Crossroads – CTad – Infant

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: _____

Military Status – Non-military, National Guard, Active

Confidentiality: ☐

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. Has adequate household food storage and preparation? Yes No
3. Has household food insecurity? Yes No
4. Source of drinking water? City Not Sure Well Cistern Spring Other
5. Where did you hear about WIC? _____

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: _____

Gender: Male Female
Foster Child Yes No

Foster Care Entry Date: _____ or Date unknown

Proof of Foster Care: _____

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: _____
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: _____

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 _____ or 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**

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 must be scanned in later.

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: _____
Exempt reason: _____ Deferred reason_____

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
Medical Health Conditions_____

Breastfeeding Information

Data Collection Date: _____ Are you breastfeeding? Yes No

Ever Breastfed? Yes No

Breastfeeding Frequency: _____

Age Infant Stopped Breastfeeding: _____

Reason Infant Stopped Breastfeeding: _____

Age Supplement Was Given: _____ No. of Wet Diapers/24 hr. Period: _____

No. of Stools/24 hr. Period: _____

Do you give your baby any formula? Yes No

How much formula do you give your infant in a 24-hour period? ozs. _____

Complications (breastfeeding): _____

Eco-Social Assessment Screen

Participant:

Recipient of Abuse: Yes No Parent/Guardian/Caretaker limited abilities to feed: 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 using a substitute(s) for breast milk or for FDA approved iron-fortified formulas as the primary nutrient source during the first year of life.
_____ Routinely using nursing bottles or cups improperly.
_____ Routinely offering complementary foods* or other substances that are inappropriate in type or timing. *Complementary foods are any foods or beverages other than breast milk or infant formula.
_____ Routinely using feeding practices that disregard the developmental needs or stage of the infant.
_____ Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins.
_____ Routinely feeding inappropriately diluted formula.
_____ Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source of nutrients.
_____ Routinely feeding a diet very low in calories and/or essential nutrients.
_____ Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breast milk or formula.
_____ Feeding dietary supplements with potentially harmful consequences.

_____ Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements.

1. Do you have any concerns with your baby? Yes No
2. How are you feeding your baby? Breastfed Formula Fed Combination
3. If using formula, which appliances do you use to heat up formula? _____

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: _____

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

Family Individual Class Topic: _____

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: _____