Crossroads – CTad- Woman

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

Parent/Guardian1				
Participant Last Name:	First I	Name:		M.I
Last Name.		vaiiic.		
Proof of Identification:	SS	N:	DOB:	
Marital Statuc	Educati	on Lovel:		
Marital Status: Parent/Guardian2	Luucati	on Level.		
Last Name:	First I	Name:		M.I
Donal of Identification		N.I.	DOD:	
Proof of Identification:	55	N:	DOB:	
Marital Status:	Educati	on Level:		
Caretaker	· ·			
Last Name:	First i	Name:		M.I
Proof of Identification:	SS	SN:	DOB: _	
Marital Status: Physical Address:	Educatio	n Level:		
Street:				
Street 2:				
ZIP: City:		State:	County:	
,-				
Proof of Residence:				
Homeless/Incarcerated Status:		Migrant S	tatus:	
Mailing Address:				
Street:				
Street 2:				
ZIP: City:		State: _	County:	
Telephones:	moull C M/ E M	Drimorry		Voter Registration:
Telephone Number: Ty Telephone Number: Ty	pe: H, C, W, F, M			
Military Status – Non-military, National Guard		, , , , , , , , , , , , , , , , , , ,		
Confidentiality:				
Communication Options:				
Language Read: Language S	Spoken:	Interp	reter Sign Lan	guage Interpreter
Email Address:	Preferre	ed Method of Con	tact:	
Family Assessment Screen (fill-out once for e	ntire family)			
Does anyone smoke inside your hous		Yes	No	
2. Has adequate household food storage	and preparation?	Yes	No	
3. Has household food insecurity?	Not Sura	Yes	No Spring	Othor
Source of drinking water? City Where did you hear about WIC?	Not Sure Well	Cisterr 	n Spring	Other

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Participant Demographics Screen (fill out one page for each participant) **Identity Information** Last Name: First Name: DOB: WIC Category: ___ Proof of ID: _SSN: ____ Female Foster Child: Male 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: 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 Other: _ Reading assistance Education – Highest level completed: Marital Status: Single Divorced Widowed Married Separated **Employment Status:** Full-time Plans to work full-time Part-time Plans to work part-time No plans to work **Income Screen** No. of Expected Infants ____ Total Family Size Family Size Family - Adjunct Participation **SNAP** Medicaid **TANF** Participant Medicaid **TANF SNAP** Participant Medicaid Participant Medicaid **SNAP TANF** Participant _____ or Self-Declared Income Range _ Self-Declared Income ____ **Income Details** Source Proof Frequency Amount Duration Proof Frequency Duration Source Amount Source Proof Frequency Amount Duration Zero Income Declaration Reason _ Comparison Frequency _ * Remember: Foster children have their own income documentation Total Income: **Issue EBT Card Screen** Select Cardholder (Card should be 16 digits long. Double check number.) Card 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:				
Blood Work				
Blood work Date:	Hgh:	or Hct	Collecte	ad hv:
Exempt Reason:	beleft	red Reason:		
Health Information Screen				
Pre-Pregnancy		Cigarottos Por Day		
	lbs ors	Cigarettes Per Day	the Dries to Drogne	asy Taday
Pre-pregnancy Weight	025.	Three Mon	this Prior to Pregnar	icy loday
Drinks Per Week				
Three Months	Prior to Pregnancy	Last Trime	ester	
Ducanan				
Pregnancy				45
Last Menstrual Pe				1 st Prenatal Healthcare Visit
Number of Prena	tal Healthcare Visits	Date last s	seen by Physician	
Proof of Pregnancy				
Number of Fetuses this Pregna	incy Gravida _	Para		
Medical Home: (e.g. ob/gyn, c	inic)			
Dietary Supplement Taken Bef				
Pregnancy Induced Health Cor				
	2.0.0.13.			
Health Conditions:				
Currently Breastfeeding:				
_				
Postpartum				
Labor Medications:				
Health Conditions:				
Pregnancy Induced Health Cor				
Delivery Date:	Weight at Delivery	lbs	OZS.	
Number of Fetuses this Pregna				
Medical Home (e.g. ob/gyn, cli				
Participant (infant's name)				
Outcome: Live Term Birth		urriage Neonatal De	ath	
Delivery Type: Birth Length: Birtl	Vaginal Cesar	vveeks desta	ation:	
	i weight:			
Breastfeeding Information				
Data Collection Date:				Yes No
Breastfeeding Frequency:				
Age Infant Stopped Breastfeed	ing:			
Reason Infant Stopped Breastf	eeding:			
Age supplement was Given:	No. of Wet Diar	pers/ 24 hr. Period:	No. of Stools	/ 24 hr. Period:
Do you give your baby any form	nula? Yes No	·		·
How much formula do you give		riod?		
Complications (breastfeeding):				 -
Eco-Social Assessment Screen				
Participant:	Limpite at Albitain and E	and Calfe Van Na	atomod latella atomb	Disability Van Na
Recipient of Abuse: Yes No		eed-Seir: Yes No Ma	aternal Intellectual I	Disability: Yes No
Dietary Supplement During Pro	egnancy Yes No			
D				
Dietary & Health Screen				
Participant's inappropriate Nu				
	pplements with potentially h	The state of the s		
Consuming a diet ver	y low in calories and/or esser	ntial nutrients or impaire	d caloric intake or a	bsorption of essential
nutrients following ha	riatric surgery			

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Ir	nadequate vitai	gesting non-food it min/mineral supple n ingesting foods th	ementation r						
1 ⊔	low is your app	o+i+o?	Cood	_	air	Door			
	iow is your app ire you taking v		Good Yes		air Io	Poor			
		nins are you taking?		11	10				
		ngs of vegetables of		er day?	1-2	3-4	5 or m	ore	None
		ngs of fruit do you		-	1-2	3-4	5 or m		None
	•	ngs of flairy do you			1-2	3-4	5 or m		I do not eat dairy
		any issues feeding			Yes	No	3 01 111	010	r do not cut dan y
		questions regardi	•						
		n on feeding your i	_						
	Breastfeedi			Combin	nation of Br	eastfeeding &	& Infant Formula		Undecided at this time
	erts Screen								
Add F	amily Alert	Participant Alert	:						_
Start Date:	:	End Date	e:						
	Care Plan Goal								
	als (circle all th						Llaalble, Coaalea	Db.	oinal Antivity
Dairy Intak		Family Mealtimes			ruits and Ve	egetables	Healthy Snacks	PHY	sical Activity
Iron Foods		Weaning		noke Exp	Josure		Whole Grains		
Individual									
	t 1:				_				
Dairy Intak		Family Mealtime:			ruits and Ve	egetables	Healthy Snacks	Phy	sical Activity
Iron Foods		Weaning		noke Exp	oosure		Whole Grains		
Family Clas									
maividuai	Class:				nethod:				
Nutrition I	Education								
Family	Individ	ual Cla	SS			Topic:			
Nutrition	Education Refu	ısal							
Refusal Typ	pe:								
Family	y Individ	ual	Date:		Reason:				
Defermal D									
Referral Pi					Fan	silv	Individual		
						•			
						•	Individual		
					ran	···y	marviadai		
Care Plan ! Nutrition A	Summary Assessment								
_									
_									
<u>Issue Bene</u>									
Prescribe I									
		ceptions:			la act -				
	ategory:			S	ubcategory				
WIC-08 (7/20									

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Crossroads – CTad-Child

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

Parent/Guardian1 Participant				
Last Name:	First N	Name:		M.I
Proof of Identification:				
Marital Status:	Educa	tion Level:		
Parent/Guardian2 Last Name:	First N	Name:		M.I
Proof of Identification:	SSI	N:	DOB:	
Marital Status:Caretaker	Educat	ion Level:		
Last Name:	First N	Name:		M.I
Proof of Identification:	SSN	:	DOB:	
Marital Status:	Educa	tion Level:		
Physical Address: Address:				
ZIP: City:		State: _	County: _	
Proof of Residence:				
Homeless/Incarcerated Status: Mailing Address: Street:				
Street 2:				
ZIP: City:			County:	
Telephones: Telephone Number:				Voter Registration:
Telephone Number:	Type: H, C, W, F, M	Primary:	_Carrier:	<u></u>
Confidentiality:				
Communication Options: Language Read: Language	ge Spoken:	Interpr	eter Sign Lan	guage Interpreter
Email Address:	Prefe	rred Method of Co	ntact:	
1. Does anyone smoke inside your hour adequate household food stores. Has adequate household food stores. Has household food insecurity? 4. Source of drinking water? City	ouse? rage and preparation? Not Sure Well	Yes Yes Yes Cistern	No No No Spring	Other
5. Where did you hear about WIC?			_	

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Participant Demographics Screen (fill out one page for each participant) **Identity Information** Last Name: First Name: Proof of ID: ______ SSN: ______ DOB: _____ WIC Category: _____ Gender: Male Female Foster Child Yes 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 Physical Presence exception reason: **Immunization Consent** Yes 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** No. of Expected Infants _____ Family Size _ Total Family Size _ **Family – Adjunct Participation** SNAP Medicaid **TANF** Participant **SNAP** Medicaid Participant **SNAP** Medicaid **TANF** Participant Medicaid **TANF SNAP** Participant or Self-Declared Income Range Self-Declared Income ___ **Income Details** Duration Source Proof Frequency Amount Source Proof Frequency Amount Duration Proof Frequency Amount Duration Source Zero Income Declaration Reason _____ Comparison Frequency ___ * Remember: Foster children have their own income documentation Total Income: _ **Issue EBT Card Screen** Select Cardholder Card Number (Card should be 16 digits long. Double check number.)

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

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Anthro/Lab Screen Height/Weight Measurement date: _____ Height: ____ Weight: ___ lb. ___oz. Collected by: ____ Source of Measures: ____ Measurement Type: _____ Gestational Age: _____ **Blood Work** Hgb: _____ or Hct _____ Collected by: _____ Blood work Date: Source of Measures: _____ Deferred Reason: ___ Exempt Reason: ___ **Health Information Screen Infant/Child Health Information** Birth Length: _____in. Hospital Discharge Date: _____ _oz. Hospital Discharge Weight: ______lb. ____oz. Birth Weight: _____lb. 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: **Eco-Social Assessment Screen** Participant: Recipient of Abuse: Yes No Parent/Guardian/Caretaker limited abilities to feed: Yes No Maternal Intellectual Disability: Day Care Status: Yes No 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) **Family Alerts Screen**

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

Care Plan Screens

Maintain Care Plan Goals

Family Goals (circ	cle all that apply)				
Dairy Intake	Family Me	altimes	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 Me	altimes	Increase Fruits and Vegetables	Healthy Snacks	Physical Activity
Iron Foods	Weaning		Smoke Exposure	Whole Grains	,
	·				
			Method:		
			Method:		
Nutrition Educat	ion				
Family	Individual	Class	Topic:		
Number of Columns	ion Defined				
Nutrition Educat	ion ketusai				
Refusal Type:	Individual	Data	Doggony		
Family	Individual	Date: _	Reason:		
Referral Program	1				
Program Name:			Family	Individual	
				Individual	
Program Name:			Family	Individual	
Care Plan Summ	arv				
Nutrition Assessi					
Entered by:					
Littered by.					
Issue Benefits					
Prescribe Food:					
Default Package	Any Exceptions:				
WIC 53 Categor	y:		Subcategory:		
Quantity:		_			

WIC-10 (7/2020)

Crossroads – CTad – Infant

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

Parent/Guardian1				
Participant	First	. Name a .		N.A. I
Last Name:	FIRST	: Name:		IVI.I
Proof of Identification:	S	SN:		DOB:
Marital Status:	Educatio	on Level:		
Parent/Guardian2				
Last Name:	First	: Name:		M.I
Proof of Identification:	S:	SN:		DOB:
Marital Status:	Educat	ion Level:		
Caretaker				
Last Name:	First	: Name:		M.I
Proof of Identification:	S.	SN:		DOB:
Marital Status:	Educ	cation Level:		
Physical Address:	Eddo	Cation Level.		
Street:				
Street 2:				
ZIP:City:		State: _	County:	
Proof of Residence:				
Homeless/Incarcerated Status:		Migrant S	tatus	
Mailing Address:				
Street:				
Street 2:				
ZIP:City:		State:	County:	
Ziicity		State	county	
Telephones:				Voter Registration:
Telephone Number:	Type: H, C, W, F, M	Primary:	Carrier:	
Telephone Number:		Primary:	Carrier:	
Military Status – Non-military, National (Guard, Active			
Confidentiality:				
Communication Options: Language Read:Language Read	ruago Spokon:	Intorn	oreter Sign La	inguage Interpreter
Language ReduLang	Juage Spoken.	interp	oreter Sign La	inguage interpreter
Email Address:	Preferr	red Method of Cont	tact:	
Family Assessment Screen (fill-out once	for entire family)			
Does anyone smoke inside your		Yes	No	
 Has adequate household food s 		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				333.

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Identity Information		one page for each partici	<u>pant)</u>		
		First Name	2:	M.I.	
Proof of ID:		SSN:	DOB:	M.I. WIC Category:	
Gender: Male Foster Child Yes	Female No				
Foster Care Entry Dat	te:	or Date unknow	vn		
Proof of Foster Care:					
Race/Ethnicity Declared	Observed	Ethnicity: Non-His	spanic Hispanic (Ci	rcle one)	
Race (Circle all that a American Indian or A		/ Black or African Amer	ican / White / Native H	Hawaiian or Pacific Islander	
Physical Presence: Physical Presence exc	Yes ception reason:	No			
Immunization Conser Special Needs: (Circle Physically Di Reading assi	nt: Yes e all that apply) isabled	No Forms assistance Visually Impaired Other:	Hearing impaired Speech impaired	Mentally Challanged Wheelchair access	
Income Screen Family Size		No. of Expected Infants	Tota	al Family Size	
Family – Adjunct Par	ticipation		SNAP	Medicaid	TANF
Participant			SNAP	Medicaid	TANF
Participant			CNAD .	Medicaid	TANF
Participant			SNAP SNAP	Medicaid	TANF
Participant			SIVAF	Wedicald	TAINI
Self-Declared Income	2	or Self-Declare	ed Income Range		
Income Details					
Source	Proof	Frequency	Amount	Duration	
Source	Proof	Frequency	Amount	Duration	
Source	Proof	Frequency	Amount	Duration	
Zero Income Declara	tion Reason		Comparison Frequ	ency	
Total Income:		* Reme	ember: Foster children h	ave their own income docur	mentation
Issue EBT Card Scree Select Cardholder					
Card Number			(Card should b	oe 16 digits long. Double che	ck number.
Cartificant Cl					

<u>Certification Signature</u>

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 A	\ge:				
Blood Work						
Blood work Date:						
Exempt reason:	Deferred	d reason		<u>-</u>		
Health Information Screen						
Infant/child Health Informati	ion					
Birth Length:	in	1/8's	Hospital Discha	arge Date:		
Birth Weight:	lb	OZ.	Hospital Discha	arge Weight:	lb	oz
Medical Home:				Wee	ks Gestation:	
Multiple Gestation:						
Immunization Status:			ot 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 Breastfee	ding:					
Reason Infant Stopped Breast	feeding:					
Age Supplement Was Given: _	No.	of Wet Diapers/24 h	ır. Period:			
No. of Stools/24 hr. Period:						
Do you give your baby any for	mula? Yes	No				
How much formula do you giv	ve your infant in a 2	24-hour period?	ozs	<u></u>		
Complications (breastfeeding)):					
Eco-Social Assessment Screen	n					
Participant:						
Recipient of Abuse: Yes No	Parent/G	uardian/Caretaker lir	mited abilities to fo	eed: Yes No		
Maternal Intellectual Disabilit	•					
Day Care Status: Yes No			s. per day TV/V	ideo Viewing:	hrs. per da	У
Mother participated in WIC d Mother was WIC eligible but of						
Mother abused alcohol or dru			Yes No Unknov	vn		
mother abasea alcohor or are	igo darring rier mos	t recent pregnancy.	res no ommo	•		
Dietary & Health Screen						
Participant's Inappropriate N		6 554				
		st milk or for FDA ap	proved iron-fortif	ied formulas as th	e primary nutrient soui	rce
during the first year Routinely using nurs		improperly				
			ces that are inapp	ropriate in type o	r timing. *Complement	arv
foods are any foods						,
Routinely using feed				stage of the infan	t.	
Feeding foods to an			harmful microor	ganisms or toxins.		
Routinely feeding in						
	e frequency of nur	sing of the exclusive	ly breastfed infant	t when breast milk	is the sole source of	
nutrients.	diet very leve in sel	orios and for asserti	al nutrionts			
Routinely feeding a communication Routinely using inap	•			e of expressed bro	east milk or formula	
Feeding dietary supp				c of expressed ble	doc mink of formula.	

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			ts recognized as essential by nat	cional public health po	licy when an infant's diet
		rient requirements.			
1. Do you	u have any conce	rns with your baby?	Yes No		
				nbination	
3. If using	g formula, which	appliances do you i	use to heat up formula?		
Family Alerts S					
Add: Family		Participant Aleri	·· ··		
Start Date:		End Date:			
Care Plan Scree	ens				
Maintain Care	Plan Goals				
Family Goals (c	ircle all that appl	y)			
Dairy Intake	Famil	y Mealtimes	Increase Fruits and Vegetables	Healthy Snacks	Physical Activity
	Wear		Smoke Exposure	Whole Grains	
Free Form Goal	ls:				
Individual Goal	~				
•	Dairy Intake Family Mealtimes		Increase Fruits and Vegetables		Physical Activity
Iron Foods	. Wear		Smoke Exposure	Whole Grains	
Free Form Goal	ls:				
			Method:		
Individual Class	i:		Method:		
Nutrition Educa	ation				
Family	Individual	Class	Topic: _		
Nutrition Educa	ation Refusal				
Refusal Type:					
Family	Individual	Date: _	Reason:		
Referral Progra					
			Family		
			Family	Individual	
Program Name	:		Family	Individual	
Care Plan Sumi	mary				
Nutrition Asses	sment				
Entered by:					
Issue Benefits					
Prescribe Food	:				
Default Package	e Any Exception	s:			
WIC 53 Catego	ory:		Subcategory:		
Quantity:					

WIC-09 (7/2020)