

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:

Telephone Number: Type: H, C, W, F, M Primary: Carrier:
Military Status – Non-military, National Guard, Active

Voter Registration:

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 Challenged
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 <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant			
_____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant			
_____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant			
_____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
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

_____ Expected Delivery Date _____ 1st Prenatal Healthcare Visit

_____ Number of Prenatal Healthcare Visits

_____ 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: _____

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:

Address: _____

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

Proof of Residence: _____

Homeless/Incarcerated Status: _____ Migrant Status: _____

Mailing Address:

Street: _____

Street 2: _____

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

Telephones:

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

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

Voter Registration:

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 Challenged _____
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

Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>

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: _____ Source of Measures: _____ Measurement Type: _____
Gestational Age: _____

Blood Work

Blood work Date: _____ Hgb: _____ or Hct _____ Collected by: _____
Source of Measures: _____
Exempt Reason: _____ Deferred Reason: _____

Health Information Screen

Infant/Child Health Information

Birth Length: _____ in. 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: _____

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 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

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: _____

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:

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

Voter Registration:

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 Challenged _____
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

_____ Participant	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
_____ Participant	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
_____ Participant	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
_____ Participant	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>

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: _____