. - Obese (BMI > 30.0) total weight gain 11 – 20 lb. • Until research supports the use of different BMI cut-offs to determine weight categories for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.
133	I	**HIGH MATERNAL WEIGHT GAIN:** • A high rate of weight gain such that in the 2nd and 3rd trimesters, for singleton pregnancies: - Underweight (BMI < 18.5) prior to pregnancy with weight gain > 1.3 lbs. per week - Normal weight (BMI 18.5-24.9) prior to pregnancy with weight gain > 1 lb. per week - Overweight (BMI 25.0-29.9) prior to pregnancy with weight gain > 0.7 lb. per week - Obese (BMI > 30.0) prior to pregnancy with weight gain > 0.6 lb. per week • High weight gain at any point in this pregnancy, such that using an Institute of Medicine (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 respective pre-pregnancy weight category.

BIOCHEMICAL CRITERIA

201	I	**LOW HEMOGLOBIN OR HEMATOCRIT** as confirmed by lab tests:

Weeks at Test	Hgb. (gms)	Hct. (%)
0 to 13 (1st Trimester)	< 11.0	< 33
14 to 27 (2nd Trimester)	< 10.5	< 32
28 to 42 (3rd Trimester)	< 11.0	< 33

211	I	**ELEVATED BLOOD LEAD LEVEL:** blood lead level ≥ 5 ug/dL within the past 12 months

CLINICAL CRITERIA

341 342 343 344 345 346 347 348 349 351 352a	352b 353 354 355 356 357 358 359 360 361 362	I Presence of **MEDICAL CONDITION(S)** that may jeopardize the individual's nutritional status by its presence or by its treatment, through an adverse effect on the ingestion, absorption, or utilization of nutrients (see Appendix A for list of allowable medical conditions and the corresponding nutrition risk criteria codes). *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

RISK CODE	PRIORITY	CRITERION
301	I	**HYPEREMESIS GRAVIDARUM (HG):** 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. *Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or self-reported by applicant/participant/guardian/caretaker.*
302	I	**GESTATIONAL DIABETES:** Any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy. C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/ guardian/caretaker.*
303	I	**HISTORY OF GESTATIONAL DIABETES:** *Condition must have been diagnosed by a physician/ physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
304	I	**HISTORY OF PREECLAMPSIA (pregnancy-induced hypertension):** History of diagnosed preeclampsia. C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
311	I	**HISTORY OF PRETERM OR EARLY TERM DELIVERY** • Preterm Delivery: Delivery of an infant born ≤ 36 6/7 weeks gestation • Early Term Delivery: Deliver of an infant born ≥ 37 0/7 and ≤ 38 6/7 weeks gestation
321	I	**HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS** defined as having had any of the following**:** • Two or more (≥ 2) spontaneous abortions (spontaneous termination of a gestation at < 20 weeks gestation or < 500 grams) • Fetal death (spontaneous termination of a gestation at ≥ 20 weeks) • Neonatal death (death of an infant within 0-28 days of life) C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
331	I	**PREGNANCY AT A YOUNG AGE:** Conception of current pregnancy was prior to the 21st birthday
332	I	**SHORT INTERPREGNANCY INTERVAL:** Interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy
334	I	**LACK OF OR INADEQUATE PRENATAL CARE** defined as: • Woman is 14-21 wks. gestation and has had 0 prenatal health care visits • Woman is 22-29 wks. gestation and has had ≤ 1 prenatal health care visits • Woman is 30-31 wks. gestation and has had ≤ 2 prenatal health care visits • Woman is 32-33 wks. gestation and has had ≤ 3 prenatal health care visits • Woman is ≥ 34 wks. gestation and has had ≤ 4 prenatal health care visits • Prenatal care was initiated after 26 weeks gestation
335	I	**MULTIFETAL GESTATION**: More than one (>1) fetus in current pregnancy
336	I	**FETAL GROWTH RESTRICTION (FGR)** (replaces the term Intrauterine Growth Retardation (IUGR) *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

RISK CODE	PRIORITY	CRITERION
337	I	**HISTORY OF BIRTH OF A LARGE FOR GESTATIONAL AGE (LGA) INFANT:** Any history of giving birth to an infant weighing ≥ 9 lbs. or 4000 gms) Condition *must be diagnosed by a physician/ physician extender. The diagnosis may be reported or documented by a physician/ physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
338	I	**PREGNANT WOMAN CURRENTLY BREASTFEEDING** (i.e., nurses at least once every 24 hrs.)
339	I	**HISTORY OF BIRTH WITH NUTRITION-RELATED CONGENITAL OR BIRTH DEFECT:** A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess vitamin A. C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/ physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
371	I	**NICOTINE AND TOBACCO USE:** Any use of products that contain nicotine and/or tobacco to include cigarettes, pipes, cigars, electronic nicotine delivery systems, hookahs, smokeless tobacco or nicotine replacement therapies in current pregnancy.
372	I	**ALCOHOL AND SUBSTANCE USE** including: • Any alcohol use in current pregnancy, • Any illegal substance use and/or abuse of prescription medications, and/or • Any marijuana use in any form.
381	I	**ORAL HEALTH CONDITIONS**: Conditions which interfere with the ability to ingest food in adequate quantity or quality. Dental conditions may include: tooth decay, chronic oral sores/lesions, abscessed tooth, chronic bleeding gums (gingivitis, periodontal disease), loose teeth, severe edentulous conditions (missing or no teeth). *Presence of the dental problem may be diagnosed by a dentist, physician/physician extender, someone working under a dentist's or physician's/physician extender's orders; or, it may be identified through adequate documentation by the WIC CPA. If diagnosed, the diagnosis may be reported or documented by a dentist, physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
382	I	**FETAL ALCOHOL SPECTRUM DISORDERS:** Conditions that cover a range of possible diagnosis including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder that can occur in a person whose mother consumed alcohol during pregnancy. *The diagnosis may be reported by a physician/ physician extender's orders, or as self-reported by applicant/participant/caregiver.*
602	I	**BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS:** A pregnant woman who is breastfeeding with any of the following complications or potential complications limited to: severe breast engorgement; recurrent plugged ducts; mastitis; flat or inverted nipples; cracked, bleeding, or severely sore nipples; age ≥ 40 years; failure of milk to come in by 4 days postpartum; tandem nursing (breastfeeding siblings who are not twins).
		DIETARY CRITERIA
401	IV	**FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS.** Women who meet the income, categorical, and residency eligibility requirements may be presumed to be at nutrition risk for failure to meet *Dietary Guidelines for Americans [Dietary Guidelines].* Based on an individual's estimated energy needs, the *Failure to meet Dietary Guidelines* risk criterion is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans.) **401 is assigned only to individuals for whom a complete nutrition assessment (including assessment of risk criterion 427 "Inappropriate Nutrition Practices for Women") has been performed and for whom no other risk(s) is identified.**
427	IV	**INAPPROPRIATE NUTRITION PRACTICES FOR WOMEN:** Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. *(Refer to Appendix B for definitions.)*

ECO-SOCIAL CRITERIA

RISK CODE	PRIORITY	CRITERION
502	NA	**TRANSFER OF CERTIFICATION**: Person with current valid Verification of Certification (VOC) document from another State or local agency. 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. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by NC.
503	IV	**TEMPORARY ELIGIBILITY FOR PREGNANT WOMEN:** A pregnant woman who meets WIC income eligibility standards but has not yet been evaluated for nutrition risk for a period of up to 60 days. *(Refer to Chapter 6C, Section 6.)*
601	I, II, IV	**BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK:** A pregnant woman who is breastfeeding and whose breastfed infant has been determined to be at nutritional risk based on Priority I, II, or IV criteria. *Must be the same priority as at-risk infant.*
801	IV	**HOMELESSNESS:** Lacking a fixed and regular nighttime residence; or having a primary nighttime residence that 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.
802	IV	**MIGRANCY:** Being a member of a family which has 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.
901	IV	**RECIPIENT OF ABUSE:** Defined as the experience of physical, sexual, emotional, economic, or psychological maltreatment that may frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, and/or wound a woman. The abuse may be self-reported by the individual, by a family member, a social worker, health care provider or other appropriate personnel. Types of abuse include but are not limited to Domestic Violence (DV) and/or Intimate Partner Violence (IPV).
902	IV	**WOMAN WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD**. Examples include, but are not limited to a woman with the following: • Documentation or self-report of misuse of alcohol, use of illegal substance, use of marijuana, or misuse of prescription medications. • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders or as self-reported by applicant/participant/caregiver. • Intellectual disability diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Physical disability to a degree which impairs or limits food preparation abilities. • ≤ 17 years of age.
903	IV	**IN FOSTER CARE:** Designated by DSS or living in a private/public/public child placement agency licensed by the state of North Carolina/DHHS/DSS as evidenced by**:** • entering the foster care system during the previous six months; or • moving from one foster care home to another foster care home during the previous six months.
904	I	**ENVIRONMENTAL TOBACCO SMOKE EXPOSURE (ETS):** Defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as passive, secondhand, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems.

RISK CODE	PRIORITY	CRITERION

POSTPARTUM WOMAN

ANTHROPOMETRIC CRITERIA

101	III	**UNDERWEIGHT (Women):** Pre-Pregnancy or current Body Mass Index (BMI) < 18.5
111	III	**OVERWEIGHT (Women):** Pre-Pregnancy Body Mass Index (BMI) ≥ 25.0
133	III	**HIGH MATERNAL WEIGHT GAIN** in most recent pregnancy with total gestational weight gain exceeding the upper limit of the IOM's (Institute of Medicine) recommended range based on Body Mass Index (BMI) for singleton pregnancies as follows: • Underweight (BMI < 18.5) prior to pregnancy with > 40 lbs. total weight gain • Normal weight (BMI 18.5 – 24.9) prior to pregnancy with > 35 lbs. total weight gain • Overweight (BMI 25.0 – 29.9) prior to pregnancy with >25 lbs. total weight gain • Obese (BMI ≥ 30.0) prior to pregnancy with > 20 lbs. total weight gain

BIOCHEMICAL CRITERIA

201	III	**LOW HEMOGLOBIN OR HEMATOCRIT** as confirmed by lab tests: Age at Test — Hgb. (gms) — Hct. (%) < 15 yrs. — < 11.8 — < 36.0 15 to <18 yrs. — < 12.0 — < 35.9 ≥ 18 yrs. — < 12.0 — < 36.0
211	III	**ELEVATED BLOOD LEAD LEVEL:** Blood lead level ≥ 5 ug/dL within the past 12 months

CLINICAL CRITERIA

341 342 343 344 345 346 347 348 349 351 352a	III 352b 353 354 355 356 357 358 359 360 361 362 363	Presence of **MEDICAL CONDITION(S)** that may jeopardize the individual's nutritional status by its presence or by its treatment, through an adverse effect on the ingestion, absorption, or utilization of nutrients (see Appendix A for list of allowable medical conditions and the corresponding nutrition risk criteria codes). *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
303	III	**HISTORY OF GESTATIONAL DIABETES** in most recent pregnancy OR history of gestational diabetes. *Condition must have been diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
304	I	**HISTORY OF PREECLAMPSIA (pregnancy-induced hypertension):** History of diagnosed preeclampsia. C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
311	III	**HISTORY OF PRETERM OR EARLY TERM DELIVERY (**in most recent pregnancy) • Preterm Delivery: Delivery of an infant born < 36 6/7 weeks gestation • Early Term Delivery: Deliver of an infant born > 37 0/7 and < 38 6/7 weeks gestation

RISK CODE	PRIORITY	CRITERION
321	III	**SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS** in most recent pregnancy by having had any of the following**:** • spontaneous abortion (spontaneous termination of a gestation at < 20 weeks gestation or < 500 grams) • a fetal death (spontaneous termination of a gestation at ≥ 20 weeks) • a neonatal death (death of an infant within 0-28 days of life) *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
331	III	**PREGNANCY AT A YOUNG AGE:** Conception of most recent pregnancy was prior to the 21st birthday.
332	II	**SHORT INTERPREGNANCY INTERVAL:** Interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy
335	III	**MULTIFETAL GESTATION:** More than one (>1) fetus in most recent pregnancy
337	III	**HISTORY OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT** in most recent pregnancy OR history of giving birth to an infant weighing ≥ 9 lbs. or 4000 gms. *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/ physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
339	III	**HISTORY OF BIRTH WITH NUTRITION-RELATED CONGENITAL OR BIRTH DEFECT** in most recent pregnancy (A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess vitamin A) C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
371	III	**NICOTINE AND TOBACCO USE:** Any use of products that contain nicotine and/or tobacco to include cigarettes, pipes, cigars, electronic nicotine delivery systems, hookahs, smokeless tobacco or nicotine replacement therapies in postpartum period.
372	III	**ALCOHOL AND SUBSTANCE USE** including**:** • Alcohol use - A serving, or standard sized drink is 12 oz. beer; 5 oz. wine; or 1½ oz. 80 proof distilled spirits (e.g. rum, vodka, whiskey, cordials or liqueurs) – 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.
381	III	**ORAL HEALTH CONDITIONS:** Conditions which interfere with the ability to ingest food in adequate quantity or quality. Dental conditions may include: tooth decay, chronic oral sores/lesions, abscessed tooth, chronic bleeding gums (gingivitis, periodontal disease), loose teeth, severe edentulous conditions (missing or no teeth). *Presence of the dental problem may be diagnosed by a dentist, physician/physician extender, someone working under a dentist's or physician's/physician extender's orders; or, it may be identified through adequate documentation by the WIC CPA. If diagnosed, the diagnosis may be reported or documented by a dentist, physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
382	III	**FETAL ALCOHOL SPECTRUM DISORDERS:** Conditions that cover a range of possible diagnosis including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder that can occur in a person whose mother consumed alcohol during pregnancy. *The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

RISK CODE	PRIORITY	CRITERION
		DIETARY CRITERIA
401	VI	**FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS.** Women who meet the income, categorical, and residency eligibility requirements may be presumed to be at nutrition risk for failure to meet *Dietary Guidelines for Americans [Dietary Guidelines].* Based on an individual's estimated energy needs, the *Failure to meet Dietary Guidelines* risk criterion is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans. **This risk is assigned only to individuals for whom a complete nutrition assessment (including assessment of the risk criterion 427 "Inappropriate Nutrition Practices for Women") has been performed and for whom no other risk(s) is identified.**
427	VI	**INAPPROPRIATE NUTRITION PRACTICES FOR WOMEN** defined as routine nutrition practices that may result in impaired nutrient status, disease, or health problems. *(Refer to Appendix B)*
		ECO-SOCIAL CRITERIA
502	NA	**TRANSFER OF CERTIFICATION** Person with current valid Verification of Certification (VOC) document from another State or local agency. 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. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by NC.
801	VI	**HOMELESSNESS:** Lacking a fixed and regular nighttime residence; or having a primary nighttime residence that 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.
802	VI	**MIGRANCY:** Being a member of a family which has 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.
901	VI	**RECIPIENT OF ABUSE**: Defined as the experience of physical, sexual, emotional, economic, or psychological maltreatment that may frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, and/or wound a woman. The abuse may be self-reported by the individual, by a family member, a social worker, health care provider or other appropriate personnel. Types of abuse include but are not limited to Domestic Violence and/or Intimate Partner Violence.
902	VI	**WOMAN WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR TO PREPARE FOOD**. Examples include, but are not limited to, a woman with the following: • Documentation or self-report of misuse of alcohol, use of illegal substance, use of marijuana, or misuse of prescription medications • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders or as self-reported by applicant/participant/caregiver. • Intellectual disability diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Physical disability to a degree which limits food preparation abilities • ≤ 17 years of age

RISK CODE	PRIORITY	CRITERION
903	VI	**IN FOSTER CARE:** Designated by DSS or living in a private/public/public child placement agency licensed by the state of North Carolina/DHHS/DSS as evidenced by**:** • entering the foster care system during the previous six months; or • moving from one foster care home to another foster care home during previous six months.
904	IV	**ENVIRONMENTAL TOBACCO SMOKE EXPOSURE** (ETS): Defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of childcare, etc. ETS is also known as passive, secondhand, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems.

RISK CODE | PRIORITY | CRITERION

BREASTFEEDING WOMAN

ANTHROPOMETRIC CRITERIA

101 | I | **UNDERWEIGHT (Women)**:
- For women < 6 months postpartum: Pre-Pregnancy or current Body Mass Index (BMI) < 18.5
- For women ≥ 6 months postpartum: Current Body Mass Index (BMI) < 18.5

111 | I | **OVERWEIGHT (Women)**:
- For women < 6 months postpartum: Pre-Pregnancy Body Mass Index (BMI) > 25.0
- For women > 6 months postpartum: Current Body Mass Index (BMI) > 25.0

133 | I | **HIGH MATERNAL WEIGHT GAIN** in most recent pregnancy with total gestational weight gain exceeding the upper limit of the IOM's (Institute of Medicine) recommended range based on Body Mass Index (BMI) for singleton pregnancies as follows:
- Underweight (BMI < 18.5) prior to pregnancy with > 40 lbs. total weight gain
- Normal weight (BMI 18.5 – 24.9) prior to pregnancy with > 35 lbs. total weight gain
- Overweight (BMI 25.0 – 29.9) prior to pregnancy with >25 lbs. total weight gain
- Obese (BMI ≥ 30.0) prior to pregnancy with > 20 lbs. total weight gain

BIOCHEMICAL CRITERIA

201 | I | **LOW HEMOGLOBIN OR HEMATOCRIT** as confirmed by lab tests**:**

Age at Test	Hgb. (gms)	Hct. (%)
< 15 yrs.	< 11.8	< 36.0
15 to <18 yrs.	< 12.0	< 35.9
≥ 18 yrs.	< 12.0	< 36.0

211 | I | **ELEVATED BLOOD LEAD LEVEL:** blood lead level ≥ 5 ug/dL within the past 12 months

CLINICAL CRITERIA

341 352b 342 353 343 354 344 355 345 356 346 357 347 358 348 359 349 360 351 361 352a 362 363 | I | Presence of **MEDICAL CONDITION(S)** that may jeopardize the individual's nutritional status by its presence or by its treatment, through an adverse effect on the ingestion, absorption, or utilization of nutrients (see Appendix A for list of allowable medical conditions and the corresponding nutrition risk criteria codes). *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

303 | I | **HISTORY OF GESTATIONAL DIABETES** in most recent pregnancy OR history of gestational diabetes. *Condition must have been diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

304 | I | **HISTORY OF PREECLAMPSIA (pregnancy-induced hypertension):** History of diagnosed preeclampsia. C*ondition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

RISK CODE	PRIORITY	CRITERION
311	I	**HISTORY OF PRETERM OR EARLY TERM DELIVERY (History of Preterm or Early Term Delivery)** in most recent pregnancy • Preterm Delivery: Delivery of an infant born ≤ 36 6/7 weeks gestation • Early Term Delivery: Deliver of an infant born ≥ 37 0/7 and ≤ 38 6/7 weeks gestation
321	I	**FETAL OR NEONATAL LOSS** in most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living**:** • a fetal death (spontaneous termination of a gestation at ≥ 20 weeks gestation) • a neonatal death (death of an infant within 0-28 days of life) *Condition must have been diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/caretaker.*
331	I	**PREGNANCY AT A YOUNG AGE:** Conception of most recent pregnancy was prior to the 21st birthday
332	I	**SHORT INTERPREGNANCY INTERVAL:** Interpregnancy interval of less than 18 months from the date of a live birth to the conception of the subsequent pregnancy
335	I	**MULTIFETAL GESTATION:** More than one (>1) fetus in most recent pregnancy
337	I	**HISTORY OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT** in most recent pregnancy OR history of giving birth to an infant weighing ≥ 9 lbs. or 4000 gms. *Condition must have been diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
339	I	**HISTORY OF BIRTH WITH NUTRITION-RELATED CONGENITAL OR BIRTH DEFECT** in most recent pregnancy (A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess vitamin A) *Condition must have been diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian caretaker.*
371	I	**NICOTINTE AND TOBACCO USE***:* Any use of products that contain nicotine and/or tobacco to include cigarettes, pipes, cigars, electronic nicotine delivery systems, hookahs, smokeless tobacco or nicotine replacement therapies in postpartum period.
372	I	**ALCOHOL AND SUBSTANCE USE:** • Alcohol Use - A serving, or standard sized drink is 12 oz. beer; 5 oz. wine; or 1½ oz. 80 proof distilled spirits (e.g. rum, vodka, whiskey, cordials or liqueurs). – 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.
381	I	**ORAL HEALTH CONDITIONS:** Conditions which interfere with the ability to ingest food in adequate quantity or quality. Dental conditions may include: tooth decay, chronic oral sores/lesions, abscessed tooth, chronic bleeding gums (gingivitis, periodontal disease), loose teeth, severe edentulous conditions (missing or no teeth) *Presence of the dental problem may be diagnosed by a dentist, physician/physician extender, someone working under a dentist's or physician's/physician extender's orders; or, it may be identified through adequate documentation by the WIC CPA. If diagnosed, the diagnosis may be reported or documented by a dentist, physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*

RISK CODE	PRIORITY	CRITERION
382	I	**FETAL ALCOHOL SPECTRUM DISORDERS:** Conditions that cover a range of possible diagnosis including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder that can occur in a person whose mother consumed alcohol during pregnancy. *The diagnosis may be reported by a physician/ physician extender's orders, or as self-reported by applicant/participant/caregiver.*
602	I	**BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS:** A breastfeeding woman with any of the following complications or potential complications for breastfeeding and which are limited to: severe breast engorgement; recurrent plugged ducts; mastitis; flat or inverted nipples; cracked, bleeding, or severely sore nipples; age ≥ 40 years; failure of milk to come in by 4 days postpartum; tandem nursing (breastfeeding siblings who are not twins)
		DIETARY CRITERIA
401	IV	**FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS.** Women who meet the income, categorical, and residency eligibility requirements may be presumed to be at nutrition risk for failure to meet *Dietary Guidelines for Americans [Dietary Guidelines].* Based on an individual's estimated energy needs, the *Failure to meet Dietary Guidelines* risk criterion is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans). **This risk is assigned only to individuals for whom a complete nutrition assessment (including assessment of the risk criterion 427 "Inappropriate Nutrition Practices for Women") has been performed and for whom no other risk(s) is identified.**
427	IV	**INAPPROPRIATE NUTRITIONAL PRACTICES FOR WOMEN** defined as routine nutrition practices that may result in impaired nutrient status, disease, or health problems *(Refer to Appendix B).*
		ECO-SOCIAL CRITERIA
502	NA	**TRANSFER OF CERTIFICATION** Person with current valid Verification of Certification (VOC) document from another State or local agency. 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. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by NC
601	I, II, IV	**BREASTFEEDING MOTHER OF INFANT AT NUTRITIONAL RISK.** A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk based on Priority I, II, or IV criteria. *Must be the same priority as at-risk infant.*
801	IV	**HOMELESSNESS:** Lacking a fixed and regular nighttime residence; or having a primary nighttime residence that 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.
802	IV	**MIGRANCY:** Being a member of a family which has 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.

RISK CODE	PRIORITY	CRITERION
901	IV	**RECIPIENT OF ABUSE:** Defined as the experience of physical, sexual, emotional, economic, or psychological maltreatment that may frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, and/or wound a woman. The abuse may be self-reported by the individual, by a family member, a social worker, health care provider or other appropriate personnel. Types of abuse include but are not limited to Domestic Violence (DV) and/or Intimate Partner Violence (IPV).
902	IV	**WOMAN WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR TO PREPARE FOOD**. Examples include, but are not limited to, a woman with the following: • Documentation or self-report of misuse of alcohol, use of illegal substance, use of marijuana, or misuse of prescription medications • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders or as self-reported by applicant/participant/caregiver. • Intellectual disability diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Physical disability to a degree which limits food preparation abilities. • < 17 years of age.
903	IV	**IN FOSTER CARE:** Designated by DSS or living in a private/public/public child placement agency licensed by the state of North Carolina/DHHS/DSS as evidenced by**:** • entering the foster care system during the previous six months; or • moving from one foster care home to another foster care home during previous six months.
904	I	**ENVIRONMENTAL TOBACCO SMOKE EXPOSURE** (ETS): Defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as passive, secondhand, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems.

RISK CODE	PRIORITY	CRITERION

INFANT

ANTHROPOMETRIC CRITERIA

103	I	**UNDERWEIGHT** (weight-for-length ≤ 2.3rd percentile as plotted on the 2009 Centers for Disease Control (CDC)/WHO Birth to 24 months gender specific growth charts*) **OR** **AT RISK OF UNDERWEIGHT** (weight-for-length ≤ 5th percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*)
114	I	**AT RISK OF OVERWEIGHT** based on the presence of one or both of the following: • **Infant of obese mother:** Having a biological mother with BMI ≥ 30.0 at time of conception of this infant or at any time in 1st trimester of this most recent pregnancy (*BMI must be based on pre-pregnancy weight and height self-reported by the mother or on weight and height measurements that were taken during her pregnancy by staff or a health care provider.)* • **Infant of obese father:** Having a biological father with BMI ≥ 30.0 at time of certification (*BMI must be based on weight and height self-reported by the father or on weight and height measurements taken by staff at time of certification.)*
115	I	**HIGH WEIGHT-FOR-LENGTH:** weight-for-length ≥ 97.7th percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*
121	I	**SHORT STATURE** (length-for-age ≤ 2.3rd percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*) **OR** **AT RISK OF SHORT STATURE** (length-for-age ≤ 5th percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*) *For premature infants (i.e., ≤ 37 weeks gestational age), risk assignment is based on adjusted gestational age.*
134	I	**FAILURE TO THRIVE** *Presence of failure to thrive must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.* The diagnosis describes an inadequate growth pattern where growth is significantly lower than what is expected for age and sex.
135	I	**SLOWED/FALTERING GROWTH PATTERN** defined as**:** • **Infants birth to up to 2 weeks of age *(at the time of certification)*:** Excessive weight loss after birth, defined as ≥7% birth weight • **Infants 2 weeks up to 6 months of age *(at the time of certification)*:** Any weight loss. Use two separate weights taken at least 8 weeks apart.
141	I	**LOW BIRTH WEIGHT** (>1500 gms - ≤ 2500 gms or >3 lbs. 5oz - ≤ 5 lbs. 8 oz.**) AND** **VERY LOW BIRTH WEIGHT** (≤ 1500 gms or ≤ 3 lbs. 5 oz.)
142	I	**(HISTORY OF) PRETERM OF EARLY TERM DELIVERY:** • Preterm Delivery: Delivery of an infant born ≤ 36 6/7 weeks gestation • Early Term Delivery: Deliver of an infant born ≥ 37 0/7 and ≤ 38 6/7 weeks gestation
151	I	**(HISTORY OF) SMALL FOR GESTATIONAL AGE (SGA)** *Presence of SGA must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.*
153	I	**BIRTH WEIGHT ≥ 9 LBS (4000 GMS) OR LARGE FOR GESTATIONAL AGE (LGA)** *Presence of LGA must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.*

*Based on 2006 World Health Organization international growth standards

RISK CODE	PRIORITY	CRITERION
		BIOCHEMICAL CRITERIA
201	I	**LOW HEMOGLOBIN OR HEMATOCRIT** as confirmed by lab tests: Age at Test — Hgb (gms) — Hct (%) 6 to < 12 mo. — < 11.8 — < 33.0
211	I	**ELEVATED BLOOD LEAD LEVEL:** Blood lead level ≥ 5 ug/dL within the past 12 months
		CLINICAL CRITERIA
341 342 343 344 345 346 347 348 349 351 352a 352b 353 354 355 356 357 359 360 362	I	Presence of **MEDICAL CONDITION(S)** that may jeopardize the individual's nutritional status by its presence or by its treatment, through an adverse effect on the ingestion, absorption, or utilization of nutrients (see Appendix A for list of allowable medical conditions and the corresponding nutrition risk criteria codes). *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
381	I	**ORAL HEALTH CONDITIONS:** Conditions may include tooth decay (including nursing or baby bottle caries), chronic oral sores/lesions, oral candidiasis, or an abscessed tooth. *Presence of the dental problem may be diagnosed by a dentist, physician/physician extender, someone working under a dentist's or physician's/physician extender's orders; or, it may be identified through adequate documentation by the WIC CPA. If diagnosed, the diagnosis may be reported or documented by a dentist, physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.*
382	I	**FETAL ALCOHOL SPECTRUM DISORDERS**: Conditions that cover a range of possible diagnosis including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder that can occur in a person whose mother consumed alcohol during pregnancy. *The diagnosis may be reported by a physician/ physician extender's orders, or as self-reported by applicant/participant/caregiver.*
383	I	**NEONATAL ABSTINENCE SYNDROME** 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. *This condition must be present within the first 6 months of birth and diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by the infant's caregiver.*
603	I	**BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS** which are present at the time of certification and which are limited to: jaundice, weak or ineffective suck, difficulty latching onto mother's breast, inadequate stooling (as determined by physician/healthcare professional), < 6 wet diapers per day
		DIETARY CRITERIA
411	IV	**INAPPROPRIATE NUTRITION PRACTICES FOR INFANTS** defined as routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. *(Refer to Appendix C)*
428	IV	**DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES** and current chronological age is ≥ 4 months. Infants who meet the eligibility requirements of income, category and residence and who have begun or are expected to begin to consume complementary foods are at risk of inappropriate complementary feeding. **This risk is assigned only to individuals for whom a complete nutrition assessment (including assessment of the risk criterion 425 "Inappropriate Nutrition Practices for Children") has been performed and for whom no other risk(s) is identified.**

RISK CODE	PRIORITY	CRITERION
		assessment of the risk criterion 411 "Inappropriate Nutrition Practices for Infants") has been performed and for whom no other risk(s) is identified.
		ECO-SOCIAL CRITERIA
502	NA	**TRANSFER OF CERTIFICATION** Person with current valid Verification of Certification (VOC) document from another State or local agency. 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. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by NC
701	II	**INFANT < 6 MONTHS OF AGE, BORN TO WOMAN WHO PARTICIPATED ON WIC DURING THIS PREGNANCY OR INFANT < 6 MONTHS OF AGE, BORN TO WOMAN WHO DID NOT PARTICIPATE ON WIC DURING PREGNANCY BUT WHO WAS AT NUTRITIONAL RISK BASED ON PRIORITY I CRITERIA.** Document mother's nutritional risk in infant's health record.
702	I, IV	**BREASTFED INFANT WHOSE MOTHER IS AT NUTRITIONAL RISK BASED ON PRIORITY I CRITERIA OR BREASTFED INFANT WHOSE MOTHER IS AT NUTRITIONAL RISK BASED ON PRIORITY IV CRITERIA.**
801	IV	**HOMELESSNESS:** Lacking a fixed and regular nighttime residence; or having a primary nighttime residence that 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.
802	IV	**MIGRANCY:** Being a member of a family which has 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.
901	IV	**RECIPIENT OF ABUSE:** Child abuse and/or neglect defined as any act or failure to act that results in harm to a infant or put an infant at risk of harm. Child abuse may physical (including shaken baby syndrome), sexual, or emotional, or neglect of an infant by a parent, caretaker, or other person in a custodial role. It may be self-reported by the individual, by a family member, documented or reported by a social worker, health care provider or other appropriate personnel.
902	IV	**INFANT OF PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD**. Examples include, but are not limited to an infant of caregiver with the following: • Documentation or self-report of misuse of alcohol, use of illegal substance, use of marijuana, or misuse of prescription medications • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders or as self-reported by applicant/participant/caregiver. • Intellectual disability diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Physical disability to a degree which impairs ability to feed infant or limits food preparation abilities. • ≤ 17 years of age.

RISK CODE	PRIORITY	CRITERION
903	IV	**IN FOSTER CARE:** Designated by DSS or living in a private/public/public child placement agency licensed by the state of North Carolina/DHHS/DSS as evidenced by**:** • entering the foster care system during the previous six months; or • moving from one foster care home to another foster care home during previous six months.
904	I	**ENVIRONMENTAL TOBACCO SMOKE EXPOSURE** (ETS): Defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as passive, secondhand, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems.

RISK CODE	PRIORITY	CRITERION

CHILD

ANTHROPOMETRIC CRITERIA

103	III	**UNDERWEIGHT** • For age 12-23 months (weight-for-length ≤ 2.3rd percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*) • For age 2-5 years (BMI-for-age ≤ 5th percentile as plotted on the 2000 CDC 2-20 years gender specific growth charts) OR **AT RISK OF UNDERWEIGHT** • For age 12-23 months (weight-for-length ≤ 5th percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*) • For age 2-5 years (BMI-for-age ≤ 10th percentile as plotted on the 2000 CDC 2-20 years gender specific growth charts)
113	III	**OBESE (Children 2 – 5 years of age):** 2-5 years and BMI-for-age ≥ 95th percentile as plotted on the 2000 CDC 2-20 years gender specific growth charts
114	III	**OVERWEIGHT:** age 2-5 years and BMI-for-age ≥ 85th and < 95th percentile as plotted on the 2000 Centers for Disease Control (CDC) 2-20 years gender specific growth charts **OR** **AT RISK OF OVERWEIGHT** based on the presence of one or both of the following: • **Child of obese mother:** Having a biological mother with BMI ≥ 30.0 at time of certification of this child (*BMI must be based on weight and height self-reported by the mother or on weight and height measurements taken by staff at the time of certification. If mother is pregnant or had a baby within the past 6 months, use her pre-pregnancy weight to determine BMI since her current weight will be influenced by pregnancy-related weight gain.)* • **Child of obese father:** Having a biological father with BMI ≥ 30.0 at time of certification of this child (*BMI must be based on weight and height self-reported by the father or on weight and height measurements taken by staff at time of certification.)*
115	III	**HIGH WEIGHT-FOR-LENGTH (Children < 24 months of age):** weight-for-length ≥ 97.7th percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*
121	III	**SHORT STATURE** • For age 12-23 months (length-for-age ≤ 2.3rd percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*) • For age 2-5 years (stature-for-age ≤ 5th percentile as plotted on the 2000 CDC 2-20 years gender specific growth charts) **OR** **AT RISK OF SHORT STATURE** • For age 12-23 months (length-for-age ≤ 5th percentile as plotted on the 2009 CDC/WHO Birth to 24 months gender specific growth charts*) • For age 2-5 years (stature-for-age ≤ 10th percentile as plotted on the 2000 CDC 2-20 years gender specific growth charts) *For children < 2 years old with a history of prematurity (i.e., ≤ 37 weeks gestational age), risk assignment is based on adjusted gestational age.*
134	III	**FAILURE TO THRIVE** *Presence of failure to thrive must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.* The diagnosis describes an inadequate growth pattern where growth is significantly lower than what is expected for age and sex.
141	III	**LOW BIRTH WEIGHT** (> 1500 gms - ≤ 2500 gms or > 3 lbs. 5oz - ≤ 5 lbs. 8 oz.) **OR VERY LOW BIRTH WEIGHT** (≤ 1500 gms or ≤ 3 lbs. 5 oz.): current chronological age is < 24 months

*Based on 2006 World Health Organization international growth standards.

RISK CODE	PRIORITY	CRITERION
142	III	**HISTORY OF PRETERM OF EARLY TERM DELIVERY:** Current chronological age is < 24 months of age and • Preterm Delivery: Delivery of an infant born ≤ 36 6/7 weeks gestation • Early Term Delivery: Delivery of an infant born ≥ 37 0/7 and ≤ 38 6/7 weeks gestation gestational age was ≤ 37 weeks
151	III	**HISTORY OF SMALL FOR GESTATIONAL AGE (SGA):** Current chronological age is < 24 months *SGA must have been diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.*

BIOCHEMICAL CRITERIA

201	III	**LOW HEMOGLOBIN OR HEMATOCRIT** as confirmed by lab tests:

Age at Test	Hgb (gms)	Hct (%)
1 to < 2 years	< 11.0.	< 32.9
2 to < 5 years	< 11.1	< 33.0

211	III	**ELEVATED BLOOD LEAD LEVEL:** blood lead level ≥ 3.5 ug/dL within the past 12 months

CLINICAL CRITERIA

		III		Presence of **MEDICAL CONDITION(S)** that may jeopardize the individual's nutritional status by its presence or by its treatment, through an adverse effect on the ingestion, absorption, or utilization of nutrients (see Appendix A for list of allowable medical conditions and the corresponding nutrition risk criteria codes). *Condition must be diagnosed by a physician/physician extender. The diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/guardian/caretaker.*
341	348	355		
342	349	356		
343	351	357		
344	352a	359		
345	352b	360		
346	353	361		
347	354	362		

381	III	**ORAL HEALTH CONDITIONS**: Conditions may include tooth decay (including nursing or baby bottle caries) or other conditions which interfere with the ability to ingest food in adequate quantity or quality such as chronic oral sores/lesions, abscessed teeth, chronic bleeding gums (gingivitis, periodontal disease), or severe malocclusions. *Presence of the dental problem may be diagnosed by a dentist, physician/physician extender, someone working under a dentist's or physician's/physician extender's orders; or, it may be identified through adequate documentation by the WIC CPA. If diagnosed, the diagnosis may be reported or documented by a dentist, physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by parent/caretaker.*
382	III	**FETAL ALCOHOL SPECTRUM DISORDERS.** Conditions that cover a range of possible diagnosis including fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol-related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder that can occur in a person whose mother consumed alcohol during pregnancy. *The diagnosis may be reported by a physician/ physician extender's orders, or as self-reported by applicant/participant/caregiver.*

DIETARY CRITERIA

401	V	**FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS AND CURRENT CHRONOLOGICAL AGE IS > 24 MONTHS.** Children two years of age and older who meet the income categorical, and residency eligibility requirements may be presumed to be at nutrition risk for failure to meet *Dietary Guidelines for Americans [Dietary Guidelines].* Based on an individual's estimated energy needs, the *Failure to Meet the Dietary Guidelines* risk criterion is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans. **This risk is assigned only to individuals for whom a complete nutrition assessment (including assessment of the risk criterion 425 "Inappropriate Nutrition Practices for Children") has been performed and for whom no other risk(s) is identified.**

RISK CODE	PRIORITY	CRITERION
425	V	**INAPPROPRIATE NUTRITION PRACTICES FOR CHILDREN** defined as routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. (*Refer to Appendix D*)
428	V	**DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES** and current chronological age is < 24 months**.** Children who meet the eligibility requirements of income, category, and residence and who consume complementary foods, eat independently, are being weaned from breast milk or infant formula and begin to transition from a diet based on infant/toddler foods to one based on the *Dietary Guidelines for Americans,* are at risk of inappropriate complementary feeding. **This risk is assigned only to individuals for whom a complete nutrition assessment (including assessment of the risk criterion 425 "Inappropriate Nutrition Practices for Children") has been performed and for whom no other risk(s) is identified.**
		ECO-SOCIAL CRITERIA
502	NA	**TRANSFER OF CERTIFICATION** Person with current valid Verification of Certification (VOC) document from another State or local agency. 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. If the receiving agency is at maximum caseload, the transferring participant must be placed at the top of any waiting list and enrolled as soon as possible. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition or if the participant was certified based on a nutrition risk condition not in use by NC.
801	V	**HOMELESSNESS:** Lacking a fixed and regular nighttime residence; or having a primary nighttime residence that 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.
802	V	**MIGRANCY:** Being a member of a family which has 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.
901	V	**RECIPIENT OF ABUSE**: Child abuse and/or neglect is defined as any act or failure to act that results in harm or puts a child at risk of harm. Child abuse may be physical, sexual, or emotional or neglect of a child under the age of 18 by a parent, caretaker, or other person in a custodial role. It may be self-reported by the individual, by a family member, or by a social worker, health care provider or other appropriate personnel.
902	V	**CHILD OF A PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE APPROPRIATE FEEDING DECISIONS AND/OR PREPARE FOOD**. Examples may include individuals who are**:** • Documentation or self-report of misuse of alcohol, use of illegal substance, use of marijuana, or misuse of prescription medications • Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders or as self-reported by applicant/participant/caregiver. • Intellectual disability diagnosed, documented, or reported by a physician or psychologist or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Physical disability to a degree which impairs ability to feed child or limits food preparation abilities. • ≤ 17 years of age.

RISK CODE	PRIORITY	CRITERION
903	V	**IN FOSTER CARE:** Designated by DSS or living in a private/public/public child placement agency licensed by the state of North Carolina/DHHS/DSS as evidenced by**:** • entering the foster care system during the previous six months; or • moving from one foster care home to another foster care home during previous six months.
904	III	**ENVIRONMENTAL TOBACCO SMOKE EXPOSURE** (ETS): Defined as exposure to smoke from tobacco products inside enclosed areas, like the home, place of child care, etc. ETS is also known as passive, secondhand, or involuntary smoke. The ETS definition also includes the exposure to the aerosol from electronic nicotine delivery systems.

MEDICAL CONDITIONS

FOR THESE CRITERIA TO APPLY:

- **There must be a diagnosed medical condition present at the time of certification that may jeopardize the individual's nutritional status by its presence or by its treatment, through adverse effect on the ingestion, absorption or utilization of nutrients.**
  - **the presence of the condition must be diagnosed by a physician/physician extender**
  - **the diagnosis may be reported or documented by a physician/physician extender, someone working under a physician's/physician extender's orders, or self-reported by applicant/participant/caretaker.**

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
Cancer	All Categories 347	A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status.
Celiac Disease	All Categories 354	An autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. Also known as**:** • Celiac Sprue • Gluten-sensitive Enteropathy • Non-tropical Sprue
Central Nervous System Disorders	All Categories 348	Conditions which affect energy requirements, ability to feed self, or alter nutritional status metabolically, mechanically or both. These include but are not limited to**:** • Cerebral Palsy (CP) • Epilepsy • Multiple Sclerosis (MS) • Neural tube defects (NTDs), such as Spina Bifida • Parkinson's disease
Mental Illness	Excludes infants 361	A syndrome characterized by clinically significant disturbance in an individuals cognition, emotion regulation or behavior that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Include but not limited to: • Depression

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
		• Post-Traumatic Stress Disorder (PTSD) • Personality Disorders • Schizophrenia • Anxiety Disorders • Obsessive-Compulsive Disorder (OCD) • Bipolar Disorders • Attention-Deficit/Hyperactivity Disorder (ADHD)
Developmental, Sensory or Motor Disabilities Interfering with Ability to Eat	All Categories 362	Disabilities that restrict the ability to intake, chew or swallow food or require tube feeding to meet nutritional needs. Includes disabilities such as but not limited to**:** • Birth injury • Feeding problems due to developmental disability • Head trauma or brain damage • Minimal brain function • Other disabilities
Diabetes Mellitus	All Categories 343	Consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.
Drug-Nutrient Interactions	All Categories 357	Use of prescription or over-the-counter drugs that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status will be compromised and which will be used for >3 weeks. Examples of prescribed drugs which may be included are: Dilantin, steroids, diuretics, isoniazid, phenobarbital, oral contraceptives, Depo-Provera and many antimicrobials. For additional information, refer to a current drug reference such as a Physician's Desk Reference (PDR), a text such as Food-Medication Interactions, a drug insert, or consult with a pharmacist.
Eating Disorders	Excludes infants and children 358	Eating disorders are characterized by severe disturbances in eating behaviors related to thought and emotions. The most common eating disorders are:

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
		• Anorexia Nervosa (AN): Severe restriction of calories and fear of weight gain or Self-starvation • Bulimia Nervosa (BN): recurrent episodes of binge eating followed by purging. Including self-induced vomiting, use of laxatives or excessive exercising. Recurrent binge eating followed by purging. • Binge-Eating-Disorder (BED): recurrent episodes of binge eating, no purging and a sense of lack of control over food consumption and eating.
Food Allergies	All Categories 353	Adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food. Examples include IgE mediated allergic reactions and non-IgE mediated allergic reactions including: • Food protein-induced enterocolitis syndrome (FPIES) • Food protein-induced allergic proctocolitis (FPIAP) • Food protein-induced enteropathy (FPE)
Gastrointestinal Disorders	All Categories 342	Diseases and/or conditions that interfere with the intake, digestion, and/or absorption of nutrients. Diseases/conditions include but not limited to: • Biliary tract diseases • Gastroesophageal reflux disease (GERD) • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome
Genetic and Congenital Disorders	All Categories 349	Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
		metabolically, mechanically, or both. Disorders include but are not limited to: • Aplasitic, hypoplastic or hemolytic anemia • Bleeding disorders such as hemophilia • Cleft lip or palate • Down's syndrome • Fragile X • Muscular dystrophy • Muscular dystrophy • Prader-Willi • Sickle cell anemia (not sickle cell trait) • Symptomatic congenital cardiovascular defects • Thalassemia major
Hypertension and Prehypertension	All Categories 345	Hypertension: persistently high arterial blood Pressure with systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90 mm Hg Prehypertension: blood pressure readings between 130/80 to 139/89 mm Hg
Hypoglycemia	All Categories 356	Hypoglycemia can occur as a complication of diabetes, as a condition in itself, in association with other disorders, or under certain conditions such as early pregnancy, prolonged fasting, or long periods of strenuous exercise. Symptomatic hypoglycemia is a risk observed in a substantial proportion of newborns who are small for gestational age (SGA).
Inborn Errors of Metabolism	All Categories 351	Generally, refers to gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: • Galactosemia • Hyperlipoproteinemia • Maple syrup urine disease (MSUD) • Phenylketonuria (PKU) • Tyrosinemia
Infectious Diseases-Acute	All Categories 352a	Acute conditions are characterized by a single or repeated episode of relatively rapid onset

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
		and short duration. The infectious disease must be present within the past 6 months. Diseases include, but not limited to: • Hepatitis A • Hepatitis E • Meningitis (Bacterial/Viral) • Parasitic Infections • Listeriosis • Pneumonia • Bronchitis (3 episodes in last 6 months)
Infectious Diseases-Chronic	All Categories 352b	Chronic conditions are likely lasting a lifetime and require long-term management of symptoms. The infectious disease must be present within the past 6 months. Diseases include, but not limited to: • Human Immunodeficiency Virus (HIV) • Acquired Immunodeficiency Syndrome (AIDS) • Hepatitis D • Hepatitis B • Hepatitis C
Lactose Intolerance	All Categories 355	Syndrome of one or more of the following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after lactose ingestion.
Nutrient Deficiency or Disease	All Categories 341	Any currently treated or untreated nutrient deficiency or disease. Diseases caused by insufficient dietary intake of macro and micronutrients. Treated or untreated. Diseases include, but not limited to: • Protein-Energy Malnutrition • Scurvy • Rickets • Beriberi • Hypocalcemia • Osteomalacia • Vitamin K deficiency • Pellagra • Xerophthalmia • Iron deficiency

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
Other Medical Conditions	All Categories 360	Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, must be severe enough to affect nutritional status. Diseases include but are not limited to: • Juvenile Idiopathic Arthritis (JIA) • Systemic Lupus Erythematosus • Polycystic Ovary Syndrome (PCOS) • Cardiovascular Disease (CVD) • Persistent asthma (moderate or severe) requiring daily medication • Cystic Fibrosis
Pre-Diabetes	Postpartum and Breastfeeding 363	Impaired fasting glucose (IFG) and/or impaired glucose tolerance (IGT). These conditions are characterized by hyperglycemia that does not meet the diagnostic criteria for diabetes mellitus.
Recent Major Surgery, Trauma, Burns	All Categories 359	Major surgery (including C-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
Neonatal Abstinence Syndrome	Infant Category 383	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

Allowable Medical Condition	Category & FNS Risk Code	Examples of Medical Condition
		following list includes symptoms associated with NAS: • Loud, high-pitched crying • Sweating • Yawning • Sleep disturbances • Feeding difficulties • Poor weight gain • Excessive sucking • Regurgitation • Diarrhea
Renal Disease	All Categories 346	Any renal disease including pyelonephritis and persistent proteinuria but excluding urinary tract infection (UTI) involving the bladder.
Thyroid Disorders	All Categories 344	Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. These conditions include but not limited to: • Congenital Hyperthyroidism • Congenital Hypothyroidism • Hyperthyroidism • Hypothyroidism • Postpartum Thyroiditis

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Inappropriate Nutrition Practices for Women – 427

Inappropriate nutrition practices are defined as routine practices that may result in impaired nutrient status, disease, or health problems. These practices are outlined below.

Inappropriate Nutrition Practices for Women	Examples of Inappropriate Nutrition Practices
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 vitamin; ▪ Mineral supplements; ▪ Herbal or botanical supplements/remedies/teas; or ▪ Cannabidiol (CBD) (Only Pregnant and Breastfeeding women). *Products labeled as CBD with any form of THC should be a risk with 372 Alcohol and Substance Use*
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; or ▪ Any other diet restricting calories and/or essential nutrients.
427.3 Compulsively ingesting non-food items (pica).	▪ Baking soda ▪ Burnt matches ▪ Chalk ▪ Cigarettes ashes ▪ Coffee grounds ▪ Dirt/clay ▪ Large quantities of ice and/or freezer frost ▪ Paper ▪ Starch (laundry and cornstarch) ▪ Uncooked rice
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 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant woman.
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 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 cheese 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.

Inappropriate Nutrition Practices for Infants – 411

Inappropriate nutrition practices are defined as routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below.

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices
411.1 Routinely using a substitute(s) for breast milk or FDA-approved iron-fortified formula as the primary nutrient source during the first year of life.	Examples of substitutes: ▪ Low-iron formula without iron supplementation. ▪ Cow's milk, goat's milk, or sheep's milk (whole, reduced fat, low-fat, skim), canned evaporated or sweetened condensed milk. ▪ Imitation or substitution milks (such as rice- or-soy-based beverages, non-dairy creamer) or other "homemade concoctions".
411.2 Routinely using nursing bottles or cups improperly.	Examples of improper use of nursing bottles or cups: ▪ Using a bottle to feed fruit juice. ▪ Feeding any sugar-containing fluids, such as soda/soft drinks, gelatin water, corn syrup solutions, and sweetened tea. ▪ Allowing infant to fall asleep/be put to bed with a bottle at naps or bedtime. ▪ Allowing the infant to use the bottle without restriction (e.g., walking around with a bottle) or 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. ▪ Adding any food (cereal or other solid foods) to the infant's bottle.
411.3 Routinely offering complementary foods* or other substances that are inappropriate in type or timing. **Complementary foods are any foods or beverages other than human milk or infant formula.*	Examples of inappropriate complementary foods: ▪ Adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier ▪ Introducing any food other than human milk or iron-fortified infant formula before 6 months of age.
411.4 Routinely using feeding practices that disregard the developmental needs or stage of the infant.	▪ Inability to recognize, insensitivity to, or disregarding the infant's cues for hunger and satiety (e.g., forcing an infant to eat a certain type and/or amount of food or beverage or ignoring an infant's hunger cues). ▪ Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking. ▪ Not supporting an infant's need for growing independence with self-feeding (e.g., solely spoon-feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). ▪ Feeding an infant food with inappropriate textures based on his/her developmental stage (e.g., feeding primarily pureed or liquid foods when the infant is ready and capable of eating mashed, chopped or appropriate finger foods).

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices
411.5 Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.	Examples of potentially harmful foods: • Unpasteurized fruit or vegetable juice • Unpasteurized dairy products or soft cheese such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese. • Honey (added to liquid or solids, used in cooking, as part of processed foods, on a pacifier, etc.). • Raw or undercooked meat, fish, poultry, or eggs. • Raw vegetable sprout (alfalfa, clover, bean, and radish). • Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot). • Donor human milk acquired directly from individuals or the Internet.
411.6 Routinely feeding inappropriately diluted formula.	• Failure to follow manufacturer's dilution instructions (to include stretching formula for household economic reasons). • Failure to follow specific instructions accompanying a prescription.
411.7 Routinely limiting the frequency of nursing of the exclusively breastfed infant when human milk is the sole source of nutrients.	Examples of inappropriate frequency of nursing: • Scheduled feedings instead of demand feedings • Less than 8 feedings in 24 hours if less than 2 months of age
411.8 Routinely feeding a diet very low in calories and/or essential nutrients	Examples: • Strict vegan diet. • Macrobiotic diet. • Other diets very low in calories and/or essential nutrients.
411.9 Routinely using inappropriate sanitation in preparation, handling, and storage of expressed human milk or formula.	Limited or no access to a: • Safe water supply (documented by appropriate officials, e.g. municipal or health department authorities). • Heat source for sterilization. • Refrigerator or freezer for storage. Failure to prepare, handle and store bottles, storage containers or breast pumps properly. Examples include: <u>Human Milk</u>: • Thawing/heating in a microwave oven. • Refreezing. • Adding freshly expressed unrefrigerated human milk to frozen human milk. • Adding freshly pumped, chilled human milk to frozen human milk in an amount that is greater than the amount of frozen human milk. • Feeding thawed human milk more than 24 hours after it was thawed. • Saving human milk from a used bottle from another feeding. • Failure to clean breast pump per manufacturer's instruction. • Feeding donor human milk acquired directly from individuals or the Internet. <u>Formula</u>: • Failure to prepare and/or store formula per manufacturer's or physician instructions • Storing at room temperature for more than one (1) hour • Using formula in a bottle one (1) hour after the start of a feeding • Saving formula from a used bottle for another feeding

	• Failure to clean baby bottle properly
411.10 Feeding dietary supplements with potentially harmful consequences	Examples of dietary supplements which, when fed in excess of recommended dosage, may be toxic or have harmful consequences: • Single or multi-vitamins • Mineral supplements. • Herbal or botanical supplements/remedies/teas.
411.11 Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements.	▪ Infants 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 who 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.

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Inappropriate Nutrition Practices for Children – 425

Inappropriate nutrition practices are defined as routine use of feeding practices that may result in impaired nutrient status, disease, or health problems. These practices, with examples, are outlined below.

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices
425.1 Routinely feeding inappropriate beverages as primary milk source.	Examples of inappropriate beverages as primary milk source: ▪ Non-fat or reduced-fat milks (between 12 and 24 months of age unless allowed by State agency policy for a child for whom overweight, or obesity is a concern) or sweetened condensed milk. ▪ Goat's milk, sheep's milk, imitation or substitute milks (that are unfortified or inadequately fortified) or other "homemade concoctions".
425.2 Routinely feeding a child any sugar-containing fluids.	Examples of sugar-containing fluids: ▪ Soda/soft drinks; ▪ Gelatin water; ▪ Corn syrup solutions; and ▪ Sweetened tea.
425.3 Routinely using nursing bottles, cups or pacifiers improperly.	▪ Using a bottle to feed • Fruit juice, or • Diluted cereal or other solid foods. ▪ Allowing the child to fall asleep or be put to bed with bottle at naps or bedtime. ▪ Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. ▪ Using a bottle for feeding/drinking beyond 14 months of age. ▪ Using a pacifier dipped in sweet agents such as sugar, honey, or syrups. ▪ Allowing a child to carry around and drink throughout the day from a covered or training cup.
425.4 Routinely using feeding practices that disregard the developmental needs or stage of the child.	▪ Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food/beverage or ignoring a hungry child's requests for appropriate foods). ▪ Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking. ▪ Not supporting a child's need for growing independence with self-feeding (e.g., solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). ▪ Feeding a child food with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily pureed or liquid food when the child is ready and capable of eating mashed, chopped or appropriate finger foods).

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices
425.5 Feeding foods to a child that could be contaminated with harmful microorganisms.	Examples of potentially harmful foods for a child: ▪ Unpasteurized fruit or vegetable juice. ▪ Unpasteurized dairy products or soft cheeses such as feta, Brie, Camembert, blue-veined, and Mexican-style cheese. ▪ Raw or undercooked meat, fish, poultry, or eggs. ▪ Raw vegetable sprouts (such as alfalfa, clover, bean, and radish). ▪ Deli meats, hot dogs, and processed meats (avoid unless heated until steaming hot).
425.6 Routinely feeding a diet very low in calories and/or essential nutrients.	Examples: ▪ Vegan diet ▪ Macrobiotic diet ▪ Other diets very low in calories and/or essential nutrients
425.7 Feeding dietary supplements with potentially harmful consequences.	Examples of dietary supplements which when fed in excess of recommended dosage may be toxic or have harmful consequences: ▪ Single or multi-vitamins; ▪ Mineral supplements; and ▪ Herbal or botanical supplements/remedies/teas
425.8 Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.	▪ 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 (or 1 quart) of Vitamin D fortified milk or formula.
425.9 Routine ingestion of non-food items (pica).	Examples of inappropriate non-food items ▪ Ashes; ▪ Carpet fibers; ▪ Cigarettes/cigarette butts; ▪ Clay; ▪ Dust; ▪ Foam rubber; ▪ Paint chips; ▪ Soil; ▪ Starch (laundry and cornstarch).

Procedures for Measuring and Weighing
Measuring Recumbent Length

Age
- Infants
- Children up to age 24 months

Materials/Equipment
- Recumbent length board with fixed headboard and movable footboard, both at right angles
- Two people are required; the measurer and an assistant (assistant can be child's parent/guardian/caretaker).

  Note: Prior to measuring a participant or applicant, it is essential to consider their right to privacy, dignity and respect. All applicant or participant information is confidential. Refer to chapter 16 for information related to confidentiality.

Procedure*

1. Put a clean paper sheet on measuring board, being sure to cover the fixed head board.
2. Remove shoes, hats and bulky clothing from child being measured.
3. With the help of the assistant, position the child face-up on the measuring board with the head placed against the fixed headboard. The assistant should stand behind the headboard and hold the child's head firmly against the headboard.
4. With the child positioned so the head, shoulders, back and buttocks are flat along the center of the board, the measurer should hold the child's knees together, gently pushing them down against the board with one hand to fully extend the child. With the other hand, the measurer should slide the movable footboard toward the child's feet and place the footboard so both heels are firmly against it with toes pointing directly upward.
5. Read and record the measured length to the nearest 1/8 inch.
6. If the measurement deviates remarkably from previous measures, or is otherwise questionable, measure the child again.
7. Length boards must be sanitized between clients.

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* Measuring in special situations:

1. *Child is unable to straighten:* In this case, an approximate length can be obtained using the sum of partial measures. Straighten the child as much as possible then measure from the top of the head to the end of the spine, then from the end of the spine to the back of the knee, then from the back of the knee to the base of the heel. Add the measurements to determine the length.
2. *Child is too long for the length board:* In this case, a longer length board is best practice. Alternatively, attempt to obtain measures from the child's medical home. If no current reliable measure is available, an approximate length can be obtained by using a flat surface, a tape measure and two hard flat blocks (or books). Position the child face-up on the flat surface, place the blocks perpendicular to the flat surface at the child's head and feet and measure the distance between the blocks.

Procedures for Measuring and Weighing
Measuring Standing Height

Age
- Children two years of age and older who can stand unassisted
- Adolescents and adults*

Materials/Equipment
- Wall mounted measuring board with movable headboard (stadiometer), marked in increments of 1/8 inch. Stadiometers must be checked for accuracy of height. If a stadiometer protrudes from the wall such that all four contact points (see Step 3 below) are not in a straight line, an adaptation such as a heel strike plate should be made to the floor or the wall to accommodate this.
- Two people, the measurer and an assistant, may be required for children. The assistant could be the child's parent/guardian/caretaker.

  Note: Prior to measuring a participant or applicant, it is essential to consider their right to privacy, dignity and respect. All applicant or participant information is confidential. Refer to chapter 16 for information related to confidentiality.

Procedure*

1. Have child's parent/caretaker remove child's shoes, hats, obstructing barrettes and bulky clothing. Ask adult to remove shoes, hats, barrettes, and bulky outer clothing.
2. Position the child/adult against the measuring device facing forward, instructing child/adult to stand straight and tall, with shoulders level, hands at sides.
3. Make sure the child/adult stands flat-footed with feet slightly apart and knees extended, looking straight ahead, then check for four (4) contact points: 1) head, 2) shoulders, 3) buttocks, and 4) the back of the heels. If necessary, ensure the child's lower body stays in position by having the assistant firmly press his or her hands on the child's knees and ankles.*
4. Lower the headboard until it firmly touches the crown of the head.
5. Read and record the measured height to the nearest 1/8 inch.
6. If the measurement deviates remarkably from previous measures, or is otherwise questionable, measure the child or adult again.
7. Between each client, sanitize the headboard and replace the disposable paper sheet on which the child/adult stands. If a disposable paper sheet is not used, the floor must be sanitized between each client.

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* If the client cannot stand straight (due to obesity, scoliosis, or some other reason) and make contact with the board at the four points as recommended in Step 3, have client stand as reasonably straight as possible.

Procedures for Measuring and Weighing
Weighing – Infant Scale

Age
- Infants
- Young children with weights up to scale tolerance, usually 30 pounds

Equipment
- Infant scale with beam balance or digital infant scale. (The accuracy of scales must be tested annually. Refer to Section 2 for more information.)

Note: Prior to measuring a participant or applicant, it is essential to consider their right to privacy, dignity and respect. All applicant or participant information is confidential.
Refer to chapter 16 for information related to confidentiality.

Procedure*
1. Put clean, paper sheet on scale.
2. Beam balance scales: Balance the scales at zero position, i.e. with paper sheet on tray; place the main and fractional sliding beam weights directly over their zero positions. Check to see if the scale balance indicator is centered and adjust if needed to assure that the scale is balanced at zero.
3. Remove child's shoes and outer clothing. A t-shirt and a clean dry diaper may be worn. If child is wearing braces and/or orthotics, remove these also.
4. Place child in center of scale (may be sitting or lying down).
5. Beam balance scale: Move the weight on the main beam away from the zero position (left to right) until the indicator shows excess weight, then move the weight back (right to left) towards the zero position until too little weight has been obtained. Move the weight on the fractional beam away from the zero position (left to right) until the indicator is centered and stationary. Read and record weight to the nearest ½ ounce.
6. Digital scale: Allow the scale to lock onto a weight. Read the weight in the display area of the scale. Record the weight value including the first number to the right of the decimal.
7. If the weight deviates remarkably from previous measure, or is otherwise questionable, weigh the infant or child again.
8. Scales should be sanitized between clients.

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* Weighing in special situations:
Child cannot stand unassisted but exceeds infant scale tolerance:
Follow steps 1-3 above.
- a Beam Balance Scale: Ask the parent to hold the child and weigh both individuals together. Without removing any clothes or shoes, weigh only the adult and subtract this weight from the weight of both together.
- b Digital Scale: Turn off the scale and ask the parent to stand on the scale, facing out. Turn on the scale; be sure it reads 0.0, then return the child for the parent to hold.

Child is too heavy to lift:
Ask the parent if he or she knows the child's weight at the time of the last visit to the child's medical home, or, if at all possible, attempt to locate wheelchair scales to obtain current weight.

Procedures for Measuring and Weighing
Weighing – Standing Scale

Age
- Children who can stand unassisted
- Adolescents and adults *

Equipment
- Standard platform beam balance scale or digital scale. (The accuracy of scales must be tested annually. Refer to Section 2 for more information.)

Note: Prior to measuring a participant or applicant, it is essential to consider their right to privacy, dignity and respect. All applicant or participant information is confidential. Refer to chapter 16 for information related to confidentiality.

Procedure*

1. Beam balance scales: Balance the scales at zero position by placing the main and fractional sliding beam weights directly over their zero positions. Check to see if the scale balance indicator is centered, assuring the scale is balanced at zero.
2. Have child's caretaker remove child's shoes, hat and heavy clothing (including jeans and sweaters/sweatshirts). Ask adults to remove shoes, hats, bulky outer clothing, and heavy belts or jewelry.
3. Have child/adult stand with both feet in the center of the platform, body upright and arms hanging naturally (children with wandering hands may do better if asked to place their hands on their hips or stomachs or to fold their arms).
4. Beam balance scale: Move the weight on the main beam away from the zero position (left to right) until the indicator shows excess weight, then move the weight back (right to left) towards the zero position until too little weight has been obtained. Move the weight on the fractional beam away from the zero position (left to right) until the indicator is centered and stationary. Read and record weight to the nearest ¼ pound.
5. Digital scale: Allow the scale to lock onto a weight. Read the weight in the display area of the scale. Record the weight value including the first number to the right of the decimal.
6. If the weight deviates remarkably from previous measure, or is otherwise questionable, weigh the child or adult again.

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* If unable to get a weight on a client due to obesity, attempt to get the weight from the client's medical home.