Crossroads – CTad- Woman

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

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: ________

Male Female Foster Child: Yes No

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: ____

Education – Highest level completed: ____

Marital Status: Single Married Separated Divorced Widowed

Employment Status:
Full-time Plans to work full-time Part-time Plans to work part-time No plans to work

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 will 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

Pre-Pregnancy

Pre-pregnancy Weight ________lbs. _________ozs.

Cigarettes Per Day

________ Three Months Prior to Pregnancy _____ Today

Drinks Per Week

____________ Three Months Prior to Pregnancy

_________ Last Trimester

Pregnancy

__________ Last Menstrual Period
__________ Number of Prenatal Healthcare Visits
_________ Expected Delivery Date ____ 1st Prenatal Healthcare Visit
_________Date last seen by Physician
Proof of Pregnancy ____________________________________
Number of Fetuses this Pregnancy __________ Gravida __________ Para __________
Medical Home: (e.g. ob/gyn, clinic) ____
Dietary Supplement Taken Before Pregnancy: ____
Pregnancy Induced Health Conditions:

____

Health Conditions:

____

Currently Breastfeeding: ☐

Postpartum

Labor Medications: ____
Health Conditions: ____
Pregnancy Induced Health Conditions: ____
Delivery Date: __________________ Weight at Delivery ___________lbs. __________ ozs.
Number of Fetuses this Pregnancy: __________ Gravida __________ Para __________
Medical Home (e.g. ob/gyn, clinic) ____
Participant (infant's name) ____
Outcome: Live Term Birth Fetal Death Miscarriage Neonatal Death
Delivery Type: Vaginal Cesarean Weeks Gestation: __________
Birth Length: __________ Birth Weight: __________

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 Limited Abilities to Feed-Self: Yes No Maternal Intellectual Disability: Yes No
Dietary Supplement During Pregnancy Yes No

Dietary & Health Screen

Participant's inappropriate Nutrition Practices

_____ Consuming dietary supplements with potentially harmful consequences.
_____ Consuming a diet very low in calories and/or essential nutrients or impaired caloric intake or absorption of essential nutrients following bariatric surgery.

_____ Compulsively ingesting non-food items (pica).
_____ Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.
_____ Pregnant woman ingesting foods that could be contaminated with pathogenic micro-organisms.

1. How is your appetite? Good Fair Poor
2. Are you taking vitamins? Yes No
3. If so, what vitamins are you taking? ______________________________
4. How many servings of vegetables do you eat per day? 1-2 3-4 5 or more None
5. How many servings of fruit do you eat per day? 1-2 3-4 5 or more None
6. How many servings of dairy do you eat per day? 1-2 3-4 5 or more I do not eat dairy
7. Are you having any issues feeding your baby? Yes No
8. Do you have any questions regarding infant formula?
9. How do you plan on feeding your infant?
   Breastfeeding Infant Formula Combination of Breastfeeding & Infant Formula Undecided at this time

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: ______________________