



## Alaska WIC Policy & Procedure Manual

### Section: 105 Job Aids

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Alaska WIC Policy & Procedure Manual  
Section 105: Job Aids

## **State of Alaska WIC Organization Chart**

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Division of Public Assistance  
– DIRECTOR'S OFFICE –

August 2024

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350 Main Street, Room 304  
Juneau, AK 99811-0640  
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<http://dhss.alaska.gov/dpa>  
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<u>Name</u>	<u>Position</u>	<u>PCN #</u>	<u>Phone #</u>
Deb Etheridge	Director	06-8158	465-2680

Division Operations Support  
350 Main Street, Room 329  
Juneau, AK 99811-0640

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Hilary Porter	Deputy Director	163000	419-4292

Division Operations Support  
3601 C Street, Suite 460  
Anchorage, AK 99503

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Becca Stovall	DOM	068213	500-3737

Program Integrity & Analysis  
3601 C St, Ste 200  
Anchorage, AK 99503

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Tracie Dablemont	Chief	068047	269-7873
		Fax:	269-1062

Administrative Services  
350 Main Street, Room 329  
Juneau, AK 99811-0640

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Jacqueli Ziegenfuss	AOM 2	068123	500-3306

Continuous Quality Improvement  
350 Main Street, Room 304  
Juneau, AK 99811-0640

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Joel Morgan	PC 1	068637	465-2680

Director's Office Admin Support  
350 Main Street, Room 304  
Juneau, AK 99811-0640

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Vacant	AA 2	068294	TBD

\* Highlighted purple is  
work from home.

**Directors Office**  
**Division of Public Assistance**  
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**Phone: 465-3347**  
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**– LEADERSHIP –**

**August 2024**

[Doh.dpa.director.approvals@alaska.gov](mailto:Doh.dpa.director.approvals@alaska.gov)

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<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Hilary Porter	Deputy Director	163000	419-4292
Faxes: 465-5154 or 465- 5254			

**Child Care Program Office**

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>
Vacant	PAPO	068143	TBD

**Policy & Program Development**

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Fax</u>
Christina Davis	Chief	068028	500-4746	465-5254

**Family Nutrition Programs (WIC)**

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Fax</u>
Liz Walsh	Manager	061528	500-8477	269-4155

**EIS Modernization Office**

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Fax</u>
Tracy Mack	Business MGR	06T017	744-4119	334-0868

**Technology and Process Development**

<u>NAME</u>	<u>Position</u>	<u>PCN</u>	<u>Location</u>	<u>VCC Ext</u>	<u>State Cell</u>
Becky McGraw	Program Manager	068582	Wasilla	3810	414-5221

\* Highlighted purple is  
work from home.

**Family Nutrition Services**  
**Division of Public Assistance**  
**130 Seward Street, Room 508**  
**MAIL TO: P.O. Box 110612**  
**Juneau, AK 99811-0612**

**Phone: 465-3100**  
**Fax: 465-3416 (Juneau)**  
**269-4155 (Anchorage)**

**Division of Public Assistance**  
**– FAMILY NUTRITION SERVICES OF ALASKA –**  
**WIC – Special Supplemental Nutrition Program for**  
**Women, Infants & Children Program**  
**FMNP – Farmer’s Market Nutrition Program**  
**SFMNP – Senior Farmer’s Market Nutrition Program**  
**CSFP – Commodity Supplemental Food Program**  
**SNAP-ED – Supplemental Nutrition Assistance Program and Education**  
**BFPC – Breastfeeding Peer Counseling Program**

<http://dhss.alaska.gov/dpa/Pages/nutri/default.aspx>

### Family Nutrition Programs Manager

3601 C Street, Suite 814

Anchorage, AK 99503

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Liz Walsh	AK WIC Director	061528	500-8477	Anchorage

### Assistant Manager

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Taryn Bliss	PC 2	061567	419-4162	Juneau

### Vendor Management / FMNP

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Sarah Slater	PC 1	061347	500-2721	Juneau

### WIC Technology Coordinator

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Julieann Parker	PAA 2	068645	419-4163	Anchorage

### WIC Nutrition Services Coordinator

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Jennifer Johnson	Dietitian 2	061465	500-8736	Juneau

### WIC Clinic Operations & Breastfeeding Coordinator

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Amber Christis	Dietitian 2	061499	500-8184	Juneau

### SNAP-Ed & CSFP Coordinator

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Krista Jordan	Dietitian 2	061589	500-8357	Anchorage

### Midnight Sun WIC Coordinator

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Lisa Cruz	LTNP PC 2	06N14001	419-4083	Anchorage
Vacant	LTNP PC 1	16N24029	TBD	Anchorage

### WIC Technology Project Assistant

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Jacqueline Yeo	LTNP Prj Asst	16N23089	419-4327	Anchorage

### Midnight Sun Admin Unit

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Madison Reilly	LTNP AA 2	16N23003	519-9654	Anchorage
Vacant	LTNP AA 2	16N23004	419-4384	Anchorage

### WIC Clerical & Admin Support

<u>Name</u>	<u>Position</u>	<u>PCN</u>	<u>Phone</u>	<u>Location</u>
Ella Stults	AA 1	061055	465-3100	Juneau

\* Highlighted purple is  
work from home.

WIC Local Agencies Directory

I:\- Administrative Services\~Directories\WIC LA Program Mailing Directories

Family Nutrition Programs	502 - Midnight Sun	501 - MUNICIPALITY	501 - EAGLE RIVER	501 – JBER ELMENDORF	503- SEARHC- JUNEAU
State of Alaska – DOH\DPA\WIC <b>Mailing: PO Box 110612</b> Juneau, AK 99811  130 Seward Street, RM 508 (Physical) Juneau, AK 99801  Main: 465-3100 Fax: 465-3416 <a href="mailto:wic@alaska.gov">wic@alaska.gov</a>	<i>Providing servicesto Fairbanks North Star Borough</i> State of Alaska – DOH\DPAWIC <b>Mailing: PO Box 110612</b> Juneau, AK 99811  Main: 907-500-8451    Fax: 907-465-3416 <a href="mailto:doh.dpa.wic.services@alaska.gov">doh.dpa.wic.services@alaska.gov</a>  M – F 10:00am – 3:00pm  Lisa Cruz, WIC Coordinator 907-500 -4083 <a href="mailto:Lisa.cruz@alaska.gov">Lisa.cruz@alaska.gov</a>	Municipality of Anchorage 825 L Street, Suite 215 (Physical/Mailing) Anchorage, Alaska 99501  Main: 907-343-4668, Fax: 907-249-8080 <a href="mailto:AHDWICClients@anchorageak.gov">AHDWICClients@anchorageak.gov</a>  M,T, Th,F 8:00am – 4:30pm; Wednesdays 12:30-4:30pm  Ashley Dourlain, WIC Coordinator <a href="mailto:Ashley.Dourlain@anchorageak.gov">Ashley.Dourlain@anchorageak.gov</a> 907-343-4703	Eagle River Town Center – WIC Program 12001 Business Park Blvd, Suite 137 Eagle River, Alaska 99577  Main: 907-343-4668, Fax: 907-249-8080 <a href="mailto:AHDWICClients@anchorageak.gov">AHDWICClients@anchorageak.gov</a>  Tues and Thurs only: 8:00am-4:30pm pm Closed 12-12:30 for lunch  Ashley Dourlain, WIC Coordinator <a href="mailto:Ashley.Dourlain@anchorageak.gov">Ashley.Dourlain@anchorageak.gov</a> 907-343-4703	<b>501 – JBER ELMENDORF</b> JBER Military WIC Clinic 9497 20 <sup>th</sup> Street, Arctic Oasis JBER, Alaska 99506  Main: 907-343-4668, Fax: 907-249-8080 <a href="mailto:AHDWICClients@anchorageak.gov">AHDWICClients@anchorageak.gov</a>  Mon and Fri 8:00am – 4:30pm Closed 12-12:30 for lunch Wednesdays 12:30-4:30pm  Ashley Dourlain, WIC Coordinator <a href="mailto:Ashley.Dourlain@anchorageak.gov">Ashley.Dourlain@anchorageak.gov</a> 907-343-4703	SE AK Reg. Health Consortium <b>Mailing: 3100 Channel Drive, Suite 300</b> Juneau, Alaska 99801 Physical: 3225 Hospital Drive    Main:907-463-4099    Fax:907-463-6672 Toll Free: 1-800-330-2229 <a href="mailto:wic@searhc.org">wic@searhc.org</a>  M, Tues, Thurs, Fri. 8:00am to 5:00pm Wed. 8:30am- 5:30pm Heidi Richards-Mazon, WIC Coordinator <a href="mailto:heidirm@searhc.org">heidirm@searhc.org</a>
503 - SEARHC - Ketchikan	503- SEARHC - SITKA	503 – SEARHC- METLAKATLA	504-YKHC	505 - NORTON SOUND	506 - AFS - WASILLA
SE AK Reg. Health Consortium <b>Mailing: 3100 Channel Drive, Suite 300</b> Juneau, Alaska 99801 Physical: 605 Gateway Ct Ketchikan, AK 99901  Main:907-463-4099    Fax:907-463-6672 Toll Free: 1-800-330-2229 <a href="mailto:wic@searhc.org">wic@searhc.org</a>  Hours: On-site by appointments   Heidi Richards-Mazon, WIC Coordinator <a href="mailto:heidirm@searhc.org">heidirm@searhc.org</a>	SE AK Reg. Health Consortium <b>Mailing: 3100 Channel Drive, Suite 300</b> Juneau, Alaska 99801 Physical: 210 Moller Ave Sitka, AK 99835  Main:907-463-4099    Fax: 907-463-6672 Toll Free: 1-800-330-2229 <a href="mailto:wic@searhc.org">wic@searhc.org</a>  Hours: On-site by appointments  Heidi Richards-Mazon, WIC Coordinator <a href="mailto:heidirm@searhc.org">heidirm@searhc.org</a>	Metlakatla Indian Community <b>Mailing/Physical</b> 92 Upper Milton Street, Rm 4 Metlakatla, AK 99926  Main:907-886-5872 <a href="mailto:wic@searhc.org">wic@searhc.org</a>  M-F 8:30 am – 4:30pm   Heidi Richards-Mazon, WIC Coordinator <a href="mailto:heidirm@searhc.org">heidirm@searhc.org</a>	Yukon-Kuskokwim Health Corporation <b>Mailing: P.O. Box 287</b> 800 Chief Eddie Hoffman Hwy Bethel, Alaska 99559  Main:907-543-6459    Fax: 907-543-6406 Toll Free: 1-800-764-6459 <a href="mailto:WIClist@ykhc.org">WIClist@ykhc.org</a>  M-T 8:00am – 4:00pm clients Friday Noon – 4:00pm clients M-F 8:00am – 5:00pm office hours  Henry Batchelor, WIC Coordinator 907-543-6472 Cell: 907-207-9030 <a href="mailto:Henry_Batchelor@ykhc.org">Henry_Batchelor@ykhc.org</a>	Norton Sound Health Corp. <b>Mailing: P.O. Box 966 #54</b> 1000 Greg Kruschek Avenue Nome, Alaska 99762  Main: 907-443-3299 Fax: 907-443-9723 <a href="mailto:wic-all@nshcorp.org">wic-all@nshcorp.org</a>  M – F 8:00am – 5:00pm Closed for lunch 12:00-1:00 pm  Hilary Fello, WIC Coordinator 907 443-3374 <a href="mailto:hfello@nshcorp.org">hfello@nshcorp.org</a>	Alaska Family Services – Wasilla 777 N. Crusey St, Ste. B201 Wasilla, Alaska 99654  Main:907-376-4080    Fax: 907-373-0640 <a href="mailto:valleywic@akafs.org">valleywic@akafs.org</a>  M – F 8:00am – 4:30pm  Lisa Boyles, WIC Coordinator 907-373-4462 <a href="mailto:lisab@akafs.org">lisab@akafs.org</a>
506 - AFS – Copper River Basin	506 - AFS – PALMER	506 - AFS – KENAI/SEWARD	506 - AFS - HOMER	507 - NORTH SLOPE	508 - TCC/CAIHC
Alaska Family Services – Wasilla 777 N. Crusey St, Ste. B201 Wasilla, Alaska 99654  Main:907-376-4080    Fax: 907-373-0640 <a href="mailto:valleywic@gmail.com">valleywic@gmail.com</a>  M – F 8:00am – 4:30pm  Lisa Boyles, WIC Coordinator 907-373-4462 <a href="mailto:lisab@akafs.org">lisab@akafs.org</a>	Alaska Family Services - Palmer 1825 South Chugach Street Palmer, Alaska 99645  Main: 907-746-4080    Fax:907-746-1177 <a href="mailto:valleywic@gmail.com">valleywic@gmail.com</a>  M – F – 8:00am – 4:30pm  Lisa Boyles, WIC Coordinator  907-373-4462 <a href="mailto:lisab@akafs.org">lisab@akafs.org</a>	Alaska Family Services-Kenai/Seward 601 Frontage Road Suite 209 Kenai, Alaska 99611  Main: 907-283-4172    Fax: 907-283-4174 Toll Free: 1-800-687-4172 <a href="mailto:kenaiwic@gmail.com">kenaiwic@gmail.com</a>  M – F 8:00am – 4:30pm  Lisa Boyles, WIC Coordinator  907-373-4462 <a href="mailto:lisab@akafs.org">lisab@akafs.org</a>	Alaska Family Services Homer WIC Clinic 3446 Main Street Homer, Alaska 99603  Main:907-235-5495    Fax:907-235-0655 <a href="mailto:homerwic2@gmail.com">homerwic2@gmail.com</a>  M – F 8:00am – 4:30pm  Lisa Boyles, WIC Coordinator  907-373-4462 <a href="mailto:lisab@akafs.org">lisab@akafs.org</a>	North Slope Borough WIC Program <b>Mailing P.O. Box 69</b> 579 Kingosak Street Utqiagvik, Alaska 99723  Main 907-852-0410    Fax: 907-852-3766 <a href="mailto:wic@north-slope.org">wic@north-slope.org</a>  M-F 8:30am – 5:00pm  Angela Valdez, WIC Coordinator 907-852-0410 ext 4056 <a href="mailto:Angela.valdez@north-slope.org">Angela.valdez@north-slope.org</a>	TCC/CAIHC - WIC Program 1717 West Cowles St Building A Fairbanks, Alaska 99701 Main:907-451-6682 ext. 3773 Fax: 907-459-3921 Toll Free:1-800-478-6682 ext. 3773 <a href="mailto:wic@tananachiefs.org">wic@tananachiefs.org</a> M – F 8:00am – 5:00pm Celine Siddall, Acting WIC Coordinator 907-451-6682 ext. 3725 Celine.Siddall@tananachiefs.org
509 - BRISTOL BAY	510 - KODIAK AREA	515 – MANILAQ	520 - Aleutians/ Pribilof Islands	520 –Southcentral Foundation	520 –Southcentral Foundation
Bristol Bay Area Health Corp. (BBAHC) <b>Mailing P.O. Box 130</b> 6000 Kanakanak Road Dillingham, Alaska 99576  Main:907- 842-2036    Fax: 907-842-2039 Toll Free: 1-888-842-2037  M – F 8:00am – 5:00pm  Suzie Nunn, WIC Coordinator <a href="mailto:snunn@bbahc.org">snunn@bbahc.org</a>	Kodiak Area Native Association (KANA) <b>Mailing: 3449 Rezanof Drive East</b> 2414 Mill Bay Road Kodiak, Alaska 99615  Main:907-486-7312 Fax: 907-486-1346 <a href="mailto:WIC@kodiakhealthcare.org">WIC@kodiakhealthcare.org</a> M,T,Thurs, F 8:00am – 4:30pm Wed. 9:30am- 6:00pm  Stephanie Shryock, WIC Coordinator <a href="mailto:Stephanie.shryock@kodiakhealthcare.org">Stephanie.shryock@kodiakhealthcare.org</a>	Maniilaq Association-WIC Program <b>Mailing: P.O. Box 256</b> 750 Bison Street Kotzebue, Alaska 99752  Main: 907-442-7181    Fax: 907-442-7303 Toll Free:1-800-431-3321 ext 7181  M – F 8:30am – 5:00pm  Jaelynn Tiepelman, WIC Coordinator 907-442-7183 <a href="mailto:Jaelynn.tiepelman@maniilaq.org">Jaelynn.tiepelman@maniilaq.org</a>	SCF -WIC Program 4320 Diplomacy Dr Anchorage, Alaska 99508 Main: 907-729-6390    Fax:907-729-7267  <a href="mailto:WIC@southcentralfoundation.com">WIC@southcentralfoundation.com</a>  M – F 8:00am – 5:00pm  Karen Cutler, WIC Coordinator <a href="mailto:kcutler@southcentralfoundation.com">kcutler@southcentralfoundation.com</a>	<i>Providing services to the six Iliamna village communities</i> SCF -WIC Program 4320 Diplomacy Dr Anchorage, Alaska 99508 Main: 907-729-6390    Fax:907-729-7267 <a href="mailto:WIC@southcentralfoundation.com">WIC@southcentralfoundation.com</a> M – F 8:00am – 5:00pm  Karen Cutler, WIC Coordinator <a href="mailto:kcutler@southcentralfoundation.com">kcutler@southcentralfoundation.com</a>	<i>Providing services in Anchorage</i>  SCF -WIC Program 4320 Diplomacy Dr Anchorage, Alaska 99508 Main: 907-729-7277    Fax:907-729-7267 <a href="mailto:WIC@southcentralfoundation.com">WIC@southcentralfoundation.com</a> M – F 8:00am – 5:00pm  Karen Cutler, WIC Coordinator <a href="mailto:kcutler@southcentralfoundation.com">kcutler@southcentralfoundation.com</a>



# Nutritional Education Plan (NEP) LA Annual Updates

In the State Fiscal Year 2023 Requests for Proposals the State of Alaska identified five program goals covering nutrition education.

1: WIC services are available and utilized by eligible participants throughout the state. Anticipated outcome: WIC services will be provided to a minimum quarterly average of 75% of Total Eligible WIC Participants for the proposed WIC service area.

2: Deliver quality nutrition services in compliance with state and federal requirements. Anticipated outcome: Increased percentage of children ages 2-4 at a healthy weight.

3: Households receiving WIC food benefits purchase WIC foods. Anticipated outcome: WIC foods will be purchased monthly by greater than 75% of households.

4: All pregnant and post partum WIC participants receive information and support to meet their breastfeeding goals. Anticipated outcome: Increased percentage of infants who are breastfed at one year.

5: Pregnant or breastfeeding participants will have access to a breastfeeding peer counselor. Anticipated outcome: At least 75% of pregnant participants will be offered breastfeeding peer counseling services.

**Please verify that the local agency's WIC Coordinator has access to and has had read the agency's response to SFY 2023 RFP.**

\_\_\_\_\_ Name, Title of individual

The State of Alaska presumes that local agency operations (including agency organization, job descriptions, program locations, hours, program goals, etc..) remain unchanged from the SFY 23 response unless directly discussed and approved by SOA program staff. If any changes have been made to WIC program operations please contact, Amber Christis at [amber.christis@alaska.gov](mailto:amber.christis@alaska.gov).

## SFY 2024 Evaluation

Please rate your agency's on scale of 1 to 5 (1 = Lots of room for improvements, 5 = Next to no room for improvement)

WIC services are available and being utilized by eligible participants throughout the service region. \_\_\_\_\_ Rating

Quality nutrition services in compliance with state and federal requirements are being delivered throughout the service region.

Households are able to purchase WIC foods \_\_\_\_\_ Rating

Pregnant and postpartum participants are receiving information and support to meet their breastfeeding goals. \_\_\_\_\_ Rating

Pregnant and breastfeeding participants have access to a breastfeeding peer counselor. \_\_\_\_\_ Rating

## SFY 2025 Update

Have your agency goals changed since SFY 2023? Why or why not?

What are your agencies goals in SFY 25?

Why?

In SFY 25 who is responsible for providing training to support NEP? What are their qualifications?





**Alaska WIC Policy & Procedure Manual**  
**Section 105: Job Aids**  
**Participant Centered Services Counseling Approach**

**PURPOSE:**

To define the “Participant Centered Services (PCS)” approach to counseling WIC Participants and describe how it should be used at the Local Agency.

**JOB AID: Participant Centered Services Counseling Approach**

**Participant Centered Services**

According to the *Alaska Assessing Readiness for Participant Centered Education in WIC Final Report* by Altarum Institute:

In PCS, the nutrition educator is a facilitator or partner who provides information, ideas, and support to help the participant make positive nutrition and health behavior changes. An educator conducting PCS will focus on the following:

- Builds rapport and sets the tone for the assessment by greeting the client or caregiver in a friendly way and introduces herself (himself) at the beginning of the appointment.
- Sets the agenda by:
  - Telling the client or caregiver how long the appointment will take.
  - Sharing what they will do during the appointment.
  - Letting the person know that all their information is kept private.
- Puts his or her feelings aside while learning about the client’s or caregiver’s beliefs and thoughts. Stays non-judgmental during the assessment.
- Affirms the client or caregiver with sincere and encouraging words. Keeps assessment positive and avoids making the client feel defensive or hostile.
- Explores and learns about the clients or caregiver’s culture, unique needs and beliefs. Shows sensitivity and respect towards beliefs.
- Asks for information from the WIC participant about his or her goals, interests, abilities, questions, and concerns.
- Helps the participant decide which nutrition and health behaviors she wants to change, in the context of her/his own goals, culture, and personal situation.
- Helps the participant identify barriers to change and ways in which she can overcome them.
- Offers information and ideas for how the participant can change her behavior, with small, doable action steps.
- Does all of the above by asking open-ended questions and using active listening skills to encourage the participant’s active participation.
- Asks probing questions to clarify or get more details



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The fundamental spirit of PCS includes collaborating with the client, bringing out and providing support for the client's own motivation to change, and respecting the client's independence of thought and actions. The participant's entire WIC experience is based upon PCS principles and practices. A positive centered services experience is more likely to result in behavior change which is more meaningful to both client and staff.

### REFERENCE:

State WIC Office based on: Altarum Institute recommendations

Alaska WIC CPA Training Program: VENA competencies- Getting Started with WIC and the Nutrition Education and Counseling modules



## A Comparison of Nutrition Education Approaches in WIC

### DIDACTIC

### PARTICIPANT CENTERED

#### Educator's Presentation

- o Educator strives to be seen as a knowledgeable expert

- o Educator strives to be seen as a facilitator or partner, supportive and open to the participant's views

#### Stylistic Characteristics

- o Decides nutrition/health behavior changes that the WIC participant should make
- o Informs the WIC participant what is wrong with her current nutrition/health behaviors
- o Tells the WIC participant what specific behavior changes to make to improve her health and her children's health
- o Presents an action plan with broad behavioral objectives
- o Asks close-ended questions to confirm the WIC participant's understanding of the information the educator conveys

- o Elicits information from the WIC participant about her goals and concerns
- o Helps the WIC participant determine nutrition/health behaviors she wants to change
- o Offers information and ideas for how to accomplish behavior change, with small doable action steps
- o Helps the WIC participant identify barriers to change and strategies she can use to overcome them
- o Asks open-ended questions to encourage the WIC participant's active participation
- o Uses active listening skills to make sure she (the educator) understands
- o Provides education, including information, in the context of each WIC participant's goals, culture, and personal circumstances

#### Anticipated Outcomes

- o WIC participant leaves with information she can use to change educator-identified nutrition/health-related behaviors

- o WIC participant leaves with information

+

- o WIC participant gains ideas about small steps she can take, motivation to take those steps and a feeling of support that can help her to change her nutrition/health-related behaviors



Alaska WIC Policy & Procedure Manual  
Section 105: Job Aids



## Stages of Change – A Model for Nutrition Coaching

Stage	Description	Behavior Goals	Education Strategies
<b>Precontemplation</b> <i>“I am not interested in change...”</i>	<ul style="list-style-type: none"><li>Is unaware of problems and hasn’t thought about change, or not interested in change</li><li>Has no intention of taking action within the next six months</li></ul>	<ul style="list-style-type: none"><li>Increase awareness of the need for change</li><li>Personalize information on risks and benefits</li><li>Reduce fears associated with having to change behavior. (Costs are too high, etc...)</li></ul>	<ul style="list-style-type: none"><li>Create a supportive climate for change</li><li>Discuss personal aspects and health consequences of poor eating or sedentary behavior</li><li>Assess knowledge, attitudes, and beliefs.<ul style="list-style-type: none"><li>Build on existing knowledge</li></ul></li><li>Relate to benefits loved ones will receive</li><li>Focus on the impact the negative behavior has on loved ones</li></ul>
<b>Contemplation</b> <i>“Someday I will change...”</i>	<ul style="list-style-type: none"><li>Is interested in taking action, but not yet able to commit to it</li></ul>	<ul style="list-style-type: none"><li>Increase motivation and confidence to perform the new behavior</li><li>Reduce fears associated with having to change behavior</li></ul>	<ul style="list-style-type: none"><li>Identify problematic behaviors</li><li>Prioritize behaviors to change</li><li>Discuss motivation</li><li>Identify barriers to change and possible solutions</li><li>Suggest small, achievable steps to make a change</li><li>Focus on the benefits the change will have on loved ones</li></ul>



<b>Preparation</b>  <i>"I want to change but I am not sure I can..."</i>	<ul style="list-style-type: none"><li>• Intends to take action soon and has taken some behavioral steps in this direction</li><li>• Lacks self-efficacy to take the steps necessary for long lasting change</li></ul>	<ul style="list-style-type: none"><li>• Resolution of ambivalence</li><li>• Firm commitment</li><li>• Initiate change</li><li>• Increase self-efficacy through gradually increasing more difficult tasks</li></ul>	<ul style="list-style-type: none"><li>• Assist in developing a concrete action plan</li><li>• Encourage initial small steps to change</li><li>• Discuss earlier attempts to change and ways to succeed</li><li>• Elicit support from family and friends</li></ul>
<b>Action</b>  <i>"I am ready to change..."</i>	<ul style="list-style-type: none"><li>• Has changed overt behavior for less than six months</li><li>• Needs skills for long-term adherence</li></ul>	<ul style="list-style-type: none"><li>• Commit to change</li></ul>	<ul style="list-style-type: none"><li>• Reinforce decision</li><li>• Reinforce self-confidence</li><li>• Assist with self-monitoring, feedback, problem solving, social support, and reinforcement</li><li>• Discuss relapse and coping strategies</li></ul>
<b>Maintenance</b>  <i>"I am in the process of changing..."</i>	<ul style="list-style-type: none"><li>• Has changed overt behavior for more than six months</li></ul>	<ul style="list-style-type: none"><li>• Reinforce commitment and continue changes/new behaviors</li></ul>	<ul style="list-style-type: none"><li>• Plan follow-up to support changes</li><li>• Help prevent relapse</li><li>• Assist in coping, reminding, finding alternatives, and avoiding slips/relapses</li></ul>

**source:**

Adapted from: Story M, Holt K, Sofka D, eds. 2000. *Bright Futures in Practice: Nutrition*. Arlington, VA: National Center for Education in Maternal and Child Health: Appendix F: "Stages of Change – A Model for Nutrition Counseling," page 251. Updated December, 2017



## Alaska WIC Policy & Procedure Manual

### Section 105: Job Aids



## Tools for Providing Effective Telephone Nutrition Education & Counseling

### PURPOSE:

To present resources for Local Agencies to use in assisting staff in providing effective telephone nutrition education and counseling.

To provide guidance on providing nutrition education to WIC participants using the telephone.

### JOB AID: Tools for Providing Effective Telephone Nutrition Education & Counseling

#### Tips for Telephone Counseling

Nutrition education is the Program benefit that makes WIC a premiere public health program, setting it apart from other nutrition assistance programs. Effective nutrition education should be designed to elicit a positive behavior change regardless of delivery method.

The elements of effective nutrition education can also be applied via telephone. For example, the WIC nutrition educator can assess the participant's readiness to change and determine relevant nutrition messages during a telephone conversation that use participant centered learning as the counseling method/teaching strategy. This combination of delivery medium and counseling method/teaching strategy allows for participant interaction, goal setting and immediate feedback. Information that reinforces the messages can be provided via mail, electronically or at the next clinic visit.

Sometimes, a telephone call is the best way to follow up with a participant. These sessions are low cost and do not require transportation. Also, some participants may be more open talking with you when you are not face-to-face in the WIC office. Here are some tips to make these sessions successful.

#### *Prepare for the Telephone Call*

- Ask other colleagues about their experiences with telephone counseling.
- Prepare your workspace and eliminate distractions.
- Review the participant's information and have it in front of you during the call.
- Remember to use skills like those you use in face-to-face counseling.

#### *Make the Call*

- Introduce yourself warmly.
- Welcome in a way that conveys your willingness to listen in an unhurried manner.
- Let them know how much time you anticipate the call to take.



## Alaska WIC Policy & Procedure Manual



- Ask if this is a good time to talk and whether the participant can speak freely.
- Pretend the participant can see you.
- Pay attention to the tone of your voice, breathing patterns, pauses, and speaking pace.

### *Pay Attention*

- Listen actively to the participant's words and overall message.
- Value the participant as a human being.
- Listen with an open mind and heart. Don't interrupt.
- Acknowledge the participant's feelings to continue the conversation.
- Make an effort to understand in a non-judgmental way.

### *Consider Your Words*

- Show you're listening. Use verbal cues, e.g., "Yes, I see...", "Uh huh..."
- Say the participant's name and the child's name often.
- Describe concrete examples that fit the participant's experience.
- Use language easy enough for anyone to understand.

### *Use Your Best Counseling Skills (Even Though You Are Not Face-to-Face)*

- Let the participant choose the most pressing problem they wish to discuss.
- Address other issues as time permits.
- Ask open-ended questions to draw out more feelings, concerns, and difficulties.
- Probe for more information when a superficial answer is not enough.
- Congratulate and compliment small positive steps.
- Paraphrase key content and feelings from what the participant says.
- Verify what you heard and correct misunderstandings.
- Allow for thinking with pauses and silences. These may foster more discussion.

### *Close the Call*

- Summarize the main points of the conversation.
- PRAISE the participant and help them feel confident for action.
- Set a time for the next visit with the participant.
- Limit calls to 15 minutes.

### *Take Care with Leaving Messages & Voicemail*

- Follow your WIC agency policy on leaving messages. They may compromise privacy.
- Check on the Family Information form to make sure it is ok to leave a message for a participant.

### *Guard the Participant's Confidentiality*

- Keep information quiet according to WIC policy.
- Select a time and place to make your call so others will not overhear you.
- Assume any information is confidential if you are unsure.



### *Document Contacts with WIC Participants*

- Record the date.
- Specify the type of contact you had with the participant or caregiver.
- Note any referrals you made.
- Summarize the things you talked about.
- Follow your agency policy regarding documentation.

### Telephone Nutrition Counseling and Education

Nutrition counseling is an ongoing process in which a health professional, usually a Registered Dietitian (RD), works with an individual to assess his or her usual dietary intake and identify areas where change is needed. The nutrition counselor provides information, educational materials, support, and follow-up to help the individual make and maintain the needed dietary changes.

Telephone communication and counseling are used by Alaska Local Agencies for nutrition assessment, nutrition education, counseling and follow-up. Local Agencies are responsible to review training materials, train, observe and coach staff in the implementation of telephone nutrition counseling and education principles and guidelines.

Telephone nutrition counseling should be used for the certification of rural clients, if face to face counseling or video teleconferencing isn't possible. When counseling is done via telephone, this should be noted in the SOAP note. Follow up counseling for quarterly education, or to follow up interactive on-line education, can also be done via telephone. It should also be noted in the electronic chart that this contact was made via telephone.

### Telephone Nutrition Counseling and Education Preparation

To prepare for WIC Telephone Nutrition Counseling, WIC staffs need to review the following resources:

- Stages of Change-A Model for Nutrition Counseling, Bright Futures in Practice: Nutrition (Page 2:36)
- [Bright Futures in Practice Nutrition Pocket Guide](#)





## Alaska WIC Policy & Procedure Manual

### Section: 105 Job Aids

## Five Techniques to Succeed in Answering the Telephone

### **PURPOSE:**

To present five techniques for answering the telephone.

### **Five Techniques to Succeed in Answering the Telephone**

#### Answer Right Away Greeting

- State Purpose (Callers can see you by your greeting and by your tone of voice)
- Decide appropriate greeting for you

#### Identify/Solicitation (Standard way you answer the phone after the greeting)

- Name of the clinic
- Your name
- A question, "How may I help you?"

#### Take Clear Messages

#### Practice and Use 5 Good Vocal Quality Techniques

- Normal volume
- Clear Speech
- Steady Pace
- Pleasant tone
- Energy



**Alaska WIC Policy & Procedure Manual**  
Section 105: Job Aids

**Types of Breast Pumps and Their Use**

Convenience	<ul style="list-style-type: none"><li>• Hand Expression</li><li>• Manual Pumps</li><li>• Pedal Pump</li></ul>	<ul style="list-style-type: none"><li>• Occasional separation from baby</li><li>• Used no more than 8 times per week</li><li>• Temporary or short-term use</li></ul>
Work or School	Personal-use Double Electric* (Medela Pump- In-Style)	<ul style="list-style-type: none"><li>• Infant is at least 4 weeks of age</li><li>• Used 9 or more times per week</li><li>• Plans to pump for a few months</li><li>• Attending school/work more than 20 hours per week or less frequently with an inflexible schedule</li><li>• Mothers with a well-established milk supply</li><li>• Infant is exclusively breastfed</li></ul>
Medical Need	Hospital-grade Double Electric (Medela Lactina)	<ul style="list-style-type: none"><li>• Frequent use</li><li>• To bring in or increase milk supply</li><li>• To maintain milk supply due to prematurity, hospitalization or other health problems</li><li>• Long or short term use</li><li>• Mother whose baby is not nursing</li><li>• Mother with severe, recurrent engorgement</li><li>• Mother with very sore nipples</li><li>• Mother that has had breast surgery</li><li>• Mother that is re-lactating</li><li>• Mother that needs to pump and dump</li></ul>

\* Clients living in remote areas of the state or that are homeless may be candidates for personal - use double electric pumps in lieu of hospital-grade double electric breast pumps.

- For guidance see “Type of Use” for the hospital-grade pumps to determine if this type of pump is appropriate for clients living in remote areas of the state or that are homeless.
- Special emphasis should be placed on educating the client that use of the pump is for an individual and there are risks associated with loaning personal –use double electric pumps to other women such as cross-contamination and poorly



## Alaska WIC Policy & Procedure Manual



working pumps.

- Receiving a personal-use double electric pump is a one-time only occurrence in the WIC program, and clients should be made aware of this stipulation through the Breast Pump Loan Agreement included as a Job Aid in this policy section.



## Alaska WIC Breast Pump Loan & Release Agreement



### WIC Clinic \_\_\_\_\_

The WIC Program is extremely pleased with your decision to provide your infant with breast milk. In order to borrow a pump or be issued a single-user pump, you must agree to abide by this Loan and Release Form Agreement.

### WIC Participant Information

Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Infant's DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ Email Address \_\_\_\_\_  
*Last First*  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Residence Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Additional Contact Person's Name \_\_\_\_\_ Email Address \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

-----  
**Breast Pump Issued                      Pump Serial Number      OR      State Tag Number**

☐ **Electric Breast Pump** \_\_\_\_\_  
☐ **Pump In Style** \_\_\_\_\_

**Reason for Issuance:** ☐ **Back to Work/School** ☐ **Increase Milk Supply** ☐ **NICU** ☐ **Other**

### Check as appropriate:

- ☐ **For Single User Electric Pumps Only:** I understand that I will be issued only one single-user electric pump while on the Alaska WIC Program. I understand that I should not loan out or sell this pump.
- ☐ I have received and understand instructions for operating this breast pump including how to properly close the case. I am able to operate this breast pump without assistance.
- ☐ I have inspected this breast pump and agree that it is in good condition.
- ☐ I have received and understand instructions for cleaning this breast pump.
- ☐ I agree to follow the instructions for operating and cleaning this breast pump.
- ☐ I understand that the WIC Program, or its representatives, cannot be held responsible for any personal damage caused by the use of this breast pump. I release the WIC Program from any liability regarding my use of this breast pump.
- ☐ I understand this breast pump is a loan from the WIC Program, and that it is loaned to me on a priority basis. I may be required to return it for use by a higher priority WIC participant. I agree to return the breast pump on (date) \_\_\_\_\_ or sooner, if requested or if I am not using it on a daily basis.



- ☐ I understand that I must return the breast pump undamaged and clean or be subject to a financial penalty between \$350.00-\$963 (depending on the value of the pump.). If I don't return the loaned electric breast pump, the state may use other types of legal options to collect payment, including small claims court, which could result in **Permanent Fund Dividend (PFD) garnishment**.
- ☐ I understand that this breast pump must not be removed from the local area without special permission.

**Our supplies are limited so please return the breast pump, when you no longer need it.**

***The WIC Program reserves the right to schedule monthly appointments, call you to check on the pump and may issue vouchers on a monthly basis while the pump is on loan.***

\_\_\_\_\_  
WIC Participant Signature                      Date

\_\_\_\_\_  
WIC Representative Signature                      Date

Breast pump Returned Date \_\_\_\_\_

# Checklist for Instructing Breastfeeding WIC Participants on Using Breast Pumps

**WIC Participant Name:** \_\_\_\_\_

**Instructions:** Complete the tasks listed below in person or over the phone. Initial on the space provided.

1. \_\_\_\_\_ Breast Pump Loan and Release Agreement form reviewed and signed. Original in the file, and a copy given to client.
2. \_\_\_\_\_ Demonstrate pump kit assembly, show, or send video with the pump for the client to view before using it. Disassemble the pump and have the client put it together.
3. \_\_\_\_\_ Demonstrate how to hook kit up to electric pump.
4. \_\_\_\_\_ Demonstrate how to adjust suction on pump.
5. \_\_\_\_\_ Help client, as appropriate, use pump or express milk from both breasts. Be available, in person or by phone, to help clients.
6. \_\_\_\_\_ Demonstrate how to take apart the pump, and which parts need to be washed.
7. \_\_\_\_\_ Review cleaning instructions. (Sterilization instructions must be reviewed for mothers of very small, pre-term infants and infants with an immune deficiency).
8. \_\_\_\_\_ Demonstrate how to close the carrying case.
9. \_\_\_\_\_ Review breastfeeding/pumping routine with client. (Provide handout *Working and Breastfeeding, or Balancing Act*, La Leche League International. Order from Juneau.)
10. \_\_\_\_\_ Review breast milk collection and storage with the client. (Provide handout *Human Milk Storage Guidelines for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)*).
11. \_\_\_\_\_ Give client the name and phone number of the clinic to call if she needs help.
12. \_\_\_\_\_ Notify client an RD/RN/IBCLC or Breastfeeding Peer Counselor will call within 24 hours and at least weekly to follow up.

\_\_\_\_\_  
*Staff Signature*

\_\_\_\_\_  
*Date*



## Alaska WIC Cleaning Breast Pump Equipment Procedures



### Cleaning Breast Pump Equipment

All electric breast pumps (EBP) and carrying cases will be cleaned by hand, using bleach and water with disposable towels, bleach wipes, or other appropriate disinfectant such as Cavacide before electric breast pumps may be reissued to WIC clients.

- Remove and throw away any double pumping accessory pieces left in or on EBP.
- Wipe Video case with bleach solution, if applicable.
- Remove Carrying Strap and clean both sides with bleach solution.
- Wipe all surfaces of EBP with the bleach solution; allow to remain wet for 2 minutes
- Wipe Carrying Case inside and out with the bleach solution, allow to remain wet for 2 minutes.
- Allow EBP, Carrying Case and Strap to Air Dry.
- Document any missing or broken pieces on EBP Inspection Form.
- Replace Carrying Strap, Video and EBP in case. Store closed until needed.

### Cleaning Solution Options:

- Bleach Solution: Mix 1 tablespoon of chlorine bleach with 4 cups warm water. Discard after use.
- Use commercial Bleach wipes.
- Use commercial spray sanitizing solution and paper towels.



## AK WIC Breast Pump Retrieval Letter

Date: \_\_\_\_\_

Dear \_\_\_\_\_,

I am writing to request that you return the electric breast pump we loaned you on \_\_\_\_\_(date.) We hope that you and your baby benefited from our breast pump loan program. It is important that we receive the electric breast pump back as soon as possible as we have a limited number of electric breast pumps for a large number of WIC participants.

This pump is now overdue and prevents us from serving other WIC mothers that may need the pump. By not returning the pump you are limiting our ability to help other WIC families.

I expect that you will be able to deliver the electric pump **immediately**.

If our WIC office does not hear from you or receive the pump by \_\_\_\_\_(date), we will proceed to turn over the breast pump retrieval process to the State of Alaska Fraud Control Unit .

Thank you for your prompt response. If you have any questions, please contact me at \_\_\_\_\_.

Sincerely,  
WIC Coordinator  
Contact Information





# Alaska WIC Policy & Procedure Manual

## Guidance for WIC Staff on Issuing Nipple Shields



A nipple shield is a nipple-shaped sheath worn over the areola and nipple during breastfeeding. Modern nipple shields are made of soft, thin, flexible silicone and have holes at the end of the nipple section to allow the breastmilk to pass through.

Any WIC Staff issuing nipple shields need to be appropriately trained by a DBE prior to issuance and participant education.

Assessment of need, proper fit and use of shield, follow up, and a plan for weaning from the shield can help prevent potential complications for mom and infant associated with use of nipple shields.

### A| Nipple Shield Assessment

1. Appropriate uses for a nipple shield may include:
  - a. Mother/baby unable to achieve or maintain latch, even with hands-on help from trained professionals
  - b. Preterm infant (to enhance milk transfer).
  - c. Sore nipples (along with assistance to solve the root cause).

### B| Fit of Shield

1. Nipple shields are sized based on the diameter of the nipple, not including areola, in millimeters.
2. It's possible to have large breasts, but still need a small nipple shield size. Sizing is based on nipple size, not breast size.
3. It's possible to have nipples that are two different sizes, some amount of asymmetry between breasts is normal. It's a good idea to measure both sides to ensure each side has the correct size.
4. The shield should also fit the baby's mouth.

### C| Use of Nipple Shield.

1. Instruct mother in the use of the nipple shield.
  - a. Apply Nipple Shield:
    - i. Show mother how to apply the nipple shield.
    - ii. Possible techniques include:



# Alaska WIC Policy & Procedure Manual

## Guidance for WIC Staff on Issuing Nipple Shields



- Inside-out/sombrero technique.
  - Priming with milk or water from curved-tip syringe.
  - Sticking to skin with lanolin around rim.
2. Cleaning Nipple Shield:
- i. Instruct how to clean:
    - Wash with dish soap and water.
    - Rinse well.
    - Air Dryer.

### D| Follow-up Plans

1. Discuss follow up plans with mother.
  - a. Feeding plan discussed with mother for home use of nipple shield.
    - i. Track infant's daily number of feedings and output.
    - ii. Discuss weaning techniques with goal to wean within 2-3 weeks.
    - iii. At least one follow-up call that should be 24-48 hours after issuance, and ideally again 1 week after issuance.

### F| Well Established Breastfeeding

1. Once breastfeeding is well established:
  - a. A plan for weaning should be determined, discussed, with the client, and documented in the client's chart with a plan for follow up set to help ensure success.



# Alaska WIC Policy & Procedure Manual

## Nipple Shields Guidance for WIC Participants



### A| Before Feeding

- 1| Make sure you have the correct size nipple shield; the shield should fit the baby's mouth.
  - a| The shield should be snug, but not painful.
  - b| Shield should not cause chafing or abrasion of the nipple. c| Use only the silicone shields.
  - d| Find a comfortable position for yourself.
- 2| Use warm moist packs and/or massage breasts just before applying the nipple shield.
  - a| This may help to get your milk flowing. 3|Hand express some breast milk into the shield.
  - a| This may help the infant latch and begin sucking.
- 4| When placing the shield over your nipple, fold the wide brim towards the nipple part of the shield (almost inside out or like a taco).
  - a| Your nipple should be in the middle part of the shield.
  - b| Then fold the shield brim back towards your breast so it covers the areola (dark part around the nipple).
  - c| Wetting the inside of the shield rim may help to hold the nipple shield to your breast.
- 5| Support the breast with a "C" hold.
  - a| Place your thumb on top of the breast and nipple shield and with fingers below and away from the areola.
- 6| Tickle the infant's lips with the nipple until he/she opens mouth wide.
  - a| Make sure the infant takes as much of the nipple and areola as possible into his/her mouth.
  - b| you should NOT be able to see the base of the nipple once your infant is latched.

### B| During Breastfeeding

- 1| Listen to your infant swallow.
- 2| Check that your infant is sucking well.
  - a| You should not hear clicking or smacking.



## Alaska WIC Policy & Procedure Manual Nipple Shields Guidance for WIC Participants



- b| The suck should be regular and rhythmic.
- 3| You should feel a tugging on your nipple with each suck but this should not be painful. a| If you are feeling any pain or chafing while using the shield call your WIC office.
- 4| Let your infant breastfeed as long as he/she wants.

### **C| After Feeding**

- 1| Your breast should feel softer with the end of the feeding. 2| You should also see breast milk in the nipple shield.
- 3| See if your nipple has been drawn out, with the infants sucking.
- 4| If your baby is having problems sucking or latching on, you may need to use a breast pump to get and keep a good milk supply.
- 5| Wash the nipple shield with hot, soapy water and air dry after each use.
- 6| Make sure you keep in touch with WIC staff who can help make sure your infant is gaining weight and answer your questions about breastfeeding.

### **D| Weaning**

- 1| Once breastfeeding is well established, a plan for weaning should be set. 2|

Remember:

- a| Wait until the feedings are going well and you feel calm, confident, and ready to try breastfeeding without a shield.
- b| Continue skin to skin contact with baby at the breast.
- c| Offer the breast to infant for comfort, not just when hungry.
- 3| Try these method(s) when ready to wean:
  - a| Start the feeding with the nipple shield in place; when the infant finishes on the first breast, switch to the other breast and try latching without the shield.
  - b| Start feeding with nipple shield in place.



## Alaska WIC Policy & Procedure Manual

### Nipple Shields Guidance for WIC Participants



i| Once sucking is going well (active sucking but not upset or fussy), and letdown has happened, break suction.

ii| Quickly remove infant from breast, remove shield and re-latch the baby without the shield.

iii| If he/she refuses, put the shield back on, continue the feeding, and wait until another feeding to try again.

iv| Try this 2-3 times each day.

# Alaska WIC Nutrition Program Enteral Nutrition Prescription Request Form for Therapeutic Formulas and Medical Foods

State of Alaska Department of Health & Social Services/Public Assistance

Please Fax to: \_\_\_\_\_

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent's/Caregivers Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Medicaid Eligible? ☐ No ☐ Yes Medicaid # \_\_\_\_\_ End date \_\_\_\_\_

Current Measurements (if available): Medical date \_\_\_\_\_ Ht = \_\_\_\_\_ in/cm Wt = \_\_\_\_\_ lbs/kg

## ALASKA WIC STANDARD CONTRACT FORMULAS:

The following contract formulas DO NOT REQUIRE MEDICAL DOCUMENTATION for infants younger than 12 months, except when an increased formula amount is requested for infants 6-11 months:

**Similac Advance (milk based) 20 Cal/oz**

**Similac Soy Isomil (soy based) 20 Cal/oz**

**Similac Sensitive (milk based) 20 Cal/oz**

**Similac Total Comfort (milk based) 20 Cal/oz**

**Note:** WIC cannot provide Similac Pro Advance or Similac Pro Sensitive

**Directions:** Please complete the Enteral Nutrition Prescription Request (ENPR) form so WIC can provide a Non Contract formula for your patient. This form can be provided to the WIC client or may be faxed to the WIC office. If the ENPR form is approved by the Local Agency Registered Dietitian, WIC will provide the Non Contract formula.

Infant	Child/ Woman
<p>Formula:</p> <p><input type="checkbox"/> Enfamil AR <input type="checkbox"/> Similac Neosure</p> <p><input type="checkbox"/> Similac Alimentum <input type="checkbox"/> Nutricia Neocate Infant</p> <p><input type="checkbox"/> Nutramigen with Enflora <input type="checkbox"/> Elecare</p> <p><input type="checkbox"/> Enfamil Enficare <input type="checkbox"/> Gerber Extensive HA</p> <p><input type="checkbox"/> Enfamil Gentlease <input type="checkbox"/> Parent's Choice Hypoallergenic</p>	<p>Formula:</p> <p><input type="checkbox"/> Pediasure <input type="checkbox"/> Ensure</p> <p><input type="checkbox"/> Neocare Jr</p>
<p>Prescribed amount of formula:</p> <p><input type="checkbox"/> Maximum allowable OR <input type="checkbox"/> _____ ounces</p>	<p>Prescribed amount of formula:</p> <p><input type="checkbox"/> Maximum allowable</p> <p><b>OR</b> <input type="checkbox"/> _____ ounces</p>
<p>Was another Formula Tried <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Formula Tried _____</p>	<p>Milk in addition to formula</p> <p>Specify: <input type="checkbox"/> Whole <input type="checkbox"/> 2% <input type="checkbox"/> 1% or skim</p>
<p>Duration: <input type="checkbox"/> up to age 1 <b>OR</b> <input type="checkbox"/> _____ months</p>	<p>Food Prescription (check one)</p> <p><input type="checkbox"/> No solid foods; medical formula only</p> <p><input type="checkbox"/> Infant cereal</p> <p><input type="checkbox"/> Infant fruits and vegetables</p>
<p><b>Infants 6-11 months who are not developmentally able to begin foods may receive more formula</b></p> <p><input type="checkbox"/> <b>Check foods to avoid:</b></p> <p><input type="checkbox"/> Infant Cereal</p> <p><input type="checkbox"/> Infant Fruits/Vegetables</p> <p><input type="checkbox"/> <b>Provide no infant foods, and increase formula amount</b></p>	<p>Duration: <input type="checkbox"/> 12 months</p> <p><b>OR</b> <input type="checkbox"/> _____ months</p>

The prescription must be completed by a Health Care Provider eligible to write prescriptions in Alaska. Please include your Alaska License number or Medicaid Provider number.

## Please fill in Medical Diagnosis and ICD-10 Code

(Both must be completed in order to process the request for therapeutic formulas)

Medical Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Provider Phone \_\_\_\_\_

Medical Provider Name \_\_\_\_\_

Provider Medicaid ID # \_\_\_\_\_

### Some conditions may not qualify for special formula through WIC

The program does NOT authorize issuance of therapeutic formulas for:

- 1). Nonspecific symptoms such as intolerance, fussiness, gas, spitting up, constipation or colic OR
- 2). Enhancing nutrient intake or managing body weight without an underlying medical condition

WIC REGISTERED DIETITIAN OR LICENSED NUTRITIONIST & MEDICAID USE ONLY

Date \_\_\_\_\_ RD approved \_\_\_\_\_ Denied \_\_\_\_\_ Date Range approved: \_\_\_\_\_

# Cheat Sheet for ENPRs

## Therapeutic Formulas and Medical Foods that May be Provided with Medical Documentation

WIC is a supplemental Food Program. Infants who are not breastfed may require more formula than WIC is able to provide

### Hydrolyzed Protein

Similac Expert Care Alimentum  
Nutramigen with Enflora

### Amino Acid Based

Neocate Infant  
Elecare

### WIC-eligible Nutritionals for Children/Women

Pediasure and Pediasure with Fiber  
Ensure or Ensure with Fiber  
Neocate Jr.

### Premature Infant Post Discharge

Enfamil Enfacare  
Similac Neosure

	Age in Years	RDA Energy (kcal/kg)	Protein (g/kg/day)		Velocity of Weight Gain (gm/day)	
					<i>Females</i>	<i>Male</i>
Infants	Premature	120	2.2	Birth-3 month	24	28
	0-6months	108	2.2	3-6 months	19	21
	6-12 months	98	1.6	6-9 months	14	15
				9-12 months	11	11
Children	1-3 years	102	1.2	12-18 months	8	8
	4-6 years	90	1.1	18-36 months	5	5
				3-4 years	5	5
				4-5 years	6	6

Formula average daily calorie needs for \_\_\_\_\_months = \_\_\_\_\_

Updated 2/2023

# Certificate of Medical Necessity

MEMBER INFORMATION		PROVIDER INFORMATION	
Member Name: _____ <i>(Last, First, MI)</i>		Ordering Provider's Name: _____	
Alaska Medicaid Member ID: _____		Provider Medicaid ID or NPI: _____	
Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____		Phone Number: _____ Ext. _____	
*Height: _____ (inches)    *Weight: _____ (pounds)		Prescription Start Date: _____	
Date of Last Visit: _____		Retrospective Review? <input type="radio"/> Yes <input type="radio"/> No	
<b>SECTION A - CLINICAL INFORMATION</b> <i>(This section MUST be completed by the attending physician, physician assistant, nurse practitioner, or audiologist.)</i>			
	<b>Diagnosis Code</b>	<b>Diagnosis Description</b>	
<b>ICD-10</b>			
<b>Estimated Length of Need (# of Months):</b> _____ <i>(99 = Lifetime)</i>			
<b>SECTION B - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICE(S) OR ITEM(S) AND PLAN</b> Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Attach any supporting documentation as needed for further justification. <i>(This section may be completed by the attending specialist, including the physician, physician assistant, nurse practitioner, physical therapist, occupational therapist, speech language pathology therapist, registered dietitian, audiologist, or other attending specialist within the scope of his or her specialty.)</i>			
<b>PLAN:</b> <i>The plan should list each service or item specifically needed for the treatment of the member. Additional treatment information may be attached to this form.</i>			
<b>ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN/ PHYSICIAN ASSISTANT/NURSE PRACTITIONER/ AUDIOLOGIST AND SPECIALIST</b> <i>(Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)</i>			
A physician, physician assistant, nurse practitioner, audiologist or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.			
<i>This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.</i>			
_____ Signature of Specialist, Title			_____ Date
<i>I hereby certify that I am the ordering physician/physician assistant/nurse practitioner/audiologist identified in this form.</i>			
_____ Signature of Physician / Physician Assistant / Nurse Practitioner / Audiologist			_____ Date

*Authorization does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.*



MEMBER INFORMATION						PROVIDER INFORMATION			
Member Name: _____ (Last, First, MI)						Ordering Provider's Name: _____			
Alaska Medicaid Member ID: _____						Provider Medicaid ID or NPI: _____			
Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____						Phone Number: _____ Ext. _____			
SECTION C - REQUESTED SERVICES OR ITEMS (To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)						Alaska Medicaid Fiscal Agent Use Only			
Provider Name: _____						Approved: As requested Modified request			
Address: _____						Denied:			
Provider Medicaid ID: _____						Service Authorization No: _____			
Requester Name: _____						Start Date: _____ End Date: _____			
Phone Number: _____ Ext. _____						Comments: _____			
Fax Number: _____ Ext. _____						Authorizing Agent Signature/Date: _____			
Dates of Need – Start Date: _____ End Date: _____									
	Procedure Code	Mod	Description	Qty	Charges	Authorized		Approved Quantity	Approved Amount
						Yes	No		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
SECTION D - SUPPLIER ATTESTATION, SIGNATURE AND DATE									
<p>I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering physician/physician assistant/nurse practitioner/ audiologist specified in this form, and that these exact services or items listed in this form will be supplied to the specified member. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.</p>									
Signature of Supplier _____						Date _____			

Authorization does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

## Certificate of Medical Necessity Instructions

**Submission Requirements:** This Certificate of Medical Necessity (CMN) must be completed to request services and must bear the signatures of the professionals who, by signing the form, attest that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements. **Submit all CMN requests directly to Alaska Medicaid Fiscal Agent (FA)**, by fax at 888.772.3632 or by mail at AK Medicaid FA Service Authorization, PO Box 240808, Anchorage, AK 99524-0808.

**Submitted by:** Enter the name of the individual submitting the CMN.

**Date:** Enter the date the CMN is completed.

### Member Information *This information is auto-filled on the 2<sup>nd</sup> page.*

**Member Name:** Enter the member's last name, first name and middle initial.

**Alaska Medicaid Member ID:** Enter the Alaska Medicaid Member ID number.

**Date of Birth:** Enter the member's date of birth using the calendar feature or a MM/DD/YY format.

**Age:** Enter the age of the member.

**Sex:** Select the gender of the member.

**\*Height:** Enter the member's height in inches.

**\*Weight:** Enter the member's weight in pounds.

**Note:** *Certain services/items cannot be approved without height and weight.*

**Date of Last Visit:** Enter the date of the member's last visit using the calendar feature or a MM/DD/YY format.

### Provider Information *This information is auto-filled on the 2<sup>nd</sup> page.*

**Ordering Provider's Name:** Enter the ordering provider's last name, first name, and middle initial.

**Provider Medicaid ID or NPI:** Enter the ordering provider's Medicaid ID or NPI number.

**Phone Number & Ext.:** Enter the ordering provider's contact phone number and extension.

**Retrospective Review?:** Check 'Yes' or 'No'.

### Section A – Clinical Information

**Note:** *This section must be completed by the attending physician, physician assistant, nurse practitioner, or audiologist.*

**Diagnosis Code (ICD-10):** Enter the primary ICD-10 diagnosis code, at a minimum, for the requested services.

**Diagnosis Description (ICD-10):** Enter the corresponding description for each ICD-10 diagnosis code entered.

**Estimated Length of Need:** Enter the number of months the requested services or items will be needed. Enter '99' in this field if the services or items requested are needed on a continuous basis for the member's lifetime.

**Note:** *Entering a lifetime span does not guarantee payment to the provider for these services or items for the member's lifetime. Medical justification must support the request and the member must meet eligibility requirements for the duration of the authorization. Additionally, lifetime requests are subject to a periodic recertification to ensure medical necessity.*

### Section B – Clinical Assessment of Need for Prescribed Services or Item(s) and Plan

**Note:** *This section may be completed by the attending specialist, including the physician, physician assistant, nurse practitioner, physical therapist, occupational therapist, speech language pathology therapist, registered dietitian, audiologist, or other attending specialist within the scope of his or her specialty.*

**Clinical Assessment of Need for Prescribed Service(s) or Item(s):** Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Medical justification must be complete and thorough in order to process the request. Attach additional supporting documentation as needed for further justification.

**Plan:** The plan should list each service or item specifically needed for the treatment of the member. Attach a detailed treatment plan or other pertinent information as needed.

**Attestation, Signature, and Date of Physician/Physician Assistant/Nurse Practitioner:** Enter signature of the physician/physician assistant/nurse practitioner/audiologist submitting the CMN request and date signed. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

If Section B of this form is completed by a specialist other than the ordering provider identified in Section A, the specialist must also enter their signature, title, and date signed on the lines provided. By signing the form, the specialist also attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

Authorization does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

**Forward this form to:** Alaska Medicaid Fiscal Agent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808

## Certificate of Medical Necessity Instructions (Cont.)

### Section C – Requested Services or Items

**Note:** This section is for the DME, prosthetics & orthotics, audiology, or hearing aid provider.

<p><b>Provider Name:</b> Enter the supplying provider's last name, first name, and middle initial.</p> <p><b>Address:</b> Enter the address of the supplying provider.</p> <p><b>Provider Medicaid ID or NPI:</b> Enter the supplying provider's Medicaid ID or NPI number.</p> <p><b>Requester Name:</b> Enter the name of the requesting individual.</p>	<p><b>Phone Number &amp; Ext.:</b> Enter the supplying provider's contact phone number and extension.</p> <p><b>Fax Number &amp; Ext.:</b> Enter the supplying provider's fax number and extension, if applicable.</p> <p><b>Dates of Need – Start Date / End Date:</b> Enter the start date and end date of the authorization.</p>
<p><b>Procedure/Drug Code:</b> Enter the procedure/drug code for the service or item requested.</p> <p><b>MOD:</b> Enter any applicable modifier codes for the requested service or item.</p> <p><b>Description:</b> Enter the description of the requested service or item.</p>	<p><b>Qty:</b> Enter the quantity of the service to be performed or item to be dispensed.</p> <p><b>Charges:</b> Enter the total estimated charges for the requested service or item.</p>

**Section D – Supplier Attestation, Signature, and Date:** Enter signature and title of the supplying professional submitting the CMN request. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

## Certificate of Medical Necessity Amendments

Any changes to an approved CMN or requests for additional services or items must be requested through the AK Medicaid FA Service Authorization department. All changes to any field(s) on the approved form must be initialed and dated by the original prescribing medical provider. Additionally, supporting medical documentation justifying medical necessity must accompany any requests for additional services or items.

Authorization does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

# WIC Technology Security Agreement STATE OF ALASKA

Department of Health and Social Services Division  
of Public Assistance / Systems Operations

## Women, Infants and Children (WIC) Program

I understand that all information contained in the WIC SPIRIT database, SPIRIT Utilities, and any other WIC system is confidential. I agree not to disclose any information regarding persons who have applied for, have received, or who are receiving WIC Program services to any unauthorized group or individual; or, to any person for any purpose other than the administration of the WIC Program.

I will protect all participant and/or related information made available to me through interfaces, other agencies, and/or State of Alaska sponsored password-protected websites whether this information is obtained via the WIC SPIRIT database, SPIRIT Utilities, websites, direct computer access, hard copy documents, on line viewing, or any other means of communication. This includes, but not limited to, information from other WIC Program grantees or WIC agencies outside Alaska, and any future information interfaces or Internet services that may be developed.

I understand that I may only use my access to State of Alaska systems and data for specific functions of my official job duties. I understand that my passwords are confidential and may not be kept in written form in unsecured areas.

I understand that I am the only one allowed to use my assigned passwords. I will not share my password with anyone, to include co-workers, supervisors, IT staff members, and other grantees or contractors. If I suspect anyone else has knowledge of my password, I will report this immediately to my supervisor and the WIC SPIRIT Help Desk, and I will immediately change my password.

I understand that whenever I leave my workstation and am not in close proximity, I must exit SPIRIT and lock my workstation.

**I have read this entire Security Agreement and consent to abide by it. Also, I certify that I have read, understand and will comply with the security and privacy provisions of my agency's WIC grant. Furthermore, I understand that I may be prosecuted if I use systems for fraudulent purposes. This can include, but is not limited to, termination of my SPIRIT access.**

**I have read the enclosed SPIRIT Security & Electronic Infrastructure policy, included in Alaska Policy & Procedure manual**

***I understand that any violation of this agreement may result in disciplinary action, which may include termination of my agency's grantee agreement with the State of Alaska.***

***Completion of the Online SPIRIT modules is required for SPIRIT credentials. Modules must be completed before access can be granted.***

**To formally request SPIRIT access, send your certificate of completion for the SPIRIT modules along with this signed agreement to [wicspirithelpdesk@alaska.gov](mailto:wicspirithelpdesk@alaska.gov). Once SPIRIT user credentials have been established, you will receive a confirmation email with login information.**

### Select an Action:

☐ Change Existing Account - *Please circle one*      Update in Role or Location      Deactivation of Account due to Separation of Employment

☐ New Account - Date employment began: \_\_\_\_\_

*Is this staff member replacing a previous SPIRIT user? Previous user's name:* \_\_\_\_\_

### Select Role:

- ☐ Clinic Coordinator
- ☐ CPA Nutritionist
- ☐ CPA-In-Training
- ☐ Breastfeeding Peer Counselor
- ☐ Office Staff
- ☐ Intern
- ☐ IT Support
- ☐ Contractor
- ☐ Other (please define): \_\_\_\_\_

State of Alaska:

- ☐ Program Staff
- ☐ Finance/Accounting
- ☐ IT Support
- ☐ Contractor
- ☐ Public Health
- ☐ Other (please define): \_\_\_\_\_

Employee name (printed):	Job Title:	Work Location:
Employee signature and date signed:	Email: Employee phone number:	
Supervisor name (printed):	Supervisor title:	WIC Agency:
Supervisor signature and date signed:	WIC Program Office approval:	

## SFY 2025 WIC Reporting Schedule

Q1	Q2	Q3	Q4
<ul style="list-style-type: none"> <li>• CFR (no template)</li> <li>• GL (no template)</li> <li>• Time study (template)</li> <li>• Narrative program report (template)</li> <li>• July, August, September card logs</li> </ul>	<ul style="list-style-type: none"> <li>• CFR (no template)</li> <li>• GL (no template)</li> <li>• Time study (template)</li> <li>• Narrative program report (template)</li> <li>• October, November, and December card logs</li> <li>• Inventory</li> </ul>	<ul style="list-style-type: none"> <li>• CFR (no template)</li> <li>• GL (no template)</li> <li>• Time study (template)</li> <li>• Narrative program report (template)</li> <li>• LA Annual Survey Results (no template)</li> <li>• January, February, March card logs</li> </ul>	<ul style="list-style-type: none"> <li>• CFR (no template)</li> <li>• GL (no template)</li> <li>• Time study (template)</li> <li>• Narrative program report (template)</li> <li>• April, May, June card logs</li> </ul>

### Additional directions (if applicable)

- CFR (no template)
- General ledger - GL (no template, agency specific) – General ledger must contain enough detail for the PM to determine if a position and/or item is included in an approved local agency budget.
- Time study (template)
- Narrative program report (template)
- Card logs (no template) – Agency specific
- Inventory – Typically updated from the previous year's inventory
- LA Annual Survey Results (no template) - Agency specific



## Alaska WIC Policy

### Employee Conflict of Interest Statement

I have read and do understand the Alaska WIC Program's Conflict of Interest policy.  
By signing below, I am agreeing to always follow the policy by:

1. Certifying that neither I nor any individual related to me by blood or marriage has any financial interest in or is employed by any grocer authorized to accept WIC checks.
2. Not showing any favoritism, by oral or written communication, posters, handouts, or media presentations, towards any WIC authorized vendor.
3. Not endorsing any WIC authorized vendor or discourage WIC participants from using a specific WIC authorized vendor.
4. Not engaging in any promotions for a WIC authorized vendor.
5. Not receiving any gratuities including cash, food, or food coupons from a WIC vendor.

☐ I do not have any conflict of interest

☐ I do have or may have a conflict of interest, which is: \_\_\_\_\_

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Employee name (print full name) Title

Date

Employee signature Date

Date

Supervisor's signature

Date



## Alaska WIC Policy

In case of any conflict of interest, this employee's duties will be amended as follows in order to comply with this conflict of interest policy:

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\_\_\_\_ Employee initial \_\_\_\_ Supervisor initial \_\_\_\_ State Agency initial



## IMPROPER ACTION REPORT

GIVE COPY TO PARTICIPANT

Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Local Agency Statement:

\_\_\_\_\_  
Signature of Authorized Local Agency Representative

Participant Voluntary Statement: If you would like to tell your side of what happened, please write it here. (You are not required to write anything.)

\_\_\_\_\_  
Signature of Participant

In accordance with Federal civil rights Law and Department of Agriculture (USDA) regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.





### Alaska WIC Policy

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov)



## Alaska WIC Policy

### Local Agency Determination:

- ☐ Allegation not substantiated
- ☐ Noncompliance and/or abuse

### Finding:

- ☐ Creating a public nuisance, threatening harm, or disrupting normal activities at the local agency, the vendor (store), farm stand or with the farmer.
- ☐ Physically abusing WIC, vendor staff, farm staff/farmers market or property.
- ☐ Using WIC foods to make "home brew".
- ☐ Other actions leading to improper receipt or misuse of program benefits.

Describe:

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### Decision:

- ☐ Issue a warning.
  - ☐ Provide additional education regarding rules and procedures.
- ☐ Substitute shopper designated for participant. Name: \_\_\_\_\_
- ☐ Suspend participant from program
  - ☐ 30 days
  - ☐ 90 days
- Suspension date: \_\_\_\_\_ Suspension ends: \_\_\_\_\_
- ☐ One year disqualification from program. Effective date: \_\_\_\_\_

### Notes:

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## Separation of Duties Post Review Form

Complete post review within 2 weeks of the certification date.

	Client #1	Client #2	Client #3	Client #4	Client #5
Date review completed					
Staff completing the certification					
Client ID					
Certification date					
Category					
Document below with a "C" for correct & no notes issues, "I" for appears incorrect or apparent issues, N/A for not applicable					
Income information appears valid					
Heights/lengths/weights appear consistent and probable					
Mom's & infant's food packages match					
Signature on the R & R matches signatures captured in SPIRIT or on the return receipt					
No issues found					
If "I" document follow-up completed					

Follow-Up Completed

--

# Zero Income Form

The Alaska WIC Program requires each applicant to show proof of income. You have indicated that you currently have no income. Please read the following statement before completing this form confirming you have no income:

**I understand that by signing this form, I am certifying that the information I am giving WIC is correct. I understand that intentionally giving false information may result in paying WIC back, in cash, the value of food benefits improperly received and/or being removed from the WIC Program.**

1. How do you or family meet basic expenses such as housing, food, medical care and clothing?

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2. Where is your family living?

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3. Have you applied for assistance?

☐ Yes      ☐ No

4. How long have you been without income?

---

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5. Provide additional details in the space below:

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**I will return to the WIC office every 30 days to receive WIC vouchers. I understand that I must bring in proof once I start receiving income.**

Applicant: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Staff: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

LOCAL WIC AGENCY ADDRESS  
HERE.

## HERE IS YOUR ALASKA eWIC CARD

This is your new eWIC card.  
You must select a PIN before you shop  
with the card. Set your PIN by going to  
[www.ebtEDGE.com](http://www.ebtEDGE.com) OR  
calling 1-844-386-3149.

### DO NOT THROW THIS CARD AWAY!

It is the only way to get  
your WIC food benefits.

**[www.ebtEDGE.com](http://www.ebtEDGE.com)**

## WHERE TO GET HELP WITH YOUR eWIC CARD OR ACCOUNT

Help with your eWIC Card or account is always just a click or a phone call away.

### WHEN TO GO ONLINE

**[www.ebtEDGE.com](http://www.ebtEDGE.com)**

- To set or change your PIN
- To check your balance and purchase history

### CALL CUSTOMER SERVICE

**1-844-386-3149**

- To set or change your PIN
- To check your balance and purchase history
- To report your card lost or stolen
- To ask questions or report problems about

### CALL YOUR LOCAL WIC

- To ask questions or report problems about your WIC benefits

# WIC ENCOURAGES BREASTFEEDING EVERY OUNCE COUNTS!

Please sign that you've received the card and mail the signature page back in the self-addressed, stamped envelope.

Date: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Printed Name of Authorized Representative: \_\_\_\_\_

Household #: \_\_\_\_\_

DO NOT    WIC FOOD



## Alaska WIC Policy Preventing Fraud and Abuse Phone Survey Questions

Date:\_\_\_\_\_ Client ID:\_\_\_\_\_ Clinic:\_\_\_\_\_

Client Phone Number:\_\_\_\_\_

Hi. My name is \_\_\_\_\_.

I am from the State WIC office and we are doing a survey of WIC client satisfaction to help us improve WIC services. I would like to know if you are willing to answer some questions about your experience with the WIC clinic. This will not affect your eligibility for the WIC Program in any way. Your name and any information you give me will be kept completely confidential. This is a brief survey that will take about 10 minutes. Are you willing to participate in this short survey? (If yes, proceed. If no, politely thank the client, and tell him/her this will have no effect on eligibility for WIC services.)

1. Confirm your mailing address. \_\_\_\_\_

2. How many people are living in your household? \_\_\_\_\_

3. Have you or a child under your care received WIC in the past 6 months?

☐Yes ☐No

4. Provide the date of birth for your youngest child on WIC, if applicable. If you are the only member in your household on WIC, verify your date of birth (DOB). DOB \_\_\_\_\_

5. What was the nutrition risk for you or your child being placed on the program?

4. How did you hear about the WIC Program?

- |  |   |
|--|---|
| <input type="checkbox"/> DKC/Medicaid            | <input type="checkbox"/> Health Care Provider |
| <input type="checkbox"/> Friend or family member | <input type="checkbox"/> Media                |
| <input type="checkbox"/> Local Campaign 1        | <input type="checkbox"/> Head Start/School    |



## Alaska WIC Policy

- |   |  |
|---|--|
| <input type="checkbox"/> SNAP (Food Stamps) / CSF | <input type="checkbox"/> Text Blast      |
| <input type="checkbox"/> Internet Ad              | <input type="checkbox"/> Mobile/phone ad |
| <input type="checkbox"/> Magazine ad              | <input type="checkbox"/> Other _____     |

6. Do you feel the WIC staff deals with WIC clients in a respectful and professional way?

- ☐ Yes      ☐ No

If no, please explain.

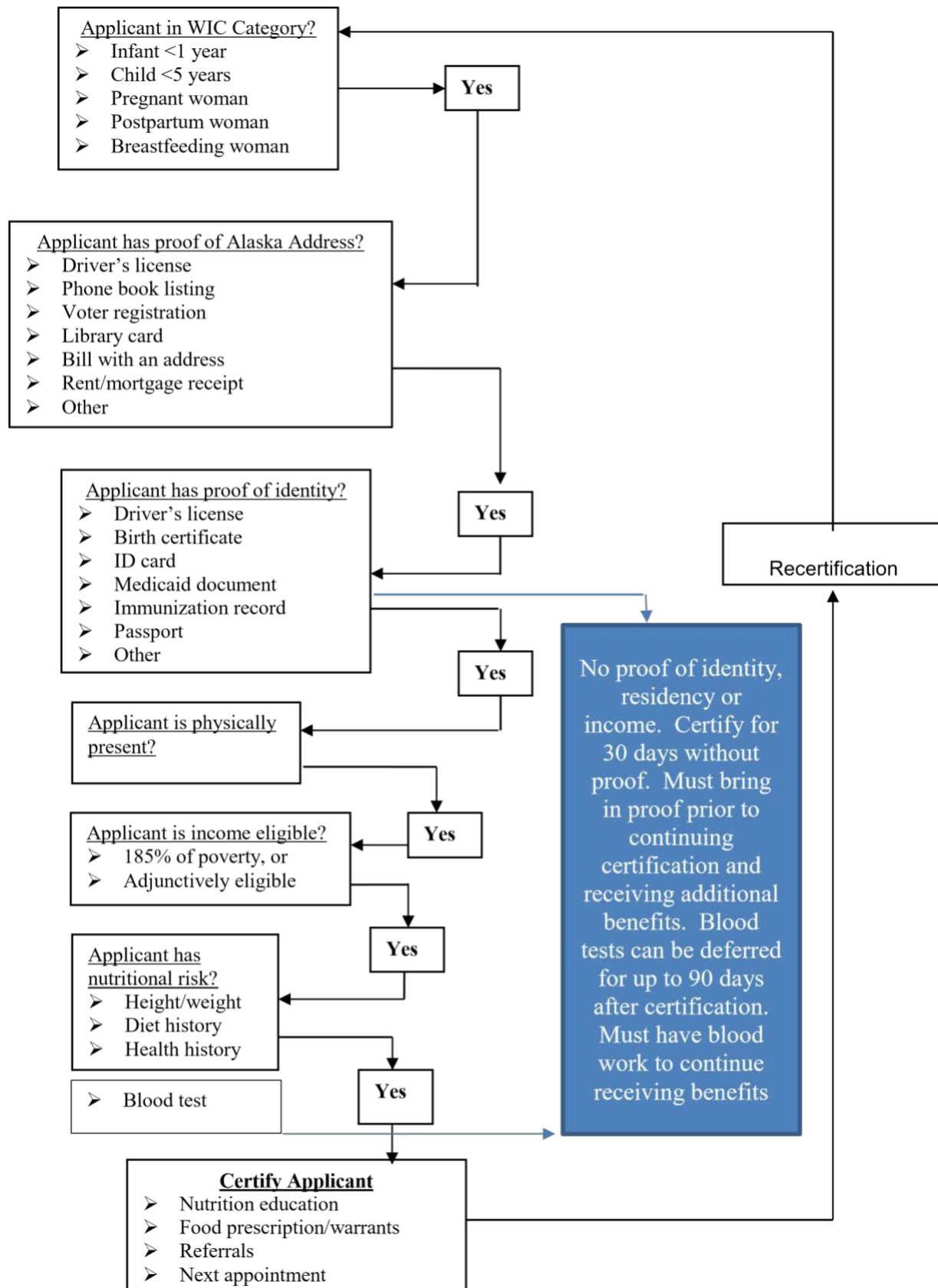
7. What is your opinion of the nutrition education you received at the WIC office?



[illegible]



## WIC Certification-at-a-Glance Flowchart



**Alaska WIC Income Eligibility Guidelines**  
**Effective from July 1, 2024 to June 30, 2025**

<b>Household Size</b>	<b>Annually</b>	<b>Monthly</b>	<b>Twice Monthly</b>	<b>Bi-Weekly</b>	<b>Weekly</b>
<b>1</b>	\$34,799	\$2,900	\$1,450	\$1,339	\$670
<b>2</b>	\$47,249	\$3,938	\$1,969	\$1,818	\$909
<b>3</b>	\$59,700	\$4,975	\$2,488	\$2,297	\$1,149
<b>4</b>	\$72,150	\$6,013	\$3,007	\$2,775	\$1,388
<b>5</b>	\$84,601	\$7,051	\$3,526	\$3,254	\$1,627
<b>6</b>	\$97,051	\$8,088	\$4,044	\$3,733	\$1,867
<b>7</b>	\$109,502	\$9,126	\$4,563	\$4,212	\$2,106
<b>8</b>	\$121,952	\$10,163	\$5,082	\$4,691	\$2,346

*This institution is an equal opportunity provider.*

**Alaska WIC Income Eligibility Guidelines**  
**Effective from July 1, 2024 to June 30, 2025**

<b>Household Size</b>	<b>Annually</b>	<b>Monthly</b>	<b>Twice Monthly</b>	<b>Bi-Weekly</b>	<b>Weekly</b>
<b>9</b>	\$134,403	\$11,201	\$5,601	\$5,170	\$2,585
<b>10</b>	\$146,853	\$12,238	\$6,119	\$5,649	\$2,825
<b>11</b>	\$159,304	\$13,276	\$6,638	\$6,128	\$3,064
<b>12</b>	\$171,754	\$14,313	\$7,157	\$6,606	\$3,303
<b>13</b>	\$184,205	\$15,351	\$7,676	\$7,085	\$3,543
<b>14</b>	\$196,655	\$16,388	\$8,194	\$7,564	\$3,782
<b>15</b>	\$209,106	\$17,426	\$8,713	\$8,043	\$4,022
<b>16</b>	\$221,556	\$18,463	\$9,232	\$8,522	\$4,261
<b>Each add'l family member add</b>	+ \$12,451	+ 1,038	+ \$519	+ \$479	+\$240

**Alaska WIC Income Eligibility Guidelines are revised annually in accordance with USDA guidance.  
Updated guidelines are distributed to all local agencies and posted to the state website.  
WIC Income Eligibility Guidelines are entered into SPIRIT computer system annually.**

*This institution is an equal opportunity provider.*



## Alaska Native Native/American Indian Income Certification

Applicant's Name \_\_\_\_\_

If application is for yourself: I am a member of the \_\_\_\_\_ tribe.

If application is for an infant or child: This child is a member of the \_\_\_\_\_ tribe.

Our household income before taking out taxes is: \$ \_\_\_\_\_

☐ Annual ☐ Monthly ☐ Twice-monthly ☐ Bi-weekly ☐ Weekly

### ALASKA INCOME ELIGIBILITY GUIDELINES

(Effective from July 1, 2024 to June 30, 2025)

**Please circle your household size.**

If you are pregnant, add one to household size.

Household Size	Annual	Monthly	Twice Monthly	Bi-weekly	Weekly
1	\$34,799	\$2,900	\$1,450	\$1,339	\$670
2	\$47,249	\$3,938	\$1,969	\$1,818	\$909
3	\$59,700	\$4,975	\$2,488	\$2,297	\$1,149
4	\$72,150	\$6,013	\$3,007	\$2,775	\$1,388
5	\$84,601	\$7,051	\$3,526	\$3,254	\$1,627
6	\$97,051	\$8,088	\$4,044	\$3,733	\$1,867
7	\$109,502	\$9,126	\$4,563	\$4,212	\$2,106
8	\$121,952	\$10,163	\$5,082	\$4,691	\$2,346
9	\$134,403	\$11,201	\$5,601	\$5,170	\$2,585
10	\$146,853	\$12,238	\$6,119	\$5,649	\$2,825
11	\$159,304	\$13,276	\$6,638	\$6,128	\$3,064
12	\$171,754	\$14,313	\$7,157	\$6,606	\$3,303
13	\$184,205	\$15,351	\$7,676	\$7,085	\$3,543
14	\$196,655	\$16,388	\$8,194	\$7,564	\$3,782
15	\$209,106	\$17,426	\$8,713	\$8,043	\$4,022
16	\$221,556	\$18,463	\$9,232	\$8,522	\$4,261
Each add'l family member add	+ \$12,451	+ \$1,038	+ \$519	+ \$479	+\$240

I certify that the family income does not exceed the maximum income for family size as shown in the table above:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*This institution is an equal opportunity provider.*



## NO PROOF & WIC IOU FORM

### Alaska WIC Program

The Alaska WIC Program requires each applicant to show proof of identification, residence (address), and income. Please read the following statement before completing this form:

**I understand that by signing this form, I am certifying that the information I am giving WIC is correct. I understand that intentionally giving false information may result in paying WIC back, in cash, the value of food benefits improperly received and/or being removed from the WIC Program.**

1. This form is for: ☐ Income ☐ Residency ☐ Identity

2. Select the type of missing proof/IOU and the reason for the No Proof / IOU:

☐ Income The amount of income for my household per month = \_\_\_\_\_

Reason proof is missing: \_\_\_\_\_

☐ ID Reason proof is missing: \_\_\_\_\_

☐ Residency Reason proof is missing: \_\_\_\_\_

☐ Formula form Reason proof is missing: \_\_\_\_\_

☐ Other Reason proof is missing: \_\_\_\_\_

**I understand that I may not receive vouchers at my next appointment unless I bring this proof in within 30 days.**

Applicant: \_\_\_\_\_  
Signature Date

Staff: \_\_\_\_\_  
Signature Date



## YOUR WIC BENEFITS HAVE ENDED

**Date:** \_\_\_\_\_

Thank you for participating in the WIC Program. We hope that WIC has helped your family. If this is your first visit into WIC and you do not qualify, thank you for applying. **If your family's income changes, please feel free to reapply for WIC.**

\_\_\_\_\_ is not able to receive WIC / or is not eligible starting \_\_\_\_\_ for one of the following reasons:

- ☐ Certification expired on \_\_\_\_\_; WIC Program benefits may still be available.
- ☐ Child is five years old.
- ☐ No longer pregnant.
- ☐ Six months past delivery and not breastfeeding.
- ☐ Stopped "breastfeeding" or 12 months past delivery.
- ☐ Over income.
- ☐ Asked to be taken off the WIC Program.
- ☐ Have moved to another service area.
- ☐ Have not received WIC benefits for two consecutive months.
- ☐ Other \_\_\_\_\_

If you feel that this decision is not fair, you may ask for a Fair Hearing by contacting the Civil Rights Coordinator at (907) 465-3100 or in writing to the State of Alaska WIC Program at 130 Seward St., Juneau, AK 99801. You must ask for the Fair Hearing within 60 days from the date of this letter. At the Fair Hearing you, a friend or a relative can help give your side of the story.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW Washington, D.C.  
20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Please continue to take of advantage of other programs in your community that benefit your family. Feel free to contact us if you would like to receive WIC in the future.

Sincerely, WIC Staff



**MEMORANDUM OF UNDERSTANDING FOR RESIDENT WIC PARTICIPANTS  
Between XXX Shelter or Homeless Facility  
and The Alaska Women, Infant and Children (WIC) Program**

**PARTIES TO AGREEMENT:**

This document is to serve as a Memorandum of Understanding (MOU) between the Alaska Women, Infants, and Children (WIC) Program and \_\_\_\_\_ Facility.

Alaska WIC agrees to:

- Provide information on program availability and eligibility requirements to institutions and shelters for the homeless.
- Provide statistical information on the numbers of WIC clients statewide.
- Renew the MOU annually to ensure continued compliance with the conditions set forth in this MOU.

Facility agrees to:

- Not accrue financial or in-kind benefit from a person's participation in the Program.
- Foods provided by the WIC Program are not subsumed into a communal food service, but are available exclusively to the WIC participant for whom they were issued.
- The homeless facility places no constraints on the ability of the participant to partake of the supplemental foods and nutrition education available under the Program.
- Inform the State of Alaska WIC Program if it ceases to meet any of these conditions.
- Refer potential participant(s) to the WIC Program.

**TERMS OF AGREEMENT:**

The term of this agreement shall be Month, Year to Month, Year.

Signed by:

Signature \_\_\_\_\_ Date \_\_\_\_\_  
WIC

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Facility Manager





# WIC Family Information Form

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date \_\_\_\_\_

1. Are you currently on WIC? ☐ Yes ☐ No If yes, where? \_\_\_\_\_
2. Have you been on WIC before? ☐ Yes ☐ No If yes, where? \_\_\_\_\_
3. How did you hear about WIC? \_\_\_\_\_

## Applicant or Parent / Guardian for applicants under age 5 (Please print and use legal names)

4. Name (First, Middle, Last)		5. Maiden Name	6. Birth Date
7. Home address			8. Apartment or suite number
9. City	10. State		11. ZIP Code
12. Mailing Address (If different from Home address)			13. Apartment or suite number
14. City	15. State		16. ZIP Code
17. Cell phone number	18. Home phone number	19. Other phone number	
20. May we call or leave a message?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
21. May we send texts to your cell phone?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. May we send mail for appointment reminders?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

23. Email address: \_\_\_\_\_

24. Are you Hispanic or Latino? ☐ Yes ☐ No
25. Race (Check all that apply)
- ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

## Household Information (Please provide proof of income and identification)

26. Are you applying for your own WIC benefits today? ☐ Yes ☐ No

27. Are you currently working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pay per hour?	Hours worked per week?
28. Is anyone else in the household working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pay per hour?	Hours worked per week?
29. Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

30. How many people are living in your household? \_\_\_\_\_

31. How many members of your household received last year's Permanent Fund Dividend? (Include even if garnished) \_\_\_\_\_

32. Check any of the following programs you or any family member is currently receiving:

☐ Food Stamps/SNAP ☐ Applied for Denali Kid Care, Medicaid, ATAP - "Application Pending" ☐ Medicaid

☐ Denali Kid Care ☐ Alaska Temporary Assistance Program - Amount: \_\_\_\_\_ ☐ Head Start/School Lunch

33. Check any other money received by you or anyone in your household. (Include monthly amount)

☐ Supplemental Security Income/Disability \_\_\_\_\_ ☐ Self Employment \_\_\_\_\_ ☐ Unemployment \_\_\_\_\_

☐ Native Corporation Dividends \_\_\_\_\_ ☐ Commissions \_\_\_\_\_ ☐ Other \_\_\_\_\_

34. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Living with a partner / significant other

35. What is the highest grade in school you completed? \_\_\_\_\_

36. If you are a U.S. Citizen, do you want to register to vote here at the WIC office? ☐ Yes ☐ Already registered ☐ Not interested

37. Would you like someone else's name on your checks, who can pick up and use your checks for you? ☐ Yes ☐ No

If yes, please print name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Please sign on the back. →

## Alaska WIC Rights and Responsibilities

You have rights and responsibilities as a WIC participant. The names and addresses of you and your child may be given to agencies such as Medicaid, Denali Kid Care, Supplemental Nutrition Assistance Program (SNAP), Heating Assistance, Temporary Assistance, Child Care, Infant Learning, Head Start and Public Health Nursing Programs for referral and outreach. Programs listed above may give the WIC program name(s), address, income, identification and residency for you and your child to help check if you qualify for WIC.

Other WIC information may also be shared with health programs to see if you qualify for their program's services, to share needed health information with programs you are already participating in, and to help assess the overall health of Alaskan families through reports and studies. These same programs listed below may also share their information with WIC for the same purposes. You may ask WIC staff for more information about these programs. These programs include: Medicaid, Denali Kid Care, Pro Care, Head Start, Supplemental Nutrition Assistance Program (Formally known as the Food Stamp Program), Immunizations Program, Public Health Nursing, State Epidemiology and Infant Learning Program.

### I understand my Rights and Responsibilities

#### Responsibilities:

- I will treat WIC and store staff with courtesy and respect.
- All the information I give WIC is true and accurate. WIC staff can check this information.
- I will immediately report any changes in my income, family size, address, phone number or eligibility for Medicaid/Denali Kid Care, or the SNAP Program. I will also notify the WIC office if my card is lost or stolen, or if I am no longer breastfeeding.
- I will get WIC benefits from only one clinic at a time. If I move out of Alaska, I will ask for a transfer.
- I will not sell, or try to sell my eWIC card, trade or give away formula or other WIC food benefits and breast pumps. This includes sell of such items in person, in print, or online.
- I will be removed from the WIC program if my benefits are not issued or I do not use my benefits, for two months in a row.
- I will allow WIC staff to take my or my child's height and weight and take a small amount of blood to check my or my child's iron level. I understand this information is needed to check nutrition needs and determine eligibility for WIC.
- I will come to my appointments or call ahead when I need to reschedule.
- I will reapply for benefits as needed. I understand that WIC benefits are for participant use only.
- I will follow the WIC program and shopping rules that are on my WIC food list.
- WIC is a Federal program. If I break the rules, make false statements, intentionally misrepresent, conceal, or withhold facts about my eligibility for the WIC Program, I understand that:
  - I or my child can be taken off WIC.
  - I will have to pay money back to WIC for foods, formula or breast pumps I should not have received. If I do not pay back the WIC program for foods and/or formula that I accepted or return loaned breast pumps that I was not eligible to receive, the state may use other types of legal options to collect payment, including small claims court, which could result in **Permanent Fund Dividend (PFD) garnishment**.
  - I can face civil or criminal prosecution under State and Federal law.

#### Rights:

- If I qualify for WIC, I will get benefits to buy healthy foods. **I understand that WIC does not give all the food or formula needed in a month.** WIC foods help promote and support the nutrition and well-being and help meet the needed intake of important nutrients or foods for myself and / or my child(ren).
- WIC will give me information for healthy eating and active living. WIC will provide me with breastfeeding support.
- WIC will give me information to find a doctor and get immunizations for my child. I will be referred to other services.
- WIC staff will treat me with courtesy and respect.
- WIC will keep information about me and / or my child(ren) confidential and share only needed information to determine eligibility and for referral to other services.
- The rules for getting on WIC are the same for everyone. I can ask for a Fair Hearing if I do not agree with a decision about my WIC eligibility. WIC will tell me why my child or I qualify for the WIC Program.

#### By signing this form I agree that:

- **I have read the Rights and Responsibilities form or a WIC staff has read it to me.**
- **I agree to the above.**

---

### Client/Guardian Signature Required for WIC Enrollment

### Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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1. mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D. C. 20250-9410;
2. fax (202) 690-7442; or
3. email: [program.intake@usda.gov](mailto:program.intake@usda.gov).



## WIC Child Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date \_\_\_\_\_

1. Child's Name (First, Middle, Last)	2. Child's Birth Date <input type="checkbox"/> Boy <input type="checkbox"/> Girl
3. Your Name (First, Middle, Last)	4. Relationship to Child

5. If receiving Medicaid, please provide Medicaid number:

6. Is this child Hispanic or Latino? ☐ Yes ☐ No

7. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

### Current History

8. What concerns, if any, do you have about your child's eating behaviors or growth?

9. What was the child's Birth Weight? Birth Length?

10. At what Birthing Facility was the child born?

11. How many weeks did your pregnancy last?

12. Please Answer if your child is under 2:

Child's birth weight was less than 5 lbs. 9 oz ☐ Yes ☐ No <sup>141</sup>

My child's immunizations are up to date ☐ Yes ☐ No

My child was born at 37 weeks or less ☐ Yes ☐ No <sup>142</sup>

13. Check the box if you have any of the following concerns about your child:

342

☐ Chewing/Swallowing ☐ Choking/Gagging ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Other

14. List any medication, vitamin, mineral or herbal supplement your child takes.

357  
425.07  
425.08

15. Please, tell us if your child sees a doctor, dietitian or health care provider for medical or emotional reason(s)

ex: hypertension, pre-hypertension, diabetes, fetal alcohol syndrome, gastrointestinal disorders or anemia.

151  
201  
341-357  
359  
360,362  
382

Describe:

16. If your child was in the hospital in the last 3 months, please tell us why.

359

### Eating & Feeding

17. What concerns, if any, do you have about having enough food to feed your family?

18. I am breastfeeding my child. ☐ Yes ☐ No

19. If breastfed, what date did it begin?

When did breastfeeding end?

20. What was the reason that breastfeeding was stopped?

21. If your child used(s) formula, at what age (weeks or months) did you first offer?

22. On a scale of 0 to 10, ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10  
How well do you think your child is eating? Not Well Very Well

a. He/she usually eats \_\_\_\_\_ meals/day and \_\_\_\_\_ snacks/day.

b. He/she usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

c. He/she usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

23. My child eats: ☐ Liquid Foods ☐ Finger Foods ☐ Table Foods ☐ Mashed, Pureed / Baby Foods

425.04  
428

\*\*\*To Be Completed by Health Care Provider (HCP)\*\*\*

Medical date\_\_\_\_\_ Current Wt\_\_\_\_\_(103,113,134,135) Ht\_\_\_\_\_(121) Hgb/Hct\_\_\_\_\_(201)  
Name of HCP verifying applicant lives in Alaska\_\_\_\_\_ ID Verified by: Visual Recognition\_\_\_\_\_/Other\_\_\_\_\_ WIC  
Name of CPA reviewing WIC application\_\_\_\_\_ Certification Date\_\_\_\_\_

24. Check the box if your child eats any these foods.

☐ Raw sprouts: alfalfa, clover and radish
☐ Raw or undercooked: meat, chicken, turkey, fish, eggs
☐ Uncooked refrigerated smoked seafood
☐ Unheated meats: lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs

☐ Food with raw or undercooked eggs: salad dressing, cookie and cake batter, sauces
☐ Soft cheese made with unpasteurized milk: feta, mexican-style (queso blanco fresco), brie, blue
☐ Unpasteurized milk or foods made with unpasteurized milk
☐ Unpasteurized fruit or vegetable juice

25. My child drinks from (Check all that apply): ☐ Sippy Cup ☐ Cup ☐ Baby Bottle

a. If your child drinks from a baby bottle, how many in 24 hours? \_\_\_\_\_

b. What's in the baby bottle?

26. When does your child get a baby bottle? ☐ Bedtime/Naptime ☐ Mealtime ☐ All day ☐ Other: \_\_\_\_\_

27. When do you want your child to only use a cup?

28. Check if your child drinks regularly

☐ Water
☐ Dry milk
☐ Whole milk
☐ Sweet tea
☐ 100% Pasteurized juice
☐ Cereal/Solid foods in a baby bottle

☐ Pedialyte
☐ Raw milk
☐ 1% or 2% milk
☐ Coffee/tea
☐ Fruit drink (not 100% juice)

☐ Soy milk
☐ Breastmilk
☐ Evaporated milk
☐ Tang/Kool-aid
☐ Raw juice
☐ Other \_\_\_\_\_

☐ Skim milk
☐ Rice milk
☐ Formula
☐ Pop/Soda
☐ Sports Drinks

29. Check if your child craves or eats:

☐ Ashes
☐ Carpet Fibers
☐ Clay
☐ Soil

☐ Baking Soda
☐ Chalk
☐ Dust
☐ Starch (laundry or corn starch)

☐ Burnt Matches
☐ Cigarettes
☐ Paint Chips
☐ Large quantities of ice and/or freezer frost

30. Does your child eat meals with the family?

31. Is your child on a special diet?

32. Does your child have any problems eating any type of food for any reason such as dental problems, food intolerances, or others?

33. List any food allergies your child may have.

## Additional

34. Has your child been screened or referred for lead poisoning?

☐ Yes ☐ No

35. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?

☐ Yes ☐ No

36. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?

☐ Yes ☐ No

37. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?

☐ Yes ☐ No

38. Did a family member have a seasonal farming job with a temporary home in the last 24 months?

☐ Yes ☐ No

39. Do you have any concerns about anyone hurting your child?

☐ Yes ☐ No

40. Has your child been in foster care or moved to a new foster home within the last 6 months?

☐ Yes ☐ No

41. What type of milk you would like with your WIC benefits?

☐ Fresh/Refrigerated
☐ Boxed (UHT)
☐ Soy
☐ Dry
☐ Evaporated
☐ Lactose Reduced <sup>355</sup>

42. In a typical day, how much time does your child watch TV, play video games and or play computer games?

☐ Less than 1 hour
☐ 1-2 hours
☐ More than 2 hours

43. Do you have problems taking care of your child?

44. Write the date of you last child's last dental check-up: (Month, Year)

45. For dads, please tell us your weight:

height:

425.05

425.03

425.03

425.01  
425.02

425.09

425.06

354  
355  
381

353

902

46. What does your family do for fun?

---

47. How can WIC help your family today?

**Thank You!**

*Revised: 5/24/19*



# WIC Infant Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date \_\_\_\_\_

1. Child's Name (First, Middle, Last)	2. Child's Birth Date <input type="checkbox"/> Boy <input type="checkbox"/> Girl
3. Your Name (First, Middle, Last)	4. Relationship to Child

5. If baby is on Medicaid, please provide Medicaid number: \_\_\_\_\_

6. Is this baby Hispanic or Latino? ☐ Yes ☐ No

7. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

## Current History

8. What concerns, if any, do you have about what, how or how much your baby eats? 342  
411.04

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9. What was the child's Birth Weight? Birth Length?

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10. At what Birthing Facility was the child born? How many weeks did your pregnancy last?

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11. Are you breastfeeding another child? ☐ Yes ☐ No

---

12. Please answer about your baby:

My baby's birth weight was less than 5 lbs. 9 oz ☐ Yes ☐ No 141 My baby weighed more than 9 pounds at birth ☐ Yes ☐ No 153

My baby was born at 37 weeks or less ☐ Yes ☐ No 142 My baby's immunizations are up to date ☐ Yes ☐ No

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13. List any medication your baby may be taking: 357

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14. Please, tell us if your baby sees a doctor, dietician or health care provider for medical reasons: 151,152  
201  
ex: hypertension, prehypertension, diabetes, fetal alcohol syndrome, small for gestational age, gastrointestinal disorders, or anemia. 341-357  
359,360  
362,382  
Describe: 359

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15. If your baby was in the hospital in the last 3 months, please tell us why. 359

## Eating & Feeding

16. What concerns, if any, do you have about having enough food to feed your family?

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17. How are you feeding your baby? ☐ Breastmilk ☐ Breastmilk + Formula ☐ Formula Only

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18. If breastfed, what date did it begin? When did breastfeeding end?

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19. What was the reason that breastfeeding was stopped?

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20. On a scale of 0 to 10, ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  
How well do you think you think breastfeeding is going? Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well 411.7  
603  
703

a. I breastfeed \_\_\_\_\_ times in 24 hours and each feeding lasts \_\_\_\_\_ minutes. 411.7

b. My baby has \_\_\_\_\_ (#) stools a day and \_\_\_\_\_ (#) wet diapers a day. 411.7

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21. How do you store breastmilk? (i.e. freeze, refrigerate, store on counter, in cabinet, etc.) 411.9

---

22. What do you usually do, if there is leftover breastmilk or formula in the bottle after feeding? 411.9

☐ Throw it out ☐ Put it in the refrigerator ☐ Leave near baby

---

23. At what age did you start your baby on formula? <sup>701</sup> What formula are you feeding your baby?

---

24. On a scale of 0 to 10, ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  
How well do you think formula feeding is going? Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well

---

25. How often do you feed your baby formula?

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26. How much formula does your baby eat at feeding?

\*\*\*To Be Completed by Health Care Provider (HCP)\*\*\*

Medical date\_\_\_\_\_Current Wt\_\_\_\_\_(103,113,134,135)Ht\_\_\_\_\_(121)Hgb/Hct\_\_\_\_\_(201)  
**Name of HCP verifying applicant lives in Alaska**\_\_\_\_\_ **ID Verified by:** Visual Recognition\_\_\_\_\_/Other\_\_\_\_\_WIC  
**Name of CPA reviewing WIC application**\_\_\_\_\_ Certification Date\_\_\_\_\_



<b>27. How do you prepare your baby's formula?</b>	411.5 411.6
<input type="checkbox"/> Powdered formula      I add _____ scoops of powder to _____ ounces of water <input type="checkbox"/> Concentrated formula      I add _____ ounces of formula to _____ ounces of water <input type="checkbox"/> Ready-to-feed formula      Do you add water? <input type="checkbox"/> Yes <input type="radio"/> No    If yes, how many ounces of water? _____	
<b>28. Does your baby drink juice, sweetened drinks, soda, sweet tea, Tang/Koolaid or Hi-C in a bottle or cup?</b>	412.2 411.3
<input type="checkbox"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	
<b>29. Do you add sugar, honey or syrup to your baby's pacifier or foods?</b>	411.3
<input type="checkbox"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes    If yes, tell us more about the reasons: _____	
<b>30. How old was your baby the first time he or she drank liquids other than breastmilk or formula? List what he or she drank:</b>	411.1
<b>31. How old was your baby the first time he or she ate food such as cereal, baby food, or any other food? List what he or she ate:</b>	411.3
<b>32. Is your baby held when bottle fed?</b>	381 411.2
<input type="checkbox"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Always	
<b>33. Where else do you give your baby a bottle?</b>	411.2
<input type="checkbox"/> Crib/Bed <input type="checkbox"/> Car Seat <input type="checkbox"/> High-chair <input type="checkbox"/> Stroller <input type="checkbox"/> Other _____	
<b>34. How do you feed your baby solid food?</b>	411.2 411.4
<input type="checkbox"/> No solid foods, only breastmilk/formula <input type="checkbox"/> By Spoon <input type="checkbox"/> In Baby Bottle	
<input type="checkbox"/> By Infant Feeder <input type="checkbox"/> Baby Foods <input type="checkbox"/> Finger Foods <input type="checkbox"/> Other _____	
<b>35. Check the box if your baby eats any these foods.</b>	411.4
<input type="checkbox"/> Raw sprouts: alfalfa, clover and radish <input type="checkbox"/> Raw or undercooked: meat, chicken, turkey, fish, eggs <input type="checkbox"/> Uncooked refrigerated smoked seafood <input type="checkbox"/> Unheated meats: lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs	<input type="checkbox"/> Food with raw or undercooked eggs: salad dressing, cookie and cake batter, sauces <input type="checkbox"/> Soft cheese made with unpasteurized milk: feta, mexican-style (queso blanco fresco), brie, blue <input type="checkbox"/> Unpasteurized milk or foods made with unpasteurized milk <input type="checkbox"/> Unpasteurized fruit or vegetable juice
<input type="checkbox"/> Strained: meat,egg yolk, yogurt, cottage cheese, tuna <input type="checkbox"/> Strained or mashed: vegetables or fruits <input type="checkbox"/> Chopped fruits/vegetables or fruits <input type="checkbox"/> Homemade baby food <input type="checkbox"/> Bread	<input type="checkbox"/> Cooked soft pieces of: beans, chicken, turkey, beef, pork <input type="checkbox"/> No solid foods only breastmilk/formula <input type="checkbox"/> Infant Cereal in the bottle <input type="checkbox"/> Infant Cereal <input type="checkbox"/> Crackers
411.5 411.8	
<b>36. How do you know your baby is done eating? (Check all that apply)</b>	
<input type="checkbox"/> Turns head away <input type="checkbox"/> Won't open his/her mouth <input type="checkbox"/> Eats all food <input type="checkbox"/> Bottle is empty <input type="checkbox"/> Spits out food	
<b>37. Please describe any teething problems your baby maybe having.</b>	
<b>38. Please describe any food intolerances or food allergies your baby may have.</b>	

## Additional

<b>39. Has your baby been screened or referred for lead poisoning?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	211
<b>40. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	904
<b>41. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	801
<b>42. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	801
<b>43. Did a family member have a seasonal farming job with a temporary home in the last 24 months?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	802
<b>44. Do you have any concerns about anyone hurting your baby?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	901
<b>45. Has your child been in foster care or moved to a new foster home within the last 6 months?</b>	<input type="checkbox"/> Yes <input type="radio"/> No	903

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46. Do you have any problems taking care of you baby?

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47. For dads, please tell us your weight:

height:

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48. What does your family do for fun?

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49. How can WIC help your family today?

**Thank You!**

*Revised: 6/26/19*



# WIC Pregnant Women Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date \_\_\_\_\_

1. Name (First, Middle, Last)	2. Birth Date	331 332 333	3. Due Date
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4. If receiving Medicaid, please provide Medicaid number:

5. Is this person Hispanic or Latino? ☐ Yes ☐ No

6. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

## Current History

7. How is your pregnancy going? Please tell us if you have any concerns.

8. The date I started seeing a doctor for this pregnancy was? ☐ I have not started seeing a doctor for this pregnancy. 334  
503

9. When was your last pregnancy? (Month, Year) 10. How many babies are you expecting? 332  
335

11. How many times have you been pregnant? (Do not count this pregnancy)

12. How old are your children? 333

13. How much did you weigh before pregnancy?

14. Are you breastfeeding another child? ☐ Yes ☐ No 338

15. Check any problems you had with any of your pregnancies?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Never pregnant before or didn't have problems	<input type="checkbox"/> Baby born 3 or more weeks early 311	<input type="checkbox"/> Genetic or birth defects 339
<input type="checkbox"/> Miscarried - How many? 321	<input type="checkbox"/> Baby, less than 5 pounds 9 oz at birth 312	<input type="checkbox"/> C-section 359
<input type="checkbox"/> Stillbirth - How many? 321	<input type="checkbox"/> Baby, 9 pounds or more at birth 337	<input type="checkbox"/> History of Gestational Diabetes 303
<input type="checkbox"/> Abortions - How many?	<input type="checkbox"/> Baby died before 1 month old 321	<input type="checkbox"/> History of Preeclampsia 304

16. Check if you are having any of the following problems with this pregnancy: 301  
Constipation Heartburn Nausea Vomiting 342

17. Did you take vitamins before your pregnancy? Yes No If yes, how often?

18. List any medication, vitamin, prenatal vitamins, mineral or herbal supplement you are taking. If not daily, how often? 357  
427.01  
427.04

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s) 201, 211  
ex: fetal growth restriction, hypertension, prehypertension, gestational diabetes, diabetes, anemia or gastrointestinal disorders. 302  
336

Describe: 341-349  
351-362

20. If you were in the hospital in the last 3 months, please tell us why. 359

## Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars? ☐ Yes ☐ No If yes, How much a day? 371

22. Did you smoke before your pregnancy? ☐ Yes ☐ No If yes, How many a day?

23. Did you smoke cigarettes, pipes or cigars at any time during this pregnancy? ☐ Yes ☐ No 371

24. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? ☐ Yes ☐ No 904

25. Do you use smokeless, chewing tobacco or iqmik? ☐ Yes ☐ No If yes, How much a day?

26. Did you drink alcohol before your pregnancy? ☐ Yes ☐ No If yes, How many a week?

27. Did you drink wine, beer or other alcoholic beverages during this pregnancy? Yes No If yes, How many a day?  
If yes, How many a week? 372

\*\*\*To Be Completed by Health Care Provider (HCP)\*\*\*

Medical date\_\_\_\_\_Ht\_\_\_\_\_Pre-Pregnancy Wt\_\_\_\_\_(101,111) Weight Before Delivery\_\_\_\_\_Current Wt\_\_\_\_\_(133) Hgb/Hct\_\_\_\_\_(201)

Name of HCP verifying applicant lives in Alaska\_\_\_\_\_ID Verified by: Visual Recognition\_\_\_\_\_/Other\_\_\_\_\_WIC

Name of CPA reviewing WIC application\_\_\_\_\_Certification Date\_\_\_\_\_

28. Check any drugs you are using during this pregnancy:

372

- ☐ Cocaine      ☐ Crack Methamphetamine      ☐ Marijuana      ☐ Speed      ☐ Other \_\_\_\_\_  
☐ Crank      ☐ Heroin      ☐ Methadone      ☐ None      ☐ Stopped Using      When? \_\_\_\_\_

## Eating & Feeding

29. What concerns, if any, do you have about having enough food to feed your family?

30. How do you plan to feed your baby?    ☐ Breastmilk    ☐ Breastmilk/Formula    ☐ Formula    ☐ Unsure

a. Have you breastfeed before?    ☐ Yes    ☐ No

31. On a scale of 0 to 10,  
How ready do you feel about breastfeeding your baby?    Not Ready    0    1    2    3    4    5    6    7    8    9    10    Ready

32. On a scale of 0 to 10,  
How well do you think you are eating?    Not Well    0    1    2    3    4    5    6    7    8    9    10    Very Well

a. I usually eat \_\_\_\_\_ meals/day and \_\_\_\_\_ snacks/day.

b. I usually eat fruits:    ☐ 1 cup/day or less    ☐ 2 cups/day    ☐ 3 cups/day or more

c. I usually eat vegetables:    ☐ 1 cup/day or less    ☐ 2 cups/day    ☐ 3 cups/day or more

33. Check the box if you are eating any these foods.

427.05

- |   |  |
|---|--|
| <input type="checkbox"/> Raw sprouts: alfalfa, clover and radish  | <input type="checkbox"/> Food with raw or undercooked eggs: salad dressing, cookie and cake batter, sauces               |
| <input type="checkbox"/> Raw or undercooked: meat, chicken, turkey, fish, eggs  | <input type="checkbox"/> Soft cheese made with unpasteurized milk: feta, mexican-style (queso blanco fresco), brie, blue |
| <input type="checkbox"/> Uncooked refrigerated smoked seafood   | <input type="checkbox"/> Unpasteurized milk or foods made with unpasteurized milk  |
| <input type="checkbox"/> Unheated meats: lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs | <input type="checkbox"/> Unpasteurized fruit or vegetable juice  |

34. Check if you crave or eat any of the following:

427.03

- |  |  |                                      |   |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Ashes         | <input type="checkbox"/> Carpet Fibers | <input type="checkbox"/> Clay        | <input type="checkbox"/> Soil   |
| <input type="checkbox"/> Baking Soda   | <input type="checkbox"/> Chalk         | <input type="checkbox"/> Dust        | <input type="checkbox"/> Starch (laundry or cornstarch)               |
| <input type="checkbox"/> Burnt Matches | <input type="checkbox"/> Cigarettes    | <input type="checkbox"/> Paint Chips | <input type="checkbox"/> Large quantities of ice and/or freezer frost |

35. Do you fast, binge, vomit to control your weight or follow a specific diet?

☐ Yes    ☐ No

358  
427.02

Describe:

36. Do you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others?

353-355  
381

## Additional

37. Have you been screened or referred for lead poisoning?    ☐ Yes    ☐ No

211

38. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?    ☐ Yes    ☐ No

801

39. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?    ☐ Yes    ☐ No

801

40. Did a family member have a seasonal farming job with a temporary home in the last 24 months?    ☐ Yes    ☐ No

802

41. Are you in a relationship with anyone who pushes, hits or threatens you in any way?    ☐ Yes    ☐ No

901

42. How often do you feel down, depressed or hopeless?    ☐ Never    ☐ Sometimes    ☐ Often    ☐ Always

361

43. What type of milk you would like on your WIC check?

- ☐ Fresh/Refrigerated    ☐ Boxed (UHT)    ☐ Soy    ☐ Dry    ☐ Evaporated    ☐ Lactose Reduced <sup>355</sup>

44. What problems, if any do you have caring for yourself or your baby/children?

902

---

45. Write the date of you last dental check-up: (Month, Year)

381

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46. What does your family do for fun?

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47. How can WIC help your family today?

**Thank You!**

*Revised: 5/24/19*

1. Name (First, Middle, Last)	2. Birth Date
	331 332 333

3. If receiving Medicaid, please provide Medicaid number:

4. Is this person Hispanic or Latino? ☐ Yes ☐ No

5. Race (Check all that apply)

☐ American Indian or Alaska Native   
 ☐ Asian   
 ☐ Black or African American   
 ☐ Native Hawaiian or Pacific Islander   
 ☐ White

## Current History

6. How are you doing after having your baby? Please tell us if you have any concerns?

7. What was the actual date your baby was born?

8. What was your baby's weight at birth? What was the baby's length at birth?

9. At what Birthing Facility was the child born?

10. How many weeks did your pregnancy last?

11. When did your Prenatal care begin? (Month, Year)

12. How far apart were your last two pregnancies?

332

13. How many babies did you have during your last pregnancy?

335

14. How many times have you been pregnant? (Do not count this pregnancy)

15. How old are your children?

333

16. How much did you weigh before pregnancy?

17. Check if you had any of the problems during your recent pregnancy?

<input type="checkbox"/> Miscarried - How many? _____ 321 <input type="checkbox"/> Stillbirth - How many? _____ 321 <input type="checkbox"/> More than one baby How many? _____ 330	<input type="checkbox"/> Baby born 3 or more weeks early 311 <input type="checkbox"/> Baby, less than 5 pounds 9 oz at birth 312 <input type="checkbox"/> Baby, 9 pounds or more at birth 337 <input type="checkbox"/> Baby died before 1 month old 321	<input type="checkbox"/> Genetic or birth defects 339 <input type="checkbox"/> C-section 359 <input type="checkbox"/> History of Gestational Diabetes 303 <input type="checkbox"/> History of Preeclampsia 304
--	--	---

18. List any medication, vitamin, prenatal vitamins, mineral or herbal supplement you are taking. If not daily, how often?

357  
427.01  
427.04

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s)

ex: hypertension, pre-hypertension, pre-diabetes, diabetes, anemia or gastrointestinal disorders.

201  
302-304  
341-349  
351-363

Describe:

20. If you were in the hospital in the last 3 months, please tell us why.

359

## Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How much a day?	371
22. Did you smoke in the last 3 months of your pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How many a day?	
23. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No		904
24. Do you use smokeless, chewing tobacco or iqmik?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How much a day?	
25. Did you drink alcohol in the last 3 months of your pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How many a week?	371
26. Do you drink, wine, beer, or other alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How many a day? If yes, How many a week?	372

\*\*\*To Be Completed by Health Care Provider (HCP)\*\*\*

Medical date\_\_\_\_\_Ht\_\_\_\_\_Pre-Pregnancy Wt\_\_\_\_\_(101,111) Weight Before Delivery\_\_\_\_\_Current Wt\_\_\_\_\_(133) Hgb/Hct\_\_\_\_\_(201)

Name of HCP verifying applicant lives in Alaska\_\_\_\_\_ID Verified by: Visual Recognition\_\_\_\_\_/Other\_\_\_\_\_WIC

Name of CPA reviewing WIC application\_\_\_\_\_Certification Date\_\_\_\_\_



27. Check any drugs you are using during this pregnancy:

☐ Cocaine      ☐ Crack Methamphetamine      ☐ Marijuana      ☐ Speed      ☐ Other \_\_\_\_\_  
☐ Crank      ☐ Heroin      ☐ Methadone      ☐ None      ☐ Stopped Using      When? \_\_\_\_\_

## Eating & Feeding

28. What concerns, if any, do you have about having enough food to feed your family?

29. How are you feeding your baby?      ☐ Breastmilk      ☐ Breastmilk+Formula      ☐ Formula Only

30. If breastfeeding, what date did it begin?

When did breastfeeding end?

31. What was the reason that breastfeeding was stopped?

32. On a scale of 0 to 10,  
How confident are you about breastfeeding your baby?      Not Confident      ☐ 0      ☐ 1      ☐ 2      ☐ 3      ☐ 4      ☐ 5      ☐ 6      ☐ 7      ☐ 8      ☐ 9      ☐ 10      Very Confident

a. How long do you plan to breastfeed? \_\_\_\_\_

601

b. I breastfeed \_\_\_\_\_ times in 24 hours and each feeding lasts \_\_\_\_\_ minute s.

601,602  
602

33. If formula only, did you ever breastfeed?      ☐ Yes      ☐ No      If yes, how long? (i.e. days or weeks)

34. When did you introduce formula?

35. On a scale of 0 to 10,  
How well do you think you are eating?      Not Well      ☐ 0      ☐ 1      ☐ 2      ☐ 3      ☐ 4      ☐ 5      ☐ 6      ☐ 7      ☐ 8      ☐ 9      ☐ 10      Very Well

a. I usually eat \_\_\_\_\_ meals/day and \_\_\_\_\_ snacks/day.

b. I usually eat fruits:      ☐ 1 cup/day or less      ☐ 2 cups/day      ☐ 3 cups/day or more

c. I usually eat vegetables:      ☐ 1 cup/day or less      ☐ 2 cups/day      ☐ 3 cups/day or more

36. Check if you crave or eat

427.03

☐ Ashes      ☐ Carpet Fibers      ☐ Clay      ☐ Soil  
☐ Baking Soda      ☐ Chalk      ☐ Dust      ☐ Starch (laundry or corn starch  
☐ Burnt Matches      ☐ Cigarettes      ☐ Paint Chips      ☐ Large quantities of ice and/or freezer frost

37. Do you fast, binge, vomit to control your weight or follow a specific diet?      ☐ Yes      ☐ No

358  
427.02

Describe:

38. Do you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others?

353-355  
381

## Additional

39. Have you been screened or referred for lead poisoning?      ☐ Yes      ☐ No

211

40. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?      ☐ Yes      ☐ No

801

41. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?      ☐ Yes      ☐ No

801

42. Did a family member have a seasonal farming job with a temporary home in the last 24 months?      ☐ Yes      ☐ No

802

43. Are you in a relationship with anyone who pushes, hits or threatens you in any way?      ☐ Yes      ☐ No

901

44. How often do you feel down, depressed or hopeless?      ☐ Never      ☐ Sometimes      ☐ Often      ☐ Always

361

45. What type of milk you would like on your WIC check?

☐ Fresh/Refrigerated      ☐ Boxed (UHT)      ☐ Soy      ☐ Dry      ☐ Evaporated      ☐ Lactose Reduced <sup>355</sup>

46. What problems, if any do you have caring for yourself or your baby/children?

902

47. Write the date of you last dental check-up: (Month, Year)

381

48. What does your family do for fun?

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49. How can WIC help your family today?

**Thank You!**

*Revised: 5/24/19*



Alaska WIC Policy & Procedure Manual  
**Section: 105 Job Aids**  
**Use of Non-Invasive Hemoglobin Testing in WIC**

**PURPOSE:**

To outline procedures when using the alternate non-invasive method to obtain hemoglobin levels in WIC participants.

**Non-invasive Hemoglobin Testing**

Pronto Non-Invasive Hemoglobin Screening - Alaska Bloodwork Protocol

Criteria for Screening

Pronto device may be used for screening adults and children, weighing 22 pounds or more.

Screening is most successful if child is at least 24 months of age. Preparation for Screening

1. Have participant wash hands or use a hand sanitizer. A 70% isopropyl alcohol pad can be used for cleaning the finger. If the participant has nail polish on her fingernails, proceed with the screening. Dark nail polish may impact the machine's ability to take a reading. Removal of dark nail polish prior to testing is optional.
2. Participant should have been seated for approximately 2 minutes before performing the screen.
3. Rest the hand/arm on the table or desk. Hand/arm should be above waist level.
4. No movement or talking.

**Site Selection**

1. Select non-dominant hand. Preferred finger is ring or middle finger. Do not ask to remove jewelry or watch due to liability reasons.
2. Select sensor size by:
  - a. Child sensor: 22 lbs. – 110 lbs.
  - b. Adult sensor: 66 lbs. or more

**Testing**

Clean sensor with alcohol wipe.

1. Place sensor on finger ensuring the tip of the finger is touching the finger stop. If the participant has a long fingernail, the fingernail can extend over the finger stop.
2. Ensure the detector is placed directly over the patient's nail bed.
3. Make sure the initial reading on the device is at least 1.0 (This initial reading is not the hemoglobin value; it is the perfusion measurement.). Readings less than 1.0 may result in an unsuccessful screening. Lightly rubbing and warming the finger before screening may help increase the reading.



## Alaska WIC Policy & Procedure Manual

4. Instruct the participant not to talk or move during the screening.
5. Document the results in SPIRIT.
6. It is not necessary to turn off the device between the screenings; however, turning off the device will extend the battery life.
7. Keep the sensor cable as straight as possible, running it up the back of the hand and lower arm.

### Tips for Screening Small Children

1. If more than one member of the family needs screening, start with the oldest family member(s).
2. If the child is awake, make eye-contact and chat with the child during the first 30 seconds of the screening. The child can be screened sitting in their parent's lap, facing outward with their hand on the parent's thigh. The child's hand can also be stabilized and held between the parent's two hands.
3. Staff should test facing the child; keep an eye on the finger in the sensor. If the fingers start to move, continue chatting with the child and have the parent place their hand over the child's hand. Staff can do this as well.
4. Children can be screened while asleep or in a drowsy state.

### Tips for Warming Cold Hands

1. Keep a heating pad on low heat next to the Pronto and warm hands up prior to testing. OR
2. Wash hands with warm water prior to testing. OR
3. Have the parent rub their hands together or the child's hands between theirs prior to testing.

### Other Helpful Hints

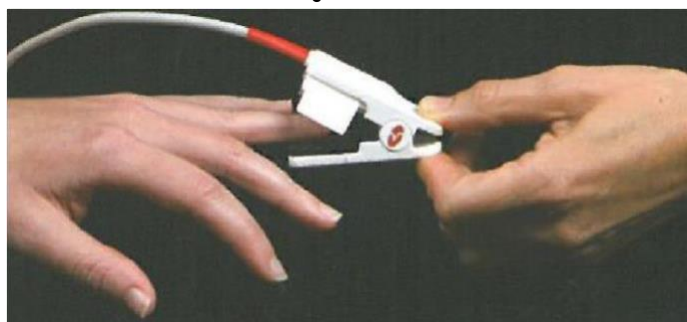
1. Always use sensor guide on adults to determine appropriate sensor size.
2. Select ring or middle finger (non-dominant) for adults.
3. Thumbs should be used in all children followed by the middle finger of non-dominant hand.

### How To Use the Pronto Non-Invasive Hemoglobin Screening Machine

1. Select sensor size



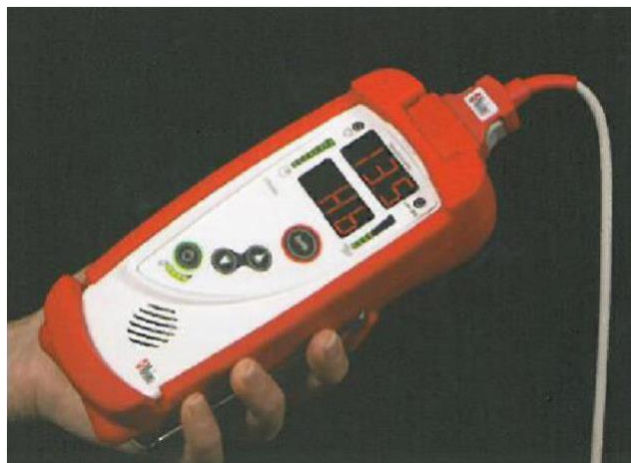
2. Place sensor on finger



3. Press SpHb button



4. Obtain results



## Batteries for the Pronto device

The Pronto device is USDA approved for use with alkaline batteries. Each device uses four AA batteries. Alkaline batteries last for about 250 tests. Rechargeable batteries can be used and last for 125-150 tests.

# High Risk Nutrition Care Plan Examples Infants/Children

Date: _____		Client: _____	
Parent/Guardian: _____		DOB: _____	Age: _____
Physician: _____		Referral Agency: _____	
PHN: _____		Case Manager: _____	
Reason for Referral: _____			
<b>Subjective</b>			
Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor GI complaints: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply: <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____ Weight history: _____ Feeding concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____ Parent/Guardian concerns: _____ Health and Social Service program participation: <input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medicaid <input type="checkbox"/> <input type="checkbox"/> ILP <input type="checkbox"/> HCP-CSHCN <input type="checkbox"/> ATAP <input type="checkbox"/> Healthy Families <input type="checkbox"/> Other: _____			
<b>Objective</b>			
Gestational age _____		Birthweight _____	Length/Height _____%tile
Length/Height _____%tile		Head Circumference _____%tile	Weight/Height _____%tile
Laboratory Values: _____		Hemoglobin: _____ Other: _____	
Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____			
Drug/Nutrient Interaction: _____			
Vitamin/Mineral Supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____			
<b>Assessment</b>			
Growth: _____			
Feeding Skills: _____			
Feeding Behavior: _____			
<b>Plan (developed by client and provider)</b>			
1. Guardian Desired Outcomes: _____			
2. Education Provided: _____			
3. Action Plan: _____			
4. Referrals: _____			
5. Follow-up Needed ? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason for Follow -up: _____			
Date of Follow-up: _____			
Signature: _____		Date: _____	Phone Number: _____

## High Risk Nutrition Care Plan Examples Women

Date: _____ Client: _____
Physician: _____ DOB: _____ Age: _____ PHN: _____
Referral Agency: _____
Case Manager: _____
Reason for Referral: _____
<b>Subjective</b>
Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor GI Complaints: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply: <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____ Concerns regarding weight and weight gain? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____ _____ Client Concerns: _____ Usual food intake: _____ Health and Social Service program participation: <input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medicaid <input type="checkbox"/> <input type="checkbox"/> ILP <input type="checkbox"/> HCP-CSHCN <input type="checkbox"/> ATAP <input type="checkbox"/> Healthy Families <input type="checkbox"/> Other: _____ _____
<b>Objective</b>
Prepregnancy Weight _____ Height _____ Weight gain _____ Weeks gestation _____ Due date _____ Laboratory Values: Hemoglobin: _____ Other: _____ Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____ Drug/Nutrient Interaction: _____ Vitamin/Mineral Supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ _____
<b>Assessment</b>
Diet: _____ Laboratory: _____ Weight Gain: _____
<b>Plan</b> (developed by client and provider)
1. Client Desired Outcomes: _____ 2. Education Provided: _____ 3. Action Plan: _____ 4. Referrals: _____ 5. Follow-up Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason for Follow-up: _____ _____ Date of Follow-up: _____ Signature: _____ Date: _____ Phone Number: _____



# Cert Form Cheat Sheet: Alaska WIC Program

Rev 04/19 \* High Risk

USDA	Risk Factor	USDA	Risk Factor
101	PG: Underweight; Prepregnancy BMI<18.5	353	ALL CAT: Food Allergies (consider RD referral if appropriate)
	BF/NBF: Current BMI<18.5	354	<b>ALL CAT*</b> : Celiac Disease
103	I/C Underweight or At Risk of Becoming Underweight	355	ALL CAT: Lactose Intolerance
	≤2.3%, I/C <24 mos; ≤5% BMI or ≤5th % wt/ht, 2-5 yrs	356	ALL CAT: Hypoglycemia
	at risk: ≥2.3th% and <5% 0-24 months; >5% and ≤10% 2-5 yrs	357	ALL CAT: Drug-Nutrient Interactions
111	PG: Overweight; Prepregnancy BMI ≥ 25	358	PG/BF/NBF: Eating Disorders
	BF:< 6mos Prepreg BMI ≥25; ≥ 6mos Current BMI ≥25	359	ALL CAT: Recent Major Surgery, Trauma, Burns
	NBF: Prepregnancy BMI ≥ 25	360	<b>ALL CAT*</b> : Other Medical Conditions
113	C: Obese, ≥95% BMI or wt/stature, C 2 to 5 yrs	361	PG/BF/NBF: Depression
114	I/C: Overweight or At Risk of Overweight	362	ALL CAT: Dev/Sens/Motor Dis Feed Prob- consider RD referral
115	I/C: High Weight for Length (0-24 months) ≥97.7th%	363	BF/NBF Pre-Diabetes
121	I/C: Short or At Risk of Stature	371	PG/BF/NBF: Maternal Smoking
131	PG: Low Maternal Weight Gain	372	PG/BF/NBF: Alcohol and Substance Use
133	PG/BF/NBF: High Maternal Weight Gain	381	ALL CAT: Oral Health Conditions
134	<b>I/C*</b> : Failure To Thrive	382	<b>I/C*</b> : Fetal Alcohol Syndrome (FAS) ( <b>H* up to 1yr cert</b> )
135	I: Slowed/Faltering Growth Pattern	383	I: Neonatal Abstinence Syndrome
141	<b>I*/C</b> : < 24 mos: LBW/VLBW: BW ≤ 5# 8oz ( <b>H:I*</b> <5#)	401	PG/BF/NBF/C ≥2yr: Fail Meet <i>Dietary Guidelines for Americans</i>
142	<b>I*/C</b> :<24mo. Prematurity. Infant born ≤ 37 wks ( <b>H:I*</b> )	411	I: Inappropriate Nutrition Practices for Infants
151	<b>I*/C</b> : < 24 mos: small for gest. age physician diag. ( <b>H:I*</b> )	411.01	I: Inappropriate Breast/Formula Substitutes
152	I*: Low Head Circumference < 2.3 % (NCHS/CDC)	411.02	I: Inappropriate Use Bottle/Cup
153	I: BW ≥9# or ≥4000 g	411.03	I: Inapprop Complementary Foods (food other than breast/formula)
201	<b>ALL Cat*</b> : Low Hct/Hgb ( <b>H*</b> <9gms/dl, <b>Hct</b> <30%)	411.04	I: Developmentally Inappropriate Feeding
211	ALL Cat: High Lead levels≥10µg/dl within 12mos	411.05	I: Feeding Harmful Foods (contaminants/toxins)
301	PG: Hyperemesis Gravidarum	411.06	I: Inappropriate Dilution of Formula
302	<b>PG*</b> : Gestational Diabetes	411.07	I: Limited Frequency of Nursing
303	PG: any history of gestational diabetes (GDM)	411.08	I: Diet Low Essential Nutrients (Vegan, Microbiotic, etc.)
	BF/NBF: GDM= most recent pregnancy	411.09	I: Lack Sanitation
304	PG BF/NBF History of Preeclampsia	411.10	I: Excess Vit/Mineral/Herb Supplements
311	PG: any history of preterm delivery (≤ 37 wks)	411.11	I: Inadequate Dietary Supplements ( fluoride, Vit D)
	BF/NBF: preterm= most recent pregnancy	425	C: Inappropriate Nutrition Practices for Children
312	PG: any history of LBW ( ≤ 5# 8oz)	425.01	C: Inappropriate Milk Substitutes
	BF/NBF: LBW= most recent pregnancy	425.02	C: Sugar Containing Fluids
321	PG: history of SAB, fetal or neonatal loss <20wks/<500gm	425.03	C: Improper use bottle/cup/pacifier
	BF: most recent preg and w/ ≥1 infant still living	425.04	C: Developmentally Inappropriate Feeding
	NBF: fetal neonatal loss= most recent pregnancy	425.05	C: Feeding Harmful Foods (contaminants/toxins)
331	<b>PG*</b> : Current Preg at ≤17 y/o ( <b>H</b> ≤15)	425.06	C: Diet Low Essential Nutrients (Vegan, Microbiotic, etc.)
	<b>BF*/NBF</b> : Preg at ≤17 = most recent preg ( <b>H-BF</b> ≤ 15)	425.07	C: Excess Vit/Mineral/Herb Supplements
332	PG: Short interpregnancy interval (<18 months)	425.08	C: Inadequate Dietary Supplements (fluoride)
	BF/NBF: Closely spaced pregnancy, current pregnancy	425.09	C: Pica
333	PG: Preg at < 20yr w/ ≥ 3 pregnancies- current preg	427	PG/BF/NBF: Inappropriate Nutrition Practices for Women
	BF/NBF: Preg at < 20yr w/ ≥ 3 preg= most recent preg	427.01	PG/BF/NBF: Excess Vit/Mineral/Herb Supplements
334	PG: Lack of or Inadequate Prenatal Care	427.02	PG/BF/NBF: Diet Low Essential Nutrients (Vegan, Microbiotic, etc.)
335	<b>PG*</b> : Multifetal gestation current pregnancy	427.03	PG/BF/NBF: Pica
	<b>BF*/NBF</b> : Multi gestation= most recent preg	427.04	PG/BF/NBF: Inadequate Diet Supplement (PG=iron, BF/NBF=folic)
336	PG: Fetal Growth Restriction (FGR)	427.05	PG: Feeding Harmful Foods (contaminants/toxins)
337	PG: Large for gest. age infant - any hx (BW ≥ 9 #)	428	I/C (4-24mo): Diet Associated w/Complementary Feed Practices
	BF/NBF: Large gest. infant= most recent preg or any hx		(i.e. gradual addition of food/bev to infant/child's diet)
338	PG: Pregnant Woman Currently Breastfeeding	501	BF/NBF/I/C: Possibility of Regression
339	PG: History of congenital birth defect	502	ALL CAT: Transfer of Certification
	BF/NBF: History of congenital birth= most recent preg	503	PG: Preg Women Presumptive Eligibility- 60 days
341	ALL CAT: Nutrient Deficiency or Disease	601	BF: Breastfeeding Mother of Infant at Nutritional Risk
342	ALL CAT: Gastro-Intestinal Disorders	602	<b>BF*</b> : BF Complications (woman)
343	ALL CAT: Diabetes Mellitus	603	<b>I*</b> : BF Complications (Infant)
344	ALL CAT: Thyroid Disorders	701	I: Infant < 6 Mo Old born to WIC/ELIG Mom
345	<b>ALL CAT*</b> : Hypertension (includes Chronic / Preg Induced)	702	I: Breastfeeding Infant of Woman at Nutritional Risk
346	ALL CAT: Renal Disease (excluding UTI)	801	ALL CAT: Homelessness
347	<b>ALL CAT*</b> : Cancer	802	ALL CAT: Migrancy
348	ALL CAT: Central Nervous System Disorders	901	ALL CAT: Recipient of Abuse: past 6 mos
349	ALL CAT: Genetic and Congenital Disorders	902	ALL CAT: Primary Caregiver w/ Limited ability feeding decisions
351	<b>ALL CAT*</b> : Inborn Errors of Metabolism	903	ALL CAT: Foster Care
352a	ALL CAT: Infectious Diseases- Acute	904	ALL CAT: Environmental Tobacco Smoke (ETS) Exposure
352b	All CAT: Infectious Diseases- Chronic		




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## WIC Referral Request

Referring Professional: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Participant is:      ☐ Pregnant                              ☐ Breastfeeding  
                            ☐ Postpartum                              ☐ Infant (0-12 months)                              ☐ Child (1-5 years)

Weight \_\_\_\_\_ Height \_\_\_\_\_ Hgb./Hct. \_\_\_\_\_ Date Taken \_\_\_\_\_

Reason(s) for referral (circle all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Inappropriate Foods for Age         |
| <input type="checkbox"/> Breastfeeding            | <input type="checkbox"/> Low Birth Weight/Prematurity        |
| <input type="checkbox"/> Chronic Disease          | <input type="checkbox"/> Nutrition Related Medical Condition |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Poor Eating Habits                  |
| <input type="checkbox"/> Feeding Problems         | <input type="checkbox"/> Poor Prior Pregnancy Outcome        |
| <input type="checkbox"/> Formula Feeding Problems | <input type="checkbox"/> Pregnancy Difficulties              |
| <input type="checkbox"/> Gaining Too Much Weight  | <input type="checkbox"/> Short Stature Height/Age            |
| <input type="checkbox"/> Homeless                 | <input type="checkbox"/> Teenage Pregnancy                   |
| <input type="checkbox"/> Inadequate Weight Gain   | <input type="checkbox"/> Other _____                         |

BRIEF DESCRIPTION OF REFERRAL REASON(S):

Signature \_\_\_\_\_

Date \_\_\_\_\_

[illegible]





# Alaska Chart Audit Form

Date:

Reviewer:

Agency:

Client File Review: Category \_\_\_\_\_

Certification							
	1	2	3	4	5	6	7
Client ID #							
Initial Contact Date							
Certification Date							
R&R form signed							
Participant category							
Certification within 10/20 days							
Separation of Duties							
Income							
Income Determination Accurate							
Proofs/Documentation							
Client Identity							
Voter Registration							
VOC							
Ineligibility Letter 15 days							
Measurements							
HGB/HCT for correct category							
HGB/HCT- recheck at 6 months w/low hgb/hct							
Mid-cert evaluation completed							
Risk Factors							
Assigned Risks Appropriate							
All applicable Risks identified and assigned							
Notes entered when appropriate and for CPA assigned risks							
High Risk Clients							
High Risk Care Plan documented by RD or WIC Nutritionist							
Nutrition Education							
Appropriate # of Nutrition Education contacts per certification (4 X 1 year)							
Food Package							
Appropriate package							
Special formula approval documented							
Referrals							
Appropriate referrals							
Follow-up on previous referrals (if needed)							
Immunization screening (< 2 years)							
Appropriate next appointment							
On-Site Observation							
Documentation of Income Sources Correct							
Length/Height/Weight at cert (< 60 days old)							
Hemoglobin value (< 90 days old)							

Standard = 90%

**Legend:**

Yes or ü = Complete, done correctly;  
No or - = Missing

I = incorrectly done. (Provide support documentation for exception)  
NA = Not Applicable

Certification							
	8	9	10	11	12	13	14
<b>Client ID #</b>							
Initial Contact Date							
Certification Date							
R&R form signed							
Participant category							
Certification within 10/20 days							
Separation of Duties							
<b>Income</b>							
Income Determination Accurate							
<b>Proofs/Documentation</b>							
Client Identity							
Voter Registration							
VOC							
Ineligibility Letter 15 days							
<b>Measurements</b>							
HGB/HCT for correct category							
HGB/HCT- recheck at 6 months w/low hgb/hct							
Mid-cert evaluation completed							
<b>Risk Factors</b>							
Assigned Risks Appropriate							
All applicable Risks identified and assigned							
Notes entered when appropriate and for CPA assigned risks							
<b>High Risk Clients</b>							
High Risk Care Plan documented by RD or WIC Nutritionist							
<b>Nutrition Education</b>							
Appropriate # of Nutrition Education contacts per certification (4 X 1 year)							
<b>Food Package</b>							
Appropriate package							
Special formula approval documented							
<b>Referrals</b>							
Appropriate referrals							
Follow-up on previous referrals (if needed)							
Immunization screening (< 2 years)							
Appropriate next appointment							
<b>On-Site Observation</b>							
Documentation of Income Sources Correct							
Length/Height/Weight at cert (< 60 days old)							
Hemoglobin value (< 90 days old)							

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Certification							
	15	16	17	18	19	20	21
<b>Client ID #</b>							
Initial Contact Date							
Certification Date							
R&R form signed							
Participant category							
Certification within 10/20 days							
Separation of Duties							
<b>Income</b>							
Income Determination Accurate							
<b>Proofs/Documentation</b>							
Client Identity							
Voter Registration							
VOC							
Ineligibility Letter 15 days							
<b>Measurements</b>							
HGB/HCT for correct category							
HGB/HCT- recheck at 6 months w/low hgb/hct							
Mid-cert evaluation completed							
<b>Risk Factors</b>							
Assigned Risks Appropriate							
All applicable Risks identified and assigned							
Notes entered when appropriate and for CPA assigned risks							
<b>High Risk Clients</b>							
High Risk Care Plan documented by RD or WIC Nutritionist							
<b>Nutrition Education</b>							
Appropriate # of Nutrition Education contacts per certification (4 X 1 year)							
<b>Food Package</b>							
Appropriate package							
Special formula approval documented							
<b>Referrals</b>							
Appropriate referrals							
Follow-up on previous referrals (if needed)							
Immunization screening (< 2 years)							
Appropriate next appointment							
<b>On-Site Observation</b>							
Documentation of Income Sources Correct							
Length/Height/Weight at cert (< 60 days old)							
Hemoglobin value (< 90 days old)							

Standard = 90%

**Legend:**

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 No or - = Missing

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 NA = Not Applicable

Certification							
	22	23	24	25	26	27	28
<b>Client ID #</b>							
Initial Contact Date							
Certification Date							
R&R form signed							
Participant category							
Certification within 10/20 days							
Separation of Duties							
<b>Income</b>							
Income Determination Accurate							
<b>Proofs/Documentation</b>							
Client Identity							
Voter Registration							
VOC							
Ineligibility Letter 15 days							
<b>Measurements</b>							
HGB/HCT for correct category							
HGB/HCT- recheck at 6 months w/low hgb/hct							
Mid-cert evaluation completed							
<b>Risk Factors</b>							
Assigned Risks Appropriate							
All applicable Risks identified and assigned							
Notes entered when appropriate and for CPA assigned risks							
<b>High Risk Clients</b>							
High Risk Care Plan documented by RD or WIC Nutritionist							
<b>Nutrition Education</b>							
Appropriate # of Nutrition Education contacts per certification (4 X 1 year)							
<b>Food Package</b>							
Appropriate package							
Special formula approval documented							
<b>Referrals</b>							
Appropriate referrals							
Follow-up on previous referrals (if needed)							
Immunization screening (< 2 years)							
Appropriate next appointment							
<b>On-Site Observation</b>							
Documentation of Income Sources Correct							
Length/Height/Weight at cert (< 60 days old)							
Hemoglobin value (< 90 days old)							

Standard = 90%

**Legend:**

Yes or ü = Complete, done correctly;  
 No or - = Missing

I = incorrectly done. (Provide support documentation for exception)  
 NA = Not Applicable

Certification							
	22	23	24	25	26	27	28
<b>Client ID #</b>							
Initial Contact Date							
Certification Date							
R&R form signed							
Participant category							
Certification within 10/20 days							
Separation of Duties							
<b>Income</b>							
Income Determination Accurate							
<b>Proofs/Documentation</b>							
Client Identity							
Voter Registration							
VOC							
Ineligibility Letter 15 days							
<b>Measurements</b>							
HGB/HCT for correct category							
HGB/HCT- recheck at 6 months w/low hgb/hct							
Mid-cert evaluation completed							
<b>Risk Factors</b>							
Assigned Risks Appropriate							
All applicable Risks identified and assigned							
Notes entered when appropriate and for CPA assigned risks							
<b>High Risk Clients</b>							
High Risk Care Plan documented by RD or WIC Nutritionist							
<b>Nutrition Education</b>							
Appropriate # of Nutrition Education contacts per certification (4 X 1 year)							
<b>Food Package</b>							
Appropriate package							
Special formula approval documented							
<b>Referrals</b>							
Appropriate referrals							
Follow-up on previous referrals (if needed)							
Immunization screening (< 2 years)							
Appropriate next appointment							
<b>On-Site Observation</b>							
Documentation of Income Sources Correct							
Length/Height/Weight at cert (< 60 days old)							
Hemoglobin value (< 90 days old)							

Standard = 90%

**Legend:**

Yes or ü = Complete, done correctly;  
 No or - = Missing

I = incorrectly done. (Provide support documentation for exception)  
 NA = Not Applicable

Certification							
	29	30	31	32	33	34	35
<b>Client ID #</b>							
Initial Contact Date							
Certification Date							
R&R form signed							
Participant category							
Certification within 10/20 days							
Separation of Duties							
<b>Income</b>							
Income Determination Accurate							
<b>Proofs/Documentation</b>							
Client Identity							
Voter Registration							
VOC							
Ineligibility Letter 15 days							
<b>Measurements</b>							
HGB/HCT for correct category							
HGB/HCT- recheck at 6 months w/low hgb/hct							
Mid-cert evaluation completed							
<b>Risk Factors</b>							
Assigned Risks Appropriate							
All applicable Risks identified and assigned							
Notes entered when appropriate and for CPA assigned risks							
<b>High Risk Clients</b>							
High Risk Care Plan documented by RD or WIC Nutritionist							
<b>Nutrition Education</b>							
Appropriate # of Nutrition Education contacts per certification (4 X 1 year)							
<b>Food Package</b>							
Appropriate package							
Special formula approval documented							
<b>Referrals</b>							
Appropriate referrals							
Follow-up on previous referrals (if needed)							
Immunization screening (< 2 years)							
Appropriate next appointment							
<b>On-Site Observation</b>							
Documentation of Income Sources Correct							
Length/Height/Weight at cert (< 60 days old)							
Hemoglobin value (< 90 days old)							

Standard = 90%

**Legend:**

Yes or ü = Complete, done correctly;  
 No or - = Missing

I = incorrectly done. (Provide support documentation for exception)  
 NA = Not Applicable

**Comments:**

Client Name/#	Explanation of Findings

# Local Agency (LA) Management Evaluation Tool

## Overview:

The USDA, Food and Nutrition Services WIC Nutrition Services Standards published in August 2013 are incorporated into the LA Self-Assessment document. It simplifies and streamlines the self-assessment process. The NSS becomes the Alaska WIC standard for LA ME review.

The standards are organized to cover the major areas of federal and state regulations and policies. Each section includes several program characteristics. Each program characteristic has several standards. The standards are perhaps the most relevant indices for measuring program performance. Throughout the LA Monitoring and Self-Assessment Form the AK WIC ME Standards reference Nutrition Services Standards (NSS), and Alaska State Policy and Procedures.

A rating scale [Is the standard met?: Yes, No, Partial, and Not Applicable (N/A)] is next to each program standard. **Finding (FD), Recommendation (R) or Best Practice (BP) possible is indicated for each standard. Findings, recommendations and best practices that have recently been received from Food Nutrition Services (FNS) are indicated with \*.** The intent of the rating scale is to allow the reviewer some flexibility in determining whether the standard was met. In addition, the forms include areas for narrative comments that can highlight positive things the program is doing or provide constructive feedback in cases where the standard was not entirely met.

Local Agency Monitoring and Self-Assessment covers WIC Functional areas:

- Vendor and Farm Management
- Nutrition and Breastfeeding Services
- Management Information and Technology Systems
- Organizational Management
- Nutrition Services and Administration
- Food Funds Management
- Caseload Management
- Certification, Eligibility and Coordination of Services
- Food Deliver & Food Instrument (Card) Accountability and Control
- Monitoring and Audits
- Civil Rights



## Local Agency (LA) Self-Assessment Form 2025 Draft

Local Agency: \_\_\_\_\_ Date: \_\_\_\_\_  
Written by: \_\_\_\_\_

How can the WIC Program Office help you achieve your program goals?

How have you used your most recent client surveys to improve program services?

Identify your areas for improvement as seen through the quarterly chart review process.

What are your organization's biggest challenges? How do these challenges affect the WIC program?

# Local Agency (LA) Monitoring and Self-Assessment

## WIC Regulations (FR) and Nutrition Services Standards (NSS)

Local Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Evaluator(s) \_\_\_\_\_

Item #	AK WIC ME Standard	Reference  Federal register, nutrition service standards, USDA memo's/management evaluations, SOA WIC Policy and Procedure Manual, SOA grant reporting documentation	Finding (FD), Recommendation (R) or Best Practice (BP) possible	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	Review method and key questions  LA/Reviewer Comments
<b>Vendor and Farm Management</b>					
Item #	AK WIC ME Standard	Reference	Finding (FD), Recommendation (R) or Best Practice (BP) possible	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	Review method and key questions  LA/Reviewer Comments
	LA is adequately responsive and communicative with State Vendor Management Unit (VMU)		R		SOA reviewer obtains information from VMU
	LA provides adequate training and technical assistance to vendors according to AK P & P, working with State Vendor Management Unit		FD		SOA reviewer obtains information from VMU
	LA monitors at least 5% of authorized vendors per year		FD		SOA reviewer obtains information from VMU
	LA meet statewide average for overall redemption		R		SOA reviewer obtains information from VMU
<i>Farmers Market Nutrition Program (FMNP)</i>					

	LA is adequately responsive and communicative with				SOA reviewer obtains information from FMNP Coordinator
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	State FMNP Coordinator				
	LA staff appropriately participate in FMNP training				SOA reviewer obtains information from FMNP Coordinator
	LA staff correctly documents FMNP benefits				SOA reviewer obtains information from FMNP Coordinator
<b>Nutrition and Breastfeeding Services</b>					
<b>Item #</b>	<b>AK WIC ME Standard</b>	<b>Reference</b>	<b>Finding (FD), Recommendation (R) or Best Practice (BP) possible</b>	<b>Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)</b>	<b>Review method and key questions</b>  <b>LA/Reviewer Comments</b>
	LA follows currently approved Nutrition Education Plan		FD*		SOA reviewer reviews document provided by LA and discusses with LA
<i>Participant Centered, Customer Service</i>					
	Participant centered (PC) skills are used whenever staff are interacting or delivering services WIC services				SOA reviewer clinic observation
<i>Anthropometric and Hematologic Assessment</i>					
	Anthropometrics are current, recorded, reflect participant status and are assessed according to AK P & P	NSS 14B1; 6B3	<b>FD</b>		SOA reviewer chart review/audit
	Anthropometrics are made available to WIC participants by LA				LA process discussed by SOA reviewer and LA during ME
	Appropriate technique used by LA staff. Results interpreted correctly by LA staff	NSS 14B1; 6B3	<b>FD</b>		SOA reviewer clinic observation
	Hematological assessments are made available to WIC participants by LA				LA process discussed by SOA reviewer and LA during ME
	Hematological assessments current, recorded, reflect participant status and assessed according to AK P & P	NSS 14B1; NSS 6B3	<b>FD</b>		SOA reviewer chart review/audit
	Appropriate technique used, and results interpreted	NSS 14B1; NSS 6B3	<b>FD</b>		SOA reviewer clinic observation

	correctly; for both Hema cue screening and Pronto screening				
<b>Dietary Assesement</b>					
	Staff demonstrates critical thinking skills in organizing and synthesizing information to evaluate and to prioritize the information appropriately.	NSS 6B8A-B, NSS 6C6  (Item #3)	<b>FD</b>		SOA reviewer clinic observation  Critical thinking is used to review measurements and other information collected and combined with the focus of the participant. Staff shows competency in their interviewing and communication techniques, resulting in an effective WIC intervention for the participant which includes interacting with the WIC participant using VENA (see competencies on abbreviations page)
<b>Nutrition Risk</b>					
	CPA or RD uses WIC Nutrition Risk Criteria to completely identify and document all nutrition risks prior to nutrition education	NSS 6A1; 6B5	<b>FD</b>		SOA reviewer chart review/audit  There are many risk factors and recognizing them all is complex. What is the agency process for regularly reviewing risk factors with staff.
<b>Food Package Tailoring</b>					
	Food packages are tailored appropriately	NSS 13B1,2,5, 8	<b>FD</b>		SOA reviewer chart review/audit
<b>Special Cirumstances – High risk participants</b>					
	CPA identifies and refers high-risk participants to a qualified nutritionist	NSS 3H7; AK P & P Chap 2	<b>FD</b>		SOA reviewer chart review/audit
	LA uses a tracking system to ensure HR clients are referred and seen by appropriate staff.	NSS 3N6			SOA reviewer discussion with LA during ME
	Appropriate HR codes are identified and correctly assigned in the computer file	NSS3H7; AK P & P Chap 2	<b>FD</b>		SOA reviewer chart review/audit
	HR SOAP notes are developed and plan identifies appropriate	NSS 3N3-6	<b>FD</b>		SOA reviewer chart review/audit

	nutrition education and support materials needed				
	HR nutrition education contact with RD must take place during certification period	AK P & P Chap 2; NSS3N	FD		SOA reviewer chart review/audit
<i>Special Circumstances – Formula</i>					
	Contract formulas are prescribed unless a non-contract formula ENPR is completed and in the chart	NSS 12B6	FD		SOA reviewer chart review/audit, use report XXX
<i>Nutrition Education</i>					
	<p>Participant centered (PC) skills are used whenever staff are interacting delivering services</p> <p>Establish rapport to begin a conversation. Practices active listening skills. Collects information without interrupting or correcting the participant. Paraphrases or reflects what was heard. Uses open ended sentences appropriately. Goal set by client.</p> <p>Staff uses VENA principles to complete nutrition assessment</p>	NSS 7A3 NSS 6; 7A3	FD		SOA reviewer clinic observation
	LA make 2 attempts to contact clients to offer nutrition education. Attempts are documented in client's electronic record. At least one attempt involves attempting to reach the participant by phone.	LA Memo 12-05			<p>SOA reviewer chart review/audit, discussion with LA during ME</p> <p>Describe the system you use to ensure that this standard is met and every participant is offered nutrition education</p>
	Nutrition education follow-	NSS 7A3; 7A5	FD		SOA reviewer clinic observation, LA

	up must be interactive, examine client's progress towards goal/behavior changes, and occur before or at next certification	LA Memo 12-05			description of practices during ME
<b>Breastfeeding Services</b>					
	LA has a clearly designated BF Coordinator  Name: _____	NSS 3I; 3J	FD		LA description of practices during ME
	LA BF Coordinator has at least 1 yr in counseling breastfeeding dyads and /or extended lactation training, CLC or IBCLC	NSS 3I; 3J	R		LA description of practices during ME
	LAs provides annual training to all staff about BF and their role in supporting PG and BF people	NSS 8A AK P & P Chap 2	FD		LA description of practices during ME; SOA reviews training logs of a randomly selected team member
	LA supports breastfeeding, both individual dyads and though community work. BF dyads are supported through education, counseling. LA conducts activities that are supportive of BF.	NSS 8	FD BP		SOA reviewer clinic observation
	LA tracks breast pumps & follow up per policy guidance.	NSS 3J7 AK P & P Chap 7;	FD		SOA reviewer review; SA reviews LA breast pump log
	Breastfeeding assessment is made and documented by a CPA or RD before changing a food package for a breastfeeding dyad	NSS 13B4, 5	FD		SOA reviewer clinic observation, LA description of practice  How does an agency work to preserve breastfeeding in these situations?
	LA workplace policies are breastfeeding-friendly	NSS 2B	BP		LA description of agency policies
<b>Breastfeeding Peer Counseling (BFPC)</b>					
	Qualified BFPC coordinator on staff. <b>BFPC Coordinator must be a CPA.</b>	NSS 3I, 3J8  State P & P Chap. 2 FD			LA description of agency practice during ME

	IBCLC is available to support BFPCs and dyads				LA description of agency practice during ME
	BFPC meet qualifications and description of a BFPC				SOA reviewer reviews LA Document during ME
	BFPC peer counselors are used according to BFPC peer standards and BFPC plans				LA description of agency practices during ME
	BFPC are available during non-clinic hours				LA description of agency practices during ME
	An up-to date BFPC training log documents that peer counselor(s) meet with the BFPC coordinator				LA description of practices during ME; SOA reviews training logs of a randomly selected team member
	LA has a referral protocol for peer counselors and a list of referral resources for their agency/community	NSS 3 R4 FD			LA description of agency practices during ME
	BFPC and WIC funds and expenditures are segregated, and reported separately				LA description of agency practices during ME

### Management and Technology Information Services

Item #	AK WIC ME Standard	Reference	Finding (FD), Recommendation (R) or Best Practice (BP) possible	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	Review method and key questions  LA/Reviewer Comments
	There is adequate IT infrastructure to support the WIC program. Including hardware, software, peripherals, etc.				
	Grantee has adequate security software to operate the WIC system				

### Organization Management

Item #	AK WIC ME Standard	Reference	Finding (FD), Recommendation (R) or Best	Yes (Y) /No (N)/ Partial (P)/ Not	Review method and key questions  LA/Reviewer Comments
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			<b>Practice (BP) possible</b>	applicable (NA)	
	Staffing education and experience are appropriate for assigned responsibilities	NSS 3G, 3I-V <b>FD-state</b>			SOA reviewer reviews document (like organizational chart) submitted by LA, discussed during ME
	Professional and paraprofessional staff have accessible documentation supporting their CEU requirements.	NSS 5E, 5H <b>FD</b>			SOA reviewer selects at random a staff member and reviews documentation regarding CE requirements
	LA must ensure that staff are regularly trained on USDA and State policies.				
<b>Nutrition Service and Administration (Finance)</b>					
<b>Item #</b>	<b>AK WIC ME Standard</b>	<b>Reference</b>	<b>Finding (FD), Recommendation (R) or Best Practice (BP) possible</b>	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	<b>Review method and key questions</b>  <b>LA/Reviewer Comments</b>
	WIC Coordinator has regular access to the WIC budget and a minimum of “read” capacity in the GEMS system in order to manage grant budget	State P & P Chapter 7			LA description of agency practice during ME
	Local Agency spends at least 1/6 of grant funding on Nutrition Education and Breastfeeding Promotion (as recorded on monthly time study)				SOA reviewer reviews previous years FFY spending
	Expenses are allowable, reasonable, and allocable:		<b>FD</b>		SOA reviewer will examine one month’s CFR and trace expenditures back to original source documents; i.e., an invoice. • Invoices are for approved, budgeted items, the items and cost are reasonable. If more than one funding source— that cost is distributed between funding sources appropriately.
	Time studies are completed by each WIC		FD		SA review reviews one month of time studies

	employee the first full week of every month				
	<p>Internal controls exist for ensuring accurate payroll reporting which includes:</p> <ul style="list-style-type: none"> <li>• After-the-fact reporting of actual work performed by the employee</li> <li>• Timesheets cover 100% of employee's time</li> <li>• Timesheet is prepared and signed by the employee at least monthly, to coincide with the end of a pay period.</li> <li>• Allocation of wages among multiple grant programs is supported by actual hours (if applicable)</li> </ul>	(OMB Super Circular)	FD		
	Inventory records are tracked according to state policies and submitted annually to the SOA				SA reviewer to view sample of at least 1 breast pump, 1 computer, and one non-invasive hemoglobin machine while on-site. Items are selected randomly from current inventory
<b>Food Funds</b>					
<b>Item #</b>	<b>AK WIC ME Standard</b>	<b>Reference</b>	<b>Finding (FD), Recommendation (R) or Best Practice (BP) possible</b>	<b>Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)</b>	<b>Review method and key questions</b>  <b>LA/Reviewer Comments</b>
<b>Caseload Management</b>					
<b>Item #</b>	<b>AK WIC ME Standard</b>	<b>Reference</b>	<b>Finding (FD), Recommendation (R) or Best</b>	<b>Yes (Y) /No (N)/ Partial (P)/ Not</b>	<b>Review method and key questions</b>  <b>LA/Reviewer Comments</b>

			<b>Practice (BP) possible</b>	applicable (NA)	
	LA has developed and is following outreach plan submitted as part of grant agreement	Alaska P & P Chap 8			LA description of agency practice
	Uses marketing strategies to promote participation in WIC		R		LA description of agency practice
	LA coordinates with other program partners to provide care and support for participants. For example: Public Health Nursing, Infant Learning Program, SNAP-ED, Homeless Shelters, Immunizations providers, Expanded Food and Nutrition Programs (EFNP), etc.	NSS 7A			LA description of agency practice
<b>Certification, Eligibility and Coordination of Service</b>					
<b>Item #</b>	<b>AK WIC ME Standard</b>	<b>Reference</b>	<b>Finding (FD), Recommendation (R) or Best Practice (BP) possible</b>	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	<b>Review method and key questions</b>  <b>LA/Reviewer Comments</b>
	<p>Follows certification Policies &amp; Procedures for all applicants</p> <ul style="list-style-type: none"> <li>• Applicant meets WIC categories</li> <li>• Applicant supplied proof of residency</li> <li>• Applicant supplied proof of identity</li> <li>• Applicant is physically present or documented reason for absence</li> <li>• Applicant is income</li> </ul>		FD		SOA reviewer chart review/audit

	eligible (observe income determinations)				
	Meet federally required application processing timelines		FD*		
	Clinic follows separation of duties policy oversight (use report "Separation of Duties Same Contact" on SPIRIT Utilities to ask for chart audits)	AK P & P Chap 4 WPM 2016-5	FD		SOA reviewer chart review/audit  LA please share the separation for duties plan for your agency including when charts are submitted to state
	LA maintain and provide a list of current resources for drug and other harmful substance abuse. Information must be given at each new pregnancy, PP and BF women, and parents/caregivers of infants and children certification.	NSS 7A2k , 11A3	FD		SOA reviewer reviews document
	LA provides and documents written referrals to Medicaid/Denali Kid Care.	NSS 11A; 11B	FD		SOA reviewer chart review/audit, clinic observation
	LA provide verbal/written referrals to SNAP, ATAP, Well Child (EPSDT), and Immunizations. (As identified by assessment). Relevant referrals are identified by staff and discussed with participant		FD		SOA reviewer chart review/audit, clinic observation
	Documents follow-up to referrals ( <b>BP</b> )	NSS 6B7, 3H8, NSS11B	BP		SOA reviewer chart review/audit, clinic observation
	Immunizations for children under age 2 are documented	Alaska P &P Chap 1	FD		SOA reviewer chart review/audit, clinic observation
	Voter Registration preference is documented, matches application and appropriate action is taken.	Alaska P &P Chap 1	FD		SOA reviewer chart review/audit, clinic observation

	All children are verbally screened for lead testing and referred if untested		R		
	Rights and Responsibilities summarized verbally by clinic staff and participants are given the opportunity to read and ask questions at every certification or recertification	Alaska P & P Chap 1	FD		SOA reviewer chart review/audit, clinic observation

### Food Delivery & Food Instrument (Card) Accountability and Control

Item #	AK WIC ME Standard	Reference	Finding (FD), Recommendation (R) or Best Practice (BP) possible	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	Review method and key questions  LA/Reviewer Comments
	Receipt of blank cards are thoroughly tracked		FD		LA description of agency practice during ME
	Cards are securely stored		FD		SOA reviewer chart review/audit, clinic observation
	Card forms are maintained daily		FD		SOA reviewer clinic observation during ME
	WIC cards and FMNP FI's are issued to participants according to AK P & P				
	LA follow AK P & P regarding enabling BALTO		FD		SOA reviewer discussion with VMU, review report
	New participants are oriented to selecting WIC foods, locating WIC vendors	Alaska P & P Chap 1			SOA reviewer clinic observation during ME

### Monitoring and Audits

Item #	AK WIC ME Standard	Reference	Finding (FD), Recommendation (R) or Best Practice (BP) possible	Yes (Y) /No (N)/ Partial (P)/ Not applicable (NA)	Review method and key questions  LA/Reviewer Comments
	Ensure all areas where staff obtains participant information and anthro data maximize privacy	NSS 2A2	FD		SOA reviewer clinic observation during ME

### Civil Rights

Item #	AK WIC ME Standard	Reference	Finding (FD), Recommendation	Yes (Y) /No (N)/ Partial	Review method and key questions
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			<b>(R) or Best Practice (BP) possible</b>	<b>(P)/ Not applicable (NA)</b>	<b>LA/Reviewer Comments</b>
	Public Notification is conducted annually informing all potential participants, minorities & women in early months of pregnancy about program				LA description of agency practice durring ME
	LA coordinates with other program partners to provide care and support for participants. For example: Public Health Nursing, Infant Learning Program, SNAP-ED, Homeless Shelters, Immunizations providers, Expanded Food and Nutrition Programs (EFNP), etc.	NSS 7A			LA description of agency practice durring ME
	Client has read and signed the rights and responsibilities form		<b>FD</b>		SOA reviewer chart review/audit, clinic observation
	Clients who have been determined ineligible must be advised of their right to a fair hearing		<b>FD</b>		SOA reviewer chart review/audit, clinic observation; Term letters are documented
	Documentation showing that staff have received annual civil rights training. Include list of staff who attended training, agenda, and date		<b>FD</b>		SOA reviewer reviews document submitted by LA
	LA staff is aware of civil rights procedures				SOA reviewer clinic observation

## WIC Local Agency (LA) Management Evaluation (ME) Preparation Materials

Local Agency Reviewed \_\_\_\_\_

Review Dates \_\_\_\_\_

Reviewers \_\_\_\_\_

Due Date for LA Self-Assessment and review materials \_\_\_\_\_

Item	Documents or Materials	Comments
1.	Client Chart Data Family Information form, signed R & Rs, ENPRs, and applications for clients on chart review form). <i>(Scan into SPIRIT and have charts available for onsite review)</i> <b>S, OS</b>	
2.	Copies of or log of current year clients' vendors complaints <b>OS</b>	
3.	Submitted Nutrition Education Plan	
4.	Breastpump Log <b>OS</b>	
5.	Agency policies supporting breastfeeding (if applicable)	
6.	BFPC position descriptions (if applicable)	
7.	Organizational chart that shows WIC	
8.	Copies of current staff training agenda and handouts (including annual civil rights training) <b>OS</b>	
9.	Support documentation for one month (October 2023) of purchases in the current fiscal year. Support documentation must align with GEMS. <b>S</b>	
10.	October 2023 Timestudies	
11.	Timesheets and/or documentation that support October 2023 Timestudies	
12.	Agency policies surrounding timesheets	
13.	If applicable any management training (agendas only) <b>OS</b>	
14.	SFY 2024 Inventory	
15.	Any Local Agency specific forms that have been developed within the last six months <b>S</b>	
16.	New participant letter/flyer <b>S</b>	
17.	Current referral flyer/letter <b>S</b>	
18.	Current No Show appointments communications letter/fax/email <b>S</b>	
19.	LA card log <b>OS</b>	
20.	Current Public Notification ad/flyer <b>S</b>	
21.	Current termination letter, if not using Spirit letter <b>S</b>	
22.	Copies of letters or log of current year civil rights complaints <b>OS</b>	

23	Selected inventory items (computer, Symphony breast pump, and Hemocue / Pronto hemoglobin machine). State staff to select one item from category from most recent inventory report to confirm. <b>OS</b>	
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\***S** indicates items to be sent to State Office for pre-review, **OS** indicates items to have available for on-site review

DRAFT

## Abbreviations Used in the LA Self-Assessment Form

AK P & P	State of Alaska WIC Policy and Procedure
ATAP	Alaska Temporary Assistance Program
BP	Best Practices
BF	Breastfeed
BFPC	Breastfeeding Peer Counselor
BFW	Breastfeeding Woman
CPA	Competent Professional Authority
CSE	Child Support Enforcement
EPSDT	Early Periodic Screening, Diagnosis and Treatment, usually performed by Public Health Nursing
FFY	Federal Fiscal Year
FD	Finding
FMNP	Farmer's Market Nutrition Program
FR	Federal regulations
LA	Local Agency
ME	Management Evaluation
MIS	Management Information System
MOV	Mail Order Vendor
NSS	Nutrition Service Standards
NE	Nutrition education
PCE	Participant Centered Education
PCS	Participant Centered Services
PG	Pregnant
SFY	State Fiscal Year
RD	Registered Dietitian
VENA	Value Enhanced Nutrition Assessment <i>VENA Competencies:</i> <ul style="list-style-type: none"> <li>• Principles of life cycle nutrition</li> <li>• Nutrition Assessment Process</li> <li>• Anthropometric and hematological data collection techniques</li> <li>• Communication</li> <li>• Multicultural awareness</li> <li>• Critical thinking</li> </ul>

## **Local Agency (LA) Monitoring and Self-Assessment Narrative**

### **Farmer's Market Nutrition Program (if applicable)**

1. Please describe specific procedures for issuing, securing, disposing of Farmer's Market Nutrition Programs (FMNP) food instruments (FIs). How do you ensure clinic staff follows proper issuance procedures?
2. Please describe FMNP promotion and outreach activities you have done in the past year.
3. Describe how you incorporate nutrition education into FMNP.
4. Other Comments:

DRAFT

## **Local Agency (LA) Monitoring and Self-Assessment Narrative**

### **Breastfeeding Peer Counseling Program (if applicable)**

1. What have been the successes and highlights of your Breastfeeding Peer Counselor (BFPC) program?
2. What have been the barriers to running your BFPC program? What have you done to overcome the barriers?
3. What are your recommendations for the Alaska WIC Breastfeeding Peer Counseling Program?
4. Other Comments:

DRAFT

# Management Evaluation Report Template 2024

## WIC Management Evaluation for Federal/State Program Compliance

WIC Local Agency Management Evaluation State Fiscal Year 2024

**DATE** Range of Entrance Conference

Attendees:

**DATE** Range of Chart Reviewed

**DATE** Site Observations

**DATE** Exit Conference

Attendees:

**WHO – SOA staff involved** completed a Management Evaluation (ME) of the **XXXX** WIC Program. This review was comprised of auditing participant charts, completion and review of local agency self assessment (LASA) by local agency (LA) and State of Alaska staff, review of LA program materials, interviews with local agency LA staff, observations of participant services and a site visits by State of Alaska program staff.

Summary of program challenges  
2020 - 2024

### Local agency summary of operations

Since the Covid-19 pandemic the State of Alaska WIC program is operating under waivers for physical presence (including anthropometric data) and remote benefit issuance.

The **LA Name** operates a primary WIC clinic at the **Anchorage Public Health Center** and satellite services at sites in **Eagle River and Joint Base Elmendorf-Richardson**. Participants can walk into a clinic, or satellite site or receive services remotely. The majority of WIC services are being delivered remotely with many staff duties including nutrition assessment and education being performed telephonically.

Anthropometric and hematological measurements are available **at all sites during operating hours.**

**XXXX** WIC Program participants can receive services in person at the **XXXX** office or during a village visit by WIC staff.

### **Functional areas reviewed:**

- Vendor and Farm Management

Comments:

Vendors are trained and monitored according to program requirements.

Accolades:

Recommendations:

Findings:

**Standardized language for Vendor and Farm Management does not seem to exist.**

**XXXX** WIC Program

## WIC Management Evaluation for Federal/State Program Compliance

- Nutrition and Breastfeeding Services including (*Participant Centered Services/Customer Services, Anthropometric and Hematologic Assessment, Dietary Assessement, Nutrition Risk, Food Package Tailoring, Special Cirumstances – High risk participants, Special Cirumstances – Formula, Nutrition Education, Breastfeeding Services, Breastfeeding Peer Counseling (BFPC) Breastfeeding Peer Counseling (BFPC)*)

Comments:

Reviewers observed XXXX provide direct WIC services to participants. LA staff completed certification/recertification, and secondary nutrition education sessions during the ME. Reviewers identified the following PCS skills used during these observed sessions:

- ☐ Good rapport with participants
- ☒ Open-ended questions
- ☒ Active listening
- ☒ Affirmation
- ☐ Reflections
- ☒ Allow silence
- ☒ Probe to clarify
- ☐ Ask permission
- ☐ Summarizing statements
- ☐ Allow client to set nutrition education goals

Accolades:

Recommendations:

Findings:

- Management Information and Technology Systems

Comments:

Accolades:

Recommendations:

Findings:

- Organizational Management

Comments:

Accolades:

Recommendations:

Findings:

- Nutrition Services and Administration

Comments:

The review consists of selecting a budget category and tracking an expense from the time it is requested by the WIC program to its payment. Supporting documentation for supplies purchased in MONTH were requested/were found to be appropriately charged and recorded) or (need further clarification and support documentation).

Accolades:

Recommendations:

XXXX WIC Program

# WIC Management Evaluation for Federal/State Program Compliance

## Findings:

- Food Funds Management  
Comments:  
Accolades:  
Recommendations:  
Findings:
- Caseload Management  
Comments:  
Accolades:  
Recommendations:  
Findings:
- Certification, Eligibility and Coordination of Services  
Comments:  
Accolades:  
Recommendations:  
Findings:

- Food Deliver & Food Instrument (Card) Accountability and Control  
Comments:

Review consists of checking for adequate controls and issuance of electronic benefits transfer (EBT) card stock, handling voided/lost EBT cards and there is separation of duties between staff that determine income eligibility and nutrition risk assignment.

Accolades:  
Recommendations:  
Findings:

- Monitoring and Audits  
Comments:  
Accolades:  
Recommendations:  
Findings:
- Civil Rights  
Comments:  
Accolades:  
Recommendations:  
Findings:

# WIC Management Evaluation for Federal/State Program Compliance

State of Alaska identified the following program goals from 2023 Request for Proposals. These goals are also highlighted on an agency annual Nutrition Education Plan.

Program Goal #1	Anticipated outcome	Data
WIC services are available and utilized by eligible participants throughout the state.	WIC services will be provided to a minimum quarterly average of 75% of Total Eligible WIC Participants for the proposed WIC service area	SFY 2023 Average LA Active Participation: SFY 2023 Average SOA Active Participation  SFY 2024 (July to May) Average LA Active Participation: SFY 2024 (July to May) Average SOA Active Participation:

Program Goal #2	Anticipated outcome	Data
Deliver quality nutrition services in compliance with state and federal requirements.	Increased percentage of children ages 2-4 at a healthy weight.	Due to Covid – 19 and USDA waivers anthropometric data has not been consistently collected.

Program Goal #3	Anticipated outcome	Data
Households receiving WIC food benefits purchase WIC foods.	WIC foods will be purchased monthly by greater than 75% of households.	SFY 2023 Average LA redemption: SFY 2023 Average SOA redemption:  SFY 2024 (July to May) Average LA redemption: SFY 2024 (July to May) Average SOA redemption:

Program Goal #4	Anticipated outcome	Data
All pregnant and post partum WIC participants receive	Increased percentage of infants who are breastfed at one year.	SFY 2023 Average LA percentage of breastfed infants: SFY 2023 Average SOA percentage of breastfed infants:



## WIC Management Evaluation for Federal/State Program Compliance

information and support to meet their breastfeeding goals.		SFY 2024 (July to May) Average LA percentage of breastfed infants: SFY 2024 (July to May) Average SOA percentage of breastfed infants:
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Program Goal #5	Anticipated outcome	Data
Pregnant or breastfeeding participants will have access to a breastfeeding peer counselor.	At least 75% of pregnant participants will be offered breastfeeding peer counseling services.	

# WIC Management Evaluation for Federal/State Program Compliance

**DELETE WHICHEVER SECTIONS ARE NOT APPLICABLE**

## Corrective Action Summary

<b>Vendor and Farm Management</b>				
<i>If applicable Farmer's Market Nutrition Program (FMNP)</i>				
Findings:	Corrective Action Required:	1st LA Response:	2nd LA Response:	Status:
<b>Nutrition and Breastfeeding Services</b>				
<i>Including Participant Centered, Customer Service; Anthropometric and Hematological Assessment; Dietary Assessment: Nutrition Risk; Food Package Tailoring; Special Circumstances – High Risk Participants; Special Circumstances – Formula: Nutrition Education, Breastfeeding Services</i>				
<i>If applicable Breastfeeding Peer Counseling (BFPC)</i>				
Findings:	Corrective Action Required:	1st LA Response:	2nd LA Response:	Status:
<b>Management and Technology Information Services</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:
<b>Organization Management</b>				
Findings:	Corrective Action Required:	1st LA Response:	2nd LA Response:	Status:
<b>Nutrition Service and Administration (Finance)</b>				
Findings:	Corrective Action Required:	1st LA Response:	2nd LA Response:	Status:
<b>Food Funds</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:
<b>Caseload Management</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:

## WIC Management Evaluation for Federal/State Program Compliance

<b>Certification, Eligibility and Coordination of Services</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:
<b>Food Delivery &amp; Food Instrument (Card) Accountability and Control</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:
<b>Monitoring and Audits</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:
<b>Civil Rights</b>				
Findings:	Corrective Action Plan	1st LA Response:	2nd LA Response:	Status:

**Recommendations made by the SOA to LA:**

## ME General Clinic Observations

### Clinic checklist

Yes ☐ No ☐ Access to the clinic and WIC services is accessible.

Reviewer: Evaluate access to physical WIC program (What is the signage like? If a participant is a non- driver what is access to the clinic like? Is there an elevator if office is on second floor?).

Notes/comment:

*Within clinic:*

Yes ☐ No ☐ Clinic environment seems supportive of the overall WIC mission.

Reviewer: Is the physical spaces comfortable for families, small children, and breastfeeding people? Environment has supportive reinforcement activities and resources are available e.g. bulletin boards, newsletters, pamphlets. Materials available are accurate, relevant, and at an appropriate cultural and literacy level. Images of formula and/or artificial nipples are not present.

Notes/comment:

Yes ☐ No ☐ Required USDA posters are visible to WIC participants

Reviewed: Both the "Justice For All" and Agriculture Office of Inspector General (OIG) USDA Hotline poster are prominently displayed in the clinic or any where services are offered. Notes/comment:

## Participant-Center Nutrition Services (PCS) Observation Tool

Name of staff completing observation: \_\_\_\_\_

Name of staff being observed: \_\_\_\_\_

1. How do you feel the appointment went?
  
  
  
  
  
  
  
  
  
  
2. What do you think went well?
  
  
  
  
  
  
  
  
  
  
3. What might you do differently?
  
  
  
  
  
  
  
  
  
  
4. What did you experience (learn) in this appointment?
  
  
  
  
  
  
  
  
  
  
5. Can I give you feedback?

Positives

Areas to improve

1.

1.

2.

2.

3.

3.

6. What do you think of my comments?

PCS SKILLS OBSERVATIONS		EXAMPLES
Start Time: _____ End Time: _____		
Opens conversation warmly	<input type="checkbox"/> Used skill	
Asks open ended questions	<input type="checkbox"/> Used skill	
Actively listens- listens with presence	<input type="checkbox"/> Used skill	
Affirms	<input type="checkbox"/> Used skill	
Uses reflections	<input type="checkbox"/> Used skill	
Probes to clarify information	<input type="checkbox"/> Used skill	
Allows silence	<input type="checkbox"/> Used skill	
Asks permission	<input type="checkbox"/> Used skill	
Ht. Wt. (<60 days old) Hgb. (<90 days old) taken accurately and according to policy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat NA <input type="checkbox"/>	
Calculation of Income done accurately	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Standard Management Evaluation Findings and CAP Language Sample Report

FUNCTIONAL AREA SUMMARY	FINDING	CORRECTIVE ACTION	ADDITIONAL NOTES/RESOURCES
<b>Vendor and Farm Management</b>			
Standardized language for Vendor and Farm Management does not seem to exist.			
<p style="text-align: center;"><b>Nutrition and Breastfeeding Services including (Participant Centered Services/Customer Services, Anthropometric and Hematologic Assessment, Dietary Assessement, Nutrition Risk, Food Package Tailoring, Special Cirumstances – High risk participants, Special Cirumstances – Formula, Nutrition Education, Breastfeeding Services, Breastfeeding Peer Counseling (BFPC) Breastfeeding Peer Counseling (BFPC)</b></p>			

PCS/Critical Thinking	Critical thinking skills were not observed during certifications. Critical thinking is a key element of the WIC nutrition and education process. Linking the participant's category and age, the information on the application and the information gathered (such as weight, height and hemoglobin collection), leads to assigning the correct risk factors, and to the nutrition education messages that stem from the nutrition assessment.	CPAs need to review the critical thinking section in the CPA training. CPAs need to observe at minimum 3 counseling sessions conducted by an RD. Submit the date and name of each CPA repeating the critical thinking section in the CPA online training. Submit dates and name of CPAs observing WIC nutrition certification and education where the RD or preceptor engages the participant and provides interactive nutrition education as the main focus, rather than reliance upon pamphlets. Each CPA should observe and document at least 3 sessions with an RD.	See The Oregon WIC Listens, Participant-Centered Services resources for sample training resources. <a href="https://wicworks.fns.usda.gov/resources/oregon-wic-listens-participant-centered-services-pcs-resources-staff">https://wicworks.fns.usda.gov/resources/oregon-wic-listens-participant-centered-services-pcs-resources-staff</a> .
VENA	Value enhance nutrition assessment (VENA) principles and skills were not used to complete nutrition assessments		
Anthros	Techniques used in obtaining anthropometric measurements did not follow State policy in the {LA} WIC Office(s).		
Anthros	Weight or height measurements completed on manual instruments must be done twice. Measurements on digital instruments can be completed once.		



Risk Factors	Documentation of required risk factors was missing or incorrectly identified on 10% of charts reviewed.	Submit documentation of training to refresh knowledge of risk factors identified by reviewers during the chart audit, using the WIC Nutrition Risk Criteria Manual (Risk Factors #, # #). Provide proof of staff training and a copy of the training agenda, staff attendance and date. Complete a ten chart review of risk factor assignment to identify risk factors that are being miss-assigned or undocumented (in addition to required chart review for quarterly report). If an {LA} procedure is developed, surrounding this finding, submit the procedure with the corrective action plan.	
NE	Nutrition Education was not based on participant risk factors, interests, or goals identified during certification appointments. Follow-up to goal setting was not provided and goal setting was not observed consistently.	Submit documentation of staff training on Participant Centered Education approaches. Training must include providing nutrition education that is relevant to participant's risk factors and/or interests, helping the participant to identify nutrition goals and how to follow-up on goals in future appointments. Please provide proof of staff training and a copy of the training agenda, staff attendance and date. If an RCPC WIC Program procedure is developed for this finding, submit the procedure with the corrective action plan.	

Food rx	Food prescription was not correct in 10% of the charts reviewed.	Submit an internal procedure and/or training on MOA's policy on documenting changing food packages in SPIRIT. Examples would include moving a participant from a specialized formula to a contract formula, tailoring food packages and reasons why a formula fed baby is not being provided formula. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a MOA internal procedure is developed surrounding this finding, submit it with the corrective action plan.	
SOAP Notes	SOAP notes must to be entered within 24 hours of each certification. As a result of the finding from the 2015 ME, an internal TCC policy was approved to defer SOAP notes up to 5 business days when staff shortages impact WIC services. While SOAP notes were documented in the SPIRIT system, many were entered later than 5 business days.	Submit an internal procedure and/or training on {LA}'s policy on entering SOAP notes in SPIRIT. The internal procedure and/or training must detail how and when notes are entered along with the time frames as set forth in the Alaska policy and procedures. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a {LA} internal procedure is developed surrounding this finding, submit it with the corrective action plan.	

NE contacts	Quarterly nutrition education contacts were missing on greater than 10% of the charts reviewed.	Submit documentation of training on how to implement nutrition education contacts policies at the [LA] WIC office(s). The training must detail requirements for conducting quarterly nutrition education during each certification period, and documenting these contacts in the nutrition education tab and in a note in SPIRIT. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a [LA] procedure is developed, surrounding this finding, submit the procedure with the corrective action plan.	
MCAs	Mid-certification Assessments (MCA) were not completed and documentation of attempts to provide MCA were not indicated in SPIRIT on 23% of charts reviewed.	Submit documentation of an internal procedure and/or training agenda on mid-certification assessments. The procedure and/or training must detail mid-certification requirements and how to document attempts to contact participants for MCAs. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a {LA} specific procedure is developed surrounding this finding, submit it with the corrective action plan.	

No BF Coordinator	[XXX WIC Program name] doe snot have an identified, qualified Breastfeeding Coordinator. Each local agency must have a Breastfeeding Coordinator who meets the qualifications for a CPA, has experience in program management, has at minimum, 1 year of experience in counseling breastfeeding women and successfully completed State approved specialized training or training in lactation management and care (International Board Certified Lactation Consultant [IBCLC] is preferred.	Submit the name of the XXX(agency) Breastfeeding Coordinator and their qualifications. If your agency does not have qualified staff, submit a plan of how to bring current staff into compliance or provide the name and qualifications of a contractor who can assist with the roles and responsibilities of the Breastfeeding Coordinator. A contractor may be used for a short-term solution until a current staff meets the qualifications. Provide the timeframe for current staff to meet the qualifications.	
<b>Management Information and Technology Systems</b>			
	WIC equipments are not properly secured. The reviewer found equipment in unlocked storage cabinets in public (LA) work locations.	(Local Agency) must store all WIC electric breast pumps and hematologic machines in a locked location that is only accessible by WIC staff. Please provide proof of secured inventory.	
<b>Organizational Management</b>			
Standardized language for Organizational Management does not seem to exist.			
<b>Nutrition Services and Administration (Finance)</b>			

	<p>{ Expenditures } were charged to the 2018 WIC grant. These costs are not considered necessary for fulfillment of program objectives and therefore are unallowable.</p>	<p>Submit documentation of an adjusted journal entry reallocating (\$8.73) to the (2018) WIC grant. Submit an internal procedure and staff training detailing allowable and unallowable costs for the WIC grant and how (LA) will ensure unallowable costs are not charged to the WIC grant. Please provide proof of staff training and a copy of the training agenda, staff attendance and date.</p>	
	<p>Shared expenses on the July CFR were not distributed between programs appropriately. While there is a standard accounting procedure for allocating shared costs among RCPC programs, this procedure was not applied consistently and alternate allocations were not documented.</p>	<p>Please submit an updated procedure on how to more clearly document WIC allocable portions of shared expenses along with a timeline of when the procedure has been implemented</p>	
	<p>The time study for (month) did not match the payroll account for (employee names) time paid for by the WIC program.</p>	<p>The time study should capture the time spent on WIC duties and paid by WIC funding during the first full week of the month worked. The time period detail dates should reflect the same days that were noted on the time study for WIC work. The time study may reflect more time spent on WIC activities than was paid out of the WIC grant. Provide a written policy to follow time study guidance along with a timeline of when the policy has been implemented.</p>	

	Intermittent salaried staff are not positive time keeping for WIC on time sheets.	Intermittent staff must do positive time keeping while working in WIC to guarantee that WIC is charged a fair and equitable amount for services provided. Please provide an updated time keeping procedure to reflect this along with a timeline of when the procedure has been implemented.	
	The current WIC Coordinator is not positive time keeping for WIC on time sheets.	Staff must do positive time keeping while working in WIC to guarantee that WIC is charged a fair and equitable amount for services provided. Please provide an updated time keeping procedure to reflect this along with a timeline of when the procedure has been implemented.	
<b>Food Funds Management</b>			
<b>Caseload Management</b>			
<b>Certification, Eligibility and Coordination of Services</b>			

Income	Income determination was done inconsistently and incorrectly at times, specifically related to the documentation of household size and inclusion of the Permanent Fund Dividend (PFD) as income. This may lead to incorrect eligibility or ineligibility determinations for some participants.	Submit a procedure and/or training agenda on [LA's] income determination processes. The procedure and/or training must detail how household size is determined, documented in SPIRIT, and the PFD included as income. Documentation in SPIRIT should reflect household size and PFD(s) indicated on the Family Information Form, or the difference explained in a note or documented on the FIF itself. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a [LA] procedure is developed surrounding this finding, submit the procedure with the corrective action plan.	
	Income determination and documentation for applicants lacking proof of income did not follow state policy. Applicants without proof of income may be provided a maximum of 30 days of food benefits.		

Income	Documentation of reported income was missing for adjunctively eligible participants. Income must be collected and documented in SPIRIT, though does not need to be verified if proof of adjunctive eligibility has been provided.	Submit an internal procedure and/or training agenda on {LA}'s income determination and documentation procedures. The procedure and/or training must detail how to properly document adjunctive eligibility in SPIRIT, including selecting the necessary proof of adjunctive eligibility and entering the reported income. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a {LA} specific procedure is developed surrounding this finding, please submit it with the corrective action plan	
Processing Standards	Required application processing standards were not met. WIC regulations require all participants to be certified within 10 or 20 days of receipt of their application, depending on their category.	Submit an internal procedure and training agenda to detail how NSHC will meet application processing standards. This procedure and training must include SPIRIT documentation and tracking of processing standards. Provide internal procedure, proof of staff training and a copy of the training agenda, staff attendance and date.	



SOD	Required separation of duties was not observed in the XX% of the charts reviewed.	Submit an internal procedure and training agenda to detail how [XXX] will meet the separation of duties (SOD) requirement. This procedure and training must include what changes to clinic flow or to processes will be implemented to correct for cases where SOD is not occurring. Provide internal procedure, proof of staff training and a copy of the training agenda, staff attendance and date.	
Referrals	Documentation of required referrals was missing on 10% of charts reviewed.	Submit an internal procedure and/or training agenda on {LA} referral methods and documentation processes. The procedure and/or training must detail which programs WIC clients must receive referrals to, assessment for needed referrals, referral methods and how to properly complete document in SPIRIT. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a {LA} specific procedure is developed surrounding this finding, submit it with the corrective action plan.	

Voter Registration	Voter registration policy is not being implemented in XX% of the charts reviewed at the {LA} WIC office(s)	Submit a procedure and/or training agenda on [LA's] voter registration services. The procedure and/or training must detail how voter registration will be offered, completed, documented and must be consistent between the Family Information Form (FIF) and what is selected in SPIRIT. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a [LA] procedure is developed surrounding this finding, submit the procedure with the corrective action plan.	
R/R	Rights and Responsibilities are not summarized for participants at certification and recertification.	Submit a policy and/or training agenda on NSB's Rights and Responsibilities procedures. The policy and/or training must detail how the Rights and Responsibilities will be reviewed, and documented in SPIRIT. At each certification and recertification appointment participants must be given a chance to read and ask questions on the Rights and Responsibilities and have staff summarize the required details. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a NSB policy is developed surrounding this finding, submit the policy with the corrective action plan.	

R/R	Participant Rights and Responsibilities policy is not being followed consistently at the XXX WIC office. Signatures were missing on 10% of charts reviewed and Rights and Responsibilities were not summarized for participants at all certification and recertification appointments.	Submit a procedure and/or training agenda on XXX's Rights and Responsibilities processes. The procedure and/or training must detail how the Rights and Responsibilities will be reviewed, signed by participants, and documented in SPIRIT. At each certification and recertification appointment participants must be given a chance to read and ask questions on the Rights and Responsibilities and have staff summarize the required details. Provide proof of staff training and a copy of the training agenda, staff attendance and date. If a {LA} procedure is developed surrounding this finding, submit the procedure with the corrective action plan.	
<b>Food Deliver &amp; Food Instrument (Card) Accountability and Control</b>			
Card tracking	cARDtracking form(s) are not maintained daily in the {LA} WIC Office(s).		
<b>Monitoring and Audits</b>			
<b>Civil Rights</b>			

"And Justice For All"	Required "And Justice for All" poster was not displayed when providing off-site clinic services at Eielson Airforce Base. These posters are required in order to notify participants of their civil rights and inform them of how to file a civil rights complaint.	When providing WIC services at off-site clinic sites (Eielson), an "And Justice for All Poster" must be prominently displayed. This may be permanently displayed in a waiting area or temporarily displayed when offering off-site services. Please provide proof of meeting this requirement.	
OIG	The Agriculture Office of the Inspector General (OIG) USDA Hotline Poster is displayed in a prominent area in the WIC office	Prior to this report, Valdez Clinic submitted photo documentation that USDA Fraud Hotline posters was posted as of October 15, 2018. Since Valdez is an itinerate clinic, please submit an internal procedure on how to ensure poster will remain in view of WIC clients.	

## WIC ME Communication Log

WIC Grantee: \_\_\_\_\_

Reviewer(s): \_\_\_\_\_

### Pre-review

- Teleconference Date: \_\_\_\_\_
- Attendees: \_\_\_\_\_
- Review schedule: include state staff travel time, entrance conference, clinic/finance staff/vendor/partner program visits, and exit conference

	Monday	Tuesday	Wednesday	Thursday	Friday
8-9 AM					
9-10 AM					
10-11 AM					
11-12					
12-1 PM					
1-2 PM					
2-3 PM					
3-4 PM					
4-5 PM					

- \*Return completed LA Self-Assessment form to the State electronically

**Pre or Final Exit Conference (circle one):**

- Date: \_\_\_\_\_
- Attendees: \_\_\_\_\_
- Program kudos: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Program Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pre or Final Exit Conference (circle one):**

- Date: \_\_\_\_\_
- Attendees: \_\_\_\_\_
- Program kudos: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Program Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State staff signatures: \_\_\_\_\_

LA staff signatures: \_\_\_\_\_

## WIC ME Schedule Tool

WIC Grantee: \_\_\_\_\_

Reviewer(s): \_\_\_\_\_

### Pre-review, Planning meeting

- Teleconference Date: \_\_\_\_\_
- Attendees: \_\_\_\_\_

Things to be considered in schedule:

- Entrance conference (Likely will include SOA reviewer/s + LA WIC Clinic Coordinator, LA WIC Clinic Coordinator's supervisor, key staff member, partner invited by LA WIC Coordinator) ~45 minutes
- Finance meeting (meet and greet) ½ - 45 minutes: SOA reviewer/s + LA WIC Clinic Coordinator
- Partner meeting (meet and greet) ½ - 45 minutes: SOA reviewer/s + partner
- Observation front end duties ½ day – day at each site: SOA reviewer/s + LA staff
- Observation certifications ½ day – day at each site: SOA reviewer/s + LA staff
- Time to review LASA, 3 – 1 hour sessions: SOA reviewer/s + LA WIC Clinic Coordinator
- Travel/outreach to remote/satellite location
- Informal exit conference (Likely will include SOA reviewer/s + LA WIC Clinic Coordinator, LA WIC Clinic Coordinator's supervisor, key staff member, partner invited by LA WIC Coordinator) ~45 minutes

	Monday	Tuesday	Wednesday	Thursday	Friday
8-9 AM					
9-10 AM					
10-11 AM					
11-12					
12-1 PM					
1-2 PM					
2-3 PM					
3-4 PM					
4-5 PM					





## Civil Rights Complaint Form

Alaska WIC Program

1. Complainant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

2. Local Agency: \_\_\_\_\_

3. Date and nature of the incident or action leading to complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Basis on which discrimination exists (race, color, national origin, age, sex, or disability):

\_\_\_\_\_

5. Name, title, and business address of individuals who may have knowledge of the discriminatory action:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Date complaint forwarded to State WIC office:

\_\_\_\_\_

7. Other relevant information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature/title of Person Completing Report

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Filing Complaint

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of staff person who examined documents

\_\_\_\_\_  
Date documents were examined

**Forward original to State WIC Office. Keep a copy for Local Agency files.**

\_\_\_\_\_