Crossroads – CTad-Child

New Family/Family Demographics Screen (fill-out once for entire family)

Parent/Guardian1

☐ Participant

Last Name: _____First Name: _____M.I._____

Proof of Identification: _____SSN: _____ DOB: _____

Marital Status: _____Education Level: _____

Parent/Guardian2

Last Name: _____First Name: _____M.I._____

Proof of Identification: _____SSN: _____ DOB: _____

Marital Status: _____Education Level: _____

Caretaker

Last Name: _____First Name: _____M.I._____

Proof of Identification: _____SSN: _____ DOB: _____

Marital Status: _____Education Level: _____

Physical Address:

Street: _____

Street 2: _____

ZIP: _____ City: _____ State: _____ County: _____

Proof of Residence: _____

Homeless/Incarcerated Status: _____Migrant Status: _____

Mailing Address:

Street: _____

Street 2: _____

ZIP: _____ City: _____ State: _____ County: _____

Telephones: **Voter Registration:** ☐

Telephone Number: _____ Type: H, C, W, F, M Primary: _____Carrier: _____

Telephone Number: _____ Type: H, C, W, F, M Primary: _____Carrier: _____

Communication Options:

Language Read: _____ Language Spoken: _____ Interpreter ☐ Sign Language Interpreter ☐

Email Address: _____ Preferred Method of Contact: _____

Family Assessment Screen (fill-out once for entire family)

1. Does anyone smoke inside your house? Yes No
2. Mother enrolled in WIC during pregnancy? Yes No
3. Has adequate household food storage and preparation? Yes No
4. Has household food insecurity? Yes No
5. Source of drinking water? City Not Sure Well Cistern Spring Other
6. Where did you hear about WIC? _____
7. Did you breastfeed in the Hospital? Yes No

Income Screen

Family Size _____ No. of Expected Infants _____ Total Family Size _____

Family – Adjunct Participation

_____ SNAP ☐ Medicaid ☐ TANF ☐
Participant

_____ SNAP ☐ Medicaid ☐ TANF ☐
Participant

_____ SNAP ☐ Medicaid ☐ TANF ☐
Participant

_____ SNAP ☐ Medicaid ☐ TANF ☐
Participant

Self-Declared Income _____ Self-Declared Income Range _____

Income Details

Source	Proof	Frequency	Amount	Duration
Source	Proof	Frequency	Amount	Duration
Source	Proof	Frequency	Amount	Duration

Zero Income Declaration Reason _____ Comparison Frequency _____

Total Income: _____ *** Remember: Foster children have their own income documentation**

Participant Demographics Screen (fill out one page for each participant)

Identity Information

Last Name: _____ First Name: _____ M.I. _____
Proof of ID: _____ SSN: _____ DOB: _____ WIC Category: _____

Male Female Foster Child: Yes No

Foster Care Entry Date: _____ or Date unknown Proof of Foster Care: _____

Identity Information

Last Name: _____First Name: _____ M.I. _____
Proof of ID: _____ SSN: _____ DOB: _____ WIC Category: _____

Race/Ethnicity

☐ Declared ☐ Observed
Ethnicity: Non-Hispanic Hispanic (Circle one)

Race: (Circle all that apply) American Indian or Alaskan Native Asian
Black or African American White
Native Hawaiian or Pacific Islander

Physical Presence: Yes No
Physical Presence exception reason: _____
Incarcerated Status: Yes No
Immunization Consent: Yes No
Special Needs: (Circle all that apply) Forms assistance Hearing impaired Mentally Challanged
Physically Disabled Visually Impaired Speech impaired Wheelchair access
Reading assistance Other: _____

Health Information Screen

Infant/Child Health Information

Birth Length: _____in. _____1/8's Hospital Discharge Date: _____
Birth Weight: _____lb. _____oz. Hospital Discharge Weight: _____lb. _____ oz.
Medical Home: _____ Last seen by Physician: _____ Weeks Gestation: _____
Multiple Gestation: Yes No Unknown
Immunization Status: unknown up-to-date not up-to-date

Anthro/Lab Screen

Height/Weight

Measurement date: _____ Height: _____ Weight: _____ lb. _____oz.
Collected by: _____ Gestational Age: _____

Blood Work

Blood work Date: _____ Hgb: _____ or Hct _____ Collected by: _____

Eco-Social Assessment Screen

Participant:

Recipient of Abuse: Yes No Limited Abilities to Feed Self: Yes No Maternal Intellectual Disability: Yes No
Day Care Status: Yes No Physical Activity: _____ hrs. per day TV/Video Viewing: _____ hrs. per day
Mother participated in WIC during pregnancy: Yes No Unknown Mother was WIC eligible but did not participate: Yes No
Mother abused alcohol or drugs during her most recent pregnancy: Yes No Unknown

Dietary & Health Screen

Participant's Inappropriate Nutrition Practices

_____ Routinely feeding inappropriate beverages as the primary milk source.
_____ Routinely feeding a child any sugar-containing fluids.
_____ Routinely using nursing bottles, cups, or pacifiers improperly.
_____ Routinely using feeding practices that disregard the developmental needs or stages of the child.
_____ Feeding foods to a child that could be contaminated with harmful microorganisms.
_____ Routinely feeding a diet very low in calories and/or essential nutrients.
_____ Feeding dietary supplements with potentially harmful consequences.
_____ Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.
_____ Routine ingestion of nonfood items (pica).

1. How many meals does your child eat per day? _____
2. How many snacks does your child eat per day? _____
3. How many servings of vegetables does your child eat per day? _____
4. How many servings of fruits does your child eat per day (includes 100% juice)? _____
5. What types of beverages does your child usually drink (list all that apply) _____

Assigned Risk Factors

Use National Risk Code Sheet
* _____ * _____ * _____ * _____

Issue EBT Card Screen

Select Cardholder _____
Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ (Card should be 16 digits long. Double check number.)

Certification Signature

Parent/Guardian will sign a hard copy of the Rights and Responsibilities. This document will be scanned in later.

Family Alerts Screen

Add Family Alert Participant Alert: _____
Start Date: _____ End Date: _____

Care Plan Screens

Maintain Care Plan Goals

Family Goals (circle all that apply)

Dairy Intake	Family Mealtimes	Increase Fruits and Vegetables	Healthy Snacks	Physical Activity
Iron Foods	Weaning	Smoke Exposure	Whole Grains	

Free Form Goals: _____

Individual Goals

Participant 1: _____ Participant 2: _____

Dairy Intake	Family Mealtimes	Increase Fruits and Vegetables	Healthy Snacks	Physical Activity
Iron Foods	Weaning	Smoke Exposure	Whole Grains	

Free Form Goals: _____
Family Class: _____ Method: _____

Individual Class: _____Method: _____

Nutrition Education Refusal

Refusal Type:

Family Individual Date: _____ Reason: _____

Referral Program

Program Name: _____ Family Individual _____
Program Name: _____ Family Individual _____
Program Name: _____ Family Individual _____

Care Plan Summary

Nutrition Assessment

_____
_____
_____

Entered by: _____

Issue Benefits

Prescribe Food:

Default Package Any Exceptions: _____
WIC 53 Category: _____Subcategory: _____
Quantity: _____