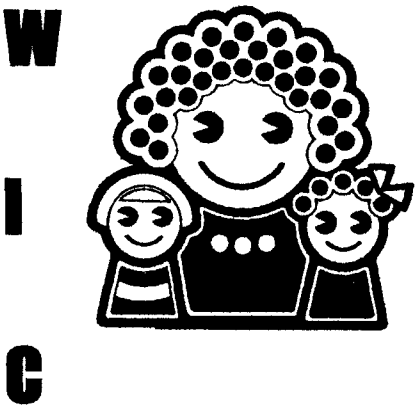

RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH
OFFICE OF WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM

STATE PLAN OF OPERATION AND ADMINISTRATION

WIC PROGRAM

FISCAL YEAR 2003

Patricia A. Nolan, MD MPH

PATRICIA A. NOLAN, M.D., M.P.H.
DIRECTOR, DEPARTMENT OF HEALTH

THE HON. LINCOLN ALMOND
GOVERNOR, STATE OF RHODE ISLAND

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Updated 5/00

RHODE ISLAND DEPARTMENT OF HEALTH

WIC PROGRAM

STATE PLAN OF OPERATION AND ADMINISTRATION

PREFACE

ACKNOWLEDGMENTS

The Rhode Island Department of Health WIC Program wishes to acknowledge the contributions of the local agency WIC staff and the WIC Parent Consultant Program, WIC participants and community representatives in the preparation of this Plan. Their input and advice greatly assisted the State agency in formulating plans to meet its responsibilities in the most efficient and effective manner.

Tables of Contents

Preface

State Plan Pages

CONTENT AND STRUCTURE

The State Plan of Operation and Administration contains the plans, policies, rules, and procedures for the operation and administration of the WIC Program in Rhode Island. The State Plan consists of three major parts:

Volume I - Goals and objectives to be achieved

Volume II - Procedure Manual - The specific procedures implemented by the local agencies.

Volume III - State Operations - The rules and procedures implemented by the state agency.

Volume IV - Farmers' market Nutrition Program (FMNP) – Goals, objectives, policies, procedures, information and other provisions specific to the FMNP

Items which might apply to one or more parts are usually only printed in one of the parts.

This submission is limited to Volume I, Goals and Objectives to be achieved. Volume IV, related to the FMNP, will be submitted separately.

Abridged Manuals

Portions of the Procedure Manual and State Operations Manual contained herein are abridged for purposes of convenience. Much material which is not being changed is excluded. For the most part, then, this State Plan contains future plans and those rules and procedures which are new or revised.

LEGAL REQUIREMENTS

NEED FOR ADOPTION, AMENDMENT, AND REPEAL OF PROGRAM RULES.

Each state agency desiring to administer the WIC Program must annually submit a State Plan to the United States Department of Agriculture describing the state agency's objectives and procedures for all aspects of WIC Program administration for the present and coming fiscal year (October 1 to September 30). The Plan is the state agency's guide for enhancing Program effectiveness and efficiency.

Development of the Plan begins with an assessment of current operations in the State, leading to the identification of those operations or aspects of the Program which are in need of improvement. After identifying the Program areas or operations in which improvements are desired, those to be actively addressed are selected. In order to accomplish the improvements, Program procedures and rules are adopted, amended, or repealed as needed to accomplish the objective. The format and content of the State Plan are in conformance, therefore, with Department of Agriculture rules, instructions, and guidance.

In order to achieve maximum Program effectiveness and efficiency, certain procedure revisions are implemented prior to the beginning of the federal fiscal year.

In January, 1999, the Department of Agriculture published its consolidated final rule, (7, CFR 246) which revised WIC Program regulations by making a number of technical revisions, reorganizing regulations to more clearly identify major program areas, and making substantive revisions to a number of areas affecting program operations. The rule is expected to reduce state and local burdens, streamline program operations and provide state agencies greater administrative discretion. This State Plan is, therefore, also intended to meet the requirements and achieve the objectives of the final rule, and subsequent amendments.

EVALUATION OF ALTERNATIVES.

Alternative approaches to accomplishing the Program's objectives were considered during the development of the State Plan by Program staff and the State Plan Committee. Alternatives other than the rules and procedures selected were found to be less effective and not less burdensome to affected private persons. The approaches selected were those which meet the Federal requirements for efficient and effective administration of the Program. Information about alternatives considered and the impact of implementing alternatives can be obtained from the WIC Program.

DUPLICATION AND OVERLAP.

There is no overlap or duplication with any other state regulations. There are no other state regulations which apply to WIC operations and services.

ECONOMIC IMPACT ON SMALL BUSINESS.

It is determined that this State Plan of Operation and Administration will not have a significant economic impact on small business.

AUTHORITY AND SEVERABILITY.

If any provisions of the WIC State Plan of Operation and Administration or of any rules, regulations, policies, procedures, or directives made or issued thereunder shall be held invalid by a court of competent jurisdiction, the remainder of the Plan of Operation and Administration and any rules, regulations, policies, procedures, or directives issued thereunder shall not be affected thereby.

In the event of any conflict between federal law or regulation and any provision of the WIC State Plan of Operation and Administration or of any policies, rules, procedures, or directives issued thereunder, federal law or regulations will govern. Should the federal regulations pertaining to the administration or operation of the WIC Program be changed, the state agency may make such changes in its rules, policies, and procedures as are required, can be responsibly

accomplished, and/or are in the interests of the effective and efficient administration of the Program, and are compatible with the state's goals and objectives.

AMENDMENTS TO THE STATE PLAN

Included herein are amendments to the Previous Plan. Said amendments will take effect January 31, 2002.

THE WIC PROGRAM

WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children. It is a federally funded program carried out according to provisions of the Child Nutrition Act passed by Congress in 1966 and amended in 1978 to create the WIC Program.

WIC is funded through the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA). It is administered in the State of Rhode Island by the Department of Health (HEALTH) through various local health centers and hospitals ("local agencies") which distribute the food funds and provide nutrition education to participants.

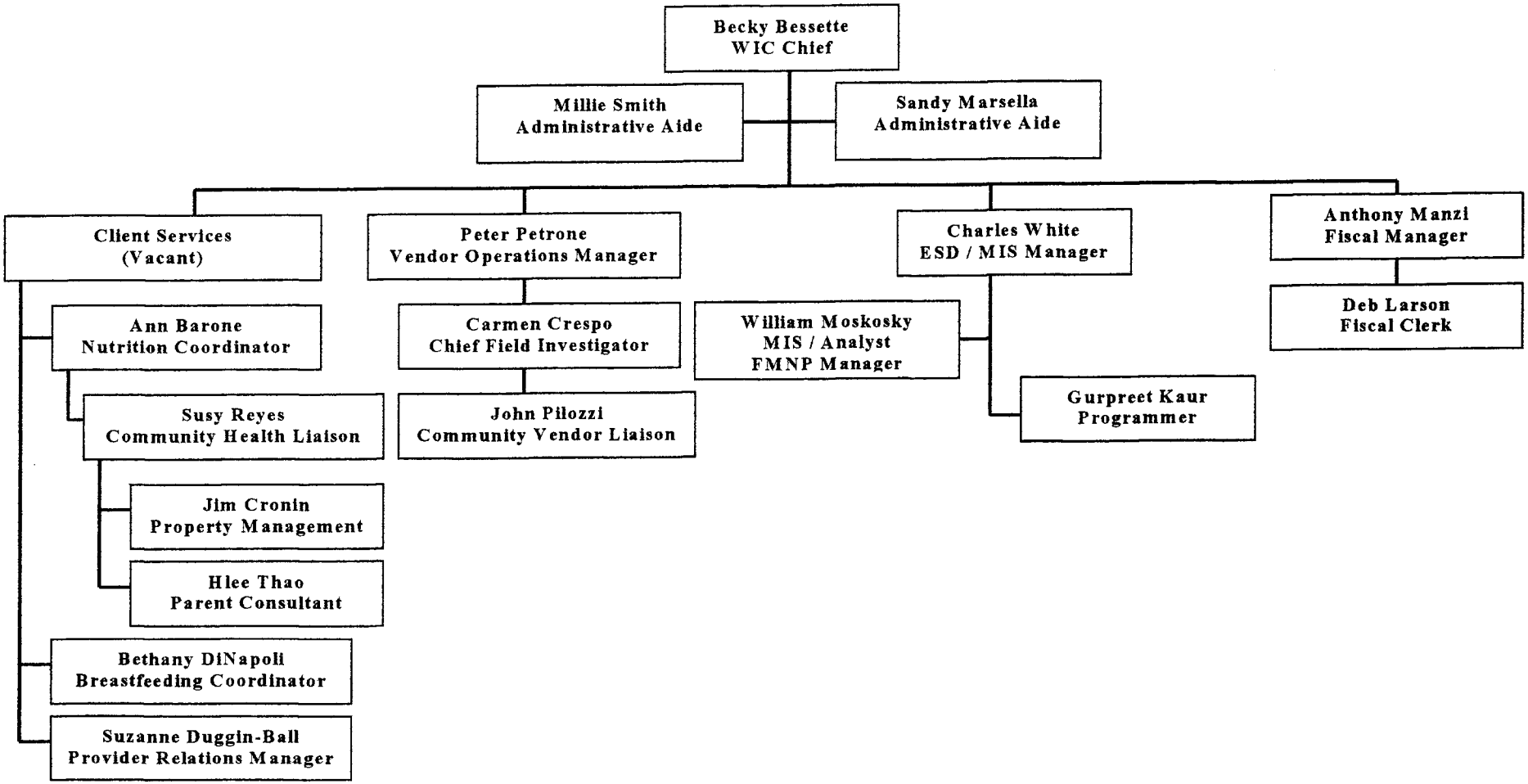
Many pregnant women, infants and young children, from families with inadequate income, are in danger of having poor physical and mental health because they eat poorly and have inadequate health care. WIC is designed to help such pregnant women, infants and young children by directly improving what they eat and the way they eat.

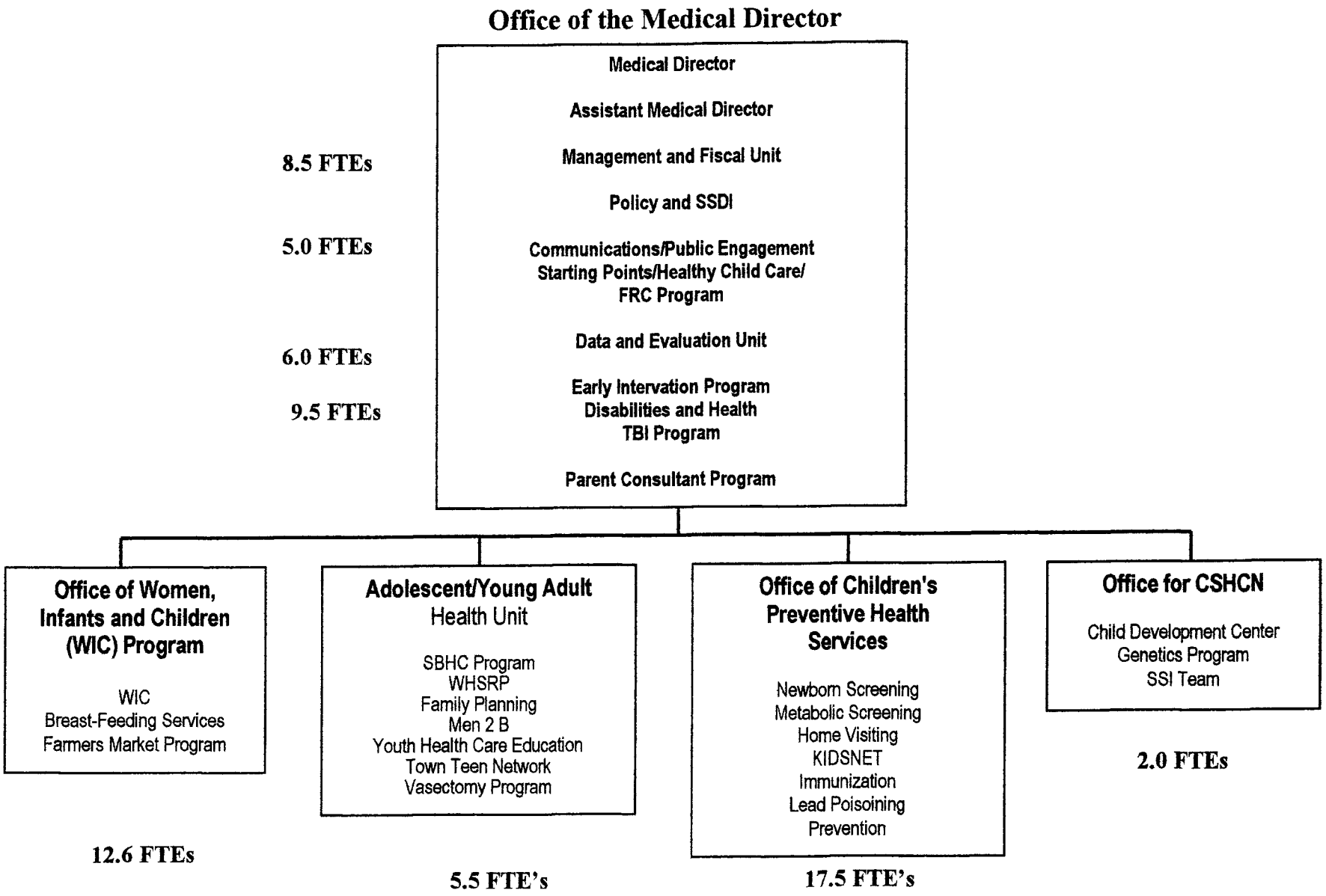
The Program serves eligible participants who meet certain income limitations and show evidence of special nutritional need. The Program provides special supplemental foods; including milk, eggs, juice, cereal, dried beans and peas or peanut butter, and cheese, plus carrots and tuna fish to breast-feeding women, and infant formula; and nutrition education. The Program provides this extra help during critical times of growth and development in order to prevent the occurrence of health problems and improve the health status of participants.

Additional information about the operation and administration of the Rhode Island WIC Program is available in the WIC Procedure Manual, State Operations Manual, federal regulations and in various informational materials and communications provided by the HEALTH to local agencies.

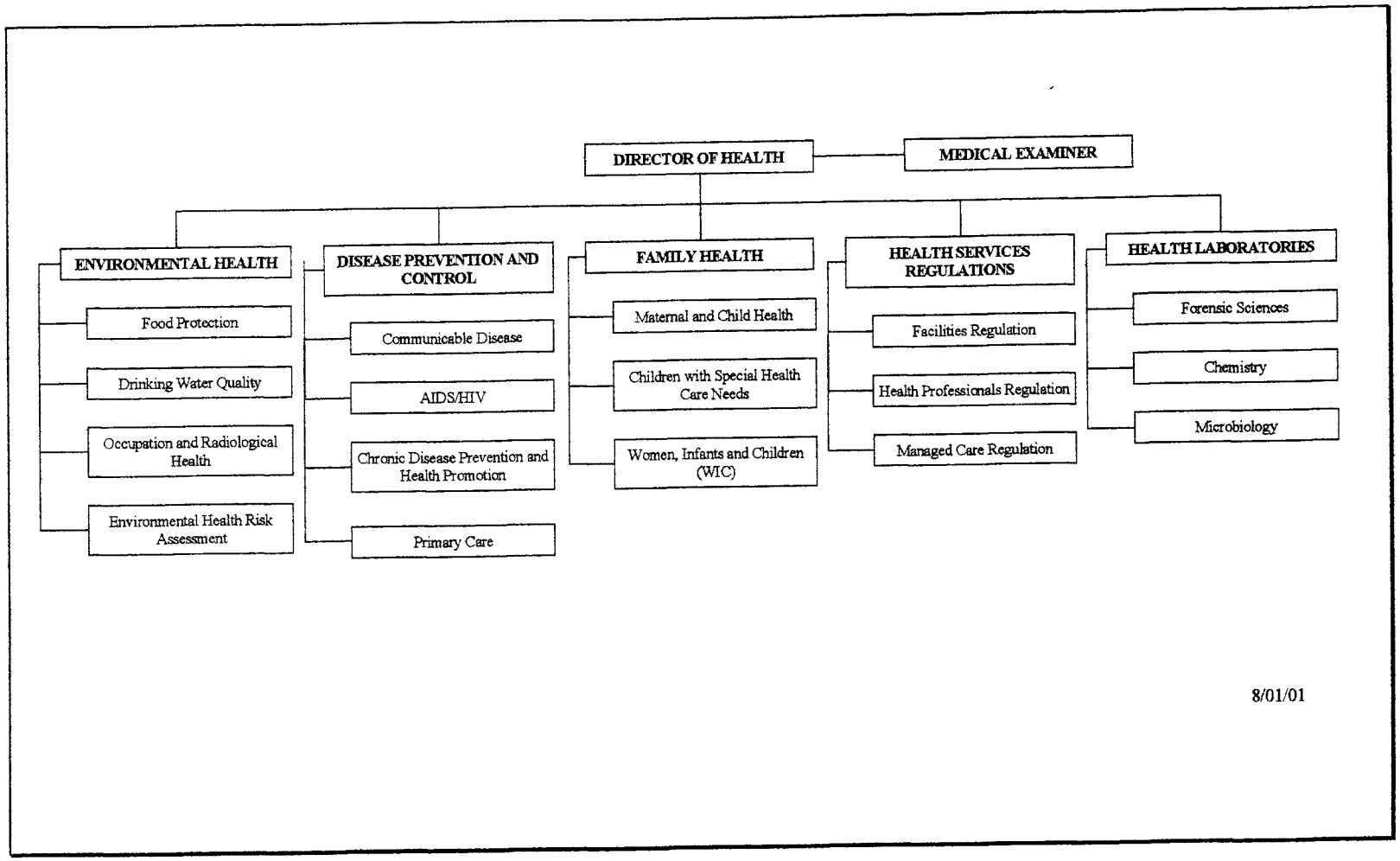
Division of Family Health

RI WIC PROGRAM ORGANIZATION CHART




Office of the Medical Director
Medical Director
Assistant Medical Director
8.5 FTEs
Management and Fiscal Unit
Policy and SSDI
5.0 FTEs
Communications/Public Engagement
Starting Points/Healthy Child Care/
FRC Program
Data and Evaluation Unit
6.0 FTEs
Early Intervation Program
9.5 FTEs
Disabilities and Health
TBI Program
Parent Consultant Program
Office of Women, Infants and Children (WIC) Program
WIC
Breast-Feeding Services
Farmers Market Program
12.6 FTEs
Adolescent/Young Adult Health Unit
SBHC Program
WHSRP
Family Planning
Men 2 B
Youth Health Care Education
Town Teen Network
Vasectomy Program
5.5 FTE's
Office of Children's Preventive Health Services
Newborn Screening
Metabolic Screening
Home Visiting
KIDSNET
Immunization
Lead Poisoining
Prevention
17.5 FTE's
Office for CSHCN
Child Development Center
Genetics Program
SSI Team
2.0 FTEs

RHODE ISLAND DEPARTMENT OF HEALTH
ORGANIZATIONAL STRUCTURE - Fiscal Year 2003



RHODE ISLAND DEPARTMENT OF HEALTH

OFFICE OF WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM

WIC and Farmers Market Services

STATE PLAN OF OPERATION AND ADMINISTRATION

VOLUME I

GOALS FOR FISCAL YEAR 2003

Proposal
Submitted to FNS / USDA
October 14,2002

GOALS FOR FY 2002

SECTION I

Preliminary Information

Refer to WIC Procedure Manual Section 100
WIC Operations Manual Section 1

Goals 2003 Section I Preliminary Information

RHODE ISLAND DEPARTMENT of HEALTH
WIC PROGRAM
LOCAL AGENCY ADMINISTRATON and LOCAL WIC CLINICS

Local WIC Agency Administration	Local WIC Agency Clinics
Mr. Ray Lavoie, Executive Director Mr. Michael Lauder, WIC Coordinator/Nutritionist Blackstone Valley Community Health Care, Inc. 42 Park Place Pawtucket, RI 02860	John J. Cunningham Health Center 42 Park Place Pawtucket, RI 02860 (401) 722-0082 BVCHC Health Center 9 Chestnut Street Central Falls, RI 02863 (401) 724-7134
Ms. Louise Ornstein, Executive Director Ms. Kerry Gregory, WIC Coordinator/Nutritionist Chad Brown Health Center 285A Chad Brown Street Providence, RI 02908 (401) 831-0020	Chad Brown Health Center 285A Chad Brown Street Providence, RI 02908 (401) 831-0020
Ms. Joanne McGunagle, Executive Director Comprehensive Community Action Program, Inc. 311 Doric Avenue Cranston, RI 02908 (401) 467-9610 Ms. Kathy Higgins, WIC Coordinator/Nutritionist Family Health Services of Cranston 1090 Cranston Street Cranston, RI 02920 (401) 946-4650	Family Health Services of Cranston 1090 Cranston Street Cranston, RI 02920 (401) 946-4650 Cranston Satellite 191 MacArthur Blvd. Coventry, RI 02816

Ms. Maria Montanaro, Chief Executive Officer Ms. Jennifer Clough, WIC Coordinator Thundermist Health Center of South County WIC Program One River Street Wakefield, RI 02879 (401) 782-0855 Ms. Lori Austin, Coordinator/Nutritionist Thundermist Health Center of Woonsocket WIC Program 191 Social Street - 9th Floor Woonsocket, RI 02895 (401) 767-4109	Thundermist Health Center of South County WIC Program One River Street Wakefield, RI 02879 (401) 782-0855 Bayside Family Healthcare, Inc. 308 Callahan Road North Kingstown, RI 02852 Manville WIC Satellite 100 Central Street Manville, RI 02838 (401) 676-4109 Thundermist Health Center WIC Program 191 Social Street - 9th Floor Woonsocket, RI 02895 (401) 767-4109
Mr. Dennis Roy, Chief Executive Officer Ms. Beth Sapolosky, WIC Coordinator/Nutritionist New Visions for Newport County, Inc. Newport Community Health Center WIC Program 19 Broadway Newport, RI 02840 (401) 847-7821	New Visions for Newport County, Inc. Newport Community Health Center WIC Program 19 Broadway Newport, RI 02840 (401) 847-7821 New Visions for Newport County, Inc. James F. Silvia Health Center WIC Program 1048 Stafford Road Tiverton, RI 02878 (401) 625-1364 Florence Gray Multi Purpose Center 1 York Street Newport, RI 02840 (401) 848-6682

Mr. Merrill Thomas, Executive Director Ms. Lynda Greene, WIC Coordinator Providence Community Heath Centers, Inc. 375 Allens Avenue Providence, RI 02905 (401) 444-0400	Allen Berry Health Center WIC Program 202 Prairie Avenue Providence, RI 02907 (401) 444-0570 x 3845 Capitol Hill Health Center WIC Program 40 Candace Street Providence, RI 02908 (401) 444-0550 x 3545 Central Health Center WIC Program 239 Cranston Street Providence, RI 02907 (401) 444-0580 x 3841 Fox Point Health Center WIC Program 550 Wickenden Street Providence, RI 02903 (401) 444-0530 x 3342 Olneyville Health Center WIC Program 100 Curtis Street Providence, RI 02909 (401) 444-0540 x 3445
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Goals 2003 Section I Preliminary Information

Mr. Dennis M. Roy, Executive Director Ms. Beth Sapolsky, Coordinator/Nutritionist Self-Help, Inc. East Providence Community Health Center WIC Program 100 Bullocks Point Avenue Riverside, RI 02915 (401) 437-1007	East Providence Community Health Center WIC Program 100 Bullocks Point Avenue Riverside, RI 02915 (401) 437-1007 Warren Health Center 1 Joyce Street Warren, RI
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Mr. Thomas Parris, President Ms. Doreen Chin Pratt, MS, RD, Director of Nutrition Services/WIC Coordinator Women & Infants' Hospital WIC rogram 2 Dudley Street WPCC Nutrition Services - Suite 565 Providence, RI 02905-2401 (401) 274-1122 ext. 2768	Women and Infants' Hospital WIC Program 2 Dudley Street WPCC Nutrition Services – Suite 565 Providence, RI 02905-2401 (401) 274-1122 ext. 2768
Mr. Ernest Balasco, LICSW, Executive Director Mr. Douglas Jones, WIC Coordinator/Nutritionist Wood River Health Services WIC Program 823 Main Street Hope Valley, RI 02832 (401) 539-2461	Wood River Health Services WIC Program 823 Main Street Hope Valley, RI 02832 (401) 539-2461

Section I
Selection of Local Agencies

Goal: To ensure that local agencies are selected and funded in accordance with the need for Program benefits in an area, participant access, coordination of care and the efficient and effective utilization of nutrition and program services (NSA) funds.

Recent Trends

Enhanced collaboration between the WIC Program and "sister" health / social service programs (ie, Lead, Immunization, Ritecare {medicaid}) is continuing to expand. Although targeted funding for these activities is lagging behind, RI WIC is focusing on use of Kidsnet (RI's public health preventive services database) to monitor and target cross program initiatives.

Rhode Island's RIte Care Program (RITECARE), implemented in 1994, brought radical restructuring to the health care system for low income mothers and children:

- All eligible pregnant women and children up to age six are covered for comprehensive preventive and corrective health care.
- The care is rendered in the context of a chosen primary provider and health plan, with restrictions on using out of plan services.
- Twelve current WIC providers are affiliated with one of the three remaining *competing RITECARE plans.
- Financial eligibility was expanded to include almost 10,000 women and children between 185 and 250 percent of poverty.
- This additional group is adjunctively income eligible for WIC.

As of February 2002, 93.7% of WIC participants were insured, with an additional 4.6% referred for health insurance. Since 1998, there has been a significant shift of participants from private insurance (67% Medicaid, 26% Private) to Medicaid in 2002 (79% Medicaid, 15% Private).

Objective 1: Evaluate anticipated changes in the Rite Care Eligibility criteria related to potential impact on determination of adjunctive eligibility.

Delegation of Contractual Authority

The Director of the Department of Administration (DOA) is the individual with the authority to enter into binding agreements on behalf of the State. Delegated Authority allows HEALTH to procure direct service providers (such as WIC local agencies). Under delegated authority the Department must be able to demonstrate that providers selected are those which most efficiently and/or effectively deliver services and/or make maximum use of Department resources through lowered cost or increased productivity.

Goals 2003 Section I Preliminary Information

Objective 1: **In the event the delegation of authority is canceled by either Department, the DOH or DOA will issue a Request for Proposals for WIC local agency services. In that event, HEALTH would likely request the contracts be multi year, annually renewable.**

Additional WIC Program Services and Service and Performance Objectives

In recent years, the growing savings from food cost containment supported significant participation increases. However, growing food costs and changes in infant formula rebates need to be carefully monitored and managed to ensure continued growth is possible.

Objective 1: **Investigate if additional WIC sites are needed to fully utilize funding. HEALTH estimates these site needs:**

1. One full time site coordinated with a major pediatric ambulatory setting.
2. One part-time satellite sites accessible to unserved suburban pockets of need

In FY 2002, Thundermist Health Associates, Inc. and the Health Center of South County merged into Thundermist Health Center. Another two agencies have started the merger process, with anticipated completion slated for FY 2003. These agencies will continue to maintain the individual WIC sites currently managed by their agencies.

Congressional directives and Federal regulations have defined a number of areas in which the WIC Program is to conduct additional activities (e.g. information and referral, health care coordination, immunizations, substance abuse education and voter registration). At the same time allied programs are receiving similar instructions to more closely coordinate their services with WIC.

The underlying objectives of these changes include the accessibility of these public benefits to potential clients through outreach, more accessible clinic operations and closer coordination and maximizing the preventive or restorative effects of the various programs by coordination among services which can compliment and enhance each other.

In light of federal and public health objectives, HEALTH has identified the following areas to be addressed in structuring the local WIC services system:

Objective 1: **Ensure prompt access to services**

1. The Program must make available evaluation and receipt of benefits to non-breastfed infants in a much shorter time span, including ability to respond on a crisis intervention basis.

2. The Program's preventive effectiveness has been shown to be greatest when pregnant women receive benefits as early in pregnancy as possible. Any delay

in responding to a request from a pregnant woman in effect undermines the Program's effectiveness.

3. Accessible hours for the working eligible. Congress has mandated that WIC services be available during hours in which the working eligible (over two thirds of WIC families) can apply for the Program without interfering with their jobs.

4. Prompt enrollment of other high risk individuals.

Objective 2: **Ensure coordination of WIC services with on-site health care services, especially to increase immunization rates for WIC children. HEALTH must recognize changes in location of health care services to WIC participants and potential eligibles. Efforts must be made to increase access to WIC services at all sites where such persons are receiving health care.**

Objective 3: **Coordinate simplified access to multiple services at one appointment ("one stop shopping").**

Objective 4: **Increase and enhance breastfeeding support and promotion.**

Objective 5: **Monitor, support and ensure the quality of delivery of WIC services.**

Objective 6: **Ensure compliance with Program rules and requirements.**

Reduce Imbalances in Ratios of Enrollment to Need
(see Affirmative Action Plan)

Objective 1: **Continue efforts to reduce disparities between high and low percentages of met need around the State through continual State office review of:**

1. Caseload and allocation adjustment,

2. Local agency performance in high risk identification, caseload maintenance,

3. Establishment of local agency satellite sites in areas of particularly high unmet needs,

4. State and local outreach activities.

Objective 2: **Review the contracting process as related to**:

1. Continued variations in the percent of need met where some communities have remained at more than ten percent below the statewide need met average over the

course of several years.

2. Despite substantial success in targeting benefits to high risk eligibles (more than eighty percent of current enrollments) such items as clinic location, additional satellite clinics, and local outreach need to be further evaluated to further improve such targeting.

Other Considerations

Objective 1: **Continue monitoring the impact of Ritecare on the WIC provider network. Ten of the thirteen current WIC local agencies are members of a single competitive Ritecare provider plan . This means that perhaps half of the WIC clients at an agency may be members of its plan and half not.**

Objective 2: **Continue monitoring the impact of RITECARE and its effects on the ability of the current WIC network of local agencies to maintain services to all, both community health plan members and non-member WIC clients. HEALTH will need to assess whether any current WIC local agency is unable to maintain services due to RITECARE non-participation or RITECARE restrictions.**

Objective 3: **The Program needs to be ready to respond to continued expansion opportunities, through either federal or state cost saving or funding initiatives. Determination will have to be made whether the current network is capable of meeting its program expansion goals.**

Objective 4: **If the current network is adequately providing services, then a further review would be made as to whether there is any compelling need or gain to seek other providers through other RITECARE plans. If the current network is not sufficient to continue to provide WIC services to all eligible clients for which the Program has funds, or if there is any other compelling need to seek other providers then the HEALTH would perform a feasibility study of the benefits and drawback to additional providers, especially in relation to client access and caseload expansion needs. This review will consider:**

1. The ability of other providers to provide quality WIC nutrition, eligibility and coordination and outreach services.

2. Evaluate different provider models to determine if any, all or which can provide services which equally or better meet the needs of the Rhode Island WIC Program and actual and potential clients.

Caseload Allocation and Adjustment

Goal: To ensure service to the maximum number of women and children allowed by available funds, while protecting the Program from overspending.

Goals 2003 Section I Preliminary Information

Objective 1: **Continue to utilize accurate, reliable, and quickly accessible measures of utilization of available funds and caseload. This will be accomplished through applying better planning techniques to the improved data collection, storage, and reporting capabilities of the MI System. Measures being developed include:**

1. Developing measures of local agency performance and indicators of future capability,

2. Improved measures of relative need in each service area,

3. Automated on-going caseload tracking and control tools.

Goal: To ensure that all agencies are providing services to the number of participants authorized or directed by the State agency, to the extent permitted by federal funding. It is essential that locals maintain caseload at the assigned level and utilize administrative funds at an appropriate rate. Unutilized funds must be directed on a timely basis toward local agencies which can utilize them.

Objective 1: **To take such temporary actions and adjustments as are necessary to efficiently manage funds in order to avoid over or under spending.**

Goals 2003 Section I Preliminary Information
Affirmative Action Plan

Goal: To allocate additional slots to areas based on need and ability to utilize additional caseload.

Evaluation: Rhode Island is currently providing WIC benefits to the eligible population in all the state's thirty-nine cities and towns and will continue to do so as long as federal funding permits.

Potentially Eligible WIC Population

The population of Rhode Island potentially eligible to participate in the WIC Program was estimated from demographic and economic data available on a city and town basis.

Vital Records data were used to estimate by city and town the number of women, infants, and children. A five-year average of the most recent resident live births was used.

- The number of infants was calculated based on the average number of live births to residents of Rhode Island.
- The number of children one through four was estimated as the average number of live births to residents of Rhode Island times four.
- The number of pregnant women was estimated as 0.75 times the average number of live births (note that multiple births were controlled in the estimate).
- The number of postpartum and breastfeeding women was calculated as 0.5 times the average number of live births (as was the number of pregnant women).

These cohorts were summed to produce an estimate of the population by city and town with the demographic characteristics required for enrollment in WIC.

The 1990 census data of the number of related children under 5 under 185% of the OMB poverty level by city and town were used. These numbers were divided by the five-year average of live births to determine the percent financially eligible for the program. This percentage was multiplied by the number demographically eligible to give an estimate for each city or town of the number of individuals residing in each who have both the demographic and income characteristics required for participation in WIC (Table I).

Revised 9/02
Maternal and Child Health Risk Indicator

The following maternal and child health risks were selected for the RI WIC MCH indicator.

Women with Delayed Prenatal Care	*(% of pregnant women who did not obtain prenatal care during their first trimester)*
Low Birthweight Infants	*(% of infants born weighting under 2,500 gms[5.5 lbs])*
Infant Mortality	*(rate/1000 births of deaths occurring to infants under 1 year of age)*
Births to Teens	*(# of births to girls aged 15 to 17 per 1000 teen girls)*

Children in Poverty *(% of related children under age 18 who live in families below the US OMB defined poverty threshold)*

The 5 year average for each risk was calculated as a standard score for each community, and at the state level (Table II). This illustrates the MCH risk by each town / city.

WIC Need Index and Rank

For the 39 RI communities and the state, the MCH risk score doubled and then combined with the standard score of WIC Unserved by Community. This index was then ranked by town / city

.

Statewide Parity

Rhode Island receives funding (federal grant and infant formula rebates) for and provides service to an estimated 76 percent of its WIC eligible population. Locality analysis of enrolled participants indicates that service levels vary significantly between cities and towns from over 100 percent of the eligible population being served in some towns (indicating a potential problem with the basic poverty data) to 5 percent of the eligible population on Block Island. Thirty-four percent (34%) of the total WIC eligible population resides in the City of Providence.

Following previous allocation formulas, 39 percent of the total caseload (as of June, 1997) was designated to the four local agencies (8 sites) in Providence. In FY'80 the state's AAP first introduced the expansion goal of Statewide Parity. For FY'2002, the AAP in its expansion criteria again incorporates this goal. Additional slots will be allocated to local sites in relation to the expansion rank of the cities and towns served, the state mean, and the size of the needy population (Tables I, IV, VI). Unfilled slots shall be counted as allocated.

Service Areas - Market Share Concept

In Rhode Island's WIC Program, residence is defined as state residency. The service areas of locals are generally consistent with the geographic location of the agency. Eligible participants are encouraged to enroll in the WIC Program at the site where they and their families receive medical care, and at a site that is easily accessible to them. Individuals, nevertheless, may apply for and receive benefits at an agency of their choice, where there is an opening. Some local sites that provide specialized medical care and unique services, moreover draw eligibles from many of Rhode Island's communities. In order to define service areas this plan incorporates two concepts:

1. Market Sharing

   A local agency is considered as impacting or eligible to receive allocations targeted to increase participation in a particular city or town if it serves a minimum of 10 percent of the enrolled population of the city or town. For the analysis of the local agency's impact on each community served, local agency caseloads were assigned census tract codes to indicate cities and towns served by each local and determine the percentage of caseload composed by this

distribution (Tables III and V).

2. Normative Concept

The use of the Normative Concept involves the utilization of traditional demographically designed target populations in order to stabilize the areas. The application of this concept, it is hoped, will control the normative aspects of market sharing, such as the natural numerical advantage enjoyed by agencies with large caseloads, or possible competition among local agencies for participants on the basis of residency.

Table V indicates current assignment of service areas.

4. Realignment of Service Areas

Objective 1: If an area has been underserved by more than 750 potential eligibles or 10% of the statewide average, in accordance with the AAP, in the current Plan and for two of the past three Plans, the State Agency may solicit or accept proposals from other agencies to provide service which is likely to significantly increase the number or percent served in the defined area.

Future Allocations

Table VI shows the final ranking for expansion by city and town.

Objective 1: Caseload expansions will be allocated in accordance with need and local agency ability to provide service.

Methods - The following criteria will be applied in implementing the Affirmative Action Plan.

1. Current or previous unutilized caseload at an agency shall be considered before allocating it additional slots.

2. The most current economic and health data, if feasible, will be incorporated to update the Affirmative Action tables.

3. Recognition will be given to each agency's willingness and capacity to expand operations. Agencies desiring increased caseload may be required to submit a plan of the methods they will utilize to ensure that the additional caseload is enrolled.

4. The need rankings and other measures of need in the Affirmative Action Plan will be applied. In addition the census tracts identified as those with the highest need (Factor Analysis review 9/02, Division of Family Health, RI Dept of Health) will be viewed for effective penetration.

5. Preliminary and final identification of each local agency's estimated proportion of increased caseload will be made.

6. Enrollment and spending will be monitored and the expansion plan may be adjusted as warranted.

Goals 2003 Sec. 1 Preliminary Information

Table 1

Number and Percent of WIC Eligible Population Served by Each City and Town

	Estimated WIC Eligible	WIC Eligible Enrolled	WIC Eligible Unserved	Adjusted Eligible Unserved*	% WIC Eligible Unserved	standard score of unserved
Barrington	211	29	182	182	86	1.478
Bristol	403	180	223	223	55	0.413
Burrilville	427	226	201	201	47	0.129
Central Falls	1,642	1,517	125	125	8	-1.230
Charlestown	105	85	20	20	19	-0.836
Coventry	592	282	310	310	52	0.311
Cranston	1,753	871	882	882	50	0.240
Cumberland	554	216	338	338	61	0.609
East Greenwich	241	53	188	188	78	1.194
East Providence	1,205	708	497	497	41	-0.072
Exeter	13	36	-23	0	0	-1.492
Foster	10	47	-37	0	0	-1.492
Glocester	293	28	265	265	90	1.622
Hopkinton	33	82	-49	0	0	-1.492
Jamestown	96	13	83	83	86	1.485
Johnston	598	294	304	304	51	0.258
Lincoln	360	144	216	216	60	0.574
Little Compton	63	9	54	54	86	1.459
Middletown	694	248	446	446	64	0.721
Narragansett	71	90	-19	0	0	-1.492
Newport	1,332	606	726	726	55	0.385
New Shoreham	39	1	38	38	97	1.863
North Kingstown	370	174	196	196	53	0.332
North Providence	262	331	-69	0	0	-1.492
North Smithfield	59	48	11	11	19	-0.850
Pawtucket	3,198	2,772	426	426	13	-1.033
Portsmouth	249	84	165	165	66	0.790
Providence	11,280	8,982	2298	2298	20	-0.791
Richmond	24	55	-31	0	0	-1.492
Scituate	75	60	15	15	20	-0.803
Smithfield	174	67	107	107	61	0.625
South Kingstown	402	193	209	209	52	0.298
Tiverton	260	89	171	171	66	0.772
Warren	156	119	37	37	24	-0.675
Warwick	1,613	872	741	741	46	0.090
Westerly	648	307	341	341	53	0.320
West Greenwich	38	17	21	21	55	0.411
West Warwick	777	664	113	113	15	-0.991
Woonsocket	2,566	1,561	1005	1005	39	-0.143
No town listed		38				
State Wide	32,886	22,198		10,954	1690	

State mean of unserved WIC eligible population = 33.3%
SD% of unserved =29
*Negative numbers of WIC eligible unserved were adjusted

Table II
City / Town* Rank Based on 5 MCH Indicator's Standard Score (S.S.)

Rank	City/Town	S.S. (teen birth)	S.S. (prenatal)	S.S. (IMR)	S.S. (Lo Birthwt)	S.S (poverty)	Total S.S.	Average S.S
3	Barrington	-0.950	-1.192	-1.180	-0.398	-0.716	**-4.435**	**-0.887**
26	Bristol	-0.136	0.173	-0.135	-0.025	-0.028	**-0.151**	**-0.030**
22	Burrillville	-0.477	-0.066	0.055	-0.044	-0.357	**-0.889**	**-0.178**
38	Central Falls	3.168	2.999	0.879	0.211	3.219	**10.476**	**2.095**
18	**Charlestown	0.492	-0.138	-0.832	-0.241	-0.490	**-1.209**	**-0.242**
15	Coventry	0.144	-0.330	-0.895	-0.182	-0.398	**-1.660**	**-0.332**
24	Cranston	-0.033	-0.330	-0.040	-0.025	-0.090	**-0.517**	**-0.103**
19	Cumberland	-0.388	-0.449	0.562	-0.103	-0.655	**-1.033**	**-0.207**
11	East Greenwich	-0.846	-0.809	0.087	-0.201	-0.552	**-2.321**	**-0.464**
28	East Providence	-0.181	0.173	0.182	-0.123	0.126	**0.178**	**0.036**
7	**Exeter	-0.440	-0.569	-0.673	-0.751	-0.203	**-2.635**	**-0.527**
27	**Foster	-0.225	-0.354	1.607	-0.241	-0.675	**0.112**	**0.022**
21	**Glocester	-0.728	-0.090	0.435	-0.260	-0.316	**-0.959**	**-0.192**
31	**Hopkinton	0.048	1.083	0.467	0.172	-0.408	**1.362**	**0.272**
1	**Jamestown	-0.920	-1.312	-1.560	0.073	-0.829	**-4.548**	**-0.910**
25	Johnston	-0.410	-0.330	0.309	0.015	-0.048	**-0.465**	**-0.093**
17	Lincoln	-0.817	-0.497	0.372	-0.241	-0.336	**-1.519**	**-0.304**
20	**Little Compton	-0.551	0.437	0.404	-0.437	-0.870	**-1.018**	**-0.204**
16	Middletown	-0.136	-0.617	0.150	-0.633	-0.336	**-1.573**	**-0.315**
13	Narragansett	-0.292	-0.928	-0.641	0.054	-0.110	**-1.918**	**-0.384**
34	Newport	1.098	0.796	-0.008	-0.378	1.472	**2.980**	**0.596**
39	**Newshoreham	-1.053	2.065	3.539	5.863	0.075	**10.488**	**2.098**
8	North Kinstown	-0.469	-0.809	-0.927	-0.437	0.013	**-2.628**	**-0.526**
32	North Providence	-0.063	-0.378	1.607	0.309	0.034	**1.509**	**0.302**
9	North Smithfield	-0.469	-0.521	-0.958	0.132	-0.685	**-2.502**	**-0.500**
35	Pawtucket	1.520	1.634	1.100	0.093	1.544	**5.891**	**1.178**
6	Portsmouth	-0.528	-0.976	-0.198	-0.319	-0.685	**-2.707**	**-0.541**
37	Providence	3.154	1.227	1.544	0.329	3.147	**9.400**	**1.880**
10	**Richmond	-0.144	-0.473	-0.895	-0.339	-0.542	**-2.392**	**-0.478**
5	Scituate	-0.691	-0.665	-0.927	-0.103	-0.531	**-2.917**	**-0.583**
4	Smithfield	-0.676	-0.857	-1.180	-0.476	-0.572	**-3.761**	**-0.752**
12	South Kingstown	-0.277	-0.785	-0.356	-0.299	-0.470	**-2.187**	**-0.437**
14	Tiverton	-0.225	0.125	-0.578	-0.456	-0.696	**-1.830**	**-0.366**
29	Warren	-0.092	0.365	0.055	0.113	-0.141	**0.300**	**0.060**
23	Warwick	-0.166	-0.569	0.404	-0.044	-0.316	**-0.692**	**-0.138**
30	Westerly	0.278	1.730	-0.641	-0.319	0.013	**1.060**	**0.212**
2	**Westgreenwich	-0.639	-1.000	-1.560	-0.633	-0.696	**-4.528**	**-0.906**
33	Westwarwick	0.847	0.341	0.467	0.152	0.866	**2.672**	**0.534**
36	Woonsocket	2.274	1.897	-0.040	0.191	2.243	**6.565**	**1.313**

Note: * The method used for calculating the rank is the same method used in the 2002 Kids Count book (page 185).
** indicates cities/towns with less than 500 births during 1996-2000, resulted in statistically unreliable MCH score
These cities/towns are recommended to be excluded in ranking.

Goals 2003
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Table III
Number of WIC Participants Served by WIC Agencies
By City or Town of Participant Residence

	Women & Infants Hospital	St. Joseph's Hospital	Self-Help Inc. Hlth. Ctr.	Tri Town Hlth. Ctr.	Warwick Hlth. Ctr.	Hlth. Ctr. So. County	Wood River Hlth. Ctr.	BVCAP Hlth. Ctr.	Chad-Brown Hlth. Ctr.	Cranston Health Hlth. Ctr.	Thundermist Hlth. Ctr.	New Visions Hlth. Ctr.	Providence Hlth. Ctr.	Total
Barrington	0	0	31	1	0	0	0	0	0	0	0	1	0	33
Bristol	2	0	180	0	0	0	0	0	0	0	2	12	4	200
Burrilville	1	0	0	201	1	0	0	1	0	1	23	0	1	229
Central Falls	29	2	2	0	1	0	0	1,389	1	4	6	1	62	1,497
Charlestown	0	0	0	0	0	56	37	0	0	0	0	0	0	93
Coventry	0	0	0	3	151	5	5	0	0	159	1	0	2	326
Cranston	50	31	2	34	21	1	0	2	7	607	0	1	222	978
Cumberland	5	0	0	0	1	0	0	110	0	1	109	0	8	234
East Greenwich	4	0	0	0	25	23	0	0	0	8	0	0	6	66
East Providence	30	6	530	10	4	1	0	13	4	3	4	2	136	743
Exeter	0	0	0	3	2	25	8	0	0	0	0	0	0	38
Foster	2	0	0	31	2	0	0	0	0	4	2	0	1	42
Glocester	0	0	0	24	0	0	0	0	0	0	2	0	0	26
Hopkinton	0	0	0	0	2	4	74	0	0	0	0	0	0	80
Jamestown	0	0	0	0	0	7	0	0	0	0	0	9	0	16
Johnston	18	2	9	275	1	1	0	3	0	8	2	0	12	331
Lincoln	2	0	0	4	0	0	0	45	1	0	102	0	0	154
Little Compton	0	0	0	0	0	0	0	0	0	0	0	2	0	2
Middletown	3	0	2	0	0	2	0	0	0	0	0	260	0	267
Narragansett	0	0	0	0	1	79	0	0	0	2	0	0	0	82
Newport	1	0	0	0	0	1	0	0	0	1	0	572	1	576
New Shoreham	0	0	0	0	0	2	0	0	0	0	0	0	0	2
North Kingstown	2	1	0	2	11	242	3	1	0	4	1	2	1	270
North Providence	29	8	2	208	4	0	2	51	12	7	5	0	58	386

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Table III
Number of WIC Participants Served by WIC Agencies
By City or Town of Participant Residence

	Women & Infants Hospital	St. Joseph's Hospital	Self-Help Inc. Hlth. Ctr.	Tri Town Hlth. Ctr.	Warwick Hlth. Ctr.	Hlth. Ctr. So. County	Wood River Hlth. Ctr.	BVCAP Hlth. Ctr.	Chad-Brown Hlth. Ctr.	Cranston Health Hlth. Ctr.	Thundermist Hlth. Ctr.	New Visions Hlth. Ctr.	Providence Hlth. Ctr.	Total
North Smithfield	0	0	0	7	0	0	0	0	0	0	38	0	0	45
Pawtucket	78	29	25	13	7	2	0	2,497	24	9	16	0	202	2,902
Portsmouth	0	0	3	0	0	0	0	0	0	0	0	95	0	98
Providence	1,188	1,376	45	174	26	7	0	216	493	221	24	6	5,778	9,554
Richmond	0	0	0	0	0	3	58	0	0	0	0	0	0	61
Scituate	0	0	1	36	12	2	0	0	0	12	0	0	1	64
Smithfield	0	0	0	70	1	0	0	0	2	1	17	0	0	91
South Kingstown	1	0	0	0	1	217	5	0	0	0	0	0	0	224
Tiverton	1	0	0	0	0	0	0	0	0	0	0	123	0	124
Warren	3	2	110	0	0	0	1	2	0	2	0	4	1	125
Warwick	28	6	16	7	846	8	2	5	4	27	5	0	30	984
Westerly	1	3	0	1	0	18	298	0	0	0	0	0	1	322
West Greenwich	0	0	0	0	7	0	4	0	0	5	0	0	0	16
West Warwick	4	7	2	7	576	8	1	3	1	85	2	3	12	711
Woonsocket	9	14	1	3	1	0	0	24	7	1	1,811	0	15	1,886

Table IV
WIC Need Index and Rank
by City and Town

(Different weights were imposed between MCH Indicator Scores and Unserved Scroes to calculate Need Index)

City/Town	Average Standard Score of 5 Indicators	5 MCH Indicators Stand. Score X 2	Standard Score of WIC Unserved	Need Index*	Need Rank
**New Shoreham	2.098	4.195	1.863	6.058	1
Providence	1.880	3.760	-0.791	2.969	2
Central Falls	2.095	4.190	-1.230	2.960	3
Woonsocket	1.313	2.626	-0.143	2.483	4
Newport	0.596	1.192	0.385	1.577	5
Pawtucket	1.178	2.356	-1.033	1.323	6
**Glocester	-0.192	-0.383	1.622	1.238	7
**Little Compton	-0.204	-0.407	1.459	1.052	8
Westerly	0.212	0.424	0.320	0.744	9
Bristol	-0.030	-0.060	0.413	0.353	10
East Greenwich	-0.464	-0.928	1.194	0.265	11
Cumberland	-0.207	-0.413	0.609	0.195	12
Middletown	-0.315	-0.629	0.721	0.092	13
West Warwick	0.534	1.069	-0.991	0.078	14
Johnston	-0.093	-0.186	0.258	0.072	15
Tiverton	-0.366	-0.732	0.772	0.040	16
Cranston	-0.103	-0.207	0.240	0.034	17
East Providence	0.036	0.071	-0.072	-0.001	18
Lincoln	-0.304	-0.608	0.574	-0.034	19
Warwick	-0.138	-0.277	0.090	-0.187	20
Burrilville	-0.178	-0.355	0.129	-0.227	21
Portsmouth	-0.541	-1.083	0.790	-0.293	22
Barrington	-0.887	-1.774	1.478	-0.296	23
**Jamestown	-0.910	-1.819	1.485	-0.334	24
Coventry	-0.332	-0.664	0.311	-0.353	25
Warren	0.060	0.120	-0.675	-0.556	26
South Kingstown	-0.437	-0.875	0.298	-0.577	27
North Kingstown	-0.526	-1.051	0.332	-0.719	28
Smithfield	-0.752	-1.504	0.625	-0.879	29
North Providence	0.302	0.604	-1.492	-0.888	30
**Hopkinton	0.272	0.545	-1.492	-0.947	31
**Charlestown	-0.242	-0.483	-0.836	-1.320	32
**West Greenwich	-0.906	-1.811	0.411	-1.401	33
**Foster	0.022	0.045	-1.492	-1.447	34
North Smithfield	-0.500	-1.001	-0.850	-1.851	35
Scituate	-0.583	-1.167	-0.803	-1.970	36
Narragansett	-0.384	-0.767	-1.492	-2.259	37
**Richmond	-0.478	-0.957	-1.492	-2.449	38
**Exeter	-0.527	-1.054	-1.492	-2.546	39

*: Need Index = (Standard Score of 5 MCH Indicators * 2) + Standard Score of Unserved.

** indicates cities/towns with less than 500 births during 1996-2000, resulted in statistically unreliable MCH scores. These cities/towns are recommended to be excluded in ranking.

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Table V
WIC Local agency Current Service Areas

Agency	Local Agency Service Area Need Index	Communities Services
Blackstone Vally CHC	983	Central Falls
	1,705	Cumberland
	2,123	Lincoln
	696	Pawtucket
Chad Brown Health Center	1,494	Providence
Cranston Cap	1,677	Coventry
	1,613	Cranston
Health Center of South County	1,435	Charlestown
	1,903	East Greenwich
	-9,477	Exeter
	2,317	Jamestown
	-1,159	Narragansett
	6,581	New Shoreham
	1,008	North Kingstown
	1,606	South Kingstown
New Visions for Newport	2,317	Jamestown
	2,497	Little Compton
	2,134	Middletown
	2,719	Newport
	2,067	Portsmouth
	3,502	Tiverton
Providence Ambulatory Health Care Foundation, Inc. (PAHCF)	1,613	Cranston
	1,903	East Greenwich
	1,718	East Providence
	-2,273	North Providence
	1,494	Providence
Self-Help, Inc.	1,907	Barrington
	1,961	Bristol
	1,718	East Providence
	172	Warren
St. Joseph Hospital	1,494	Providence
Thundermist Health Associates, Inc	2,123	Lincoln
	300	North Smithfield
	1,037	Smithfield

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Table V
WIC Local agency Current Service Areas

Agency	Need Index	Local Agency Service Area Communities Services
	1,324	Woonsocket
Tri- Town Economic Opportunity Committee	1,590	Burrillville
	1,705	Cumberland
	-9,207	Foster
	1,304	Johnston
	-2,273	North Providence
	1,544	Scituate
	1,037	Smithfield
	2,178	Glocester
Westbay Community Action,Inc.	1,677	Coventry
	1,903	East Greenwich
	1,500	Warwick
	1,320	West Greenwich
	478	West Warwick
Women and Infants' Hospital	1,907	Barrington
	1,494	Providence
Wood River Health Services	1,435	Charlestown
	-9,477	Exeter
	-5,855	Hopkinton
	-4,035	Richmond
	1,320	West Greenwich
	1,982	Westerly

Affirmative Action Data

WIC Estimated Rhode Island Participation by Category
Average for FY 2002

Category	# of Estimated WIC Eligibles	Average # of WIC Participants Served per Month	Average % of WIC Eligibles Served per Month
Women	6,577	5,041	77%
Infants	5,262	5,512	105%
Children	21,047	11,685	56%
Total	32,887	22,238	68%

* Sources of data for all tables

United States Census Bureau 1990 Census
RIDH Division of Vital Records , Vital Records Reports 1992-1996
RIDH WIC Program Enrollment Reports - September 2002

** Based on USDA estimates using 1990 Census data

Goals 2003 Section I Preliminary Information

Commodities Supplemental Food Programs

The CSFP does not operate in Rhode Island

State Systems Development Initiative

The Division of Family Health, HEALTH, has received a State Systems Development Initiative (SSDI) grant to improve the accessibility and coordination of maternal and child services in the state. As a unit of the Division of Family Health serving much of the same population of other MCH programs, the Rhode Island WIC Program will endeavor to help to carry out the objectives of SSDI and to make them a part of its operations also.

The SSDI project focuses on parent led assessment of the needs of young families, and the reasons for not participating in a range of preventive programs including WIC, Early Intervention, immunizations, Medicaid, etc. Special attention will be given to families who are "lost to follow-up". A detailed inventory of all preventive services available will be compiled and a survey of all preventive service providers will be conducted. This data will be evaluated to develop new models of integrated outreach and follow-up

The project, called "Pulling It All Together With Parents As Partners" (previously implemented in Woonsocket and Central Falls) has now shifted to Providence which has substantial risk of adverse reproductive and child developmental outcomes.

Disaster Coordination and Planning

Goal: In the event of a disaster which disrupts food distribution, utilities, transportation, building security, communications or computer operations, to assure continuity of access to supplemental foods, certification services, operation of accountability systems, and information and referral response, and to extend services to newly eligible persons related to the disaster.

Objective 1: Continue working relationships with the HEALTH Disaster Coordinator and Emergency Response Primary Contacts and the State Emergency Management Agency to clarify WIC's roles, needs and communications

Evaluation: WIC was defined as a key HEALTH Program resulting in inclusion in Y2K Planning efforts. HEALTH refined its Disaster Plan, integrating WIC procedures into the process. The State WIC Office completed an assessment of the QWIC System needs for security and continuity of access, physical, operating system, network and software aspects

While Y2K was a "non-event", procedures developed were implemented when a major WIC provider went on strike and the procedures were implemented. Lessons

learned from the month long strike were reviewed.

Objective 2: By February, 2002, conduct a Disaster Procedures Training Workshop for all personnel

Objective 3: Produce a Disaster Procedures section of the State Operations Manual and the Local Agency Procedures Manual

Objective 4: By June, 2002, conduct a Disaster Drill at the State and all local WIC agencies

GOALS FOR FY 2002

SECTION II

WIC ELIGIBILITY AND ENROLLMENT

Refer to WIC Procedure Manual Section 200
WIC Operations Manual Section 2

Section II
Eligibility and Enrollment

Goal: To ensure that eligible persons are enrolled in the Program in accordance with regulatory requirements, through accurate and efficient assessments and recording.

Application and Eligibility Determination

Objective 1: Prompt implementation of revised income guidelines

Evaluation: Rhode Island Medicaid adopted the 2002 Revised income guidelines on April 1, 2002. RI WIC obtained permission to adopt the income guidelines as of April 1, 2002.

Plan: Adopt revised income eligibility guidelines at 185% of poverty level concurrent with the State's adoption for Medicaid. Obtain Regional Office approval of proposed guidelines in advance.

Objective 2: Identify training needs

Evaluation: Identified training needs of local agency nutritionists and support staff through surveys, Nutrition Education Plans, Patient Flow Analysis, management evaluations, and changes in rules, regulations, policies and procedures impacting local WIC sites.

Plan: Identify training needs of local agency nutritionists and support staff through surveys, Nutrition Education Plans, management evaluations, and changes in rules, regulations, policies and procedures impacting local WIC sites.

Objective 3: Conduct training

Evaluation: Conducted monthly orientation and training for new WIC nutritionists and support staff (as needed), trained new breast-feeding peer counselors, provided three training sessions for WIC support staff, conducted four nutrition education training (avg. attendance 25), met with WIC local agency coordinators bi-monthly, and provided individual agency training during Management Evaluations (13 sites). Over 90+ staff members attended the WIC Annual Training Event.

Plan: Conduct training monthly for new WIC nutritionists and support staff, train new breast-feeding peer counselors and provide quarterly training for all peer counselors, conduct three per year training for WIC support staff, conduct quarterly nutrition education training for WIC and community nutrition staff,

meet with WIC local agency coordinators bi-monthly. Continue the development of a RI WIC web-training site.

Objective 4: RIte Care integration

Evaluation: Collaborated within the Division of Family Health to improve and increase screening and referral to WIC / RIte Care / Food Stamps / FIP through integrated outreach efforts, training and further development of role of Family Resource Counselors. Worked with Dept of Human Services to determine potential of WIC referral via their pilot multi-program application.

Continued collaboration with Neighbor Health Plan of Rhode Island (major Rite Care provider). Staffed .25 FTE (Provider Outreach and Education Liaison position) to enhance communications with Rite Care Providers.

Plan: Continue coordination with Family Resource Counselors, although DHS Outstation worker program has been dismantled. Continue efforts to reduce duplication of services in obtaining WIC required screenings from RIte Care (Medicaid) providers. Continue with implementation and evaluation of Liaison / Provider initiative.

Objective 5: Assure enrollment of high priority applicants

Evaluation: WIC Client Services Unit, the Community Liaison Manager, the WIC Outreach Committee and local agency WIC staff collaborated in the development and presentation of provider in-service trainings. Offered to new providers, practices with questions re: WIC services, and OB / GYN offices, these in-services enhanced communication between WIC and providers. The goal was improved collaboration, enhanced referral process, and feedback loops

The Statewide Outreach Committee, comprised of staff from each local WIC agency and HEALTH, was implemented. The committee developed a power point outreach presentation, which has been presented at in-services, community referral sites, and at student presentations.

Plan: Continue work with WIC parent consultants and Communications in providing targeted outreach, including new / relocated WIC sites. Review and establish guidelines for integration of Patient Flow Analysis activities, and continue to provide technical assistance to ensure timely access to WIC services. Continue outreach efforts through managed care providers, and new providers serving the RIte Care populations through the Provider Liaison ¼ FTE position.

Objective 6: Streamline eligibility determination process

Evaluation: Continued follow-up training of local agency WIC staff on use of adjunctive eligibility for WIC income verification. Upgraded software at local agency sites

to increase intake efficiency. Implemented coordination system re: categorical and income eligibility between WIC and FRC program. Worked with Dept of Human Services in integration of WIC referral process into their pilot joint eligibility project.

Plan: Continue to support local agencies' efforts in streamlining determination process. Review documentation requirements to ensure compliance with regulations while simplifying determination process. Evaluate the interim progress of the pilot project with KidsNet, to identify risks associated with elevated blood lead levels.

Objective 7: Separation of Duties

Evaluation: The State Agency incorporates SOD monitoring into the biennial Management Evaluations performed. Seven (7) local agency management evaluations were completed. No WIC local agencies were sited for SOD non-compliance in FY 2002.

Plan: Require local WIC agencies to comply with separation of duties during certification, thus reducing the possibility of fraud and mis-use of WIC funds. Continue monitoring efforts.

Objective 8: Coordinate with RI Department of Health Minority Health Initiatives

Evaluation: Continued collaborated with Cultural Competence Coordinator to address cultural awareness and sensitivity issues among State and local WIC staff.

Plan: Continue coordination of work with Minority Health Office in addressing needs of non-English speaking, and minority communities. In collaboration with the Division of Family Health Data and Evaluation Unit, develop analytical tools to identify health disparities among ethnic/racial groups of WIC participants.

Determination of income

Objective 1: Increase efficiency and accuracy in determination of income

Evaluation: Provided training on adjunctive eligibility, assisted local agencies in making determination in questionable cases, provided a template form for income determination, and provided technical assistance on new WIC Federal Income Guidelines. Adjunctive eligibility training provided. Over the past 2 years, Medicaid enrollment has increased from 65% to 75% among WIC participants.

Plan: Continue assisting local agencies in making determination in questionable cases, provide technical assistance on new WIC Federal Income Guidelines, provide training to new WIC staff re: income determination policies and procedures, continue monitoring income screenings through management evaluations.

Nutritional Assessment

Objective 1: Monitor documentation of nutrition assessment for accuracy

Evaluation: Local WIC agencies conducted regularly scheduled quality assurance reviews of certification documentation (as outlined in their Nutrition Education Plans). These efforts were reviewed during Management Evaluations, conducted at required WIC agencies. All agencies reviewed were in general compliance with federal regulations.

USDA standardized risk code reports were analyzed and shared with local WIC agencies. Trained and monitored implementation of new blood work rules. Anthropometric measurement training is provided on an as needed basis.

Plan: Local agencies will conduct regularly scheduled quality assurance reviews of certification documentation (per Nutrition Education Plans). Management Evaluations will be conducted to monitor for documentation compliance. QWIC risk reports will be collected, analyzed, and reviewed with local WIC agencies; information will be used to target training, monitor on-going initiatives (breast-feeding support programs), re-direct efforts and develop new initiatives. Revisions and additions to allowed nutrition risk criteria will be implemented and staff will be informed and trained.

Objective 2: Dietary assessment tools

Evaluation: Rhode Island's dietary assessment tools are used statewide. Training on use of the tools is conducted by RI WIC Nutrition Coordinator for any new staff or those needing a review (usually noted at ME).

Plan: Continue to follow national initiative in the development of national dietary assessment models.

Objective 3: Coordinate procedures and criteria with other Division of Family Health programs to avoid duplication and enhance access.

Evaluation: WIC and the Women's Health Screening and Referral Program continued their coordination to enhance access to nutrition services. Evaluations of lead screening results among WIC children lead to collaboration in the review of nutrition / lead materials. Implemented the WIC / Lead / KidsNet initiative. This will allow WIC local agency staff to view KidsNet lead screening results, and act on the findings.

Plan: Continue to work with lead program in ensuring that WIC eligible children with elevated lead levels are referred to WIC. Develop Kids Net connection to enable

local agency WIC staff access to lead screening results at the time of certification and recertification.

Objective4: Biochemical and Anthropometric screening

Evaluation: Upgraded infant and adult scales at local WIC agencies as needed. WIC continued to provide measurement training to new WIC staff, and monitored techniques during Management Evaluations. Implemented new CDC/AAP/WIC blood screening guidelines. Provided training on new BMI risk codes.

Plan: Continue to provide technical assistance on the federal regulations related to blood screening. Provide on-going training to state and local agency WIC staff re: new Body Mass Index initiative from CDC. Continue to monitor measurements of children, allowing only light clothing ,dry diapers and removing shoes. Training for measuring will be conducted at both support staff meetings and Nutrition Education meetings.

Minimize violations of Program rules and misuse of Program funds.

Objective 1: Warnings and sanctions

Plan: Continue to provide training to local WIC staff on importance of educating clients on their rights along with their responsibilities using the newly revised WIC rights and responsibilities information included on the WIC ID folder. Monitor participant knowledge of rights and responsibilities during Management Evaluations through parent consultant / participant interview process.

GOALS FOR FY 2002

III. FOOD DELIVERY SYSTEM

SECTION III

Food Delivery System

Refer to WIC Procedure Manual Section 300
WIC Operations Manual Section 3

Goal: To operate a Food Delivery system which fosters Program efficiency and effectiveness, especially in maintaining enrollment records, issuing benefits, paying vendors, reconciling food instruments, maintaining accountability and controls, providing management information for the administration of the program, and vendor management.

Food Delivery System Contracts

Objective 1: Continue efficient and effective banking services.

Evaluation: Financial Management Services Corp (FSMC) was awarded the recent banking services contract through the release of a competitive RFP.

Plan: Evaluate changes in banking needs related to the upcoming PARTNER's EDS project.

Automated Data Processing

Objective 2: Continue to evaluate and enhance MIS as a management tool.

Evaluation: MIS software development contract was awarded to PDA, Inc. Fiscal management, vendor management and caseload management modules were installed and tested.

Plan: Continue conversion process. Full rollout of the new software will continue through 2003. Present to USDA and NERO the 5 year strategic MIS plan which will focus on replacement of the local clinic software and hardware.

Conversion and Upgrade of Entire System Needed

Problem

Installed in 1991 -1992, the local agency and state agency software are obsolete versions no longer supported by the maker. Nightly communication of check and participant data are sometimes incomplete, requiring later reconstruction. System functionalities for vendor and fiscal management assurance of program integrity and assessment of participant data are rudimentary and labor intensive and many functions now deemed essential are lacking.

Objective 1: Complete the System Conversion and Replacement Plan

Plan: Continue rollout of the new Convansys software modules. Release and RFP for the local agency side of the system (as funding permits).

Management Tools - Financial Reporting

Goals 2003 Section III Food Delivery System

Objective 1: **Define and implement enhanced management tools related to financial reporting.**

Evaluation: Financial reports and other analytical tools continue to be difficult to generate in a non-integrated MIS.

Plan: Rollout the new vendor, fiscal and ad hoc reporting modules to streamline, improve and support program integrity, efficiency and effectiveness.

Local Agency Clinic Data Processing

Objective 1: **Optimize the use of the QWIC MIS with clinic operations.**

Evaluation: Local agency staff turnover requires constant and continued technical assistance related to efficient patient flow, and maximum productivity of staff .

Plan: Continue to utilize the Patient Flow Analysis Study to help support efficient and effective patient services at agencies. Monitor efficiencies and provide technical assistance during routine and management evaluation site visits. Monitor the appointment times.

Objective 2: **Strengthen MIS capabilities in tracking non-participation, and redemption rates for local agencies.**

Evaluation: No reports currently track no-show, void and nonredemption rates by site.

Plan: The new Covansys software will provide summary tracking reports, general and specific, for each clinic and statewide. Continue working with clinics to develop tools they can use for reminding participants(if necessary), such as mailing labels, calling lists, etc. Monitor change in rates. Work with agencies as needed to develop alternative strategies.

Objective 3: **Limit access to check printing to a limited number of staff, and limit the check printing capabilities of certifying staff whenever possible**.

Evaluation: Check issuance assessments done completed as part of the management evaluation process. For FY '02, none of the seven WIC agencies were cited for failure to maintain segregation of duty (SOD). Additional site visit reviews were conducted to monitor segregation of duties.

Plan: Continue review of checks for issuing personnel; security of check stock; corrective action as needed. Provide technical assistance re: SOD implementation.

Goals 2003 Section III Food Delivery System

Operation of the Retail Vendor Management System

Goal: That all authorized participating WIC vendors will be a benefit to the efficient and effective administration of the Program, in particular with regard to their charges for WIC purchases, provision of authorized foods, service to participants, and cooperation with the goals of the Program and its vendor monitoring procedures.

Vendor Selection and Authorization

Objective 1: Maintain the current number of authorized WIC vendors (XXX grocers and XX pharmacies).

Evaluation: Actual vendors as of 9/30/02 were 185 grocers and 33 pharmacies.

Plan: Continue applying clear and specific selection criteria to ensure the lowest cost/most accessible vendors are enrolled, unless the need for special authorization warrants a enrollment above the maximum.

Implementation of Federal Proposed Rule – Food Delivery Systems

Objective 1: Prepare for Implementation of the new food delivery rule revised Section 246.4(a) of the Federal WIC Regulations.

Evaluation: The original implementation date of the Food Delivery Systems Rule was set for February 27, 2002. The new implementation date is set for October 1, 2002.

Plan: Revisions made to the vendor policies and procedures document for FFY2002 to ensure that necessary revisions based on the rule are included have been implemented.

Vendor Management

Objective 1: Implement an automated procedure to flag and track high risk and potentially high risk WIC vendors.

Evaluation: The newly developed Vendor Software Module included enhanced tracking of high risk and potentially high risk WIC vendors.

Plan: Rollout the new Vendor Risk Management System.

Vendor Education and Training

Objective 1: Promptly train new vendors, and provide refresher training as needed to existing vendors.

Evaluation: 55 training events were held for new vendors as part of the authorization process. 202 site visits were made during the FY 2002.

Plan: Continue training sessions at Health for applicant and existing vendors. Increase the number of one-on-one on-site training/monitoring visits and investigate alternative training methods.

Excessive Price Limits

Objective 1: Utilize the new vendor MIS module to identify potential overcharges among stores.

Evaluation: The new Vendor Software Module includes peer group pricing analysis. This will allow more specific analysis of price data. The previous method of tracking high priced vendors was labor intensive and required significant resources.

Plan: Roll out the new MIS system for vendors which includes a number of tools to determine excessive pricing and price fixing. A peer group analysis is one of the key components of the process and will allow more specific analysis of price data. Additionally, the system will be capable of automatic generation of invoice letters in order to recover identified overcharges.

Objective 2: Enhance use of a maximum price pre-edit by check type to deny payments, thus increasing vendor collections.

Evaluation: Check prices by FI type and vendor peer group were monitored to determine the reasonable maximum price/check rejection cutoff. Rejected checks were returned to vendor. Vendor must justify price and HEALTH determined allowable reimbursement.

Plan: Roll out the enhancements to the MIS Vendor Management Module which will allow for price analysis to be performed by check type within vendor peer group in order to adjust maximum check value within peer groups. (Operations Policy V-10 and V-11).

Store Monitoring

Objective 1: Conduct a minimum of twelve investigations, at least two of which should be on non-high risk vendors.

Evaluation: Two contract employees were added to perform compliance visits in FFY2002. Additional contract employees will be engaged in FFY2003 in order to carry out these activities.

Plan: Utilize new vendor analysis reports to flag potential vendors for compliance investigation.

Objective 2: **Increase staff time for vendor compliance investigation management**

Evaluation: Vendor compliance investigators need training and assistance related to effective investigation and collection of critical evidence.

Plan: Prepare a training and investigation procedures manual for new investigators.

Objective 3: **Maintain routine monitoring at 30 percent of vendors.**

Evaluation: A total of 202 on-site visits were performed in FFY2002

Plan: Continue routine visits and test new technology as part of the vendor monitoring activity.

Federal/State Information Sharing

Objective 1: **Coordinate with Northeast Regional Office (NERO) and Food Stamp Program (FSP) to improve notification of administrative/disqualification actions for WIC and food stamp authorized vendors.**

Evaluation:

Plan: Utilize electronic mail notifications and use of federal STARS computer system to track federal actions relating to Rhode Island vendors.

Community Relations

Objective 1: **Maintain a positive dialogue with the retail vendor community through the WIC & RI Food Dealers' Association Vendor Task Force.**

Evaluation: The RIFDA has provided valuable feedback and communication on issues related to Program rules and regulations and special initiatives by WIC involving the vendor community.

Plan: Continue quarterly meetings with the R.I. Food Dealers' Association and establish agenda for discussion. Keep informed of areas of mutual interest and concern.

Objective 2: **Maintain periodic communication with Newport County vendors selected for participation in the PARTNERS EBT Pilot Project.**

Evaluation: Vendors in the Newport County area have been visited and contacted regarding information updates on the pilot project and its timeline.

Plan: RI's pilot project in Newport County is scheduled for 2004. Ensure that each store

is updated via corporate contact, manager or owner re: implementation of the EBT Pilot Project.

GOALS FOR FY 2002

IV. PROGRAM BENEFITS

SECTION IV

State Agency Nutrition Education Plan

Refer to WIC Procedures Manual Section 400
WIC Operations manual Section 4

IV
Program Benefits
(Procedures - 400, Operations - 4)

Goal: **To ensure that RI WIC participants have access to health care services and appropriate referrals**

Year 2010 Objectives (16-6)

Objective 1: **Increase to 90%, early entry (first trimester) into prenatal care.**

Evaluation: More pregnant women in RI are receiving their prenatal care in the first trimester. In 1990, 86.7% of pregnant women received prenatal care in the first trimester and by 1999, the figure increased to 98.6%. (data from self-reported data on the birth certificate). In the core urban cities, 86.3% received adequate prenatal care. The rate of early entry into prenatal care varies among difference groups. During the five-year period 1996 – 2000, 90.8% of pregnant women received prenatal care in the first trimester. However, from 1996-1998, 86% received adequate prenatal care, compared with 78% of Black mothers, and 77% of Hispanic mothers.

Plan: Continue screening prenatal applicants for access to prenatal services, make appropriate referrals to health care providers as necessary. Continue collaboration with the Women's Screening Program to enhance early entry into WIC for pregnant women. Continue development of new outreach initiative to educate new Rite Care prenatal providers about WIC services.

Objective 2: **Increase to 90%, primary care services for children ages 18 month and younger.**

Evaluation: WIC continued to monitor access to health care by obtaining proof of health care (via medical referral form), interviewing caretakers, collaborating in immunization screening at the 4 largest WIC agencies, and continued working with Kids Net program.

Plan: Continue screening child applicants for access to primary care services, make appropriate referrals to health care providers as necessary, and work with Kids Net to implementation of the health data tracking and referral system.

Healthy People 2000

Objective 1: **Increase to 95%, access to primary health care**.

Evaluation: As of February 2002, 93.7% of WIC participants were insured. 79% were on Medicaid (managed care RITE Care Program), and 14.6% were privately insured.

4.6% of the WIC participants were referred to RIte Care managed Medicaid program.

Plan: With state budget constraints, Medicaid has started charging a premium for some Rite Care recipients. If the premium is unpaid, the recipient is dropped from the Rite Care Program. WIC will track Rite Care enrollment to assess the impact of premiums in continued enrollment. Continue referrals to RIte Care managed Medicaid program for uninsured applicants. Develop and run report which list those WIC participants without health insurance for follow-up contact. Provide training on new Rite Care Eligibility criteria to local agency WIC staff.

WIC Objective

Objective 1: WIC association with Priority I health care agencies

Plan: As managed care continues to impact R.I. Medicaid program, Priority 1 health care agencies with WIC sites were monitored to ensure continuity of service.

As more Medicaid / WIC participants obtained health care in new settings (HMO's, PPO's), local agencies continued to encourage on-going health care. Monitoring of WIC charts for documentation of health services and referrals continued during this transition period.

Plan: Continue to monitor stability of WIC sites in Priority 1 health care agencies.

Objective 2: Participate in RIte Care planning and service integration

Evaluation: Continued working with the Family Resource Counselor program, WIC ensured that referrals to health and social services was provided. Local WIC agencies continued to provide the majority of blood screening. Collaborated with the Women's Assessment Project to ensure that pregnant women are identified and referred to WIC early in the pregnancy. Revised the blood screening schedules to more closely align with standards of practice with recommendations by the AAP and CDC and provided training for WIC staff.

Plan: Continue to collaborate in the implementation of the new Women's Assessment Project and encourage providers to completed the WIC Medical Referral Forms to reduce duplication of screenings. Monitor Local Agency WIC Programs to ensure compliance with the New Bloodwork Requirements, by reviewing DOB, date bloodwork was performed and date recorded at the WIC clinic, This will be done at Management Evaluations. Collaborate with the RI Dept of Human Services in the pilot of joint services application process for WIC, child care, Food Stamps, FIP, Rite Care.

IV
State Agency Nutrition Education Plan
(Procedures - 420, Operations - 4)

Goal To ensure that quality nutrition education, which recognizes the individual needs of participants, is provided to every WIC participant or guardian in a manner consistent with federal regulations, state guidelines, and appropriate health care standards.

Provision of Quality Nutrition services

Year 2000 Objectives

Objective 1: (19-12) Reduce iron deficiency to less than 5% among children aged 1 – 2 years old, to 1% among children 2-4 years old and to 7% among women of childbearing age.

Evaluation: As of July, 2001, 8.5% of children and 13% of women on the WIC Program had low hemoglobin levels. Participants continued to receive targeted counseling re: iron rich foods and their importance using the newly developed and translated nutrition education materials.

Plan: Continue providing targeted nutrition education re: iron nutrition. Continue WIC caseload expansion (if feasible) to prevent iron deficiency by reaching more children aged one through 4. Continue Kids Net collaboration in providing lead blood level test results at WIC certification and recertification. (adequate iron nutrition is a barrier to lead poisoning). Implement the new USDA blood screening schedule which is aligned with AAP and CDC recommendations.

Objective 2: (19-11) Increase calcium intake of persons 2 years and older so at least 75% meet dietary recommendations for calcium.

Evaluation: In July, 2001, 5.7% of children had inadequate calcium intakes, Of pregnant and breastfeeding women, 55.1% failed to meet the dietary recommendations for calcium. Women continued to receive targeted nutrition education re: calcium sources and the importance in their diet. Low and lactose-free dairy products were provided to lactose intolerant WIC participants, and new nutrition education materials were developed re: calcium nutrition. Food packages with calcium fortified orange juice were available for select women.

Plan: Continue providing targeted nutrition education re: calcium nutrition. Continue provision of alternate calcium sources (due to lactose intolerance, food or cultural preferences). Counsel WIC pregnant and lactating women on the importance of calcium in their diet and recommended daily intakes and calcium sources. Provide feedback on anticipated changes to the WIC Allowed Food Package.

Objective 3: **Work towards increasing to at least 75% the proportion of parent and care givers who use feeding practices that prevent baby bottle tooth decay.**

Evaluation: WIC nutritionists educated parents on the dangers of baby bottle tooth decay. Care givers continued to receive counseling regarding proper feeding practices that prevent baby bottle tooth decay.

Plan: Based on positive responses from local agency staff and parents, if funding allows, the sippy cup distribution project will be repeated. Continue providing caregivers with information re: proper feeding practices that prevent baby bottle tooth decay.

Objective 4: **(16-17) Increase abstinence from alcohol (to 94%), cigarettes (to 98%), and illicit drugs (to 100%) among pregnant women.**

Evaluation: WIC implemented the new risk criteria related to tobacco use. In July, 2001, approximately 8.3% of pregnant women on WIC smoked. Illicit drug use is rarely identified as a risk due to attached stigma and fear of discovery. WIC continued to counsel women on the implications of abusing drugs and other harmful substances. Referrals were made to community organizations with smoking cessation programs and alcohol / drug abuse treatment services.

Plan: Continue to counsel women on the implication of abusing drugs and other harmful substances. Assist local agencies in identifying community resources and referral agencies available to WIC participants which deal with substance abuse issues. Refer to community organizations with alcohol and drug abuse treatment services. Collaborate with Project Assist and Rite Care providers in to develop cohesive strategies in reducing smoking rates among WIC participants. Support NHPRI's initiative to sponsor a smoking cessation program for pregnant RIite Ccare members.

Objective 5: **Work towards increasing to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies.**

Evaluation: Counseled WIC mothers on the importance of proper weight gain during pregnancy and sound dietary practices and a nutritionally adequate diet. Provided customized food packages based on nutritional needs and preferences. As of July, 2001,approximately 25.1% of prenatal women on WIC were risked with insufficient wt gain (loss), while .2% of postpartum women were risked with insufficient wt gain in their last pregnancy.

Plan: Continue providing targeted counseling on desirable weight gain to pregnant women, ensuring that high risk women receive required nutrition education contacts. Increase the inventory of available food package choices that will meet the needs of high risk clients.

Healthy People 2000 Objectives

Goal: Increase the span of healthy life for all Rhode Islanders, reduce health disparities among Rhode Islanders and achieve access to preventive services for all Rhode Islanders.

Objective 1: Increase healthy diet by reducing fat intake and increasing servings to fruits and vegetables to 5 or more servings per day, and grain products by 6 or more servings daily.

Evaluation: Counseled WIC participants on the importance of a balance diet along with the WIC foods to meet these goals, increased WIC participation in the Farmer's Market Nutrition Program to all WIC local agencies. An additional Farmer's Market was added in Foster. . Collaborated with Johnson and Wales University for "Veggin Out" cooking and nutrition education demonstrations at urban market sites. Two additional Veggin' Out locations were added this year. The Veggin' Out Recipe Book was expanded and offered at all Farmers' Market Locations.

Plan: Work to obtain additional FMNP funds for continuation and expansion of the FMNP to additional FM sites . Continue counseling participants on the importance of a balanced diet, and ways of incorporating fruits, vegetables and grains into their diets. Develop a mini-cookbook for legumes, peas and dried beans for distribution at WIC sites. Distribute 5-a -day information through WIC sites. Expansion of the "Veggin Out" cooking and nutrition education demonstrations.

Objective 2: Reduce tobacco exposure by reducing the prevalence of smoking in caretakers and reducing exposure to second hand smoke.

Evaluation: Counseled WIC participants on the dangers of exposure, coordinated WIC operations with smoking cessation programs to assist clients wishing to stop smoking, designated WIC clinics as "Smoke Free" zones.

Plan: Continue in these efforts

Objective 3: Reduce alcohol and other drug related health problems.

Evaluation: Counseled WIC participants of the dangers of substance abuse and coordinated WIC operations (when possible) with alcohol and drug treatment services.

Plan: Continue in these efforts

Objective 4: Reduce children's blood lead levels by reducing the prevalence of levels exceeding 10 mcg/dl by 50% and exceeding 20 mcg/dl by 75% among children through age 5 years.

Evaluation: Assisted in screening children, or referring for lead poisoning when possible, counseled WIC care givers on ways to prevent lead poisoning through dietary interventions, environmental interventions and screenings, worked with Lead Program to ensure that lead burdened children were referred to WIC through distribution of WIC outreach materials to families of lead burdened children. WIC/Lead materials were developed by HEALTH's communications unit and are in the process of being tested with focus groups in the community.

Plan: Continue with these efforts. Coordinate with Kids Net to provide lead screening results at WIC sites to determine the WIC lead risk status.

Objective 5: Improve oral health by preventing dental caries.

Evaluation Care givers continued to receive counseling regarding proper feeding practices that prevent baby bottle tooth decay.

Plan: If funding is available, re-institute sippy cup distribution project. Training will be offered to Nutritionists and Support Staff on Oral Health. Continue to counsel care-givers re: proper feeding practices which prevent baby bottle tooth decay. Refer WIC participants to dental care providers as needed.

Objective 6: Reduce poor birth outcomes by reducing the incidence of low birth weight infants, reducing tobacco and illicit substance use by pregnant women.

Evaluation: As of 7/01,12.7% of infants on the WIC program were premature or low birth weight infants. WIC counseled WIC pregnant women on the effect smoking and drug use has on the birth outcome and referred participants (when appropriate) to abuse treatment centers and/or smoking cessation programs, instructed clients on optimal weight gain during pregnancy, and monitored high risk participants for optimal weight gain during their pregnancy.

Plan: Continue to analyze data in more detail. Continue with WIC referrals, counseling and monitoring

R.I. WIC Objectives

Objective 1: Nutrition Education Plans, Quality Assurance Reviews and Self Monitoring

Evaluation: Reviewed and evaluated FY 2001 Nutrition Education Plans submitted by the 13 local WIC agencies; ensured their consistency with federal and state rules and regulations and emphasized the development of quality assurance systems to monitor the provision of nutrition education to WIC clients. During Management Evaluations, are reviewing the quality assurance program used as a local agency self evaluation systems. The results of the self assessment component have been

incorporated into the Nutrition Education Plan to allow quick/consistent feed back to the agency. A 2 year nutrition education plan was developed which will allow strategic planning to span 2 years, with the ability to evaluate and revise at a 1 year mid-point.

Plan: Continue with review and evaluation of Nutrition Education Plans, monitoring quality assurance and self-monitoring systems.

Objective 2: Provision of training programs for local agency staff.

Evaluation: Provided series of nutrition meetings and training for nutritionists (quarterly), breastfeeding peer counselors (quarterly and new peer counselor training), WIC coordinators (bi-monthly), local agency support staff series (3 times per year), and new staff training offered monthly. The annual meeting addressed civil rights, program integrity, and customer service and program procedures. Topics for trainings were based on staff requests and surveys, needs identified through management evaluations, policy and procedural changes, latest research.

WIC support staff received training in the provision of second nutrition education contacts, enabling them to provide low-risk participants with specific nutrition education based on topics pre-selected by the CPA.

Plan: Training will be provided based on needs identified through management evaluations, surveys of local agency nutritionists regarding their training needs/interests, and training which covers new information/research in nutrition and implementation of new policies and procedures.

WIC support staff will be provided training in low-risk nutrition education contacts (SNEC). SNEC training will be revised and competencies will be reviewed at Local Agency Management Evaluations.

As expansion funding becomes available, training additional breastfeeding peer counselors for placement at under served WIC sites.

Objective 3: Interview a random sample of WIC participants to ascertain their views of the benefits of nutrition education and nutrition services provided; and to make recommendations based on these findings.

Evaluation: WIC parent consultants conducted participant interviews related to access to WIC services, and client satisfaction /rights and responsibilities surveys as part of the Management Evaluation process, Focus groups were conducted with select WIC participants to improve access and quality of WIC services. Local WIC agencies surveyed their participants in the annual WIC Participant Survey and through the FMNP participant survey. The results were used to reduce barriers to service,

improve WIC services can be better provided, and the quality of services provided.

Plan: Continue annual WIC participant and FMNP survey, and the use of WIC parent consultants in obtaining participant information regarding WIC services they receive. HEALTH's communications unit plan to conduct focus groups with WIC eligible families, who have not received WIC benefits, to look at barriers to services.

Objective 5: Develop and test pilot group nutrition education contacts for WIC participants, to maximize nutrition education time.

Evaluation: Several Breastfeeding Peer Counselors have implemented group contacts (as space permits in local agencies) to promote and support breastfeeding.

Plan: Continue to support expansion of group nutrition education contacts.

Breastfeeding Promotion

Goal Increase breastfeeding initiation and duration

Year 2000 Objective

Work towards increasing to at least 75% the proportion of WIC mothers who breastfeed their babies in the early postpartum period and to at least 50% the proportion who continue breastfeeding their 5 to 6 month old babies.

Objective 1: To continue TLC project which promotes breastfeeding by offering in-hospital counselors, with follow-up support services to WIC participants.

Evaluation: Hospital based support services were available 7 days per week. Referrals are made by WIC TLC Counselors to WIC Breastfeeding Peer Counselors for follow-up after hospital discharge.

Plan: Improve two-way communication methods between hospital based TLC Counselors and agency based Breastfeeding Peer Counselors regarding referrals.

Objective 2: To develop computer generated reports which provide information on the incidence and duration of breastfeeding. The breastfeeding rate will be determined as the total number of breastfeeding women divided by the total number of infants.

Evaluation: Reports have been generated on a monthly basis to provide overall WIC breastfeeding rates both at the local agency level and state level.

Plan: If resources allow, develop a computer generated report that will determine

breastfeeding *duration* rates at the local agency and state level for 3 months, 6 months, 9 months, and 12 months.

Objective 3: **To expand and improve the effectiveness of the Breastfeeding Peer Counseling Program ("Mother to Mother") .**

Evaluation: The Peer Counselor Program currently provides services at 11 WIC sites. Breastfeeding training was provided to all staff, helping them to identify barriers to breastfeeding specifically related to WIC. Statewide WIC breastfeeding rates have increased steadily over the past year from 11.6% (9/99) to 14.6%as of 8/02, a 25% increase.

Plan: Continue to monitor WIC breastfeeding rates on a monthly basis. Develop a comprehensive standardized Peer Counselor Manual to include both training materials and operational policies and procedures. Provide quarterly trainings for peer counselors offered by State WIC Staff and offer other training opportunities outside of WIC. Implement and evaluate the effectiveness of Breastfeeding Classes designed for all prenatal participants as a breastfeeding promotion method.

Objective 4: **All local agencies will designate a WIC nutritionist to serve as the Local Agency Breastfeeding Coordinator.**

Evaluation: All local WIC sites designated a Breastfeeding Coordinator

Plan: Ensure that Breastfeeding Coordinators are conduits for sharing of breastfeeding support and promotion information, clinical updates, and breastfeeding data sharing.

Objective 5: **Assist in development and support of statewide infrastructure which support and promote breastfeeding.**

Evaluation: Participated and supported the on-going efforts of the RI Breastfeeding Coalition in the support-promotion of breastfeeding by attending monthly meetings and assisting in special projects. Distributed the revised 2001 Breastfeeding Resource Directory for Health Care Professionals. Partnered with several agencies and organizations for the 2002 WIC World Breastfeeding Week Event.

Plan: Continue support and participation of R.I. Breastfeeding Coalition, distribution of latest edition of the Breastfeeding Resource Guide, promotion of World Breastfeeding Week and provide leadership for implementation of a 3-year statewide strategic plan to increase breastfeeding rates in RI.

IV
Supplemental Foods
(Procedures - 420, Operations - 41)

Goal: To provide nutritious supplemental foods to all WIC participants according to nutritional need and federal regulations within the financial means of the Program.

Objective 1: Review and modify the WIC Allowed Foods List and Food Packages

Evaluation: Began a review of the WIC Allowed Food List, and revised as needed the procedures for selection of WIC allowed foods. Included cost consideration, market availability, funding restrictions, local agency and WIC client input. Included review of private label cereal for inclusion on WIC allowed food list.Held focus groups with WIC participants, Parent Consultants, Vendors and WIC Local Agency staff to have input about the acceptability of the new food package. Starting programming to expand selection of food packages on the QWIC system.

Plan: Complete food package programming. Add to WIC food package tailoring guide those packages that meet program and client needs. Complete the review of WIC Allowed Food List evaluation

Objective 2: Provide alternate sources of calcium

Evaluation: Calcium fortified juice is available to women's food package.

Objective 3: WIC Nutrition Risk Criteria

Evaluation: Implemented revisions to the WIC Nutrition Risk Criteria. Provided on-going technical assistance in implementing the risks.

Plan: Implement the newest risks released by USDA.

GOALS FY 2002

V. OUTREACH AND COORDINATION

SECTION V

Outreach and Coordination

Refer to WIC Procedure Manual Section 500
WIC Operations Manual Section 5

V

Outreach and Coordination

OUTREACH PLAN

Goal: To communicate the availability of WIC services to all potentially eligible Rhode Islanders.

Healthy People 2010 Objective 16-6

Objective 1: **Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy and the proportion of pregnant women and infants who receive risk-appropriate care.**

Evaluation: Statewide, delayed prenatal care rates have dropped by almost 50% over the past 10 year. Vital Records data for 1996-2000 show a state-wide rate of 9.2%, the best in the country. However, core cities have a rate of 13.7%. There are, however, significant differences along racial/ethnic lines. During 1996 – 1998, 86% of White mothers received adequate prenatal care. The rate for African Americans (78%) was 78%. For Hispanic women, it was 77%. WIC provided referrals to RIte Care and Rite Start for uninsured pregnant women to improve access to health care. 95% of WIC participants have health insurance in RI.

Plan: Continue screening prenatal applicants for access to prenatal services, make appropriate referrals to health care providers as necessary.

Objective 2: **Increase to at least 75% the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionist or dietitians.**

Evaluation: WIC Outreach information was distributed by Neighborhood Health Plan, United Health Care, and Blue Chip Plan. A WIC Provider relation's position was added, which provided physicians information about WIC and the Kidsnet program. The WIC provider relations position along with local agency staff, provided in-services to physicians clarifying the WIC eligible population and WIC policies and procedures. On-going coordination continues with Division of Family Health program (Early Intervention, Lead Program, Kids Net) to improve access to needed services.

Plan: Ensure referral of all appropriate hospital and health center patients to clinics and ensure that WIC nutrition services are included in team managed care for patients. Coordinate WIC risk assessment procedures and WIC risk-criteria definition with

other Division of Family Health programs so as to complement and not duplicate nutrition assessments for pediatric and prenatal clients. Contact, at least annually, by phone, mail, or visit local health care providers to educate, solicit referrals and encourage sharing of information. Target providers who serve Ritecare populations and provide prenatal care.

Healthy People 2010 Objective 1-5

Objective 1: **Increase the proportion of persons with a usual primary care provider to 85%.**

Evaluation: Continued to screen and refer applicants for health care needs, and provided risk appropriate nutrition services. Provide information to families on new RIte Care age and income eligibility.

Plan: Identify all high risk areas in Rhode Island and target them for outreach to pregnant women. Bring women, infants and children into the health care system and provide risk-appropriate nutrition services. Analyze Local WIC Agency Risk Reports to identify local agencies' high-risk caseloads. Assist local agencies in targeting outreach effectiveness.

WIC Objectives

Objective 1: **The State and Department of Health have developed an automated tracking and follow up system to ensure a comprehensive approach to monitoring children's individual services and needs. The system is titled Kids Net.**

Overview: Enrollment of additional providers is continuing. WIC provides demographic and certain health data to KidsNet. Plans include developing data systems links to obtain participant/applicant information needed for WIC purposes to simplify client access to WIC by reducing duplicate information submission.

Kids Net is a designated public organization to receive WIC participant information only for purposes of establishing eligibility for services and conducting outreach to WIC participants, in conformance with 246.26, (d) of WIC regulations.

WIC is completing an automated immunization and lead outreach and referral link with KIDSNET which will accept out of compliance and shots due messages from KIDSNET for transmission to parents, reinforcement and follow-up.

WIC and KidsNet will establish a KN transmission to WIC of lead screening results for follow-up and WIC eligibility determination.

Kids Net will provide WIC outreach information to potential WIC eligibles.

Evaluation: WIC continued to collaborate with Kids Net during the development phase of the Kids Net MIS.

Goals 2003 Section V Outreach And Coordination

Plan: Continue with Kids Net collaboration, working towards full implementation of system in 2003. Evaluate the implementation of the Lead / Kidsnet / WIC pilot at select WIC sites.

Objective 2: **Share relevant need data, with local agencies including socioeconomic and demographic data by census tract.**

Evaluation: Local WIC sites were able to request reports to assist in needs assessment and strategic planning.. Periodic reports were provided to local WIC coordinators highlighting participant profiles (demographic and socioeconomic data) and use of certifying risks.

Plan: Continue to provide socioeconomic and demographic data by census track to focus outreach to under served areas. Share with local WIC agencies the Providence analysis by census tract.

Objective 3: **Saturate identified high risk areas with outreach materials, including posters and brochures in churches, Laundromats, grocery stores, resale shops, PSAs etc.**

Evaluation: Reviewed and monitored local agency outreach plans (in Nutrition Education Plans). Provided outreach materials to local WIC sites. Ensured that accurate outreach materials were available in Spanish. Outreach mailings targeted licensed day-care facilities, major employers Human Services Offices, Unemployment Offices, Head Start Programs and health fairs. Organized a Statewide Outreach Committee to develop, coordinate and evaluate outreach services.

Plan: Assist and ensure that local agency Nutrition Education Plans include outreach targeting high risk areas, continue with targeted outreach efforts, and collaborate with implementation of Outreach RFP with the Division of Family Health. Work with HEALTH Communications unit to evaluate effectiveness of outreach efforts.

Objective 4: **Identify any migrant populations and target them for outreach, if appropriate.**

Plan: Coordinate with the R.I. Department of Environmental Management, Division of Agriculture, and the Department of Employment and Training to identify areas of the state which offer migrants jobs. Employers will be provided with WIC outreach brochures.

Note: Full funding may be necessary to serve those WIC clients who may be certified based only on migrancy due to the low priority level (as currently proposed).

Objective 5: **Solicit public and legislative support for WIC by promoting positive accomplishments through press releases, human interest stories, presentations to groups and appearances on radio and television shows.**

Evaluation: Had newspaper and radio interviews re: WIC services, and presentations to parent and professional groups, initiated news articles about local agencies with positive Management Evaluation findings, opening of new WIC sites, editorial article published re: World Breastfeeding Week. Provided information to congressional staff.

Plan: Continue with outreach efforts to solicit public and legislative support for WIC.

Objective 6: **Publicize availability of WIC services and eligibility information to general population through monthly classified ads posters, distribution of pamphlets, annual public notice in a statewide newspaper, and listings in Hispanic directory**

Evaluation: WIC services were publicized by distribution of new WIC outreach brochures (targeting working eligibles), and annual public notice in a statewide newspaper along with 5 community meetings; arranged for special telephone directory listing of all local agencies and state (800) info line. A WIC listing was added to a Hispanic directory.

Plan: Continue outreach efforts as above. Collaborate with the Division of Family Health in the implementation of an integrated RFP for outreach initiatives targeting under served populations. Develop outreach connection with Kids Net.

Objective 7: **Increase by 10% the proportion of all WIC pregnant women who enroll in the WIC program in the first trimester of pregnancy.**

Evaluation: WIC Community Liaison focused on outreach visits to OB /GYN offices. Due to MIS problems, unable to evaluate the impact at this time.

Plan: Continue target WIC outreach to health care providers, with particular emphasis on health care providers not associated with community health centers, this will be accomplished by our provider relations person. Evaluate the current WIC data related to month of entry into WIC during pregnancy.

Objective 8: **Enroll at least 85% of estimated eligible pregnant women in designated high priority areas.** (Refer to Goals Section IV)

At a point in time, 67% of WIC eligible participants are being served statewide.

Plan: In collaboration with Family Planning, complete the development of a WIC /Family Planning brochure which would inform pregnant women of WIC when their pregnancy is confirmed. Continue visits and mailing to health care provider's offices once a year.

Objective 9: **Contact RIte Care (expanded Medicare program) HMOs and care providers to educate and solicit referrals for newly adjunctively eligible clients (185% to 250% of federal poverty level).**

Evaluation: Rite Care (Medicaid) distributed WIC information to new enrollees. Rite Care providers referred enrollees to WIC, and provided case management for select high risk patients. Collaborated with Rite Care HMO's at outreach events.

Plan: Continue with outreach plan for HMOs and care providers regarding WIC eligibility. Identify and target Ritecare providers through MCO physician directories. Encourage MCO's distribution of WIC materials at new site visits.

Objective 10: Support partnerships between non-health center providers and WIC site staff.

Evaluation: Members of WIC Outreach Committee joined the Provider Relations staff in providing WIC in-service to private providers in the community.

Plan: Build communication links. Invite WIC staff to join provider relation's staff at provider's visits. Identify provider needs and share with WIC. Educate WIC eligibility and criteria guidelines.

Objective 10: Monitor telephone calls to state agency by line used and source of referral.

Evaluation: 1798 WIC related calls were received from October 1, 2001 to September 26, 2002. There was in increase in referrals from providers' offices, and the internet. Fewer referrals came from directory assistance and the phone book. Spanish speaking callers decreased from 316 to 199.

Plan: Continue to periodically evaluate telephone calls to state agency by line used and source of referral.

Objective 11: Monitor use of referral fields on QWIC system, which document how a WIC applicant heard of WIC.

Plan: Prepare and analyze local agency use of QWIC system re: type and frequency of referrals documented on QWIC system. Provide technical assistance as needed.

Objective 12: Compare WIC referral data with data collected by RIte Care.

Evaluation: RIte Care implemented but referral data not yet available.

Plan: Develop strategy for using RIte Care data to improve referrals to WIC.

Objective 13: Distribute outreach materials, annually, to shelters and organizations serving the homeless, including program availability and eligibility information.

Evaluation: Ensured that local agencies included homeless shelters and other organizations serving the homeless in their outreach efforts as documented in the LA Nutrition Education Plan submitted on a yearly basis. Review the current listing of homeless

/ safety shelters, confirm and document status as WIC eligible facility, provide updated information to local agencies and hotline staff.

Plan: Continue outreach to shelters and organizations serving the homeless.

Objective 14: Provide all local agencies with up-to-date lists of homeless facilities in their vicinity, which comply with required conditions.

Evaluation: This objective was not met last year. Recently purchased 2001-2003 Emergency Services Directory from Traveler's Aid to distribution to local WIC agencies.

Plan: Distribute Emergency Services Directory from Travelers' Aid to local WIC agencies.

Objective 15: Review for any barriers to service for children in foster care or protective services care and revise policies and procedures to improve access.

Evaluation: Client Services Unit continued to act as liaison for foster parents/foster services and local WIC sites. Provided technical assistance to local agencies re: foster services to ensure continuity of service.

Plan: Continue to review and respond to any barriers to service for children in foster care or protective services. Prepare at least once a year an article for the foster parents' newsletter, or a mailing to all foster parents.

Objective 16 Develop and carry out effective outreach to Native Americans in consultation with the Narragansett Indian Tribe, the Rhode Island Indian Council and HEALTH Minority Health Office.

Evaluation: Preliminary development of options was cooperatively developed with the NIHC nutrition services unit in FY '97.

Plan: Continue in efforts with the NIHC in increasing access to WIC services, working with the HEALTH Minority Health Office.

Objective 18: Distribute outreach videotape to WIC agencies and other agencies in the outreach network, as appropriate.

Evaluation: The Outreach Committee developed and produced a WIC outreach power point presentation. This was duplicated and distributed to local WIC agencies for use within their service area.

Objective 19: Provide assistance to prepare / provide targeted outreach to terminated WIC participants.

Prepare / provide postcards and computer generated labels with reminders to

all terminated participants, to improve participant retention rates.

Coordination

Goal: ***To maximize the health gains of WIC benefits by insuring that WIC participants receive all needed health care and preventive health care services. The effectiveness of WIC benefits will be reinforced by ensuring that the families of WIC participants meet basic sustenance needs.***

Healthy People 2010 Objectives

Objective 1: **Reduce the prevalence of blood lead levels exceeding 10ug/dL to 0 in children aged 1-5.**

Evaluation: Assisted in screening and/or referring to health care providers for blood lead levels, documented and forwarded abnormal blood screening results, including elevated lead levels to health care providers, counseled WIC care givers on ways to prevent lead poisoning through dietary interventions, environmental interventions and screening. Implemented the pilot project with Kidsnet re: assessment of child's lead screening status, with appropriate education, referrals and WIC services.

Plan: Continue with these efforts, investigate inclusion of WIC referral information on lead screening test slips sent to health care providers, and evaluate WIC enrollment of children with lead poisoning. Continue the Kidsnet / WIC lead initiative to assess lead status at pilot WIC site.

Health People 2010 Objectives 16-19

Objective 2: **Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old, and to 25% at 1 year.**

Evaluation and Plan: Refer to Section IV, Breastfeeding Promotion

Objective 3: **Reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births.**

Plan: Continue to screen, counsel and refer WIC applicants re: the dangers of alcohol use during pregnant, and fetal alcohol syndrome. Ensure that local WIC agencies are familiar with substance abuse service providers in their communities.

Healthy People 2010 Objective 16 - 17

Objective 4: **Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women to:**

Alcohol – 94%
Binge Drinking – 100%

Cigarette Smoking – 98%
Illicit Drugs – 100%

Evaluation: Evaluated policies and procedures that coordinate operations with and facilitate referrals to and from programs such as special counseling services, EFNEP, DCYF, Food Stamp Program, TANF, Medicaid, Child Support Enforcement Program and Title V funded programs and local breastfeeding support programs. Monitored efforts during local agency management evaluations.

Plan: Continue efforts.

Objective 5: **Participate in 90% of planning meetings for Healthy Mothers/Healthy Babies Coalition, R.I. Breastfeeding Coalition, KidsNet, the RI Food Security Coalition and other MCH/DOH advisory committees.**

Plan: Recruit and hire a new state Breastfeeding Coordinator and public health nutritionist. Continue efforts outlined above.

Objective 6: **Train local agency staff in scheduling certification, recertification, check pickup and nutrition education appointments for the convenience of clients and to optimize opportunities for nutrition education. Schedule WIC appointments, as much as possible, with other local agency clinic visits and where possible combine intake procedures for other services with WIC. Monitor health appointments.**

Evaluation: Continued to uses results of Patient Flow Analysis, client surveys and Management Evaluations to target training for local staff re: clinic efficiency and client satisfaction issues.

Plan: Continue with efforts.

Objective 7: **To improve access in high needs areas, investigate and, if feasible and cost effective, provide coordinated WIC services through HMO and PPO sites. If not feasible, develop and implement coordinated referral system from HMO and PPO sites established WIC sites, and improve ability of current infrastructure to handle increased demand.**

Plan: Continue with current efforts in improving access to WIC through coordination with HMO and PPO sites, and Narragansett Health Center.

Objective 8: **Ensure referral of all appropriate hospital and health center patients to WIC clinics and ensure that WIC nutrition services are included in team managed care for participants.**

Evaluation: Continued collaboration with Family Resource Counselors who perform some pre-screening for WIC and Medicaid outreach in health centers. Monitored referral

systems during local agency Management Evaluations.

Plan: Continue with efforts. Investigate the development of a WIC participant flyer, which would be placed in waiting areas and carry human-interest stories about WIC.

Objective 9: Ensure health care referrals or continuation for all participants whether within the agency or with private providers.

Evaluation: RIte Care implementation resulted in an increased selection of health care providers. WIC continued to assist families through referrals to Medicaid; WIC outreach/referrals were included in the KidsNet Risk Response-Home Visiting initiative which will focus on home visiting, improved coordination and outreach for high risk children and families.

Plan: Continue coordination with Kids Net implementation, and screening and referrals to Medicaid (including WIC families with children up to age 18 now eligible for RIte Care)

Objective 10: Provide written information concerning the Food Stamp Program, Family Independence Program, the Child Support Enforcement Program and Medicaid income eligibility to WIC applicants.

Evaluation: Revised and distributed pamphlet which gives information on the above programs and RI's RIte Care Program, and in-service training was provided to local WIC staff regarding it's use.

Plan: Continue efforts for distribution.

Objective 11: Update, annually, eligibility requirements of General Public Assistance, Family Independence Program, Food Stamps and Medicaid and disseminate information to local agency staff.

Evaluation: Information was updated in the Procedure Manual, and new income guidelines were effective April 1, 2002.

Plan: Continue efforts

Objective 12: Contact, at least annually, by phone or mail, local health care providers to educate, solicit referrals and encourage sharing of information.

Evaluation: Monitored local agencies outreach efforts via the management evaluation and the Nutrition Education Plan. Tracking system development to monitor progress. Outreach to health care providers conducted via office visits, mailings and provision of outreach materials

Plan: Continue efforts. Provide feedback to local agencies regarding their referral profile,

include in the newsletter. Develop and outreach packet, including social marketing principles that are effective, easy to use, inexpensive and provide practical example of outreach methods that local agencies may use. Use newly developed tools as WIC Provider Liaison Manager contacts providers.

HP 2010 Objective 21

Objective 13: Achieve immunization coverage of at least 90% among children 19 – 35 months of age.

Evaluation: At WIC sites, staff inquired as to immunization status of WIC children and encouraged caretakers to have children immunized, and referred child to health provider if necessary. 95% of RI WIC participants have health insurance. Collaborated in the expansion of Kids Net, which will enable statewide tracking of the immunization status of children.

Plan: Implement mandated immunization screening process. Continue with immunization efforts in collaboration with the Immunization Program, evaluate effectiveness of collaboration, work to obtain additional funding to support WIC clinics programming and hardware needs for Kids Nets implementation.

Objective 14: Explore available electronic communications devices and systems to communicate between helping agencies.

Evaluation: Attended meetings of regional EBT executive committee (New England Partners) and Kidsnet Planning Committee. Continued to participate in the development of electronic sharing of eligibility information between agencies (see Kids Net, Outreach Obj. 4).

Plan: Continue development of EBT pilot project, and collaboration with Kids Net.

JP 2010 Objective 19 – 18 Food Security

Objective 15: Increase food security among US households to 94%, and in so doing reduce Hunger.

Evaluation: The RI Food Security Monitoring Project (RIFSMP) estimated that 24.4% of households residing in poverty census tracts in RI were food insecure in 1999. The WIC Participant Survey results from '96 – '00 indicated that about 75% of WIC participants surveyed worry they will run out of money to buy food and only 50% indicated they could "often" eat properly.

Plan: To continue assessing food insecurity indicators on the annual WIC Participant Survey and to continue annual statewide monitoring activities of the RIFSMP. Participate in the statewide efforts of the RI Food Security Coalition and other food and nutrition programs that are working to improve food security among low-income Rhode Island individuals and families.

Goals 2003 Section V Outreach And Coordination

STATEMENT ON SPECIAL POPULATIONS

American Indians

The 1990 census indicates the American Indian population of Rhode Island to be 3987. Based on socioeconomic data all categorically eligible Indians may be eligible. Statewide, 26% of American Indians are below poverty in the 1990 census and 50.3% of American Indians ages 0 to five.

Past data indicated that most Rhode Island Indians were served by the Thundermist Health Center of South County or Wood River Health Services. Recent census data shows that Indians live across the state and that a significant number live in Providence. Discussions with Native American representatives suggest that Native Americans served by WIC may be under counted or be applying at lower rates than other population groups. The state WIC office plans to work with Native Americans to consider options for better serving this population, including WIC access at the new Narragansett Indian Health Center.

Migrant Farm workers

Migrant Farm workers who come to Rhode Island during the spring and summer number approximately 281, according to the U.S. Department of Health and Human Services Migrant Health Branch. Many may come without their families. Therefore, the estimate for possible migrant WIC participants in Rhode Island is negligible.

There are approximately 178 seasonal workers, according to DHHS. Contact has been made with the New England Farm workers Council alerting them to the WIC Program and location of the WIC agencies in Rhode Island. All Program materials have been made available to the Council. Contact with the representative of the Farm worker's Council is maintained through various social service organizations and meetings.

GOALS FY 2002

VI. FINANCIAL MANAGEMENT

SECTION VI

Financial Management

Refer to WIC Procedures Manual Section 600
WIC Operations Manual Section 6

VI

FINANCIAL MANAGEMENT SYSTEM
(Procedures - 600, Operations - 6)

Goal:

Cost Containment

Objective 1: To complete each fiscal year with food expenditures within five tenths of one percent of the Federal Grant, including utilization of any funds conserved through food cost containment savings, or added by local sources.

Evaluation - Per participant food costs have increased in FY 2002. RI WIC implemented revisions in the WIC Approved Food List by restricting milk selections to least expensive, the addition of private labels cereals and the removal of refrigerated juices. However, the loss of the Northeast Dairy Compact rebate, increased breastfeeding rates, increased formula costs, and increased cheese costs have increased the average cost of the food package.

Plan: With the implementation of the new Vendor Management software module, food cost analysis will be expanded and include peer group comparisons. Continue efforts.

Limiting High Cost Food Items

The prices for certain types, brands and packages of allowed foods significantly exceed the prices for nutritionally equivalent products, even allowing for maintaining of reasonable participant choice.

Objective 1: Review the current WIC allowed food list and WIC eligible foods for cost, availability, consumer preference and nutritional value. Select cost effective WIC eligible foods that would meet the needs of WIC participants.

Evaluation: WIC eligible foods were reviewed for inclusion on the RI WIC Allowed foods list. Focus groups with participants determined that the additional of private label cereals would enhance the perceived value of the WIC food list.. The addition of "least expensive milk" was considered a neutral issue. Implemented the new WIC allowed food list to enhance cost containment while using the new list as a marketing tool to retain current WIC participants and promote the value of the WIC food benefit package among applicants.

Goals 2003 Section VI Financial Management

Plan: Continue food review efforts.

Food Price Reduction Initiatives

Infant formula manufacturers have reduced the cost of infant formula to WIC programs significantly by paying rebates on a portion of the sales price to the WIC Program. Under current federal law, such rebates can be used not only to provide food benefits for additional participants but also to purchase breast pumps. In Rhode Island, choice of infant formula for over 96% of WIC infants has been limited to the rebate contract products of one manufacturer, to achieve the greatest cost savings. This has allowed RI WIC to serve almost 6,000 additional people. It would seem prudent to explore rebate cost savings for other foods, even if it meant some restriction of brand choice.

To the extent that a WIC foods cost containment system may place constraints on participant choice, it will be necessary to work closely with the participants and vendors in order to establish the most beneficial system; balancing off patient choice and convenience, impact on vendors, financial implications and opportunity for services to additional needy persons.

Objective 1: Solicit comments on proposed methods of containing costs of WIC foods concerning the impact on health/nutritional needs of participants, effects on Program attractiveness, increasing the number served through reducing costs and the relative merits of different methods and the present purchase system.

Objective 2: Solicit and evaluate the comments of medical and nutritional professionals, participants, vendors and others and secure the acceptance by such groups of a WIC foods cost containment process

Objective 3: To make a determination whether the adoption of a cost containment system is in the interests of the Rhode Island WIC Program, both in the short and long terms.

Plan: Continue comment and evaluation process in the finalization of the WIC Allowed Foods List. Once implemented, track the impact of the changes on food costs, participation rates and retention rates.

If a determination, following thorough evaluation, is made to adopt food cost containment rebate initiatives, the following objectives will be pursued:

Objective 4: Determine which WIC food types (ex. cereal, juice, peanut butter, etc.) lend themselves to cost containment by limiting which can be purchased to those for which a rebate or other cost reduction can be achieved.

Objective 5: Based on an analysis of all information available, and best administrative judgment by the state agency, request for proposal specifications will be issued

concerning food cost containment methods.

Objective 6 : Selection of the cost containment system which best meets client needs, in light of the most efficient and effective administration of the Program.

Objective 7 : Evaluation of client nutrition and health factors and establishment of guidelines to ensure that needed foods are available.

Objective 8 : Prior to implementation of the system selected, a final decision, based on a review of all available information and relevant factors, to adopt cost containment will be made if determined to still be in the best interests of the RI WIC Program.

Objective 9 : Implementation of cost containment system

Objective 10: Periodic review of the operation of the cost containment and state agency decision on system adjustments, revisions or termination as appropriate.

Description of Cost Containment Initiative

The Rhode Island WIC Program is proposing to adopt specific guidelines and criteria for selecting limited food brands for purchase in the Rhode Island WIC Program. Such guidelines and criteria will implement the relative cost criteria for selection of WIC Allowed Foods mentioned in the State Operations Manual, Section 4. This proposal is also in accordance with the State Plan provision for review of WIC Allowed Foods for inclusion of additional items or removal of items that do not meet state criteria.

The Department is proposing a method of selecting food brands for inclusion as WIC Allowed Foods by which the most efficient and effective brand selection and cost containment system for the WIC Program can be derived through the options described later. In addition, the Department wishes to distribute standard foods through the retail distribution system.

By this method of selecting food brands based on relative cost, the Department seeks to expand its services to serve currently unserved, but eligible, populations. This would be accomplished through either a Sole Source or Multisource rebate system, or a combination bid of these, and other methods.

The state may offer manufacturers of WIC foods the opportunity to bid on a sole source and/or multisource rebate systems. Comparisons shall be made among all bids received and based on these comparisons, the decision will be made whether to adopt a sole source system, or a multisource system. The Division of Purchases has indicated that such bids may be issued by the HEALTH. The rebate bid process and the operation of the system shall be as follows:

Sole Source Rebate System

For a specific food type, or form or composition, the product(s) of only one manufacturer will be designated as the primary brand(s) for purchase in the WIC Program. The designation will be based upon the rebate bid which will yield the lowest net cost for the food type taking into account the amount of the rebate bid, the wholesale price and future cost guarantees, participant acceptance, variety of types and choices, statewide availability and established market share.

Multisource Rebate System

The products of all manufacturers for which the Rhode Island WIC Program receives a minimum acceptable rebate amount or price reduction or which do not have a cost/price above a stipulated level, would be authorized for purchase with WIC checks. Manufacturers will be billed for purchases of that manufacturer's brand(s) in accordance with documented market shares. The state shall make such determinations needed to resolve any market share differences of varying documentations submitted.

A manufacturer may bid, and be awarded, a market share which exceeds its documented market share.

Award(s)

A. Sole Source Bid:

All sole source bids will be compared to each other and the bid yielding the lowest net cost for a stipulated minimum variety of the foods.

B. Multisource Bid:

1. If a multisource bid is also sought, the lowest net cost sole source bid shall become the standard against which all bids received for any multisource option will be compared.

2. All multisource bids will be evaluated and a determination of combined costs will be made based on the bids, wholesale prices, future cost guarantees and the bidders' market shares.

3. Both the sole source and the multisource bids being evaluated will be further adjusted for identified costs and savings related to the sole source system in the one case and the multisource system in the other to determine for each system a total annual food type system cost. The total annual system cost for sole source and multisource will be compared to see which system and bid(s) will be implemented, provided the bids assure a satisfactory variety of product.

C. Awards

To select allowed brands, sales data or a participant survey will be consulted in making a final determination. Contractual Agreement(s) will be entered into between the state and the manufacturers awarded the bid(s).

D. Refusal of Bids

The State may refuse all bids if the responses are inadequate to achieve the objectives of this Initiative and cancel, postpone, revise or retry the Initiative.

Alternative Proposals and Methods

The state may accept and consider alternative cost containment proposals during the state plan comment, proposal development, and bid period. The State will consider such alternative proposals if equivalent or better as to the cost containment savings, contribution to the stability of the Program, safeguards and other such factors related to the efficient and effective administration of the Program. The method of consideration of such alternatives and comparison against the sole source/multisource proposal in this State Plan will be determined by the State depending on the nature of such alternative proposal(s).

In addition, the State will exclude from approval any product whose cost or price exceeds a stipulated amount or percent above the average cost or price for the products of its type which meet all the WIC food criteria.

WIC Foods to be Procured.

Adult cereal
Infant cereal
Juice
Peanut butter

All companies known to the Office of Women, Infants and Children to manufacture foods meeting the requirements of the invitation to bid will be offered an opportunity to bid.

Accountability System.

The number of units to be rebated will be determined from the monthly check reconciliation which lists checks redeemed during a given month.

The reconciliation covers checks paid during the preceding month. Bills based upon checks paid will be prepared and sent to the contractor(s) by the end of the month in which the reconciliation is received. The contractor will submit payment to the Department within fifteen calendar days of the

date of the Department's invoice. A penalty, as stipulated in the contract, will be charged on any unpaid balance until such time as payment is received the Department.

Conversion of Funds to Administrative and Program Services Funds.

Once FNS has approved this State Plan the state agency may begin converting funds for each participant served on a monthly basis over the FNS projected average monthly anticipated level established by the Administrative Funding Formula. The proportion of money to be converted to Administrative and Program Services Funds shall be in accordance with federal regulations and directives.

Local Agency Allocation.

At such time as appropriate the state agency shall notify local agencies of authorized caseload expansion based on rebate income. Such authorizations may be either a fixed authorized number or permission to expand on a "subject to further notice" basis.

Administrative and Program Services reimbursement will be based on the number of the authorized additional persons actually enrolled.

Program Income

State law has established fines for violation of program rules by vendors, participants or other parties. Procedures will be put in place for restitution by participants of program funds obtained through fraud or misinformation. Fee schedules for vendor authorization and excessive monitoring activities will be investigated.

Objective 1: Establishment of policies for instituting claims against participants for funds received through fraud or misinformation.

Objective 2: Establishment of policies for imposition of fines for fraud or abuse of the program by any parties.

Objective 3: Investigation of establishment of a fee schedule for vendor authorization activities such as application fees, enrollment fees, renewal fees and fees for monitoring activities following a final warning of a violation.

Administrative Funding Formula

In order that local agencies can anticipate stability of the basis on which their funding is calculated, the state will maintain the same administrative funding formula as outlined in the previous State Plan. From total available administrative funds, up to 63% of the basic grant, including any

negotiated amounts, will be allocated for local agency administration.

Utilization of State of Rhode Island Appropriation

For state FY 2003, no State appropriated funds are expected.

Since 1995, state funds were made available for food and administrative costs of the Farmers' Market Nutrition Program. In the event that other than Federal funds are again made available to supplement the Program, such funds will be received, allocated, expended and accounted for in accordance with the legislation or executive directive making the funds available, or the conditions of any non-government grant. In addition, such funds will be managed in accordance with applicable federal and state laws and rules. In particular, such funds will be utilized in conformance with the provisions of this State Plan of Operation and Administration.

State appropriated funds may be used either for WIC or Farmers' Market services.

Internal Controls And Reporting

Goal: **To pilot electronic transmission of WIC local agency monthly expenditure reports as a means to facilitate processing of payments and to reduce maintenance of paper backup of reports.**

Objective 1: Develop electronic filing mechanism for local agency reporting of WIC Monthly Expenditure Reports - Nutrition Services and Administration

Evaluation: Covansys financial management module has been developed. The system will allow the import of transactions from the RISAIL system. However, due to cost constraints, RI WIC was unable to include the ability to transmit bills electronically.

Plan: Investigate the use of web technology to allow entry of billing data from local agencies to the state agency.

AUDITS
(Procedures-622, Operations-6)

The Regional Inspector General for Audit, Department of Health and Human Services, has been designated as the Cognizant Audit Agency for the State of Rhode Island with respect to the major compliance programs.

In Rhode Island, the State Office of the Auditor General is responsible for annual audits of the WIC Program in conjunction with audits of other significant federal programs. Either the Auditor General or the Bureau of Audits may actually conduct the audits.

Objective 1 - Collaborate with the OAG re: required single audit requirement.

Evaluation: The draft Audit Report for State FY '01 has not yet been received. The Audit Exit Conference revealed no material weaknesses or findings.

Plan: Prepare for FY '02 audit cycle focusing on impact of RISAIL implementation.

Objective 2 - Review the audit reports and management letters of independent audits performed for local agencies.

Plan: Findings from audit reviews will be addressed as appropriate to ensure that all federal and state financial requirements are met.

Evaluation: A review of the FY '02 findings of an independent audit for each local agency was scheduled and 11 of 13 received to date.

General Administration

Local Agency financial staff have expressed an interest in state-provided training the area of WIC Program funding and expediture policies and procedures.

Objective 1: To plan and hold a WIC financial management seminar for local agency finance administrators and/or finance staff to review financial management issues relating to WIC Program reimbursement. This meeting will be one-half day in length and will be education and training oriented.

GOALS FY 2002

SECTION VII

Monitoring

Refer to WIC Procedure Manual Section 700
WIC Operations Manual Section 7

VII
MONITORING

Local Agency Reviews

Objective 1: **A biannual local agency review will be conducted for each local agency, including a site visit. Monitoring shall include, but not be limited to, evaluation of management, certification, nutrition education, civil rights, compliance, accountability, financial management systems and food delivery systems.**

Evaluation: All required financial and management evaluations were conducted for FY '02. Management evaluation findings were transmitted to executive directors and WIC Coordinators. Corrective plans were developed, reviewed and approved by the State agency.

Plan: Schedule and complete monitoring visits as required. Focus will be placed on the implementation of new bloodwork and physical presence regulations. Findings from previous evaluations will be used in assessing training needs of local agency staff.

Objective 2: **Follow-up on implementation of needed corrections and corrective action plan schedule in order to correct cited deficiencies and prevent their recurrence.**

Evaluation: Interim site visits were made to provide technical assistance in areas related to programmatic deficiencies noted during evaluations as needed.

Plan: Follow up, as needed, to review implementation plans and check progress in correction of deficiencies.

Objective 3: **Conduct additional review activities, as are needed, to ensure local agency compliance with changed or additional federal or state requirements, directives or guidance.**

Evaluation: Follow-up activities related to new blood work rule were conducted. This included additional technical assistance and feedback on risk criteria selection use, segregation of duties and other topics.

Plan: Provide additional technical assistance in the implementation of the new blood handling regulations, self declaration of income, residency and ID, and physical presence.

Objective 4: **Assist local agencies in developing and establishing self assessment management evaluation systems. These systems will be implemented to review their operations and those of associated clinics on a yearly basis.**

Plan: Focus on self assessment process during management evaluations. Provide technical assistance in the development, implementation and use of the assessment process.

Objective 5: Provide technical assistance to local agency Coordinators in how to self-assess quality and write useful corrective action plans.

Plan: During the management evaluation process, provide technical assistance to local agency WIC coordinators on the development of plans of corrections, and how to incorporate the cited areas into their internal QA process.

Objective 6: Review management evaluations to determine further training needs.

Plan: Incorporate ME findings (as needed) into the training sessions scheduled for WIC Coordinators, Nutrition Staff, Support Staff, Breastfeeding Peer Counseling Staff and/or at the Annual WIC Training Meeting.

GOALS FY 2002

SECTION VIII

Civil Rights and Appeal

Refer to WIC Procedure Manual Section 800
WIC Operations Manual Section 8

VIII

CIVIL RIGHTS AND APPEAL

Civil Rights Compliance

Goal

To ensure that no person shall, on the basis of race, color, national origin, age, sex or handicap, be denied the benefits of or be otherwise subjected to discrimination under the WIC Program.

Objective 1: Assure access to minorities through multi-lingual information.

Evaluation: Rhode Island WIC includes significant populations speaking one of six non-English languages. Program forms and outreach materials are translated in up to six languages.

Plan: Newly developed or revised outreach materials will be translated into appropriate languages based on need. Racial/ethnic participation reports will be reviewed annually and shared with WIC local agencies. Reviews will compare most recent report to previous reports for each local agency and statewide, observe for trends as to changes in participation proportions for each group and observe for disproportionately low participation by any groups. Plans will be developed as needed to assure all groups have equal opportunity to participate.

Objective 2: Assure new local agencies meet all nondiscrimination requirements.

Evaluation: R.I. did not officially consider any new agencies this year. Requirements are set forth in the Operations Manual.

Plan: Conduct a pre-award review on each new agency being considered for acceptance as a participating WIC Local Agency, in accordance with Sec. 8, State Operations Manual and FNS Instruction 113-2.

Objective 3: Assure current local agencies meet all nondiscrimination requirements.

Evaluation: Incorporated into the Management Evaluation Process, is a review of nondiscrimination requirements. No agencies were sited deficiencies in this area in FY 2002.

Plan: Continue to review nondiscrimination requirements during the integrated Management Evaluation process.

Objective 5: Assure existing state and local agency staff are aware of nondiscrimination policies.

Evaluation: One instance of a report of a possible civil rights noncompliance was reported in FY 2001 and the investigation (in collaboration with NERO) concluded in FY 2002. The finding was that the complaint could not be substantiated. This is still being investigated. All nondiscrimination requirements were met. The Annual WIC Training Conference included training on civil rights and cultural competence. It was attended by 95% of state and local agency WIC staff. State WIC staff attended cultural competence training as part of a Departmental initiative.

Plan: Conduct compliance reviews of local agencies at least bi-annually. Provide civil rights training to all staff and as part of the orientation training. Integrate cultural competence training into the Annual Training.

Objective 6: Assure public notification of nondiscrimination.

Evaluation: The new nondiscrimination statement has been placed on all appropriate public information documents produced by the State Agency, and has been forwarded to local agency WIC programs.

Plan: Continue to include the nondiscrimination statement on information notices, outreach materials and educational materials.

Objective 7: Develop and provide an expanded report of racial, ethnic and language spoken participation by clinic.

Evaluation; A monthly report is generated and reviewed at the State WIC office which provides information on participant demographic characteristics. This is shared with the local WIC sites on a yearly basis and upon request.

Plan: Continue with process outlined above.

FAIR HEARINGS
(Procedures 820, Operations - 8)

Objective: **Assure all participants/caretakers are advised of the right to a Fair Hearing**

Evaluation: Local agencies currently provide such information via standardized practices and forms.

Plan: Review the translation of fair hearing information to ensure accuracy. Continue to provide appropriate information to appellants of fair hearings such as:

- What to expect at the hearing.
- Planning needed by the appellant.
- Appellant's responsibility to present his/her case.
- What documents appellants are entitled to see.
- How to request such documents.

GOALS FY 2002

IX

Public Input / Notification

See WIC Operations Manual Section 9

PUBLIC INPUT
(Operations - 9)

In conjunction with the Division of Family Health, WIC and other Family Health units have taken a proactive approach to seek out input from consumers, providers and the public. The Division conducted a statewide series of community forums to receive comment on operations, services, future directions and unmet needs related to its programs, including WIC, and maternal, child and adolescent health. WIC managers and parent consultants played key roles, to assure the project met WIC's need for input. Several parents and community service organizations commented about WIC. These comments have been considered, and have affected the development of this Plan, as well as changes in operational policies.

In addition, to meet FNS review and State legal requirements, a Public Hearing will be scheduled within the quarter to receive comments on proposed revisions to the Goals, herein, in accordance with the conduct, attendance, comment, and recording procedures described in Section 9 of the State Operations Manual. Notices will be published in newspapers having aggregate statewide distribution.

Draft copies of the State Plan and Manuals will be available for public inspection thirty days prior to the public hearing at the Department of Health, Room 303. The mechanisms for comments on the State Plan include verbal and written statements given prior to, at and immediately following the public hearing. These comments are then reviewed by the WIC Program Administration. All comments will be given full consideration in making corrections, additions, and changes to the State Plan and Manuals.

Following this comment period, proposed policy and procedure changes, as well as any modifications of these Goals, will be submitted as State Plan Amendments to Food and Nutrition Services.

PUBLIC HEARING NOTIFICATION
(Operations - 9)

A Public Hearing will be scheduled regarding the State Plan of Operation and Administration of the Special Supplemental Nutrition Program (WIC and Farmers Market Services) for fiscal year 2001, at the Rhode Island Department of Health in accordance with the conduct, attendance, comment, and recording procedures described in Section 9 of the State Operations Manual. Notices will be published in newspapers having aggregate statewide distribution.

Draft copies of the State Plan will be available for public inspection thirty days prior to the public hearing at the Department of Health, Room 303.

The mechanisms for comments on the State Plan include verbal and written statements given prior to, at and immediately following the public hearing. These comments are then reviewed by the WIC Program Administration.

In addition, The Division of Family Health conducted a statewide series of community forums to receive comment on operations, future directions; services and unmet needs of its programs, including WIC. Several parents and community service organizations commented about WIC. These comments have been considered, and have affected the development of this Plan.

All comments will be given full consideration in making corrections, additions, and changes to the State Plan proposal.

ROMAN JEWELERS
1000 Reservoir Ave., Cranston 946-4850

Governor | Director

October 21, 2002 Providence

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OFFICE OF WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM

WIC AND FARMER'S MARKET SERVICES

STATE PLAN OF OPERATION AND ADMINISTRATION

VOLUME II

REVISIONS AND ADDITIONS TO PROCEDURE MANUAL

Section 200
Eligibility and Enrollment
RI WIC Procedure Manual

Revisions and / or Additions

Revisions to the WIC Nutritional / Medical Risk Criteria

Addition of Immunization Screening procedures

Addition of Kidsnet Program Request for Release of Information Procedures

Revision of infant / child growth charts to incorporate Body Mass Index measurements

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Anthropometric Risks
1	1	6 / 3				A	A01	**Underweight** (women) Pregnant: Prepregnancy Body Mass Index (BMI) < 19.8 Non-Breastfeeding: Prepregnancy or current Body Mass Index < 18.5 Breastfeeding (< 6 Months Postpartum) Prepregnancy or current BMI < 18.5 Breastfeeding (≥ 6 Months Postpartum) Current BMI < 18.5
			1	1	3	C	A03	**Low Weight for Height or At Risk of Becoming Underweight** (infant / child) ≤ 10th percentile Body Mass Index (BMI) or ≤ 10th percentile weight for length or height
			1	1	3	A	A04	**Lower Weight for Height** (infant / child) ≤ 5th percentile Body Mass Index (BMI) or ≤ 5th percentile for high risk
1	1	6				C	A11	**Overweight** (women) Pregnant: Pregnancy weight BMI ≥ 26.1 Non-Breastfeeding: Prepregnancy BMI ≥ 25 Breastfeeding: (< 6 months Postpartum) prepregnancy BMI ≥ 25 Breastfeeding: (≥ 6 months postpartum) current BMI ≥ 25
					3	C	A13	**Overweight** (child ≥ 24 months) ≥95th percentile Body Mass Index (BMI) or ≥ 95th percentile weight-for-stature

❖ Attached to a Code means diagnosed by a physician as self reported by the applicant / participant/caretaker. The CPA may, however require documentation if deemed appropriate or necessary.

♦ Attached to a Code means medical documentation is required by a physician or someone working under the physician's orders.

C,P = lower risk sub-priority

Participant Codes:
P = pregnant women
B = breastfeeding woman
N = postpartum woman

Priority & Subpriority Codes
1 through 6 denotes priority level
A = high risk sub-priority

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
			1	1	3	C	A 14	**At Risk of Becoming Overweight** (Infant/child) Have one or more risk factors for being at-risk of becoming overweight. The risk factors are limited to: 1. ≥24 months of age and ≥85th and, 95th percentile Body Mass Index (BMI) or ≥85th and, 95th percentile weight-for-stature (WFS) Using only standing height. 2. <12 months of age and born to a woman who was obese (BMI ≥ 30) at the time of conception or at any point in the first trimester of the pregnancy (BMI must be based on self reported, by the mother, prepregnancy weight and height or on a measured weight and height documented by staff or other health care provider.) 3. ≥ 12 months of age and having a biological mother who is obese (BMI ≥ 30) at the time of certification (BMI must be based on self reported, by the mother, weight and height or on weight and height measurements taken by staff at the time of certification. If the mother is pregnant or has had a baby within the past 6 months, use her prepregnancy weight to assess for obesity since her current weight will be influenced by pregnancy related weight gain.) 4. An infant or child and having a biological father who is obese (BMI ≥ 30) at the time of certification (BMI must be based on self reported, *by the father*, weight and height or on weight and height measurements taken by staff at the time of certification.)
			1	1	3	C	A21	**Short Stature (Stunting)** (infant / child) ≤ 10th percentile length or height for age

R.I. WIC Risk Criteria 2002
Master List

Priority P B N I F C	Sub Priority	Code	Standard

Anthropometric Risks

Priority P B N I F C	Sub Priority	Code	Standard
1	A	A31	**Low Maternal Weight Gain or loss During Pregnancy as defined by:** 1. *A slow rate of weight gain, such as:* In the 2nd and 3rd trimesters, singleton pregnancies: • Underweight women gain < 4 lbs. per mth • Normal / Overweight women gain < 2 lbs. mth • Obese women gain , 1 lb. mth OR 2. *Low weight gain at any point in pregnancy, such that:* A pregnant women's weight plots below the recommended weight gain curve for her prepregnancy weight category. Prepregnancy Weight Groups — Definition — Recommended weight gain Underweight — <19.8 BMI — 28 to 40 lbs. Normal Wt — 19.8 to 26.0 BMI — 25 to 35 lbs. Overweight — 26.1 to 29.0 BMI — 15 to 25 lbs. Obese — ≥29.0 BMI — at least 15 lbs. 3. *Any weight loss below pregravid weight during 1st trimester* OR Weight loss of ≥2 lbs. in the 2nd or 3rd trimesters (14 to 40 weeks gestation) *Although the 1998 National, Heart, Lung and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, define adult obesity as ≥ 30 BMI, the IOM (1990) Prepregnancy weight classifications define obese prenatal women as, 29.0 BMI.*

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Anthropometric Risks – continued
1	1	6				C	A33	**High Maternal Weight Gain** Singleton Pregnancies Pregnant Women (current pregnancy), all trimesters, all weight groups: > 7 lbs./mo. Breastfeeding or Postpartum women (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the IOM's recommended range based on prepregnancy IBM or BMI, as follows: Prepregnancy Weight Groups — Definition — Cut-off Value Underweight — < 19.8 BMI — > 40 lbs. Normal Weight — 19.8 to 26.0 BMI — > 35 lbs. Overweight — 26.1 to 29.0 BMI — >25 lbs. Obese — ≥ 29.0 BMI — > 15 lbs. Multifetal pregnancies: There are no nationally recognized recommendations for upper limit for multifetal gestations at this time. *Although the 1998 National, Heart, Lung and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, define adult obesity as ≥≥ 30 BMI, the IOM (1990) prepregnancy weight classifications define obese prenatal women as, 29.0 BMI>*
			1	1	3	A	♦ A34	**Failure to Thrive**

Priority P	B	N	I	F	C	Sub Priority	Code	Standard

Anthropometric Risks - continued

			1	1	3	A	A35

Inadequate Growth *(corrected 11/99)*

An inadequate rate of weight gain as defined below:

A. Infants from birth to 1 month of age;

- excessive weight loss after birth
- not back to birth weight by 2 weeks of age

B. Infants from birth to 6 months of age:

Based on 2 weights taken at least 1 month apart, the infants actual weight gain is less than the calculated expected minimal weight gain based on the table below.

	Average Weight Gain		
Age	**week**	**month**	**month**
Birth - 1 mo	*4 ½ oz/wk*	*19 oz/mo*	*1 lb. 3 oz/mo*
1 - 2 mo	*6 ¼ oz/wk*	*27 oz/mo*	*1 lb. 11 oz/mo*
2 - 3 mo	*4 ½ oz/wk*	*19 oz/mo*	*1 lb. 3 oz/mo*
3 - 4 mo	*4 oz/wk*	*17 oz/mo*	*1 lb. 1 oz/mo*
4 - 5 mo	*3 ½ oz/wk*	*15 oz/mo*	
5 - 6 mo	*3 oz/wk*	*13 oz/mo*	

C. Infant & Children from 6 months to 59 months of age:

Option 1: Based on 2 weights taken at least 3 months apart, the infant's or child's actual weight gain is less than the calculated expected weight gain based on the table below.

	Average Weight Gain		
Age	**week**	**month**	**month**
6 - 12 mo	2 ¼ oz/wk	9 2 oz/mo	3 lbs. 10 oz/6 mth
12 - 59 mth	0.6 oz/wk	2.7 oz/mo	1 lb./ 6 mth

Or

Option 2: A low rate of weight gain over a 6 month period (+ or - 2 weeks) as defined by the following chart.

Age in months at end of 6 month interval	Weight gain per 6 month in pounds
6 mth	≤ 7 lbs.
9 mths	≤ 5 lbs.
12 mths	≤ 3 lbs.
18 - 60 mths	≤ 1 lb.

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Anthropometric Risks - continued
			1	1	3	A	A41	**Low Birth Weight** Birth weight ≤ 5 pounds 8 ounces (≤2500 g) For infants and children <24 months of age
			1	1		A	A42	**Prematurity** Infant born at ≤ 37 weeks gestation
			1	1	3	A	♦ A51	**Small for Gestational Age** - For infants and children < 2 years of age: **< 10th percentile weight for gestational age at birth**
			1	1	3	A	♦ A52	**Low Head Circumference** < 5th percentile head
			1	1		C	❖ A53	**Large for Gestational Age** Birth weight ≥ 9 pounds (≥ 4000 g) or ≥ 90th percentile weight for gestational age at birth
								Biochemical Risks
1	1	6	1	1	3	C	B01	**Low hemoglobin / hematocrit** - see attached appendix
1	1	3	1	1	3	A	B02	**Lower hemoglobin / hematocrit** - see attached appendix
1	1	6	1	1	3	C	B11	**Elevated Blood Lead Levels** within the past 12 months Blood lead level of ≥ 10 ug / deciliter
								Pregnancy-Induced Conditions
1						C	❖ P01	**Hyperemesis Gravidarum** Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic.
1						A	♦ P02	**Gestational Diabetes** Presence of gestational diabetes
1	1	3				C	P03	**History of Gestational Diabetes** History of diagnosed gestational diabetes. Pregnant Women: any history of gestational diabetes Breastfeeding/Postpartum: most recent pregnancy

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Delivery of Low-Birth Weight / Premature Infant
1	1	3				C	P11	**History of Preterm Labor** Birth of an infant at ≤ 37 weeks gestation Pregnant Women: any history of low birth weight Breastfeeding/Postpartum: most recent pregnancy **History of Low Birth Weight** Birth of an infant weighing ≤ 5 lb. 8 oz. (≤2500 grams) Pregnant Women: any history of low birth weight Breastfeeding/Postpartum: most recent pregnancy
								Prior Stillbirth, Fetal or Neonatal Death
1	1	3				C	P21	**History of Fetal or Neonatal Loss** *(revised 11/99)* A fetal death (death at ≥ 20 weeks gestation) or a neonatal death (death within 0-28 days of life), *or 2 or more spontaneous abortions (< 20 weeks gestation or < 500 grams)* Pregnant Women: any history of fetal, neonatal loss or spontaneous abortions Breastfeeding: most recent pregnancy with one or more infants still living Postpartum: most recent pregnancy
								General Obstetrical Risks
1	1	6				C	P39	**History of Birth with Nutrition Related Congenital or Birth Defects** A woman who has given birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess Vitamin A. Pregnant Women: any history of birth with nutrition-related congenital or birth defect Breastfeeding/Postpartum: most recent pregnancy

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								General Obstetrical Risks – continued
1	1	3				C	P31	**Pregnancy at a Young Age** Conception ≤ 17 years of age Pregnant Women: current pregnancy Breastfeeding / Postpartum: most recent pregnancy
1	1	6				C	P32	**Closely Spaced Pregnancies** Conception before 16 months postpartum Pregnant Women: current pregnancy Breastfeeding / Postpartum: most recent pregnancy
1	1	3				C	P33	**High Parity and Young Age** Women ≤ 19 years of age at date of conception, who have had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome. Pregnant Women: current pregnancy Breastfeeding / Postpartum: most recent pregnancy
1						C	P34	**Lack of or Inadequate Prenatal Care** Prenatal care beginning after the 1st trimester (after 13th week)
1	1	3				C	P35	**Multi-Fetal Gestation** More than one (> 1) fetus in a current pregnancy (Pregnant Women) or the most recent pregnancy (Breastfeeding and Postpartum Women). Twins: maternal weight gain of 1.5 pounds per week during the second and third trimesters with a total weight gain of 35-45 pounds. Underweight women should gain at the higher end of the range and overweight women should gain at the lower end of the range. Triplet Pregnancies: Should gain around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week through out the pregnancy.
1						C	♦ P36	**Fetal Growth Restriction** Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation (IUGR), may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight < 10th percentile for gestational age.

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
1	1	6				C	P37	**History of Birth of a Large for Gestational Age Infant** Pregnant Women: any history of birth of a large for gestational age infant Breastfeeding/Postpartum: most recent pregnancy, or History of birth of an infant weighing ≥ 9 lbs. (4000 grams) or ≥ 90th percentile weight for gestational age at birth, based on a generally accepted intrauterine growth reference.
1						C	P38	**Pregnant Woman Currently Breastfeeding** Breastfeeding woman now pregnant.

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Nutrition Related Risks (e.g. Chronic Disease, Genetic Disorder, Infection) – continued
1	1	3	1	1	3	C	♦ M41	**Nutrient Deficiency Diseases** Diagnosis of nutritional deficiencies or a disease caused by insufficient dietary intake of macro and micro nutrients. Diseases include, but are not limited to, Protein Energy Malnutrition, Scurvy, Rickets, Beri Beri, Hypocalcemia, Osteomalacia, Vitamin K Deficiency, Pellagra, Cheilosis, Menkes Disease, Xeropthalmia.
1	1	3	1	1	3	C	♦ M42	**Chronic Disease** *(revised 11/99)* ***Gastro-Intestinal Diseases*** • Stomach or intestinal ulcers • Small bowel enterocolitis and syndrome • Malabsorption syndromes • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Gallbladder disease • *Gastroesophageal reflux (GER)* ***Thyroid Disorders*** Hypothyroidism (insufficient levels of thyroid hormone produced or defect in reception) or hyperthyroidism (high levels of thyroid hormone secreted). ***Hypertension*** (Includes Chronic & Pregnancy-induced) ***Renal Disease*** Any renal disease including pyelonephritis and persistent proteinuria but excluding urinary tract infections (UTI) involving the bladder ***Cancer*** A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status. ***Diabetes Mellitus***

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
Nutrition - Related Risk Conditions (e.g. Chronic Disease, Genetic Disorder, Infection)								
1	1	3	1	1	3	C	❖ M48	**Central Nervous System Disorders** *(revised 11/99)* Conditions which affect energy requirements and may affect the individual's ability to feed self that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: • Epilepsy • cerebral palsy (CP) and • neural tube defects (NTD, such as: spina bifida or myelomeningocele • *Parkinson's disease* • *Multiple sclerosis (MS)* **Developmental Delays, Sensory or Motor Delays Interfering with Ability To Eat** Developmental, sensory or motor disabilities that restrict the ability to chew or swallow food or require tube feeding to meet nutritional needs. Includes but not limited to: • minimal brain function • *feeding problems due to a developmental disability such as pervasive development disorder (PDD) which includes autism (7/02)* • feeding problems due to developmental delay • birth injury • head trauma • brain damage • other disabilities
1	1	3	1	1	3	C	♦ M49	**Genetic and Congenital Disorders** *(revised 11/99)* Hereditary or congenital condition at birth that causes physical or metabolic abnormality. The current condition must alter nutrition status metabolically, mechanically, or both. May include, but is not limited to, cleft lip or palate, Down's syndrome, thalassemia major and sickle cell anemia (<u>not</u> sickle cell trait), *and muscular dystrophy.*
			1	1		C	❖ M50	**Pyloric Stenosis** Gastrointestinal obstruction with abnormal gastrointestinal function affecting nutritional status.
1	1	3	1	1	3	C	♦ M51	**Inborn Errors of Metabolism** *(revised 11/99)* Presence of inborn error(s) of metabolism . Generally refers to gene mutations or gene deletions that alter metabolism in the body including, but not limited to: • phenylketonuria (PKU) • galactosemia • homocystinuria • histidinemia • glutaric aciduria • glycogen storage disease • fructoaldolase deficiency • hypermethioninemia maple syrup urine disease hyperlipoproteinemia tyrosinemia urea cycle disorders methylmalonic acidemia galactokinase deficiency propionic acidemia *medium-chain acyl-CoA dehydrogenase (MCAD)*

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Nutrition Related Medical Risks – continued
1	1	3	1	1	3	C	♦ M52	**Infectious Diseases** *(revised 11/99)* A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to: • tuberculosis • pneumonia • meningitis • parasitic infections • *hepatitis* • bronchiolitis (3 episodes in last 6 months) • HIV (Human Immunodeficiency Virus infection)* • AIDS (Acquired Immunodeficiency Syndrome)* The infectious disease must be present within the past 6 months. * breastfeeding is contraindicated for women with HIV or AIDS. *Breastfeeding may be permitted for women with hepatitis (see WIC Risk Resource Book" for guidelines.*
1	1	6	1	1	3	C	❖ M53	**Food Allergies** An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. **Lactose intolerance** Lactose intolerance occurs when there is an insufficient production of the enzyme lactase (needed to digest lactose). Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Symptoms must be well documented by the competent professional authority. Documentation should indicate that the ingesting of dairy products causes the above symptoms and the avoidance of such dairy products eliminates them.
1	1	6	1	1	3	C	❖ M54	**Celiac Disease** Also known as: • Celiac Sprue • Gluten Enteropathy • Non-tropical sprue Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individual with certain genetic make-up.

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Nutrition Related Medical Risks – continued
1	1	6	1	1	3	C	❖ M56	**Hypoglycemia**
1	1	6	1	1	3	C	M57	**Drug Nutrient Interactions** Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised.
1	1	6				C	❖ M58	**Eating Disorders** Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming overweight:. Symptoms are manifested by abnormal eating patterns including, but not limited to: • self-induced vomiting • purgative abuse • alternating periods of starvation • use of drugs such as appetite suppressants, thyroid preparations or diuretics • self-induced marked weight loss Evidence of such disorders must be documented by the CPA or physician
1	1	3	1	1	3	C	❖ M59	**Recent Major Surgery Trauma, Burns** Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. Any occurrence: • within the past two (≤ 2) months may be self reported • more than two (≥ 2) months previous must have the continued need for nutritional support
1	1	3	1	1	3	C	♦ M60	**Other Medical Conditions** Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition or treatment for the condition must be severe enough to affect nutritional status. Includes, but is not limited to: • juvenile rheumatoid arthritis (JRA) • lupus erythematosus • cardiorespiratory diseases • heart disease • cystic fibrosis • moderate persistent or severe persistent asthma • persistent asthma (moderate or severe) requiring daily medication
1	1	6			3	C	❖ M61	**Depression** Presence of clinical depression

R.I. WIC Risk Criteria 2002
Master List

Priority P B N I F C	Sub Priority	Code	Standard
			Nutrition Related Medical Risks – continued
1 1 6 1 1 3	C	❖ M81	**Dental Problems** Diagnosis of dental problems (may be adequately documented by the CPA) include, but not limited to: • Tooth decay, periodontal disease, tooth loss and or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality (children and all categories of women); and • Gingivitis of pregnancy (pregnant women); • Presence of nursing or baby bottle caries, smooth surface decay of the maxillary anterior and the primary molars (infants and children).
1 1 3	C	♦ M82	**Fetal Alcohol Syndrome** Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation.
			Substance Abuse (drugs, alcohol, tobacco)
1 1	C	M71	**Maternal Smoking** Any daily smoking of tobacco products, e.g. cigarettes, pipes, or cigars
1 1 6	C	M72	**Alcohol & Illegal Drug Use** For Pregnant Women: • Any alcohol use • Any illegal drug use For Breastfeeding and Postpartum Women • Routine current use of ≥ 2 drinks per day (1). A serving or standard sized drink is: 1 can of beer (12 fluid oz.); 5 oz. Wine; and 1 1/2 fluid ounces liquor (1 jigger gin, rum, vodka, whiskey (86-proof), vermouth, cordials or liqueurs), or • Binge Drinking, i.e., drinks 5 or more (≥ 5) drinks on the same occasion on at least one day in the past 30 days; or • Heavy Drinking, i.e., drinks 5 or more (≥ 5) drinks on the same occasion on five or more days in the previous 30 days; or • Any illegal drug use.

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
Inadequate / Inappropriate Nutrient Intake								
4	4	6			5	C	D04	**Inadequate protein intake - see appendix** (rev 7/99)
4	4	6			5	C	D05	**Inadequate dairy foods -- see appendix** (rev 7/99)
4	4	6			5	C	D06	**Inadequate grain products -- see appendix** (rev 7/99)
4	4	6			5	C	D07	**Inadequate fruits / vegetables -- see appendix** (rev 7/99)
4	4	6			5	C	D08	**Excessive fats/sweets -- see appendix** (rev 7/99)
			4	4	5	C	D09	**Excessive Calories -- see appendix**
			4	4	5	C	D10	**Inadequate Calories – see appendix**
4	4	6			5	C	D01	**Vegan Diet** (rev 7/99) Consumption of plant origin foods only, an eating plan with no animal products (no meat, poultry, fish, eggs, milk, cheese, or other dairy products) and avoidance of foods made with animal product ingredients.
4	4	6	4	4	5	C	D02	**Highly Restrictive Diets** Diets that are very low in calories, severely limit the intake of important food sources of nutrients, or otherwise involve high-risk eating patterns.

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Priority P	B	N	I	F	C	Sub Priority	Code	Standard
			4	4		C	D11	***Inappropriate Feeding Practices for Infants (revised 11/99)*** Routine use of any of the following: *Types of fluids offered:* a) Infant not fed breast milk or iron-fortified infant formula as primary source of nutrients during first 6 months of life and as primary fluid consumed during the second 6 months of life (includes infants prescribed low iron formula without iron supplementation). b) Feeding goat's milk, sheep's milk, imitation / substitute milks in place of breast milk or FDA-approved infant formula during the first year of life. c) Feeding whole, low fat, reduced fat, skim, or non-fat milk (fresh, canned evaporated or sweetened condensed), or recipes using any of these products as the primary source of milk before the 1st. birthday. d) Feeding >10 oz /day of full strength juice (revised 11/99) *Introduction of Solids:* e) Addition of solid food(s) into the daily diet before four 4 months of age. f) Failure to introduce solids by 7 months of age. g) No routine age-appropriate iron source after 6 months of age, such as: Iron-fortified cereals, Iron-fortified infant formula *(at least 10 mg of iron per liter of formula prepared at standard dilution),* Meats, Oral iron suppl h) Routine over-dilution or under-dilution of formula i) Infants routinely consuming foods low nutrients/ high calories, or caffeine-containing foods or beverages that replace or are in addition to age-appropriate nutrient dense foods needed for growth and development. This includes excessive feeding of water. *Feeding Styles:* j) Infant not beginning to finger feed by 7-9 months. k) Using a syringe-action nipple feeder. l) Inappropriate, infrequent or highly restrictive feeding schedules, or forcing an infant to eat a certain type and/or amount of food. m) Not using a spoon to introduce and feed early solids.

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
			4	4		C	D11	*Continued –* ***Inappropriate Feeding Practices for Infants (revised 11/99) continued*** Routine use of any of the following: *Food Safety:* n) Feeding foods of inappropriate consistency, size, or shape that put the infant at risk of choking. o) Feeding any amount of honey to infant under 1 year of age (added to liquids or solid foods, used in cooking, as part of processed foods, on a pacifier, etc.). *p) Limited or no access to a safe water supply (documented by appropriate officials), a stove for sterilization; and/or a refrigerator or freezer (ie if breastmilk is to be stored for mare than 1-2 days) for storage.* *q) Limited knowledge on how to prepare bottles, nipples, and/or formula, handle prepared formula and/or expressed milk; and/or store prepared or opened formula and/or expressed breastmilk.* *r) Failure to properly prepare, handle and store bottles or storage containers of formula or expressed breastmilk, such as:* *Feeding formula held at room temperature longer than 2 hours or longer than recommended by the manufacturer;* *Feeding prepared formula held in refrigerator longer than 48 hours, and* *Feeding formula remaining from an earlier feeding.* *Inappropriate Use of Nursing Bottles:* s) Routine use of the bottle to feed liquids other than breast milk, formula, or water. This includes: fruit juice — soda soft drinks — gelatin water corn syrup solutions — milk other sugar-containing beverages — diluted cereal or other solid foods t) Allowing the infant/child to fall asleep at naps or bedtime with the bottle. u) Allowing the infant/child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. v) Propping the bottle.
			4			C	D18	**Infrequent Breastfeeding as Sole Source of Nutrients** The fully breastfed infant (i.e., NOT consuming any solid foods) who is routinely taking: • < 8 feedings in 24 hours if <2 months of age, or • < 6 feedings in 24 hours if ≥ 2 months of age
	4					C	D20	**Excessive Caffeine Intake** Routine intake of ≥ 3 cups of coffee, or the caffeine equivalent from other caffeine-containing beverages.

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Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
4	4	6			5	C	D21	**Pica** Current or recent craving for or ingestion of nonfood items including, but not limited to: • clay — starch (laundry and cornstarch) • dirt — ashes • paint chips — large quantities of ice • baking soda
								Other Dietary Risks
4	4	6	4	4	5	C	D23	**Inappropriate or Excessive Intake of Dietary Supplement Including Vitamins, Minerals, Herbal Remedies** Participant routinely taking inappropriate or excessive amounts of any dietary supplement with potentially harmful consequences, including but not limited to ingestion of un-prescribed excessive or toxic: • multi or single vitamins • mineral doses • herbal remedies
4	4		4	4	5	C	D24	**Inadequate Vitamin/Mineral Supplement** *(revised 11/99)* Participant not routinely taking a dietary supplement recognized as essential by national public health policy makers because diet alone cannot meet nutrient requirements Examples include but are not limited to: • Pregnant Women not taking 30 mg of iron daily, • *when their water supply contains < 0.3 ppm of fluoride and:* *.Infants ≥ 6 months and Children < 36 months not taking 0.25 mg of fluoride daily and:* *Children 36 – 72 months not taking 0.50 mg fluoride daily.* ♦ *When the water supply contain 0.3 – 0.6 ppm fluoride and;* *children 36 – 72 months not taking 0.25 mg fluoride daily.*

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Priority P	B	N	I	F	C	Sub Priority	Code	Standard
					5	C	D25	***Inappropriate Feeding Practices for Children*** Routine consumption or feeding of: • 12 or more ounces of any juice per day • Non-fat or reduced-fat milks as primary milk source between 12 and 24 months of age. • Foods low in essential nutrients and high in calories that replace age appropriate nutrient dense foods needed for growth and development between 12 and 24 months of age; or • Foods of inappropriate consistency, size, or shape that put children less than 4 years of age at risk of choking. Routine use of any of the following inappropriate feeding practices: • Forcing a child to eat a certain type and/or amount of food: • Ignoring a child's request for appropriate foods (e.g., when child is hungry): • Restricting a childs ability to consume nutritious meals at an appropriate frequency per day: • Not supporting a childs need for growing independence with self-feeding (e.g., spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils); • Feeding or offering a child primarily pureed or liquid food when the child is ready and capable of eating foods of an appropriate texture. ***Inappropriate Use of Nursing Bottles*** a) Routine use of the bottle to feed liquids other than breast milk, formula, or water. This includes: • Fruit juice • soda • Soft drinks • gelatin water • Corn syrup solutions • milk • Other sugar-containing beverages • diluted cereal or other solid foods b) Allowing the infant/child to fall asleep at naps or bedtime with the bottle. c) Allowing the infant/child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. d) Propping the bottle. e) Use of a bottle for feeding or drinking beyond 14 months of age.
	4	6				C	D26	**Inadequate Folic Acid Intake to Prevent Neural Tube Defects (NTD's).** (7/02) Women who consumes less than 400 mcg. Of folic acid (synthetic) from fortified foods and/or supplements daily.
								Breastfeeding Risks
	1					C	L00	Breastfeeding mom with Priority 1 infant

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Priority P	B	N	I	F	C	Sub Priority	Code	Standard
	2					C	L01	Breastfeeding mom with Priority 2 infant
	4					C	L02	Breastfeeding mom with Priority 4 infant
			1			C	L03	Breastfed infant with P1 mom
			2			C	L04	Breastfed infant with P2 mom
			4			C	L05	Breastfed infant with P4 mom
			1			A	L07	**Infant with Breastfeeding Complications or Potential Complications** A breastfed infant with any of the following complications or potential complications for breastfeeding: a. jaundice b. weak or ineffective suck c. difficulty latching onto mother's breast d. inadequate stooling (for age, as determined by a physician or other health care professional), and/or less than 6 wet diapers per day
	1					A	L08	**Women with Breastfeeding Complications** or Potential Complications A breastfeeding woman with any of the following complications or potential complications for breastfeeding: a. severe breast engorgement b. recurrent plugged ducts c. mastitis (fever or flu-like symptoms with localized breast tenderness) d. flat or inverted nipples e. cracked, bleeding or severely sore nipples f. age $\geq$ 40 years g. failure of milk to come in by 4 days postpartum h. tandem nursing (breastfeeding two siblings who are not twins)
Regression / Transfer / Presumptive eligibility								
4	6	4	4	5		P	R51	**Possibility of Regression** A participant who has previously been certified eligible for the Program
							R52	**Transfer of Certification** Person with current valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid until the certification period expires and shall be accepted as proof of eligibility for program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants.
4						C	R53	**Presumptive Eligibility for Pregnant Women** A pregnant women who meets WIC income eligibility standards but has not yet been evaluated for nutrition risk, for a period of up to 60 days.

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Priority P	B	N	I	F	C	Sub Priority	Code	Standard
								Homelessness / Migrancy
4	4	6	4	4	5	C	R81	**Homelessness** A woman, infant or child who lacks a fixed and regular night time residence; or whose primary nighttime residence is: • a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations; • an institution that provides a temporary residence for individuals intended to be institutionalized; • a temporary accommodation of not more than 365 days in the residence of another individual; or • a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
4	4	6	4	4	5	C	R82	**Migrancy** Categorically eligible women, infants and children who are members of families which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.
								Other Nutritional Risks
			2	2		C	R71	**Infant up to 6 Months Old of WIC Mother or of a Woman Who Would Have Been Eligible During Pregnancy.** An infant < 6 months of age whose mother was a WIC Program participant during pregnancy or whose mothers medical records document that the woman was at nutritional risk during pregnancy because of detrimental / abnormal nutritional conditions detectable by biochemical / Anthropometric measurements, or other documented nutritionally related medical conditions.
			1	1		C	❖ R73	**Infant of Woman With Mental Retardation, or Alcohol, or Drug Abuse During Most Recent Pregnancy** Infant born of a woman: • Diagnosed with mental retardation; or • Documentation or self-report of any use of alcohol or illegal drugs during most recent pregnancy
4	4	6	4	4	5	C	R91	**Recipient of Abuse** Battering or child abuse/neglect within past 6 months, self-reported or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider, or other appropriate personnel. A Battering generally refers to violent assaults on women.

R.I. WIC Risk Criteria 2002
Master List

Priority P	B	N	I	F	C	Sub Priority	Code	Standard
Other Nutritional Risks								
4	4	6	4	4	5	C	R92	**Woman or Primary caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food** Woman, (pregnant, breastfeeding or postpartum) or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples may include individuals who are: • ≤ 17 years of age; • mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist); • physically disabled to a degree which restricts or limits food preparation abilities; or • currently using or having a history of abusing alcohol or other drugs.
4	4	6	4	4	5	C	R93	**Foster Care** Entering the foster care system during the previous 6 months or moving from one foster care home to another foster care home during the previous 6 months.
9	9	9	9	9	9	A	Z11	**Other high risk** (cannot be used as only code for certification) corrected 3/30/99

213 NUTRITIONAL ASSESSMENT

A. Assessment Procedures

Revised 12/98

1. A Competent Professional Authority determines nutritional risk by performing a complete nutritional assessment on a one-on-one basis. *Each individual seeking certification or recertification for participation in the program shall be physically present at the clinic site for determination of program eligibility. This applies to all new applicants for their initial certification as well as participants who are presently receiving benefits and who are applying for a subsequent certification. The only exceptions to this policy are:*

   (a) for newborn infants certified as Priority II (see number 3 below).

   (b) if the agency determines that presence would present an unreasonable barrier to participation, a local agency may waive the physical presence clause for an infant or child who:

      (I) was present at the initial certification visit; and is receiving ongoing health care from a provider other than the local agency; or

      (ii) was present at the initial certification visit; was present at a certification or recertification determination within the 1-year period ending on the date of the certification or recertification determination described above (I); and has one or more parents who work.

   In the case of severe hardship contact the State WIC Agency.

2. Referral information from a Competent Professional Authority not on the staff of the local agency may be used in making the determination. If the applicant would incur a cost to obtain data from an outside health care provider, solely to obtain the data for WIC, the local agency should offer to conduct the assessment procedures free of charge. Infants and children cannot be certified on the basis of a medical referral form without being physically present.

3. An exception to the assessment procedure can be made only for Priority II infants. When it is impossible to get anthropometric data or when the parent or guardian cannot bring the infant or medical records to the local agency promptly after birth, the infant may be certified on the basis of the mother's documented status during

pregnancy. Either the payee or the alternate shopper may pick up the first set of checks for a preliminary infant. Such infants should be given benefits to six weeks of life only, to ensure that complete nutritional assessment data will be secured within a reasonable time. Benefits should not be issued after the first six weeks unless the nutritional assessment is complete.

Revised 12/00

4. *Anthropometric measurements may not be more than 60 days old prior to certification,* ***and blood work (hemoglobin/hematocrit) must be no older than 90 days from the date of the*** *WIC certification. Lead screening results may not be more than 180 days old. Collected data must be reflective of the category.*
5. The following assessment tools should be considered in determining the individual's nutritional status:

   - ✓ WIC Medical Information Form (WIC-2A or 2B)
   - ✓ Prenatal Weight Gain Grid (WIC-49)
   - ✓ Infant or Child NCHS Growth Grids (WIC-47A and B, WIC-48A and B)
   - ✓ Nutrition and Risk Assessment Form for Infants and Children, and Women (WIC 3B, 3C, 3D, 3E

B. The assessment includes all the following areas:

1. An individual history that includes:

   (a) Dietary history obtained through the use of:

      (i) Dietary recall and food frequency.
      (ii) Exploration of food preferences, nutritional supplements, fads, etc.

   (b) Medical history related to nutrition. The history may be obtained through a review of the applicant's medical record or referral information from a competent professional not on staff of the local agency. For example:

      (i) Obstetrical history.
      (ii) Condition of teeth.
      (iii) Use of drugs or medications.

   (c) Socioeconomic factors that affect nutrition.

(i) Resources available for food purchase.
(ii) Availability of food storage and cooking facilities.
(iii) Educational level of the participant.

Particular attention should be paid to determine whether nutritional patterns are subject to variation over time, such as when personal or family resources, situations, or functioning impact on nutritional patterns.

2. Anthropometric Measurements - The consistent and accurate use of pregnancy weight gain grids, or growth grids as a recording and evaluation tool for the following measurements is imperative:

(a) For Women and Children 2 years of age or older, and at least 35 inches in height.

(i) Height
(ii) Weight

(b) For Infants and Children up to 2 years of age and older children under 35 inches.

(i) Recumbent length
(ii) Weight

Revision implemented 11/96

(C) Measurements shall be conducted not more than 60 days prior to certification for program participation. Note: pregnant and postpartum women's measurements must be taken during their pregnancy (pregnant women), or after the termination of their pregnancy (postpartum and breastfeeding women).

Revision implemented 3/98

Note: Scales must be calibrated based on manufacturer's schedule and procedures, but at least on a yearly basis. Zero-balance scales on a daily basis and document on form WIC-86. See Appendix for information on Municipal Sealers.

Revised 12/00

3. Laboratory Analyses:

(a) Hematocrit/hemoglobin measurement must be done as follows:

(i) Pregnant Women:

- *The data collected must be taken as early as possible during the current pregnancy.*
- *Prenatal women may be certified without receipt of bloodwork for up to 90 days after the date of WIC certification, but only for patients with at least one nutrition risk factor at the time of their WIC appointment. The date, bloodwork is recorded in the record will be documented in the chart.*
- *For pregnant women, use the bloodwork cutoff that corresponds to the woman's trimester when the bloodwork was taken.*

(ii) Breastfeeding and Postpartum Women:

- *The data collected must be taken once during the postpartum period, ideally 4-6 weeks after delivery.*
- *Breastfeeding women 6-12 months postpartum, no additional blood test is required if a blood test (taken after delivery) was already obtained and documented by the WIC local agency.*

(iii) Infants:

- *The bloodwork must be collected between 9-12 months.*
- *However, bloodwork may be acceptable for infants 6 - 12 months old under certain circumstances (i.e. on low-iron formula, preterm and low birthweight infants, fully breastfed infant, and when deemed prudent based on a case-by-case basis).*
- *If no nutrition risk factor can be determined, a blood test must be performed on-site by WIC-or be obtained from a clinician-before the person can be determined to be eligible for WIC services.*

(iv) Child:

- *Children need bloodwork at their initial certification as a child*
- *Additionally, bloodwork is required between 15 and 18 months*
- *Thereafter, if blood values were normal, bloodwork should be done every 12 months*
- *However, If blood values were low, blood work must be done again in 6 months*

- *Bloodwork results may be deferred for up to 90 days after the date of WIC certification, but only for patients with at least one nutrition risk factor at the time of their WIC appointment.*
- *If no nutrition risk factor can be determined, a blood test must be performed on-site by WIC, or be obtained from a clinician, before the person can be determined to be eligible for WIC services.*
- *The date, bloodwork is recorded in the record will be documented in the chart.*

Example:

CHILD (9-12 months) CERTIFICATION :	*Blood test is required. Results are normal.*
CHILD (15-18 months) RECERTIFICATION	*New blood test is required. Results are normal.*
CHILD (21-24 months) RECERTIFICATION	*New blood test is not required, because results were normal at last certification.*
CHILD (27 –30 months) RECERTIFICATION:	*New blood test is required. Blood test was not done at last certification.*

All children must be screened at least once per year.

Follow up: Follow up monitoring of blood values of persons with low hemoglobin/low hematocrit is largely the responsibility of health care providers and should be treated as a medical concern. Therefore, if low hemoglobin/low hematocrit is suspected, the following will occur:

a. *Notations in the participant's file with respect to nutrition risk factors listed and priority as appropriate.*
b. *Document the date the nutrition risk data were taken if different from the date of certification.*
c. *Inform the woman or parent/guardian of the outcome and meaning of the blood*

test.

d. Provide follow-up nutrition education, if appropriate.

e. Make adjustments in the food package, as appropriate

f. Make referrals to health care or social services, as appropriate.

Note: The results of blood lead screenings may not be more than 180 days old if used as a certifying risk.

(e) These tests may not otherwise be avoided unless:

The agency has received a signed statement by a recognized member of the clergy to the effect that the applicant is known to the clergy person as a member of that clergy person's religious body, and that the laws or rules of that religious body prohibit its members from having any test for blood iron performed on them.

Note: Blood screening equipment must be calibrated according to the manufacturer's schedule and procedures. Document daily calibration results on WIC-86 Calibration Log.

4. The Competent Professional Authority records the results of the assessment on the appropriate Nutritional Risk Criteria Sheet.

Clarified 2/97

5. The Competent Professional Authority determines the applicant's nutritional risk. See appendix 200 for approved WIC Risk Criteria for Women, Infants and Children (WIC - 3AA and WIC-3AB).

6. The Nutritional Risk Criteria Sheet and other documents used in determining nutritional risk are placed in the applicant's file. Agencies whose WIC records are integrated with their agency's medical records will maintain documents used in determining nutritional risk in the participant's individual medical record.

7. If the applicant meets all eligibility criteria, including nutritional risk, the local agency personnel will proceed to certification (or recertification) procedures.

C. Priority System for Nutritional Risk Criteria

1. The following priorities shall be applied by the Competent Professional Authority. When vacancies occur after a local agency has reached its maximum participation level, these priorities will assure that those persons at greatest nutritional risk receive

Program benefits, in accordance with WIC Risk Criteria: WIC-3AA, WIC-3AB. In all cases, assess for and select the highest priority for which a person is qualified. The QWIC computer system will-assign all applicants a subpriority based on the following criteria:

Income

Eligible participants will be subprioritized first according to income.

- ✓ Those applicants with incomes <185% of the federal poverty guidelines will be subprioritized first in each of the priorities.
- ✓ Applicants whose income are >185% and <250% of the federal poverty guidelines will be prioritized second.

After applicants are subprioritized by income, they will be subprioritized as follows:

A: Applicants with risk factors that place them at high risk.
B: Children up to 24 months of age.
C: Applicants who are not at high risk.
P: Applicants who are eligible based on a prevent regression risk factor.

The computer will automatically assign the highest priority and subpriority for each applicant.

2. A person, certified as an infant, whose certification period extends beyond 12 months of age, shall carry the infant priority if such priority is higher than any child priority he/she would otherwise be assigned.

3. Regression- A participant who has previously been certified eligible for the Program may be considered to be at nutritional risk in the next certification period if the competent professional authority determines there is a possibility of regression in nutritional status without the supplemental foods or nutrition education. Such participant should be placed in the lowest priority for his/her category.

Persons may be certified for regression if benefits are to be issued in consecutive months between the previous and next certification periods (i.e. no "break" in receipt of benefits). **Regression cannot be used for a person being added to the Program.** Regression may not be used a second consecutive time.

Exceptions to this rule may only be made when a local agency documents to the state agency a special need for a person to remain on the Program and receives approval from the state agency. Priority II infants may not be recertified for regression.

Added 7 / 02

3. *Minimum Immunization Screening and Referral Protocol in WIC*

The following minimum screening protocol was developed by CDC and the American Academy of Pediatrics specifically for use in WIC Programs ***where children are not screened and referred for immunizations by more comprehensive means.*** *The purpose of the minimum screening and referral protocol is to identify children under age two who may be at risk for under-immunization. It is not meant to fully assess a child's immunization status, but allows WIC to effectively fulfill its role as an adjunct to health care by ensuring that children who are at risk for under-immunization are referred for appropriate care.*

Minimum Screening and Referral Protocol

a) *When scheduling WIC certification appointments for children under the age of two, advise parents and caretakers of infant and child WIC applicants that immunization records are requested as part of the WIC certification and health screening process. Explain to the parent/caretaker the importance that WIC places on making sure that children are up to date on immunizations, but assure applicants that immunization records are not required to obtain WIC benefits.*

b) *At initial certification and all subsequent certification visits for children under the age of two, screen the infant/child's immunization status using a documented record. A documented record is a record (computerized or paper) in which actual vaccination dates are recorded. This includes a parent's hand-held immunization record (from the provider), an immunization registry, an automated data system, or a client chart (paper copy).*

c) *At a minimum, screen the infant/child's immunization status by counting the number of doses of DTaP vaccine they have received in relation to their age, according to the following table:*

By 3 months of age, the infant/child should have at least 1 dose of DTaP.
By 5 months of age, the infant/child should have at least 2 doses of DTaP.
By 7 months of age, the infant/child should have at least 3 doses of DTaP.
By 19 months of age, the infant/child should have at least 4 doses of DTaP.

d)*If the infant/child is not fully immunized: (1) provide information on the*

recommended immunization schedule appropriate to the current age of the infant/child, and (2) provide referral for immunization services, ideally to the child's usual source of medical care.

d) If a documented immunization record is not provided by the parent/caretaker:
- *(1) provide information on the recommended immunization schedule appropriate to the current age of the infant/child,*
- *(2) provide referral for immunization services, ideally to the child's usual source of medical care, and*
- *(3) encourage the parent/caretaker to bring the immunization record to the next certification visit.*

e) Document the immunization assessment on the infant / child's WIC Certification Form (WIC –3A, 3B, 3C, 3D)

214 DENIAL OF ELIGIBILITY

1. If the applicant is determined ineligible for the Program, or there are insufficient Program funds to enroll the applicant, local agency personnel will complete duplicate copies of WIC-9A, Program Denial/Termination (Appendix).

2. Local agency personnel will explain to the applicant or caretaker of the applicant the reason(s) for denial of eligibility for program benefits and provide the person with a copy of the completed form in the appropriate language.

3. Local agency personnel will inform the applicant or caretaker of his/her right to appeal any decision made by the local agency regarding his/her eligibility for the program.

4. Local agency personnel will provide the applicant or caretaker with the WIC-14, Fair Hearing Information. A WIC-15, Request for Fair Hearing form, will be given if the applicant expresses a wish to appeal a denial. Information about available resources for legal counsel must be given.

5. Local agency personnel will ensure that a completed copy in English, of the Denial of Eligibility form and other eligibility determination documents are signed by a WIC staff person and are retained in the applicant/participant's file. If the copy of the WIC-9A provided to the applicant or caretaker is in a foreign language, that language should be indicated on the bottom of an English language version of the form.

6. A complete record should be made of dates of activity, assessment data and reasons for denial.

7. If the denial is due to insufficient Program funds, and the applicant meets all other eligibility criteria, place the person's name on the appropriate waiting list. Determine whether another agency may be able to serve the person and refer as appropriate. If waiting lists are long and low priority applicants may not be reached in a reasonable period of time, consult with the state agency to see if a portion of the waiting list may be discontinued.

8. If the denial is due to reasons other than insufficient Program funds, the applicant/participant may reapply whenever circumstances change.

9. Local agency personnel will provide information about other potential sources of food assistance in the local area to individuals who apply in person to participate in the WIC Program, but who cannot be served because the Program is operating at capacity in the local area.

216 FOREIGN STUDENT ELIGIBILITY

First, U.S. citizenship is not a condition of WIC eligibility. Therefore, foreign students and other aliens cannot be denied participation in the WIC Program solely on this basis.

A person entering the country as a foreign student is allowed entry solely to pursue a full course of study at an established institution of learning or other recognized place of study in the U.S., particularly designated by the student and approved by the Attorney General after consultation with the Office of Education. The alien spouse and unmarried minor children of any such student if accompanying or following to join the student are classified by the Immigration and Naturalization Service (INS) as foreign students. However, participation in the WIC Program may jeopardize a foreign student's visa because it may be construed by INS as evidence that the participant has become a public charge. Any children born to foreign students during their stay in the United States may participate in WIC without jeopardizing their parents' visas.
Local agencies should implement the following procedures:

1. If the local agency believes or knows for a fact that the applicant is an alien, the local agency should tell the applicant that participation in the WIC Program could jeopardize retention of his or her visa, if the financial situation which makes them eligible for WIC existed before entering this country. Refer the alien to the local INS office for further information.

2. If, after the local agency cautions the alien applicant of the possible consequences of his or her participation in WIC, the applicant still wants to apply for benefits, the local agency should require documentation of income eligibility, since a prerequisite
for a foreign student visa is economic self-sufficiency. The local agency can require that the alien submit the same financial information that was submitted to INS to obtain a visa or give written authorization for the agency to obtain any and all income information from INS.

3. If the student is self-supporting, he/she must document to INS that he/she has sufficient funds to cover all living costs for the planned years of study including living expenses.

4. If the student is dependent on financial support from his parents or other persons, the sponsoring persons may complete and sign an INS Form I-134 outlining their income and assets, and their ability to support the alien student. The student should have copies of this documentation or other documents such as an IAP-66 or I-20.

5. Eligibility should be denied if income documentation is incomplete. Fair Hearing rights must still be made available, however.

6. WIC regulations specifically restrict the use or disclosure of information obtained from program applicants or participants to persons directly connected with the administration or enforcement of the WIC Program. All information provided by applicants and participants, including their names and addresses, is covered by this restriction. Sharing such information with the Immigration and Naturalization Service (INS) would not be in accord with program regulations. In other words the WIC Program is not obligated to and is restricted from sharing any information on a participant with INS.

217 OTHER ALIENS

- o U. S. Citizenship is not a condition of WIC eligibility.
- o WIC does not need to have any information about an applicant's alien status.
- o Benefits can not be denied on the basis of alien status.
- o WIC regulations prohibit the sharing of any information with INS.
- o Aliens must provide proof of identification, residence and income, just as any other applicant must.
- o Eligibility should be denied if income documentation is incomplete.
- o Illegal aliens already in a health center or clinic for health care can use that health center's existing documentation as a source of documentation for identification.
- o If any applicant is receiving benefits from Medicaid, Food Stamps, AFDC or GPA, it can be used as income documentation for WIC.
- o Written anecdotal documentation from a reliable, independent third party individual, can be accepted as documentation.
- o Refugees must provide proof of income just as any other applicant must, whether employment or documentation of support by others.

240 PARTICIPATION PROCEDURES

241 Participant Transfers and I.D. Number Changes

A. Verification of Certification Cards

Verification of Certification (VOC) Cards are used in each of the Rhode Island WIC Programs. These cards are completed for WIC participants who are relocating to areas outside the State of Rhode Island or those eligible for the WIC Overseas Program.

WIC participants from other jurisdictions with current Verification of Certification cards or Department of Defenses Verification of Certification Card (VOC), must be enrolled in local agency programs in the next available funded opening. If placed on a waiting list, the transferring participant shall be placed ahead of all waiting applicants regardless of their nutritional risk criteria.

The local agency must accept verification of certification as proof of eligibility until expiration of the certification period.

If the applicant lacks a VOC card, local staff may call or write to the transferring agency to obtain or verify needed information. If required by the out of state agency, send an Authorization To Obtain Confidential Information form (WIC-24) signed by the caretaker/applicant. Such Transfers are to be enrolled as soon as information is sufficient.

B. In State Agency Transfers

1. Transferring Agency

   (a) When a participant requests a transfer to another agency, select the appropriate agency for transfer.

   (b) Call to notify the receiving agency of the transfer and to give the participant's name and I.D. number. Make an appointment for the participant at the receiving agency, if appropriate. If participant is due to recertify the same month, the Payee should keep the existing recertification appointment(s) and then transfer.

If checks are due to be issued, give one month, thereby giving receiving agency time to get client into QWIC system.

(c) Do not terminate the transferring participant from your caseload. The computer will do it automatically when the participant is added to another agency's caseload. Put a termination notice in the chart and give one to the participant.
(Note: The receiving agency must put the participant's I.D. number into the computer when adding the participant.)

2. Receiving Agency

(a) When receiving a participant transfer, enter the participant number into the computer. The participant must receive the next available opening, regardless of priority. Use the full 8 digit number from the old agency and enter "M" for moved on the Intake screen.

(b) Document proof of residency and identity on the Eligibility Agreement form. Have Payee sign the Eligibility Agreement and give a Proxy form to be completed.

(c) Note completed transfer in the progress note.
Issue an ID Folder to the participant.

NOTE!! **The Receiving Agency must wait a day before requesting transfer because of the possibility of conflicting transactions by the computer.**

C. Out of State Transfers

1. Transferring Agency

(a) If a participant requests a transfer out of state, determine the date of the move and the last set of checks to be issued from the transferring agency. Checks may be issued up to the day the person moves from the state.

(b) Complete a VOC card and give it to the participant after issuing the last set of checks and record the VOC card on the VOC card register. Follow instructions as follows:

i) The payee signature must e completed before the VOC card leaves the agency. If a payee cannot request a VOC card The payee signature must be completed in person, the card must be sent to the specified out-of-state agency directly. Only the receiving agency or the payee may make this request.

ii) The " First day to use" noted on checks last received by the participant should be listed on the VOC card.

(iii) A description of the food package must be written out.

(iv) Write out the nutritional risk criteria, do not use codes.

(v) The person completing the VOC card is the local agency official. The official's name should be printed clearly above his/her signature on the back of the card.

(vi) The name of the receiving agency may be completed if it is known.

(c) Terminate the participant.

(d) If a transferring participant or a WIC program in another state requests any information about a participant, such information may be transferred either to the participant (or guardian), or, for purposes of coordination of health care, to qualified personnel and health care providers within the health care system. No information may be given to any other party unless the request is made by the participant/guardian or a proper release of information form is received (Section 243).

2. Receiving Agency

(a) When receiving a participant transfer, enter the participant on the computer. The participant must receive the next available opening, regardless of priority. In the Intake screen put "M" in the action space and the transferring state in the previous site space. If the VOC Card is incomplete, attempt to verify missing information. However, if the VOC card includes the minimum requirements of the participant name, when the certification period ends, and the name and address of the local agency, the next available opening must be given to the participant. Individuals presenting a valid VOC card must provide proof of residency and identity.

(b) Document Proof of residency and identity on the Eligibility Agreement form. Have Payee sign an Eligibility Agreement for any person transferring into the agency. Also give Payee A Proxy form to be completed.

(c) Staple the VOC card to the participant chart if out of state and note completed transfer in the progress note. Issue an ID folder to the participant.

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D. ***Department of Defense WIC Overseas Program***

The Department of Defense (DoD) is authorized by law to establish and operate a program like WIC, using DoD funds, for United States (U.S.) active duty military personnel and other support staff stationed overseas and their dependents.

<u>The Transferring Agency</u>

1. *State and local agencies must issue WIC VOC cards to WIC participant affiliated with the military who will be transferred overseas.*
2. *WIC clinics are not responsible for screening and determining eligibility for WIC Overseas Program eligibility.*
3. *WIC participants issued VOC cards when they transfer overseas must be instructed of the following:*
   a. *There is no guarantee that the WIC Overseas Program will be operational at the overseas site where they will be transferred*
   b. *By law only certain individuals are eligible for the WIC Overseas Program*
   c. *Issuance of a WIC VOC card does not guarantee continued eligibiltiy and participation in the WIC Overseas Program.*

4. *All information on the VOC card must be completed, because WIC Overseas Program personnel cannot readily contact a WIC Program to obtain further information. All VOC cards must contain the following:*
   a. *The name of the participant*
   b. *The dat the certification was performed*
   c. *The date income eligibility was last determined*
   d. *The nutrition risk conditions of the participant*
   e. *The date the certification period expires*
   f. *The signature and printed or typed name of the certifying local agency official*
   g. *The name and address of the certifying local agency*
   h. *An identification number or some other means of accountability*

Special emphasis should be place on ensuring local agencies specify the nutrition risk conditions on the VOC card and avoid the use of codes.

5. *Follow the procedures described for an out of state transfer.*

Acceptance of WIC Overseas Program VOC Cards

1. *State and local agencies must accept a valid Wic Overseas Program VOC card presented at a WIC clinic by WIC Overseas Program participants returning to the U.S. from an overseas assignment.*
2. *In accepting a VOC card, minimally the following elements on the cards are absolutely essential:*
   a. *The participants's name*
   b. *The date the participant was certified*
   c. *The date that the current certification period expires*

WIC Overseas Program participants arriving in a WIC clinic and showing a VOC card with only these three pieces of information should be treated just as if the VOC card with only these three pieces of information should be treated just as if the VOC card contains all of the required information.

3. *Individuals presenting a valid VOC card must Provide proof of residency and identity, with limited exception, in accordance with WIC Program regulations and policies.*
4. *Follow the procedure for an out of state transfer as outlined above.*

E. Important Points About Transfers

1. **Do not** transfer a participant during the month recertification is due

if transfer is within state.

2. Submit an original VOC card register to the state WIC office when it is completed to its capacity or at least once every six months and retain a copy for your records.

3. Some states certify infants up to their first birthdays. If a VOC card is received with a certification period that extends beyond six months, that certification period must be granted. The state agency should be notified of all cases involving extended certification periods.

4. Keep all un-issued VOC cards locked up at all times.

242 Program Violations or Abuse/Multiple Participation

A. Local Agency Procedures for Minimizing or Determining Abuse or Violations

As the primary contact with participants, and source of information given to participants, local agencies play a crucial role in preventing, uncovering, and correcting participant violations of Program procedures. Local agency activities should include the following:

1. Careful documentation of income, nutritional risk, and other eligibility data.

2. Educational efforts and provision of materials aimed at making participants aware of Program rules, regulations, and correct redemption practices, and of the importance of these rules to themselves and the Program.

3. Review of check redemption practices and utilization of supplemental foods.

4. Developing a relationship with participants, based on mutual concern and interest in the nutritional benefits and integrity of the Program, which encourages the flow of information regarding participant and

vendor practices through:

a. periodic interviews regarding shopping and redemption practices and vendor practices.

b. specific interviews when requested by the state agency regarding specific concerns.

c. reporting data obtained in a usable manner to establish conclusions about participant or vendor practices and as evidence in subsequent actions.

d. obtaining statements from participants when an investigative action has been initiated.

B. Program Abuse

(All references to "Participant" also apply to any parent, guardian, payee, applicant, or alternate shopper as appropriate).

1. Definition of Abuse and Violation

CATEGORY I
Participant abuse of the Program, Category I, includes, but is not limited to, knowing and deliberate:

a. Misrepresentation of circumstances or concealing or withholding information to obtain benefits.

b. Sale or exchange of supplemental foods or food instruments with any individuals or entities except those duly authorized to receive checks or foods and in accordance with WIC Program rules.

c. Receipt of credit or refund in exchange for WIC food instruments or food items from any party.

d. Dual/Multiple Participation (C below).

e. Committing a Category II violation after having been warned

or disqualified for a previous Category I or II violation or committing a total of three Category II violations separately or in combination.

f. Committing two Category III violations following any disqualification for violation(s).

g. Physical abuse, or threat of physical abuse of Program, clinic, or vendor staff.

h. Failure by the participant to utilize, or failure of the payee to make available to the participant, the supplemental foods in any month.

6/98 i. *Participating in WIC at any local agency while disqualified at any local agency.*

CATEGORY II

Violations of Program rules, Category II, shall include but not be limited to committing or attempting:

a. Misuse of food instruments or supplemental foods, other than a Category I violation.

b. Purchasing food or other items other than the authorized allowed WIC supplemental foods.

c. Redemption of checks outside the use dates listed on the check.

d. Redemption of WIC checks after they have been reported lost/stolen.

e. Committing a Category III violation after having been warned or disqualified for any violation or committing a total of three Category III violations, separately or in combination.

f. Signing the check before the price of the WIC food is entered on the check or when not in the presence of the store

personnel.

g. Redeeming WIC checks with anyone other than a vendor which is authorized to accept Rhode Island WIC checks.

2. Procedures

a. When evidence of possible abuse or violations is uncovered, the local agency shall consult with state agency staff concerning a course of action.

b. When the evidence is lacking, or when further action is counter to the effective and efficient administration of the Program action by the local agency may be deferred or halted. Further efforts may be made to verify or monitor possible abuse or violation.

c. If a finding of abuse cannot be substantiated, or if other mitigating circumstances exist, the local agency will counsel the participant:

i. Inform the participant that there is some evidence that abuse or violation may have or has taken place.

ii. A participant may not be required to admit to guilt.

iii. Warn the participant that any information given may be used against him/her in determining sanctions or in any appeal proceedings.

iv. Inform the participant as to the practice or practices which are abuses or violations of the Program and the penalties of disqualification and/or prosecutions which such practices may result in. Describe the correct procedures to be followed by participants in obtaining and utilizing benefits, including the reasons.

v. Offer the opportunity to ask any questions concerning the matter.

vi. The content of the counseling session, any warnings and the participant's response should be carefully documented in the record. If requested, forward a copy to the state agency.

vii. If the participant refuses to cooperate with the counseling process, review the case for possible disqualification from the Program, based on the available evidence.

d. If a finding of abuse or violation can be substantiated, sanction procedures may be initiated.

e. If needed, the local agency may request advice or assistance from the state agency, at any point.

3. Sanctions

a. Authority - Local agency appropriate sanctions for abuse or violations of the Program in accordance with this procedure. The local agency shall confer with the state agency, before imposing any sanction. The State Agency reserves the authority, in particular instances, to direct that sanctions be imposed by the local agency or that sanctions be modified or not imposed.

b. When sanctions are to be imposed, the local agency shall notify the participant by registered mail, return receipt requested, that there is evidence that he/she has engaged in violation(s) or abuse of the Program. Notice of imposition of the sanction may be included or deferred until further steps are completed.

c. The participant should be advised of the sanction to be imposed for the abuse or violation, and/or the effective date of the sanction (giving at least fifteen day's notice). He/she should be offered an opportunity prior to the imposition or effective date of the sanction to meet in conference to present any information or evidence that the information is in error, that the violation did not take place, that extenuating

circumstances exist, or that severe hardship or serious health risk may result from Program disqualification.

d. The competent professional authority shall determine whether a serious health risk may result from Program disqualification.

e. The local agency may consider a serious health risk to the participant and other relevant factors in determining whether or not the sanction should be waived in a particular case.

f. If restitution by the participant is required under section 246.23(c) of USDA Regulations such restitution will be in cash and will equal the value of Program benefits improperly issued unless it is determined that the recovery would not be cost effective.

11/98 g. If not waived or modified, the following sanctions shall apply:

Category I - Disqualification for three months *and, if appropriate, restitution of the value of benefits improperly issued.*

Category II - Disqualification for one month *and, if appropriate, restitution of the value of any benefits improperly received.*

h. In the event of physical abuse or threat of physical abuse of staff (1.,f., above), the sanction may be imposed without offering a conference as above (3, c), or despite a determination of health risk (3, d), if appropriate to protect the safety of staff. Notify the participant as in 3, j below. Such abuse during a certification appointment may prevent the completion of the certification/recertification and lead to denial of eligibility or failure to recertify.

i. Before disqualifying a child participant, the local agency may determine whether the abusive person can be excluded from the agency and an acceptable alternative payee utilized.

j. If not already accomplished, the participant shall be given fifteen day notification by certified mail, return receipt requested, of the implementation of the disqualification from the Program. Any notice of violation or disqualification shall include the Fair Hearing statement, request, and information forms. Specify the date that the person may reapply for the Program. This date should allow for enough time in advance of the end of the disqualification period for the person to be reinstated in the following month.

k. After this period, the local agency shall review the eligibility of the participant as a new applicant.

C. Dual/Multiple Participation

1. The Rhode Island Department of Health WIC Office and local agencies should print down daily and monthly printouts of all possible dual participants.

2. The WIC computer system will not allow checks to be printed for a participant listed as a possible dual participation until local agency staff enter into the computer that the listing has been resolved.

3. Whether discovered through participation reports or other sources, once dual participation is verified, do not issue checks. The local agency with which the participant has the next scheduled appointment or check pickup shall:

(a) Discuss dual participation with participant.

(b) Inform participant that dual participation is not allowed.

(c) Have participant determine which agency he/she prefers.

(d) Retrieve WIC ID folder of other agency and send it to the Rhode Island Department of Health WIC Office.

(e) Determine with the state agency whether checks should be issued. The dual benefits received should, in most cases, be applied towards the current or next month.

(f) Notify in writing the state agency as to local agency preference, and steps that have been taken.

(g) Terminate the participant from one agency.

4. The circumstances of the dual participation will be reviewed by a state supervisor and local agency liaison and the local agency. This review will especially include a determination as to whether the child participants have been receiving the supplemental foods.

5. The state and local agency shall then determine the severity of the violation, procedures to be followed, and sanctions, if any, to be imposed (see procedures for B. Program Abuse, above and D, Other Violations...,below).

6. If the participant refuses reduction of service to one local agency or persistently denies dual participation, in the face of conclusive evidence or there is evidence of deliberate dual participation, a supervisor at the State agency and the WIC coordinator at the local agencies involved shall review the case for disqualification from the Program.

D. Other Violations of Program Rules

CATEGORY III

1. Violations of Program rules, Category III, shall include but not be limited to:

a. The violations described above where evidence indicates absence of intent or deliberateness or where other extenuating circumstances would not support a conclusion of Program abuse.

b. Failure by the participant to utilize, or failure of the payee to make available to the participant, all of the supplemental foods in any month.

c. Failure to inform the local agency of a change in address,

residence, or other circumstances which might have an effect on eligibility.

d. Failing to report any unused WIC foods to the local agency WIC staff.

e. Any other violation of Program regulations, rules, or procedures, not classified as Category I or II.

f. Attempting any violation of Program rules.

2. When there is reasonable evidence of such violations, the local agency will notify the participant (contact, telephone, mail etc.) and offer an interview to consult with and counsel the participant covering relevant topics, such as:

a. What occurred and where in a manner indicating that the participant is given the benefit of the doubt.

b. Advise the participant that the practice is in violation of Program regulations or procedures and warn that person that any information given may be used against him/her in determining sanctions or penalties or in any subsequent appeal procedure, and of the penalties that may be instituted for such practices.

c. Counsel and educate the participant on the proper procedures to be used, indicating the correct procedures and why they are necessary. Offer the participant the opportunity to ask any questions and answer them.

d. A determination will then be made of the participant's intention, the severity of any violation, and of the participant's cooperation in attempting to change the practices. The local agency will then take appropriate additional measures as warranted.

e. Additional measures may include:

i. A warning letter, indicating further violations would be grounds for more severe penalties or for establishing a case of abuse.

ii. Cancellation of checks or reduction or deletion of items in the food package as determined by the competent professional authority as being unusable, unneeded, excess benefits, or not being made available to the participant.

iii. Disqualification for one month if the investigation or review reveals that the participant is ineligible or violates Program rules, regulations, or requirements twice within a 24 month period. Disqualification for three months for three violations within a 24 month period.

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iv. If restitution by the participant is required under section 246.23(c) of USDA Regulations such restitution will be in cash and will equal the value of Program benefits improperly issued unless it is determined that the recovery would not be cost effective.

f. Document in the record the efforts for counseling, content, and the response of the participant.

E. Prosecution of Fraud and Abuse

1. All instances of fraud, abuse, misrepresentation, etc. must be reported to the State WIC Office.

2. The State Agency may, at its discretion, refer cases which appear to violate the provisions of RIGL Section 23-13-17 may be referred to federal, state or local authorities for prosecution.

F. USDA "Whistle Blower Hotline" for Fraud Control

Reports of fraud or abuse are usually handled by the local or state agency.

Participants or other citizens may, if they prefer, report suspected fraud by stores or participants to the USDA by calling the toll free hotline (1-800-424-9121) or writing to:

United States Department of Agriculture
Office of Inspector General
PO Box 23399
Washington, DC 20024

They may remain anonymous. They should try to give details of the fraud or abuse such as names, places, times and other information.

243 Guidelines for WIC Medical Record Organization

Each local agency should have a method of organizing records which is suitable to the individual needs of the agency. (Note: See Section 600 re: Retention of Records)

The advantages of having a system of WIC medical record organization are as follow:

1. All records are in uniform order
2. Local agency personnel know where to find forms
3. Records are organized for outside auditors
4. Easy to recognize missing forms
5. If record is bound, less likely to lose forms

A medical record has many purposes, below a few are listed:

1. Communicates with other members of the health care team such as nurses, social workers, clerks, nutritionists. Verbal communication is informative but is often sporadic due to time limitations. Verbal communication never replaces the need for written documentation which has the potential to reach all members of the health care team.
2. Monitors a participant's progress while participating on the Program.
3. Integrates care for the individual participant. Promotes and assists coordination

between WIC staff and health care team.

4. Documents communications with participant.

5. Refreshes memory regarding participant before a recertification or second nutrition education visit. Ideally, previous SOAP notes should be reviewed before seeing the participant. This makes the patient feel comfortable and it reinforces that the nutritionist cares about the patient.

6. Documents compliance with professional, legal and regulatory standards. Provides protection against liability and sanctions. Permits quality assurance.

   Many WIC medical record formats are possible. Records may be bound in the center or at the top of the folder. If individual agencies would like assistance in designing a system suitable tot he needs of their agency contact the state WIC office.

The following are recommendations of recognized authorities and this office in terms of medical records:

1. All progress notes and high risk care plans should be together and in chronological order in the medical record. The progress notes should read like a book: First visit, in the beginning, to most recent visit, in the end of the book.

   An individual page <u>is not</u> needed for each visit. Use of both the back and front of the progress note pages will decrease the overall number of pages in the record. Scrap paper should not be used to write progress notes.

2. Have all WIC forms from the certification period together in the supporting documents section of the medical record. Each agency should establish an order for the WIC forms in the medical record and have all records in this order for subsequent certifications.

Progress Notes (WIC Nutrition and Risk Assessment forms WIC -3B, 3C, 3D, 3E).

The dictionary definition of progression is sequence. SOAP notes should show a progression or sequence of events from first visit to termination from the Program. All significant actions or sessions with the participant should be recorded in the progress notes. Local agency nutritionists should record DNKAS, terminations, non-standard food package changes, transfers into or out of an agency, and prorating of checks.

Each progress note should have a full date - a month, day and year. To complete the note, the individual writing the note should write his/her full first and last name and title if it was the first time they have seen the participant. For subsequent visits the individual's first initial and full last name is an acceptable signature for the note.

Progress Note Dos:

1. Do record information in chronological order.

2. Do accurately and carefully record data obtained through interview, observation, and measurements.

3. Do be brief without sacrificing essential information or facts.

4. Do document opinion if it is yor professional opinion.

5. Do record all visits with the participant.

Progress Note Do Nots:

1. 1. Do not use white out in progress note or in any part of the WIC record. If a mistake is made, draw one line through the mistake, initial it and write correct information.

2. Do not use professional jargon as those outside the profession may not understand.

3. Do not use unconventional abbreviations. Refer to following list of accepted abbreviations - use only these in the progress notes.

4. Do not be critical of treatment carried out by others.

5. Do not make remarks that would indicate bias against the participant.

Progress notes are to be done using the SOAP format. SOAP note format should include the following:

S: Subjective information that the CPA observes ie: overweight, underweight, etc.

O: Objective information that is measurable ie: height, weight, hematocrit, etc.

A: Assessment. Write an assessment of the client's nutritional status based on the subjective and objective information.

P: Plan. Set out the plan of care and action for the client to address the issues and conditions identified in the assessment.

Supporting documents

The following is a listing of some WIC forms which will be found in the supporting documents section of the WIC medical record and recommendations for their use.

1. WIC Nutrition and Risk Assessment Forms (WIC 3B, 3C, 3D, 3E)

2. Eligibility Agreement - a copy of this form must be filed in each participant record for every certification. Also, if two family members are in for certification on separate days, a new agreement needs to be filled out for each day's appointment.

3. Proxy form - one form is required for each family. The form must list all participants receiving WIC in that family. If the copy will be kept only in one family member's record, it must be cross-referenced in the remaining family members' records. If a new proxy is desired, a new form must be completed and all old forms are to be kept as a permanent part of the record. If a payee does not want an alternate shopper, a copy of the proxy form should be signed by the payee with none listed as the alternate shopper.

4. Recertification notices- recertification notices must be kept in the record. If the physician sends information in for the participant that form must also be filed in the record.

5. Termination/denial notice - a copy must be kept in each participant record.

6. Medical verification for special formula or medical conditions must become a permanent part of the medical record.

244 Confidentiality and Release of Health Care Information

A. Confidential health care information means all information relating to a patient's health care history, diagnosis, condition, treatment or evaluation. Disclosure of other information obtained from applicants or participants, including name or address, is also to be restricted as described below.

B. Limitations on Disclosure

(1) Each agency shall restrict the use of disclosure of information obtained from Program applicants or participants to persons directly connected with the administration or enforcement of the Program and to those public health or helping organizations listed on the Participant Agreement which the state agency has designated, for purposes of establishing eligibility for other programs or services which may be of help to the participants for such programs.

(2) Any person seeking permission to inspect WIC records shall provide his identity and shall state his reasons for making such a request.

(3) A patient's confidential health care information shall not be released or transferred without the written consent of such patient or his authorized representative, on a consent form meeting designated requirements. (See (4) below).

(4) Consent forms for the release or transfer of confidential health care information shall contain the following information.

(a) A statement of the need for and proposed uses of such information.

(b) A statement that all information is to be released or clearly indicating the extent of the information to be released.

(c) A statement that such information will not be given, sold, transferred or in any way relayed to any other person not specified in the consent form or notice without first obtaining the individual's additional written consent on a form stating the need for the proposed new use of such information or the need for its transfer.

(d) A statement that the consent for release or transfer of information may be withdrawn at any future time.

C. Use of WIC Eligibility Agreement Release of Confidential Information

1. The patient, or the patient's authorized representative, should be given a copy of the Eligibility Agreement in the appropriate language, to read. If he or she is unable to read, and understand the form, an appropriate explanation of its contents should be given, so that the rights of confidentiality are

understood.

2. All WIC applicants or their guardians must sign an English language eligibility Agreement form which must be filed in their records. The completed form in the record will suffice for requests by federal, state, or local Rhode Island WIC Program agencies or authorized agents, staff, or representatives, or authorized agents of the Rhode Island Department of Health. The form must be witnessed and signed by a WIC staff person.

3. An Eligibility Agreement form, if the patient is unable to sign it, must be signed by he patient's authorized representative. Parents or authorized representatives may sign for or on behalf of minors. For persons legally incompetent to affix their own signature, a reason why the patient cannot sign must be supplied.

4. An Eligibility Agreement form, in the event that the patient is competent but cannot sign by written signature should be marked by the patient with an (x). Such signature must be witnessed and signed that the patient is unable to affix her written signature.

5. For WIC related confidentiality purposes, the form need only be signed once, unless there is a participant or payee name change, a change in guardianship or the release is withdrawn in writing. A copy of any such withdrawal must be filed in the record. Invalid release forms should be voided and kept in the record.

6. If the consent is withdrawn, however, the agency must review whether the withdrawal prohibits the determination of eligibility or Program compliance, or whether information is denied that is needed to implement, administer, enforce, or monitor the Program. Such withdrawal may be grounds to terminate participation.

7. A patient's confidential health care information shall not be released or transferred without presenting the written consent of such patient or his authorized representative, on a consent form meeting designated requirements (see B. (4) above).

8. A WIC patient or the authorized representative of such WIC patient may review the patient's record at any time so long as it is in the presence of a WIC official or competent professional authority. Copies of health care

information appropriate for release, subject to the execution of a proper authorization, may be supplied, upon request, to the patient or patient's authorized representative at the usual or customary cost.

Added 10/02

D. Use of Kidsnet Program Request for Release of WIC Program Information Form

1. The participant, or the participant's authorized representative, should be given a copy of the Kidsnet Program Release Authorization Form in the appropriate language, to read. If he or she is unable to read, and understand the form, an appropriate explanation of its contents should be given, so that the rights of confidentiality are understood.

2. The Kidsnet Program Release Authorization Form should not be given until the WIC applicant's eligibility has been determined. The participant or the participant's authorized representative's decision to authorize or deny release of WIC Program information to the Kidsnet Program should have no impact of their eligibility determination.

3. All WIC participants or their guardians must authorize or decline release of WIC Program data to the Kidnset Program. Once signed, the completed English language Kidsnet Program Release Authorization Form must be filed in the participant's records. The completed form in the record will suffice for transmission of select data to the Kidsnet Program. The form must be witnessed and signed by a WIC staff person.

4. If the participant is unable to sign, it must be signed by the participant's authorized representative. Parents or authorized representatives may sign for or on behalf of minors. For persons legally incompetent to affix their own signature, a reason why the patient cannot sign must be supplied.

5. In the event that the patient is competent but cannot sign by written signature should be marked by the patient with an (x). Such signature must be witnessed and signed that the patient is unable to affix her written signature.

6. The Kidsnet Program Release Authorization Form must be signed at each certification visit. A copy of any completed form must be filed in the record. Invalid release forms should be voided and kept in the record.

7. If the consent is denied, the agency must forward this information to the State

WIC Office on a weekly basis.

8. *This permission may be withdrawn in writing at any time.*

E. Penalties

1. Under the Rhode Island Confidentiality of Health Care Information Act (5-37.3) the following penalties apply:

   (a) Civil Penalties--"Anyone who violates the provisions of this chapter may be held liable for actual and exemplary damages."

   (b) Criminal Penalties--"Anyone who intentionally and knowingly violates the provisions of this chapter shall, upon conviction, be fined not more than one thousand dollars ($1,000), or imprisoned for not more than six (6) months or both."

   (c) "The civil and criminal penalties above shall also be applicable to anyone who obtains confidential health care information through the commission of a crime."

   (d) "Attorney's fees may be awarded, at the discretion of the court, to the successful party in any action under this chapter.>"

2. Local agencies which violate state or federal laws or regulations concerning confidentiality can be subject to penalties as provided for in the WIC Local Agency Agreement and said laws and regulations

Rhode Island WIC Assessment and Certification Form – Infant WIC Program WIC-3B 7/02

Name: **Age** **DOB:**

Certify up to 1 yr? **6 mths?**

WIC ID# **Chart#** **WIC mom?** **Visit Date**

Is WIC baby present right now, at time of certification? Yes__ No__ Reason:_____

Approved by State employee (name)_____

S: ***Food habits, parental concerns of nutritional status, concerns or well-being of medical health***

Doctor:_____ Last Visit Date:_____ Medical Concerns:_____

UTD Immunizations? Number of DtaP shots (from record)_____

Breastfed? Any feeding concerns? Parent Wt:_____ Ht:_____ BMI:_____

Constipation/Diarrhea?
Projectile Vomiting?

Intro to solids? Spoon or bottle?

Medication? Vitamins? Herbal remedies?

Lead Test Done (> 9 mths)? Results?

Dental care?

Infections?

Adequate quality, quantity of food available?

O: ***Also see growth chart, diet assessment, MRF***

Information Obtained	*Date Obtained*	*Results*	*Date Results Recorded*
Length			
Weight			
Lgth/ Wt %ile			
Hgb / Hct			

Premature?

Weight at birth?

A: ***Risk Identified***

- ❑ A03 Low wt/ht
- ❑ A04 Lower wt/ht
- ❑ A13 Overweight
- ❑ A21 Short stature
- ❑ D09 Exc calories
- ❑ D10 Inadeq calories
- ❑ D11 Inadeq feeding prac
- ❑ L03 L04 L05 BF Inf
- ❑ R71 WIC mom

Other risks:

P: ***Counseling / Education Provided***

- ❑ Basic WIC Info
- ❑ Infant nutrition
- ❑ Overweight
- ❑ Underweight
- ❑ Growth Pattern
- ❑ Breastfeeding
- ❑ Intro of Solids
- ❑ Making Baby Food
- ❑ Table Foods
- ❑ Cup Use
- ❑ Self Feeding
- ❑ Weaning
- ❑ Dental Care
- ❑ Dietary Iron
- ❑ Lead
- ❑ Immunization

Other topics

Referrals made to:
HCP:
Other:

Followup Nutrition Education Contacts

- ❑ Secondary Contact Date:_____
  Topic:_____
- ❑ High Risk Contact Date:_____
  HRCP: Participant will:

Food Pkg **Planned Recert Date:** **Cert Date:** **File Complete or Pending?**

Priority **CPA:**

Caloric and Formula Intake Requirements for Full Term Infants Updated 7/02

0 To 6 Months (49 Kcal/lb.)					6 To 12 Months (45 Kcal/lb.)			
Weight (lbs.)	Kcal Reg.	Formula Required Reg. (20 cal/oz.)	Below Reg. 20%	Above 20%	Weight (lbs.)	Kcal Reg.	Below Reg. 20%	Above Reg. 20%
7 lb.	343 cal.	17 oz.	274 cal	412 cal.	14 lbs.	630 cal.	504 cal.	756 cal.
8	392	20	314	470	15	675	540	810
9	441	22	353	529	16	720	576	864
10	490	25	392	588	17	765	612	918
11	539	27	431	647	18	810	648	972
12	588	29	470	706	19	855	684	1026
13	637	32	510	764	20	900	720	1080
14	686	34	549	823	21	945	756	1134
15	735	37	588	882	22	990	792	1188
16	784	39	627	941	23	1035	828	1242
17	833	42	666	1000	24	1080	864	1296
18	882	44	706	1058	25	1125	900	1350
19	931	47	745	1117	26	1170	936	1404
20	980	49	784	1176	27	1215	972	1458

From Food and Nutrition Board: Recommended Daily Dietary Allowances, 10th ed., Washington, DC, 1989, National Academy of Sciences, national Research Council. *Low Birth Weight and Small for Gestational Age Infants* Low Birth Weight and Small for Gestational Age Infants may have greater caloric requirements per unit of body weight. Caloric needs may vary from 48 to 59 Kcal/lb. From Committee on Nutrition of the Preterm Infant, ESP GAN, Oxford, England; Blackwell Scientific Publications; 1987

24 Hour recall

Morning Noon Evening Night

Food Frequency Questionnaire			Recommendations for Dietary Intake During Infancy						Assessme
Age Intr. Food	Food	Kcal per oz. or Tbsp.	Intake	0-4 Mo.		4-6 Mo.	6-8 Mo.	8-10 Mo.	10-12Mo.	Total Kc OK / + /
	Breastmilk (# Feeding/day)	20 cal /oz.		8-11	6-8	5-7	4-6	4-6	4-6	
	Formula Type __ cup __ bottle __ conc. __ RTF __ powder	20 cal/ oz.		16 - 32 oz. 5 - 10 feedings		24 - 40 oz.	24 - 32 oz.	16 - 32 oz.	16- 24 oz.	
	Milk Type _____ __ cup __ bottle	20 cal/ oz. (whole milk)		**Discourage until 1 year old**						
	Infant Cereal __ Jar If dry mixed with __ Dry	11 cal/ Tbsp 9 cal / Tbsp		0		2 - 4 Tbsp	2 - 8 Tbsp.	2 -8 Tbsp.		
	Juice __ cup infant __ __ bottle reg __	15 cal/ oz.		0		2-4oz./day **Use Cup** (no citrus, tomato)	4oz./day	4 oz./day Add Citrus, tomato	4 oz./day	
	Fruit __ Homemade, (fresh, canned) __Commercial , (strained or Jr.) ___Plain ___Tapioca (discourage)	5 cal / Tbsp 10 cal / Tbsp		0		0	2 - 8 Tbsp.	4-8 Tbsp.	6 -8 Tbsp.	
	Fruit Desserts	11cal / Tbsp		0		0	**Discourage**			
	Vegetables- daily (Vitamin A, 3-4 x wk) __ Homemade (fresh, froz., can) __ Commercial (plain, mixed, strained or Jr.)	5 cal / Tbsp		0		0	Mashed 4 - 8 Tbsp.	Ground 4-8 Tbsp.	6-8 Tbsp.	
	Potatoes, Rice, Pasta	12 cal / Tbsp		0		0		Rice,Pasta		
	Meats (Plain) __ Homemade __ Commercial (strained or Jr.)	16 cal/ Tbsp		0		0	Intro puree or strained meats **if added iron source needed** 2 - 5 Tbsp.	Intro puree or strained meats 2- 5 Tbsp	4-6 Tbsp.	
	Cheese (American, Cheddar, other)	100 cal / oz.		0		0	0	cheese, yogurt Total 1-6T/ Day		
	1 lg. Egg = 77 Kcal Yolk = 59 cal White = 16cal	28 cal / Tbsp		0		0	0	Egg yolk pureed		
	High meat dinner (strained or Jr.) Vegetable meat Dinner (strained or Jr.) Meat Sticks	11cal / Tbsp 9 cal / Tbsp 70 cal / jar		0		0	0	**Discourage**		
	Finger Foods (Zwieback, Saltine, Animal Cracker) 30 cal/ 12 cal / 10 cal / each			0		0		Toast, Bagel, Crackers	Plain Bread	
	Other Foods _____			0		0				
	Other Liquids (Kool-aid, punch, HiC)	13 cal / oz.		0		0	0	0	0	
	Water (Plain)_____ _____ (Sugar, jello, Karo, Honey)			0		0	(If protein added to diet) 4-8 oz. **Plain water**			
	Vitamin/mineral supplement (rx or self)Type _____									

Approximate Measurements
1 Tbsp = ½ oz.
2 Tbsp = 1 oz.
4 Tbsp = 2 oz. = ¼ cup
8 Tbsp = 4 oz. = ½ cup

Jars 2.5 oz. = 5 Tbsp
4 oz. = 8 Tbsp.
6 oz. = 12 Tbsp

Current Weight _____

Kcal Required / Weight_____

Total Kcal/ day_____

OK / + / --_____

forms/WIC-3Bn 7/02

Progress Notes

Rhode Island WIC Mid Certification Follow-up Infant WIC Program WIC-3M 7/02

Name: **WIC ID#** **Age**

Is WIC baby present now, at time of certification? Yes__ No__

(If not present) Reason_____Approved by State (name)_____

S: ***Food habits, parental concerns of nutritional status, concerns or well-being of medical health***

Doctor:_____ Last Visit Date:_____ Medical Concerns:_____

UTD Immunizations? Number of DtaP shots (from record)_____

Breastfed? Any feeding concerns? Parent Wt:_____ Ht:_____ BMI:_____

Constipation/Diarrhea?
Projectile Vomiting?

Intro to solids? Spoon or bottle?

Medication? Vitamins? Herbal remedies?

Lead Test Done (>9 mths)? Results?

Dental care?

Infections?

Adequate quality, quantity of food available?

O: ***Also see growth chart, diet assessment, MRF***

Information Obtained	*Date Obtained*	*Results*	*Date Results Recorded*
Weight			
Length			
Lgth / Wt %ile			
Hgb / Hct			

A: ***Additional Risks Identified***

P: ***Counseling / Education Provided***

❑ Basic WIC Info	❑ Table Foods
❑ Infant nutrition	❑ Cup Use
❑ Overweight	❑ Self Feeding
❑ Underweight	❑ Weaning
❑ Growth Pattern	❑ Dental Care
❑ Breastfeeding	❑ Dietary Iron
❑ Intro of Solids	❑ Lead
❑ Making Baby Food	❑ Immunization

Other topics

Referrals made to:
HCP:
Other:

Followup Nutrition Education Contacts

❑ Secondary Contact Date:_____
Topic:_____

❑ High Risk Contact Date:_____
HRCP: Participant will:

Food Pkg **Planned Recert Date:**

Priority **CPA:** **Date Follow-up Provided:**

24 Hour Recall

Morning	Noon	Evening	Night

Food Frequency Questionnaire			Recommendations for Dietary Intake During Infancy						Assessmen
Age Intr. Food	Food	Kcal per oz. or Tbsp.	Intake	0-4 Mo.		4-6 Mo.	6-8 Mo.	8-10 Mo.	10-12Mo.	Total Kcal OK /+/ --
	Breastmilk (# Feeding/day)	20 cal /oz.		8-11	6-8	5-7	4-6	4-6	4-6	
	Formula Type __ cup __ bottle __ conc. __ RTF __ powder	20 cal/ oz.		16 - 32 oz. 5 - 10 feedings		24 - 40 oz.	24 - 32 oz.	16 - 32 oz.	16- 24 oz.	
	Milk Type _____ __ cup __ bottle	20 cal/ oz. (whole milk)		**Discourage until 1 year old**						
	Infant Cereal __ Jar If dry mixed with __ Dry	11 cal/ Tbsp 9 cal / Tbsp		0		2 - 4 Tbsp	2 - 8 Tbsp.	2 -8 Tbsp.		
	Juice __ cup infant ____ __ bottle reg ____	15 cal/ oz.		0		2-4oz./day **Use Cup** (no citrus, tomato)	4oz./day	4 oz./day Add Citrus, tomato	4 oz./day	
	Fruit __ Homemade, (fresh, canned) __Commercial , (strained or Jr.) ___Plain ___Tapioca (discourage)	 5 cal / Tbsp 10 cal / Tbsp		0		0	2 - 8 Tbsp.	4-8 Tbsp.	6 -8 Tbsp.	
	Fruit Desserts	11cal / Tbsp		0		0	**Discourage**			
	Vegetables- daily (Vitamin A, 3-4 x wk) __ Homemade (fresh, froz., can) __ Commercial (plain, mixed, strained or Jr.)	5 cal / Tbsp		0		0	Mashed 4 - 8 Tbsp.	Ground 4-8 Tbsp.	6-8 Tbsp.	
	Potatoes, Rice, Pasta	12 cal / Tbsp		0		0		Rice,Pasta		
	Meats (Plain) __ Homemade __ Commercial (strained or Jr.)	16 cal/ Tbsp		0		0	Intro puree or strained meats **if added iron source needed** 2 - 5 Tbsp.	Intro puree or strained meats 2- 5 Tbsp	4-6 Tbsp.	
	Cheese (American, Cheddar, other)	100 cal / oz.		0		0	0	cheese, yogurt Total 1-6T/ Day		
	1 lg. Egg = 77 Kcal Yolk = 59 cal White = 16cal	28 cal / Tbsp		0		0	0	Egg yolk pureed		
	High meat dinner (strained or Jr.) Vegetable meat Dinner (strained or Jr.) Meat Sticks	11cal / Tbsp 9 cal / Tbsp 70 cal / jar		0		0	0	**Discourage**		
	Finger Foods (Zwieback, Saltine, Animal Cracker) 30 cal/ 12 cal / 10 cal / each			0		0		Toast, Bagel, Crackers	Plain Bread	
	Other Foods _____			0		0				
	Other Liquids (Kool-aid, punch, HiC)	13 cal / oz.		0		0	0	0	0	
	Water (Plain)____ _____ (Sugar, jello, Karo, Honey)			0		0	(If protein added to diet) 4-8 oz. **Plain water**			
	Vitamin/mineral supplement (rx or self)Type _____									

Approximate Measurements
1 Tbsp = ½ oz.
2 Tbsp = 1 oz.
4 Tbsp = 2 oz. = ¼ cup
8 Tbsp = 4 oz. = ½ cup

Jars 2.5 oz. = 5 Tbsp
4 oz. = 8 Tbsp.
6 oz. = 12 Tbsp

Current Weight _____ Total Kcal / day _____

Kcal Required / Weight_____ OK / + / -- _____

Rhode Island WIC Assessment and Certification Form – Child WIC Program WIC-3C 7/02

Name: **Age** **DOB:**

WIC ID# **Chart#** **Visit Date**

Is WIC child present now, at time of certification? Yes__ No__ Reason_____

Approved by State (name)_____

S: ***Food habits, parental concerns of nutritional status, concerns or well-being of medical health***

Doctor:_____ Last Visit Date:_____ Medical Concerns:_____

UTD immunizations? Number of DtaP shots (from record)_____

Any feeding concerns? Parent (under 2 yrs) Wt:_____ Ht:_____ BMI:_____

Food Allergy/Intolerance?

Constipation/Diarrhea?

Medication? Vitamins? Herbal remedies?

Lead Test Done? Results?

Pica?

Dental care? / Bottle use?

Infections?

Premature (if < 2 yrs old)

Adequate quality, quantity of food available?

O: ***Also see growth chart, diet assessment, MIF***

Information Obtained	*Date Obtained*	*Results*	*Date Results Recorded*
Height			
Weight			
Ht / Wt %ile or BMI			
Hgb / Hct			
Birth weight (if<2 yrs old)			

A: ***Risk Identified***

- ❑ A03 Low wt/ht
- ❑ A04 Lower wt/ht
- ❑ A13 Overweight
- ❑ A21 Short stature
- ❑ B01 Low hgb/hct
- ❑ B02 Lower hgb/hct
- ❑ D04 Inadeq protein
- ❑ D05 Inadeq dairy
- ❑ D06 Inadeq grain
- ❑ D07 Inadeq fruit/veg
- ❑ D08 Excess fats/sweets
- ❑ D25 Inapp feeding

Other risks:

P: ***Counseling / Education Provided***

- ❑ Basic WIC Info
- ❑ Pre-school Nutr
- ❑ Overweight
- ❑ Underweight
- ❑ Growth Pattern
- ❑ Picky Eater
- ❑ Anemia
- ❑ Healthy Snacks
- ❑ Immunizations
- ❑ Weaning
- ❑ Table Foods
- ❑ NBS/Dental Care
- ❑ Lead
- ❑ Self Feeding

Other topics

Referrals made to:
HCP
Other

Followup Nutrition Education Contacts

- ❑ Secondary Contact Date:_____
  Topic:_____
- ❑ High Risk Contact Date:_____
  HRCP: Participant will:

Food Pkg **Planned Recert Date:** **Cert Date:** **File Complete or Pending?**

Priority **CPA:**

Food Frequency Diet Assessment

Food Items Bread, Cereal, Rice & Pasta Group	Standard Portion Sizes 1-3 yrs	 4-5 yrs	Freq / Amt	Assessment + OK --
Sliced bread or tortilla	½	1		
Dry cereal	½ c	¾ c		
Cooked cereal	¼ c	½ c		
Cooked rice, pasta, grits	¼ c	½ c		
Pancake, waffle, biscuit, roll, muffin or bagel (small)	½	1 sm		
Crackers (saltine size)	4	6		
Other:				6 / day
Fruit & Vegetables Group			*1 Vitamin C Daily 3 to 4 Vitamin A Weekly*	
Fruit juice (type) (C)	½ c juice	¾ c juice		
Citrus fruit; grapefruit, oranges* (C)				
Peach, nectarine, mango (A)	½ piece fruit	1 piece fruit		
Tomato, strawberry, melon (C)				
Dried fruit: raisins,dates, prunes, apricots*	¼ c canned, cooked or fresh fruit	½ c canned, cooked or fresh fruit		
Other fruit: bananas, apple, pears, grapes, plum*				
Cantaloupe (A&C)				
Other:	2 Tbsp dried	¼ c dried		2 / day
Broccoli (A & C)	¼ c ckd veg	½ c ckd veg		
Orange Vegetables: carrots*, sweet potatoes, winter squash (A)	½ c leafy* raw veg	1 c leafy raw veg		
Cabbage, cauliflower, pepper* (C)				
Potatoes , corn, peas				
Greens: chard, collards, spinach (A & C)	½ c veg juice	¾ c veg juice		
Other veg: lettuce, green beans, cucumber*	¼ c tom sce	½ c tom sce		
Other:				3 / day
Milk, Yogurt & Cheese Group – *partial servings are often served*			Serving size based on calcium content of food	
Milk (Type:)	1 c			
Cheese	1 ½ to 2 oz			
Yogurt	1 c			
Cottage cheese	2 c			
Frozen yogurt , pudding	1 c			
Other:				2 / day
Meat, Fish, Poultry, Eggs and Legumes Group – *partial servings often served*			These amounts = 1 oz each	
Meat, fish or poultry, fresh or canned	1 oz			
Luncheon meats , hot dogs*, sausage	2 slices or 1 ½ dogs			
Eggs	1 white & yolk			
Legumes, cooked beans, lentils	½ c			
Soy protein (tofu, tempeh, etc)	½ c			3 oz if 1-3 yr old
Peanut butter*, nuts*	2 Tbsp			
Other:				5 oz if 4-5 yr old

Sweets and Fats – foods from top of Food Pyramid

Fats / Oils butter, margarine ,oil, mayo , salad dressing **Sweets** Pie, cake, cookies, donuts, pastry, Danish, candy **High Fat Snacks**- Potato or corn chips **Beverages**- Soda, punch, kool-aid Coffee, tea Alcohol, beer, wine	< 4 servings per day

*** consider if age appropriate raw fruit and vegetables, dried fruit and nuts**

24 Hour Dietary Recall - include foods and beverages, and the amounts consumed

Morning	*Snacks*
Noon	
Evening	

Progress Notes

Rhode Island Department of Health
WIC Program Eligibility Agreement

Participant No(s) _____ Participant(s) Names _____

_____ _____

_____ _____

I permit the _____ to:
(WIC local agency)

Release and/or transfer any medical, nutritional and/or demographic information on my child(ren) or myself from WIC records to the Rhode Island Department of Health WIC Program or any of its agents and providers of WIC services in order to run the Program and/or provide services to the above participants.

I also permit health care providers/doctors and WIC to transfer WIC medical, nutritional and / or demographic information on my child(ren) or myself to and from the Rhode Island WIC Program for purposes of coordination of health care services and/or to tell whether or not my child(ren) and/or I are eligible and will continue to be eligible for WIC.

I also give permission to release WIC medical, nutritional and/or demographic information from WIC records to:

-R.I. Department of Human Services – Food Stamps, Medicaid and Family Independence Programs
-R.I. Dept. of Health - Early Intervention and Family Outreach Programs
-University of Rhode Island/Cooperative Extension Nutrition Programs
-Programs I agree to be referred to by my local WIC agency

in order to tell if my child(ren) or I might be eligible for other programs that might help us and/or for the coordination of care. These programs have agreed to keep my information confidential. I may cancel this permission at any time but it may mean that I would have to be terminated from WIC.

_____

X Signature (mark) of Participant, Parent or Guardian /Date

Your Rights and Obligations On the WIC Program

1. Standards for participation in the WIC Program are the same for everyone regardless of race, color, national origin, age, sex or handicap.
2. I may appeal any decision made by the local agency regarding my child's or my eligibility for the Program.
3. The local agency will make health services and nutrition education available to me, and I am encouraged to participate in these services.
4. I/my child is not currently receiving WIC checks.
5. I/my child will not receive WIC checks at more than one WIC site during any month.
6. I know that if I do not pick up two (2) months of WIC checks in a row I/my child will be terminated from the Program.
7. I agree to follow all WIC rules.
8. I have been advised of my rights and obligations under the WIC Program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge.

   This certification form is being submitted in connection with the receipt of federal assistance. Program officials may verify information on this form.

I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying the State Agency, in cash, the value of the food benefits improperly issued to me, and may subject me to civil or criminal prosecution under State and Federal law.

Household Size _____ Proof of Address _____

_____/_____/_____
Gross Income/ Frequency/ Source

Current Recipient of: FIP _____ Food Stamps _____

Medicaid _____ Katie Beckett _____ Medicaid Waiver Program

_____
Applicant/ Payee Proof of ID

I agree to all of these statements.

_____

X Signature (mark) of Participant, Parent or Guardian /Date

I hereby attest that the **WIC applicant is present**, and that this family meets the income eligibility requirements set by the WIC Program. I also verify that the participant or his/her parent or guardian has read, or was read, the information on this Eligibility Agreement.

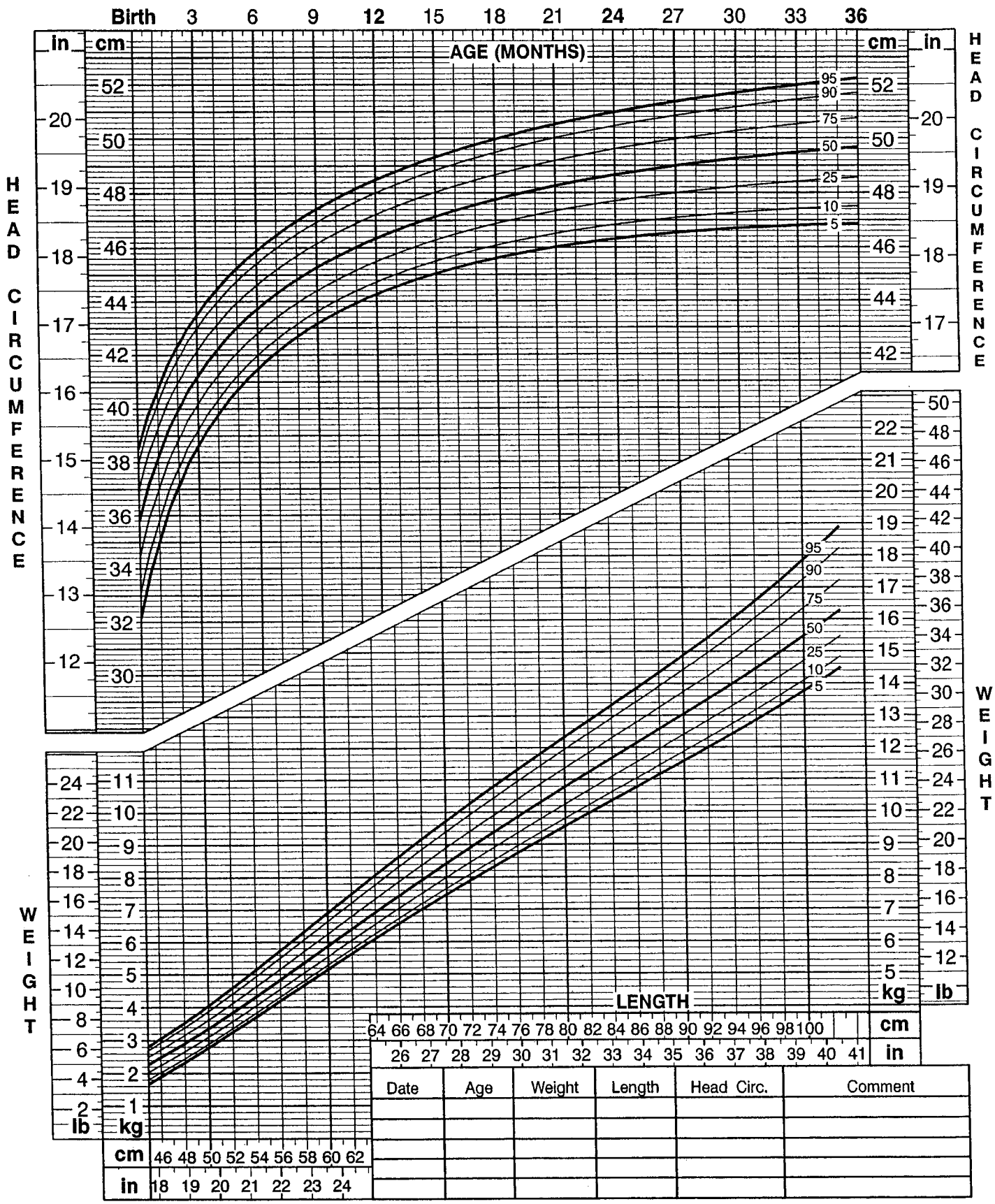
_____
Witness Signature of WIC Staff Member /Date

_____
Language explanation given in

Birth to 36 months: Boys
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



Date	Age	Weight	Length	Head Circ.	Comment

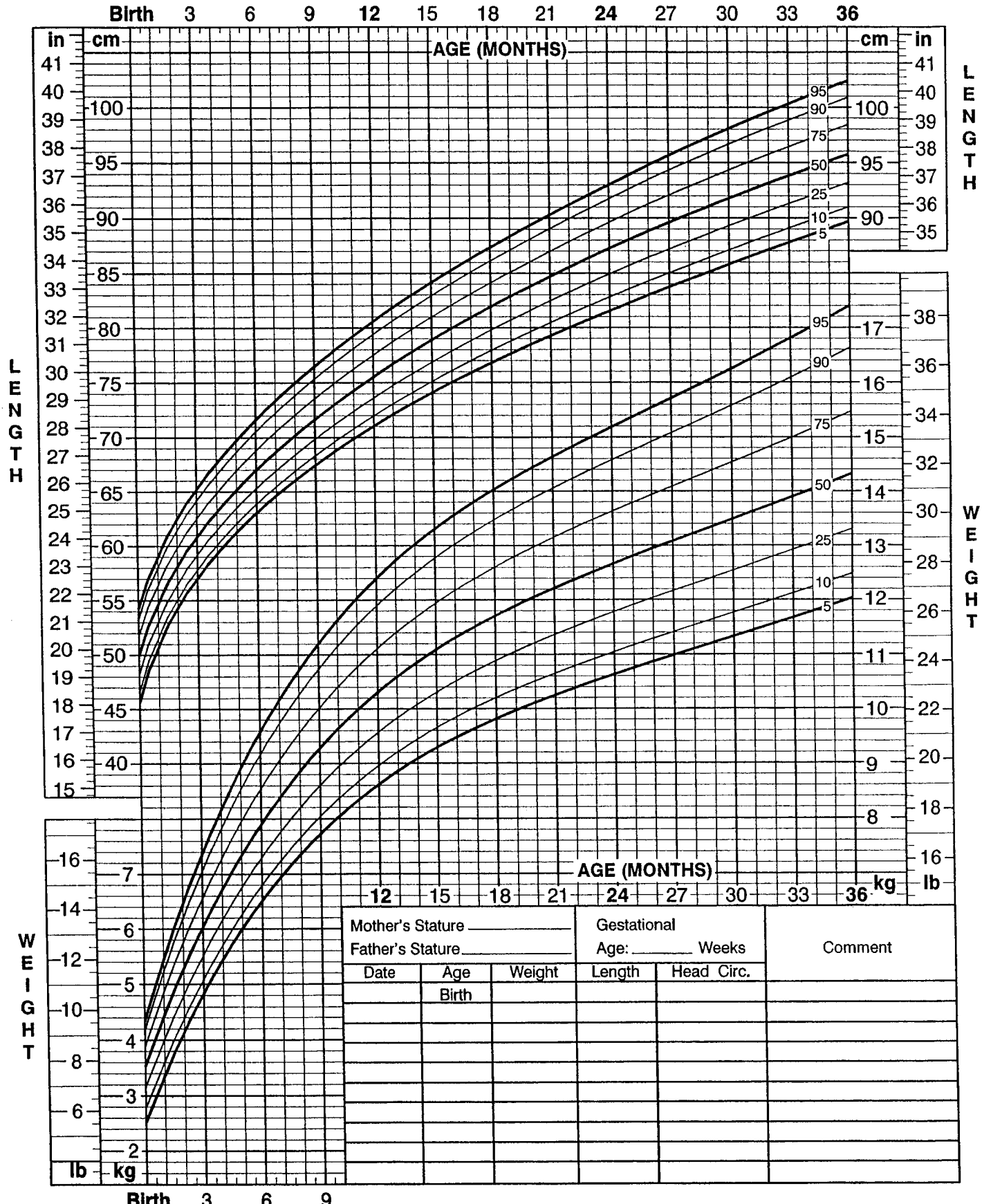
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



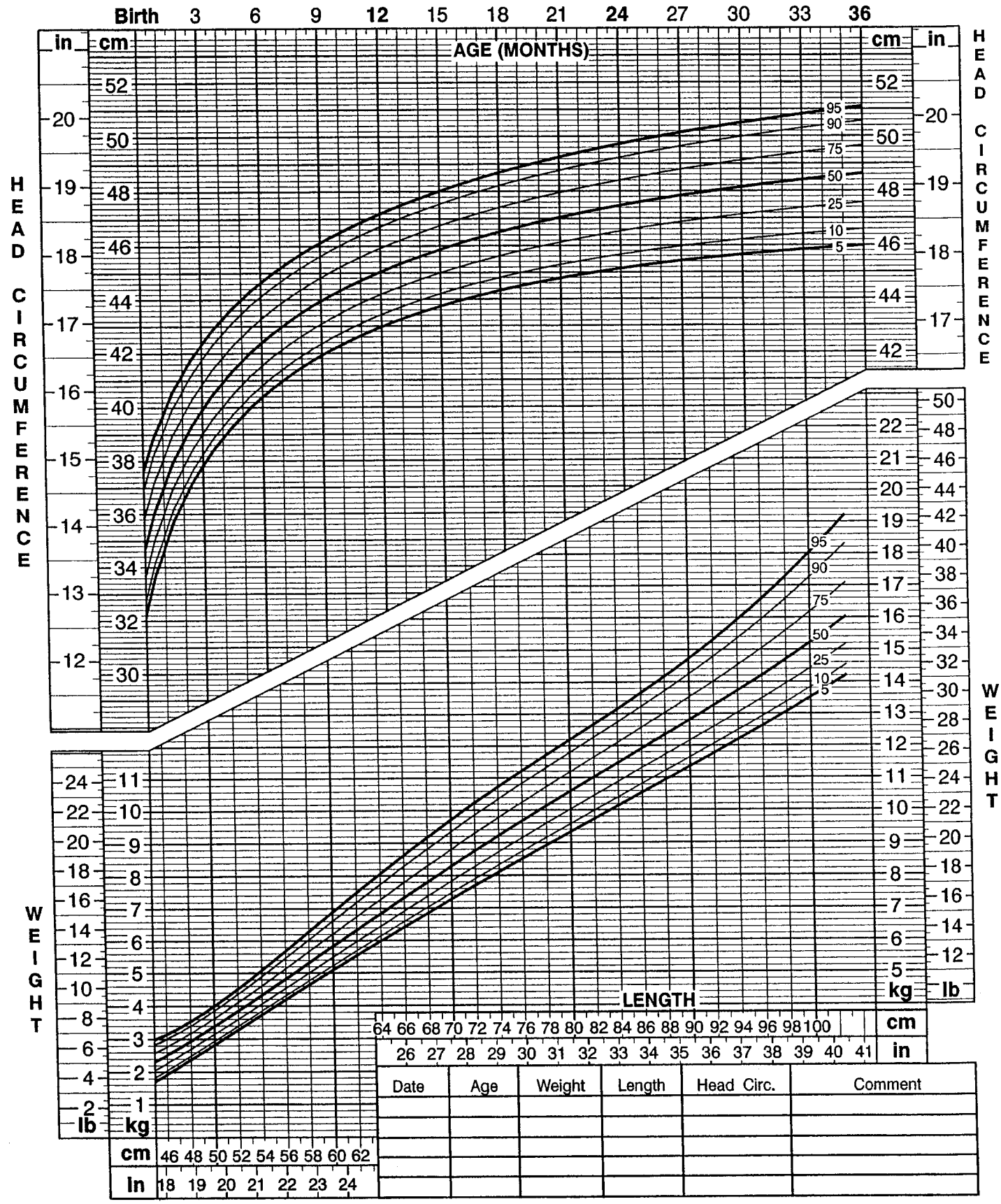
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC

Birth to 36 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



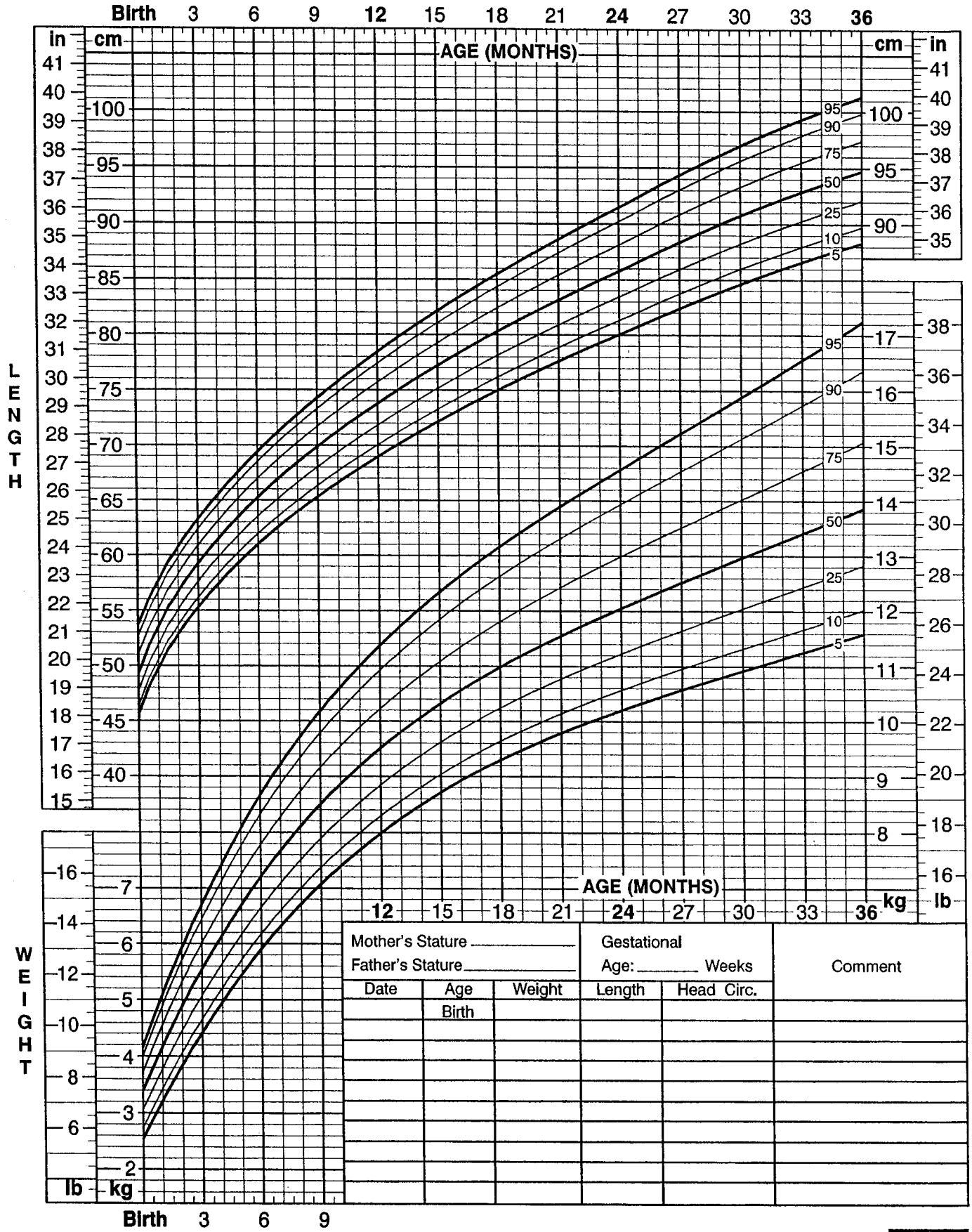
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC

Birth to 36 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Mother's Stature _____ Father's Stature _____			Gestational Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC

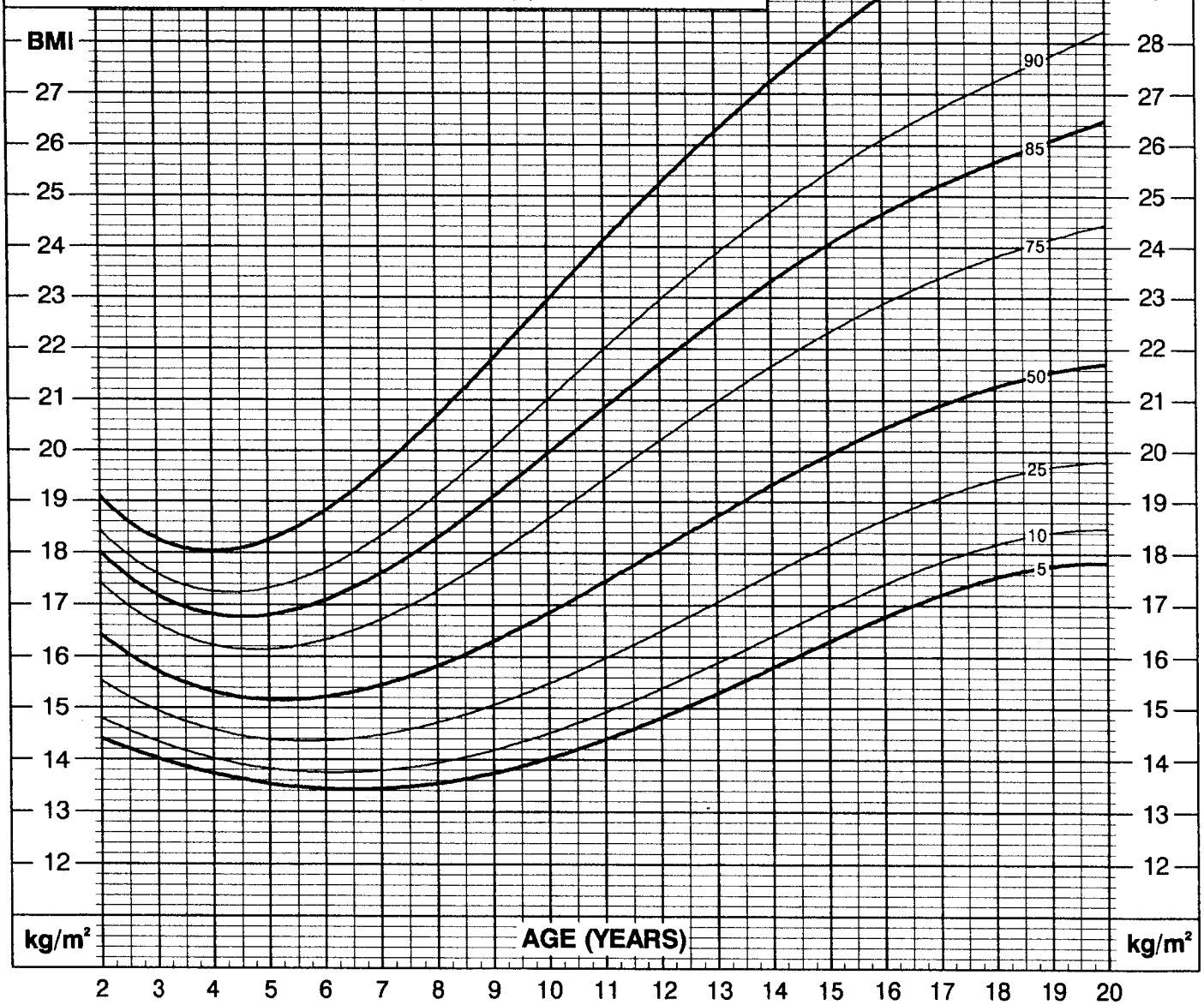
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



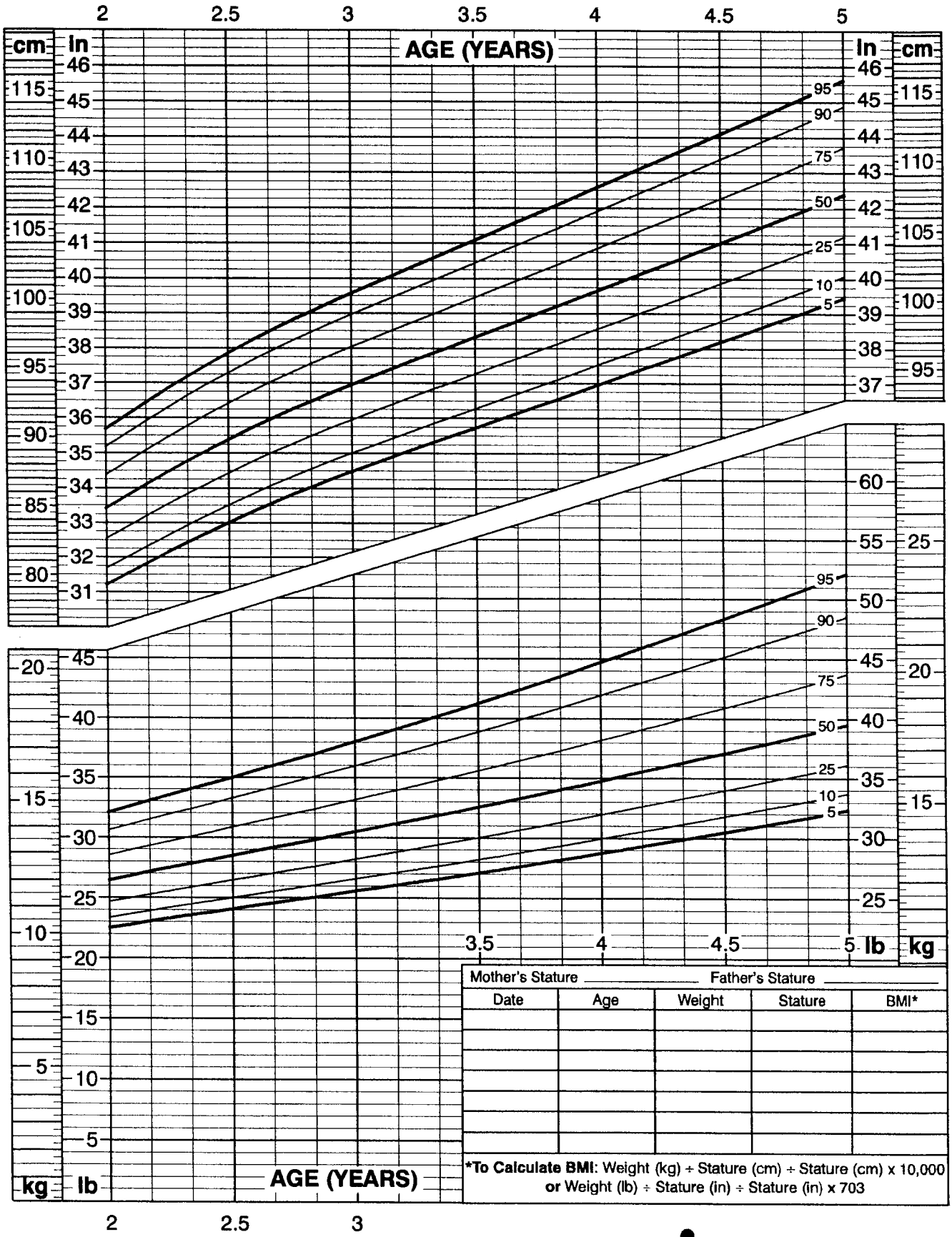
Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
SAFER · HEALTHIER · PEOPLE™

2 to 5 years: Girls
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI:** Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703

Available at **http://www.nal.usda.gov/wicworks**

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2002).
http://www.cdc.gov/growthcharts

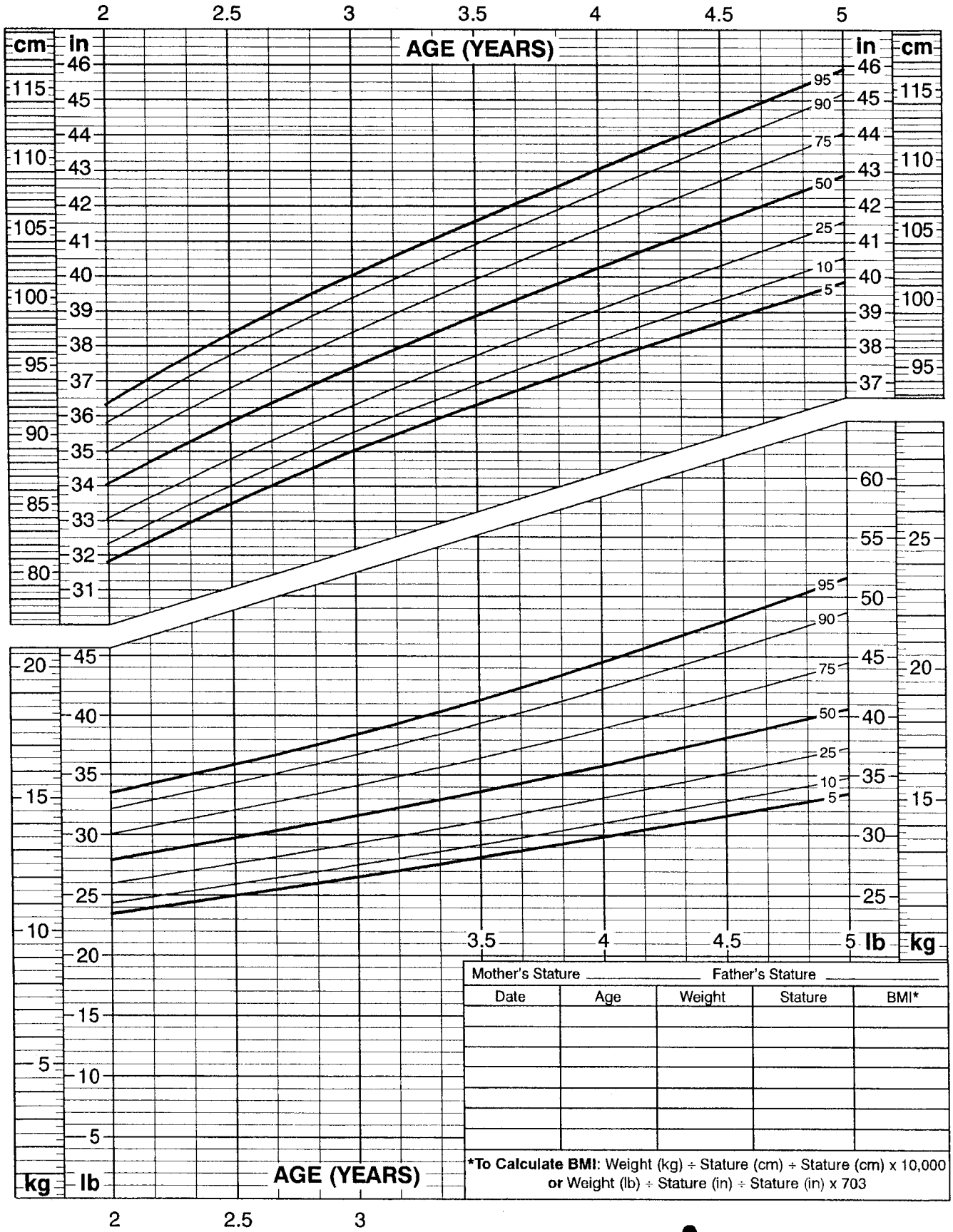
WIC Makes A Difference

CDC SAFER • HEALTHIER • PEOPLE™

2 to 5 years: Boys
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



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Available at **http://www.nal.usda.gov/wicworks**

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2002).
http://www.cdc.gov/growthcharts

WIC Makes A Difference

CDC SAFER · HEALTHIER · PEOPLE™

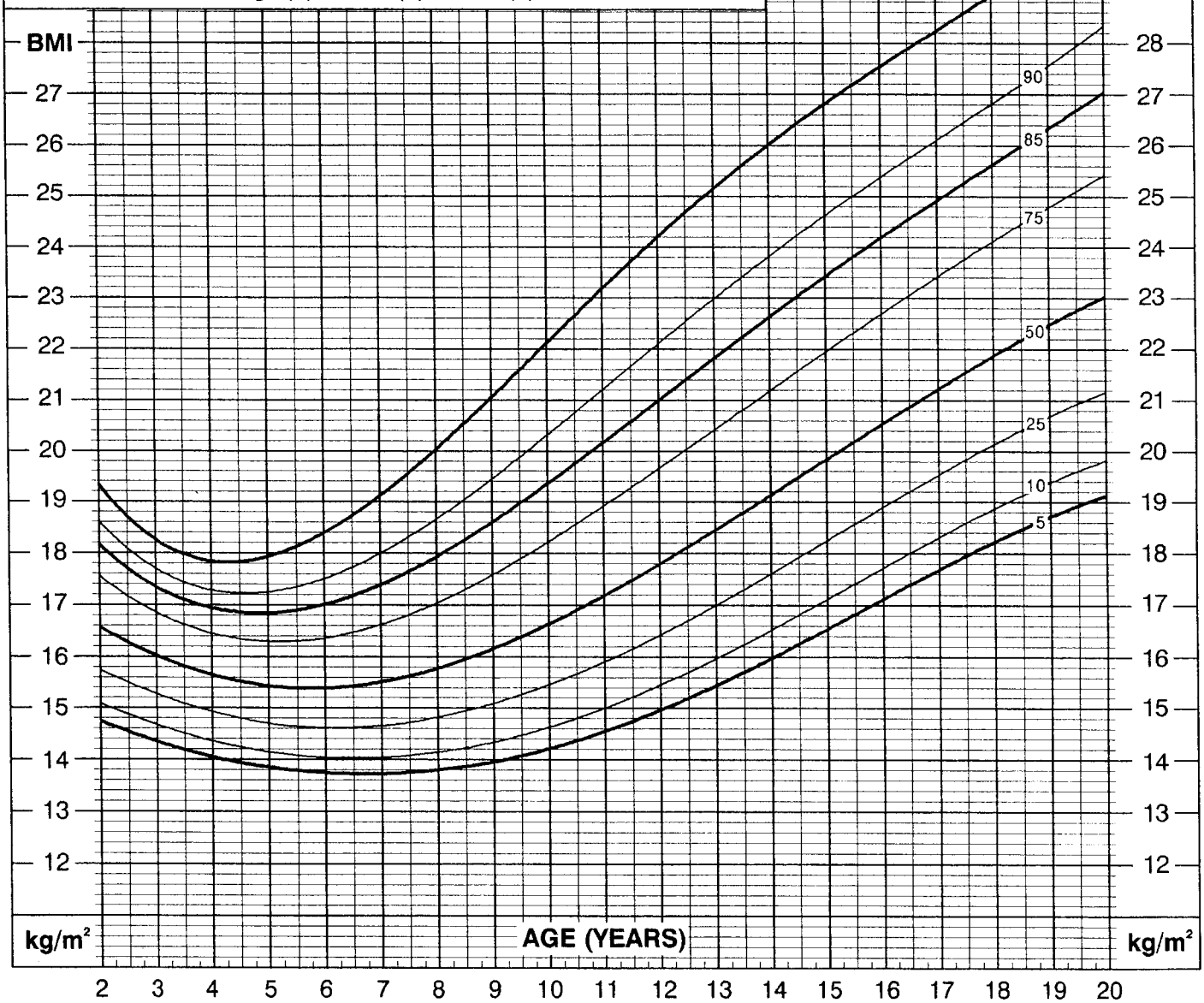
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
SAFER·HEALTHIER·PEOPLE™

Request for Release of WIC Program Information
To The Rhode Island Kidsnet Program

Participant No(s) _____ Participant(s) Names _____

No(s)_____ Names _____

I permit / deny the_____ to:
(WIC local agency)

Release WIC medical, nutritional and/or demographic information from WIC records to the Kidsnet Program at the RI Department of Health.

Kidsnet tracks children's vaccinations, lead screenings, WIC services, home visits and other preventive services. The information in Kidsnet is used to coordinate my child's care, to assure my child receives preventive health services, and for other public health services.

Kidsnet information is confidential. Only authorized users are able to view sections of the information necessary to help my child. Authorized users include

- my child's health care provider,
- school nurses,
- Head Start nurse coordinators,
- Lead Center caseworkers,
- the staff of Kidsnet Program, and Kidsnet participating programs-Lead Poisoning Prevention Program, Immunization Program, Newborn Screening Program, Family Outreach Program, Early Intervention Program,

I may cancel this permission at any time and it will not effect my WIC eligibility.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of WIC Staff Witness Date

_____WIC 101 11/02_____

Request for Release of WIC Program Information
To The Rhode Island Kidsnet Program

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I may cancel this permission at any time and it will not effect my WIC eligibility.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of WIC Staff Witness Date

Section 400
Program Benefits
RI WIC Procedure Manual

Revisions and / or Additions

Revisions to the Food Package Tailoring Guide to provide optional reduced juice food packages for children

RHODE ISLAND DEPARTMENT OF HEALTH
WIC PROGRAM

FOOD PACKAGE TAILORING GUIDE
June 2002

TABLE OF CONTENTS

Rhode Island WIC Program
Food Packages for Pregnant and Breastfeeding WIC Participants

Note: Exclusively breastfeeding women receive an additional 46 oz juice, 18 oz peanut butter, 1 lb cheese, 26 oz tuna fish and 2 lbs carrots.

Food Packages for Pregnant / Breastfeeding Women	**Code**	**With 1 lb beans / peas**	**with 18 oz peanut butter**
28 qts milk 2 1/2 dz eggs 276 oz juice 36 oz cereal	167 A	185 A	145 A
for exclusively breastfeeding women	267 A	285 A	245 A
22 qts milk 2 lbs cheese 2 1/2 dz eggs 276 oz juice 36 oz cereal	168 A	186 A	146 A
½ Gallon Milk Option		126 A	127 A
for exclusively breastfeeding women	268 A	286 A	246 A
½ gallon milk option for exclusively breastfeeding women		226 A	227 A
19 qts milk 3 lbs cheese 2 1/2 dz eggs 276 oz juice 36 oz cereal	*173 A*	*172 A*	*171 A*
for exclusively breastfeeding women	271 A	*297 A*	*298 A*
16 qts milk 4 lbs cheese 2 1/2 dz eggs 276 oz juice 36 oz cereal	169 A	187 A	147 A
for exclusively breastfeeding women	269 A	287 A	247 A

Food Packages for Pregnant / Breastfeeding Women	**Code**	**With 1 lb beans / peas**	**with 18 oz peanut butter**
No Eggs, No Cheese 28 qts milk 276 oz juice 36 oz cereal	194A	*198 A*	*199 A*
Lactaid, Milk 36 oz WIC Cereal 2 lbs WIC Cheese 6 cans WIC Juice 2 Dozen eggs 22 qts Lactaid		*128 A*	*129 A*
For Exclusively Breastfeeding Women		*228 A*	229 A
No Eggs 22 qts milk 2 lbs cheese 276 oz juice 36 oz cereal	1A3A	*1A8 A*	*1A9 A*
No Milk, No Cheese W/ <u>Calcium Fortified Juice</u> 2 1/2 dz eggs 276 oz *orange juice - calcium fortified* 36 oz cereal	*1M3 A*	*1M8 A*	*1M9 A*
No Juice 22 qts milk 2 lbs cheese 2 1/2 dz eggs 36 oz cereal	1J3A	1J8 A	1J9 A

Food Packages for Pregnant / Breastfeeding Women	**Code**	**with 1 lb beans / peas**	**with 18 oz peanut butter**
Non Fat Dry Milk or Evaporated Milk			
6 lb dry milk or 30 cans milk 2 1/2 dz eggs 276 oz juice	1P8 A	*1P4 A*	*1P5 A*
5 lb dry milk or 27 cans milk 1 lb cheese 2 1/2 dz eggs 276 oz juice 36 oz cereal	1P6A	*1P3 A*	*1Q1 A*
4 lb dry milk or 23 cans milk 2 lb cheese 2 1/2 dz eggs 276 oz juice 36 oz cereal for exclusively breastfeeding women	1P7A	*1P1 A* *1B1 A*	*1P2 A* *1B2 A*
3 lb dry milk or 17 cans milk 4 lb cheese 2 1/2 dz eggs 276 oz juice 36 oz cereal	1P9A	*1Q2 A*	*1Q3 A*

Food Packages for Postpartum WIC Participants

Food Packages for Postpartum Women	Code
Milk / Cheese Choices	333A
24 qts milk 2 dz eggs 184 oz juice 36 oz cereal	
18 qts milk 2 lbs cheese 2 dz eggs 184 oz juice 36 oz cereal	334A
½ gallon Milk Option	324A
12 qts milk 4 lbs cheese 2 dz eggs 184 oz juice 36 oz cereal	335A
Lactaid Milk	325A
36 oz WIC Cereal 2 lbx. WIC Cheese 2 dozen eggs 4 cans WIC Juice 18 qts. Lactaid Milk	
<u>No Eggs, No Cheese</u> 24 qts milk 184 oz juice 36 oz cereal	391A
No Eggs	
18 qts milk 2 lbs cheese 184 oz juice 36 oz cereal	3A1 A

Food Packages for Postpartum Women	**Code**
No Milk, No Cheese W/ Calcium Fortified Juice	
2 1/2 dz eggs 184 oz *calcium fortified orange juice* 36 oz cereal	*3M1A*
Non-Fat Dry Milk or Evaporated Milk	
5 lb dry milk or 26 cans milk 2 1/2 dz eggs 184 oz juice 36 oz cereal	338A
4 lb dry milk or 22 cans milk 1 lb cheese 2 1/2 dz eggs 184 oz juice 36 oz cereal	3P8A
3 lb dry milk or 16 cans milk 2 lb cheese 2 1/2 dz eggs 184 oz juice 36 oz cereal	339A
2 lb dry milk or 13 cans milk 4 lb cheese 2 1/2 dz eggs 184 oz juice 36 oz cereal	3P9A

Food Packages for Children from 1 to 2 years old

Food Packages for Children 1 - 2 yrs old	Code	with 1 lb beans / peas	with 18 oz peanut butter
Milk / Cheese Choices 18 qts milk 192 oz juice 1 1/2 dz eggs 36 oz cereal	934 A	815 A	818 A
15 qts milk 1 lb cheese 192 oz juice 1 1/2 dz eggs 36 oz cereal ½ Gallon Milk Option	935 A	816 A 801A	819 A 802A
12 qts milk 2 lbs cheese 192 oz juice 1 1/ dz eggs 36 oz cereal	936 A	817 A	820 A
Lactaid, Milk 36 oz. WIC Cereal 1 lb. WIC Cheese 192 oz. juice 2 Dozen Eggs 16 qts. Lactaid Milk		910A	911A
No Eggs, No Cheese 18 qts milk 192 oz juice 36 oz cereal	8E3A	8E8 A	8E9 A
No Eggs 15 qts milk 1 lb cheese 192 oz juice 36 oz cereal	8H3A	*8H8 A*	*8H9 A*
No Juice 17 qts milk 1 lb cheese 2 dz eggs 36 oz cereal	8J3 A	*8J8 A*	*8J9 A*

Food Packages for Children 2 to 3 years old

Food Packages for Children 2 - 3 yrs old	Code	with 1 lb beans / peas	with 18 oz peanut butter
Milk / Cheese Choices 20 qts milk 2 dz eggs 192 oz juice 36 oz cereal	943 A	854 A	857 A
17 qts milk 1 lb cheese 2 dz eggs 192 oz juice 36 oz cereal	944 A	855 A	858 A
½ Gallon Milk Option		803 A	804 A
14 qts milk 2 lbs cheese 2 dz eggs 192 oz juice 36 oz cereal	945 A	856 A	859 A
Lactaid Milk 36 oz. WIC cereal 1 lb. WIC cheese 192 oz juice 2 dozen eggs 17 qts. Lactaid Milk		912 A	913 A
No Eggs, No Cheese 20 qts milk 192 oz juice 36 oz cereal	8F3 A	8F8 A	8F9 A
No Eggs 17 qts milk 1 lb cheese 192 oz juice 36 oz cereal	8I3 A	*8I8 A*	*8I9 A*
No Juice 17 qts milk 1 lb cheese 2 dz eggs 36 oz cereal	8J3 A	*8J8 A*	*8J9 A*

Food Package Codes for Children 3 to 5 years of age

Food Packages for Children 3 - 5 yrs old	Code	with 1 lb beans / peas	with 18 oz peanut butter
Milk / Cheese Choices			
24 qts milk 2 dz eggs 192 oz juice 36 oz cereal	952 A	884 A	887 A
18 qts milk 2 lbs cheese 2 dz eggs 192 oz juice 36 oz cereal	954 A	886 A	889 A
½ Gallon Option		805 A	806 A
12 qts milk 4 lbs cheese 2 dz eggs 192 oz juice 36 oz cereal	953 A	885 A	888 A
Lactaid Milk 36 oz. WIC cereal 2 lbs WIC Cheese 192 oz juice 2 dozen eggs 18 qts. Lactaid Milk		914 A	*915 A*
No Eggs, No Cheese 24 qts milk 192 oz juice 36 oz cereal	8G3 A	*8G8 A*	*8G9 A*
No Eggs 17 qts milk 1 lb cheese 192 oz juice 36 oz cereal	8I3 A	*8I8 A*	*8I9 A*
No Juice 18 qts milk 2 lbs cheese 2 1/2 dz eggs 36 oz cereal	8K3 A	*8K8 A*	*8K9 A*

Evaporated Milk and Dry Milk Food Packages for All Children

Food Packages for Children	**Code**	**with 1 lb beans / peas**	**with 18 oz peanut butter**
Non Fat Dry Milk or Evaporated Milk			
5 lb dry milk or 26 cans milk 192 oz juice 2 1/2 dz eggs 36 oz cereal	8P2A	*8S1 A*	*8S2 A*
4 lb dry milk or 22 cans milk 1 lb cheese 2 1/2 dz eggs 192 oz juice 36 oz cereal	8P3 A	*8S3 A*	*8S4 A*
3 lb dry milk or 16 cans milk 3 lb cheese 2 1/2 dz eggs 192 oz juice 36 oz cereal	8P4 A	*8P6 A*	*8P7 A*
2 lb dry milk or 13 cans milk 4 lb cheese 192 oz juice 2 1/2 dz eggs 36 oz cereal	8P5 A	*8P8 A*	*8P9 A*
<u>Full Juice Package</u> 18 qts milk 2 lbs cheese 2 dz eggs 276 oz juice 36 oz cereal		890 A	891 A

Food Packages for WIC Infants

Food Packages for Infants	**Code**	**Code**
	(0 to 5 months)	***(6 to 12 months)***
Only for fully breastfed infant Congratulations check	001A	
For fully breastfed infant, or infant receiving no WIC formula no formula provided 96 oz juice 24 oz infant cereal		002A

Level 1
FORMULA-FED INFANTS
Contract Standard Formula - Enfamil

	CONCENTRATE	POWDER	READY-TO-FEED **
Enfamil with iron		*1 (14.3 oz.) can*	*12 (8 oz.) cans*
BREASTFEEDING SUPPLEMENT		708A	*720A*
with cereal and juice		709A	721A
		2 (14.3 oz.) cans	*24 (8 oz.) cans*
SMALL PACKAGE		710A	722A
with cereal and juice		711A	723A
	15 (13 oz.) cans	*4 (14.3 oz.) cans*	*13 (32 oz.) cans*
HALF PACKAGE	**700A**	712A	724A
with cereal and juice	**701A**	713A	725A
	25 (13 oz.) cans	*6 (14.3oz.) cans*	*19 (32 oz.) cans*
THREE-QUARTER PACKAGE	**702A**	714A	726A
with cereal and juice	**703A**	715A	727A
	31 (13 oz.) cans	*8 (14.3oz.) cans*	*25 (32 oz.) cans*
FULL PACKAGE	**704A**	716A	728A
with cereal and juice	**705A**	717A	729A

INFANT CEREAL AND JUICE: **Standard amounts are 24 oz. cereal and 96 oz. juice.**
Cereal and Juice for infants from 6 to 12 months

** **Ready-to-feed issuance requires documentation of unsafe water supply, the lack of proper facilities for sterilization and refrigeration, or mother/caretaker with physical or mental impairments resulting in inability to properly prepare concentrate or powdered formula.**

Level 1
FORMULA-FED INFANTS
Contract Standard Formula - Prosobee

	CONCENTRATE	POWDER	READY-TO-FEED **
Prosobee		*1 (14.3 oz.) can*	*12 (8 oz.) cans*
BREASTFEEDING SUPPLEMENT		758A	*770A*
with cereal and juice		759A	771A
		2 (14.3 oz.) cans	*24 (8 oz.) cans*
SMALL PACKAGE		760A	772A
with cereal and juice		761A	773A
	15 (13 oz.) cans	*4 (14.3 oz.) cans*	*13 (32 oz.) cans*
HALF PACKAGE	**750A**	762A	774A
with cereal and juice	**751A**	763A	775A
	25 (13 oz.) cans	*6 (14.3 oz.) cans*	*19 (32 oz.) cans*
THREE-QUARTER PACKAGE	**752A**	764A	776A
with cereal and juice	**753A**	765A	777A
	31 (13 oz.) cans	*8 (14.3 oz.) cans*	*25 (32 oz.) cans*
FULL PACKAGE	**754A**	766A	778A
with cereal and juice	**755A**	767A	779A
with cereal and juice			

INFANT CEREAL AND JUICE: **Standard amounts are 24 oz. cereal and 96 oz. juice.**
Cereal and Juice for infants from 6 to 12 months

** **Ready-to-feed issuance requires documentation of unsafe water supply, the lack of proper facilities for sterilization and refrigeration, or mother/caretaker with physical or mental impairments resulting in inability to properly prepare concentrate or powdered formula.**

Level 2

Requires Physician's Order and Approval of Nutritionist

FORMULA-FED INFANTS

Contract Special Formula

	POWDER	CONCENTRATE	READY-TO-FEED **
Enfamil Low-iron	*1 (14.3 oz.) can*		*12 (8 oz.) cans*
BREASTFEEDING SUPPLEMENT	**458A**		470A
with cereal and juice	**459A**		471A
	2 (14.3 oz.) cans		*24 (8 oz.) cans*
SMALL PACKAGE	**460A**		472A
with cereal and juice	**461A**		473A
	4 (14.3 oz.) cans	*15 (13 oz) cans*	*13 (32 oz.) cans*
HALF PACKAGE	**462A**	450A	474A
with cereal and juice	**463A**	451A	475A
	6 (14.3 oz.) cans	*24 (13 oz) cans*	*19 (32 oz.) cans*
THREE-QUARTER PACKAGE	**464A**	452A	476A
with cereal and juice	**465A**	453A	477A
	8 (14.3 oz.) cans	*31 (13 oz) cans*	*25 (32 oz.) cans*
FULL PACKAGE	**466A**	454A	478A
with cereal and juice	**467A**	455A	479A

INFANT CEREAL AND JUICE: **Standard amounts are 24 oz. cereal and 96 oz. juice. Cereal and Juice for infants 6 to 12 months old**

Powdered forms of non-standard formula should be provided

** **Ready-to-feed issuance requires documentation of unsafe water supply, the lack of proper facilities for sterilization and refrigeration, or mother/caretaker with physical or mental impairments resulting in inability to properly prepare concentrate or powdered formula.**

Issuance of this formula requires a physicians order and approval of WIC Local Agency nutritionist

FORMULA-FED INFANTS

Non-Contract Standard Formula

	POWDER	CONCENTRATE	READY-TO-FEED **	
SIMILAC WITH IRON OR ISOMIL	*1 (14 oz.) can*		*12 (8 oz.) cans*	
BREASTFEEDING SUPPLEMENT	**508A**		520A	
with cereal and juice	**509A**		521A	
	2 (14 oz.) can		*24 (8 oz.) cans*	
SMALL PACKAGE	**510A**		522A	
with cereal and juice	**511A**		523A	
	4 (14 oz.) cans	*15 (13 oz) cans*	*13 (32 oz.) cans*	
HALF PACKAGE	**512A**	500A	524A	
with cereal and juice	**513A**	501A	525A	
	6 (14 oz.) cans	*24 (13 oz) cans*	*19 (32 oz.) cans*	
THREE-QUARTER PACKAGE	**514A**	502A	526A	
with cereal and juice	**515A**	503A	527A	
	9 (14 oz.) cans	*31 (13 oz) cans*	*25 (32 oz.) cans*	
FULL PACKAGE	**516A**	504A	528A	
with cereal and juice	**517A**	505A	529A	
	9 (14 oz.) cans	*31 (13 oz) cans*	*25 (32 oz.) cans*	*100 (8 oz.) cans*
HOMELESS PACKAGE	**516A**	504A	528A	530A
with cereal and juice	**517A**	505A		

INFANT CEREAL AND JUICE: **Standard amounts are 24 oz. cereal and 96 oz. juice. Cereal and juice for infants 6 to 12 months**

Powdered forms of non-contract formulas should be issued

** **Ready-to-feed issuance requires documentation of unsafe water supply, the lack of proper facilities for sterilization and refrigeration, or mother/caretaker with physical or mental impairments resulting in inability to properly prepare concentrate or powdered formula.**

Level 3

Issuance of this Formula requires a physician's order and approval of WIC Local Agency nutritionist

FORMULA-FED INFANTS

Non-Contract Standard Formula

	POWDER	CONCENTRATE	READY-TO-FEED **
SIMILAC (LOW IRON)	*1 (14 oz.) can*		*12 (8 oz.) cans*
BREASTFEEDING SUPPLEMENT	**558A**		570A
With cereal and juice	**559A**		571A
	2 (14 oz.) cans		*24 (8 oz.) cans*
SMALL PACKAGE	**560A**		572A
With cereal and juice	**561A**		573A
	4 (14 oz.) cans	*15 (13 oz) cans*	*13 (32 oz.) cans*
HALF PACKAGE	**562A**	550A	574A
With cereal and juice	**563A**	551A	575A
	6 (14 oz.) cans	*24 (13 oz) cans*	*19 (32 oz.) cans*
THREE-QUARTER PACKAGE	**564A**	552A	576A
With cereal and juice	**565A**	553A	577A
	9 (14 oz.) cans	*31 (13 oz) cans*	*25 (32 oz.) cans*
FULL PACKAGE	**566A**	554A	578A
With cereal and juice	**567A**	555A	579A

0.

INFANT CEREAL AND JUICE: **Standard amounts are 24 oz. cereal and 96 oz. juice. Cereal and juice for infants 6 to 12 months**

Powdered forms of non-contract formulas should be issued

** **Ready-to-feed issuance requires documentation of unsafe water supply, the lack of proper facilities for sterilization and refrigeration, or mother/caretaker with physical or mental impairments resulting in inability to properly prepare concentrate or powdered formula.**

Level 4- Issuance requires physicians order and review and approval by local agency nutritionist

RHODE ISLAND WIC PROGRAM SPECIAL NON-CONTRACT FORMULAS

(Abridged Version)

Contact State Agency Nutritionist for additional unlisted formulas

Product I = Infant C = Child W = Women	Manufacturer	Description	Pack	CODES 0-5 months or Formula Only	6-12 months Formula & 96 oz. Juice 24 oz. Infant Cereal	Child/Women Formula & 144 oz. Juice 36 oz. Adult Cereal
Alimentum (I, C)	Ross Lab	Protein hydrolysate formula with iron, hypoallergenic feeding	25 - 32 oz. cans RTF 8 - 1 lb. cans powder	ALA 1 ALD 1	ALB 1 ALE 1	ALC 1 ALF 1
Enfacare (I, C) 22 cal / oz	Mead Johnson	Iron fortified formula for premature infants	8– 14.3 oz. Cans powder	ENA 1	ENB 1	ENC 1
Enfamil with Iron (C)	Mead Johnson	Iron fortified infant formula for routine feeding	31 - 13 oz. cans conc 8 – 14.3 oz. cans powder 25 - 32 oz. cans RTF			EIA 1 EIB 1 EIC 1
		Above standard package	35 - 13 oz. cans conc. 9 – 14.3 oz. cans powder 28 - 32 oz. cans RTF			EID 1 EIE 1 EIF 1
Prosobee (C)	Mead Johnson	Iron fortified infant formula, soy based protein	31 - 13 oz. cans conc. 8 – 14.3 oz. cans powder 25 32 oz. RTF			PRA-1 PRB-1 PRC-1
		Above standard package	35 - 13 oz. cans conc. 9 – 14.3 oz. cans powder 28 - 32 oz. RTF			PRD 1 PRE 1 PR F 1
Enfamil, low iron (C, W)	Mead Johnson	Low iron infant formula	31 – 13 oz. cans concentrate 8 – 14.3 oz. cans powder 25 – 32 oz. cans RTF			EFK 1 EFM 1 EFO 1

Product **I = Infant** **C = Child** **W = Women**	**Manufacturer**	**Description**	**Pack**	**0-5 months or Formula Only**	**6-12 months Formula & 96 oz. Juice 24 oz. Infant Cereal**	**Child/Women Formula & 144 oz. Juice 36 oz. Adult Cereal**
Ensure with Fiber (W & C)	Ross Lab	Nutritionally complete liquid formula with fiber	100 – 8 oz. R-T-F cans	ERA 1		ERB 1
Ensure (W & C)	Ross Lab	Nutritionally complete liquid formula	9 – 14 oz. powder	ESA 1		ESB 1
Ensure Plus (W & C)	Ross Lab	High calorie, nutritionally complete liquid formula	102 – 8 oz. cans	ESF 1		ESE 1
Good Start (I, C. W)	Carnation	Iron Fortified Infant Formula	9 – 12 oz. cans powder 31 – 13 oz. concentrate	GDD 1 GDA 1	GDE 1 GDB 1	GDF 1 GDC 1

Product I = Infant C = Children W = Women	Manufacturer	Description	Pack	0-5 months or Formula Only	6-12 months Formula & 96 oz. Juice 24 oz. Infant Cereal	Child/Women Formula & 144 oz. Juice 36 oz. Adult Cereal
Goat Milk	Myenberg, Evaporated	Evaporated goats milk	32 - 12.5 oz cans conc.			MRC 1
Isocal (C, W)	Mead Johnson	Nutritionally complete isotonic, lactose-free, low -residue formula	25 - 32 oz. cans RTF	ISA 1		ISB 1
Isomil (see Similac formula)						
Kindercal 30 cal./oz (C)	Mead Johnson	Nutritionally complete pediatric liquid diet above standard package	100 - 8 oz. cans RTF 114 - 8 oz cans	KIA 1		KIC 1 KID 1
Lacto free (I,C,W)	Mead Johnson	Lactose free cows milk protein infant formula	8 - 14 .3oz. cans powder 31- 13 oz. cans conc. 25- 32 oz. cans RTF	LAD 1 LAA 1 LAG 1	LAE 1 LAB 1 LAH 1	LAF 1 LAC 1 LAI 1
Neosure , Similac (I,C) 22 cal / oz	Ross Lab	Iron fortified formula for premature infants	9 -14 oz cans powder	SIX 1	SIY 1	SIZ 1
Nutramigen (I, C, W)	Mead Johnson	Nutritionally complete, lactose-free protein hydrolysate formula	31 - 13 oz. cans conc. 8 - 1 lb. cans powder 25 - 32 oz. cans RTF	NUA 1 NUD 1 NUG 1	NUB 1 NUE 1 NUH 1	NUC 1 NUF 1 NUI 1
Osmolite (C, W)	Ross Lab	Nutritionally complete, isotonic, lactose-free, low-residue liquid food	25 - 32 oz. cans RTF	OTA 1		OTB 1
PediaSure (C) 30 cal / oz	Ross Lab	Nutritionally complete, virtually lactose-free, gluten-free liquid food Above standard package	102 - 8 oz. cans RTF **(Mos. 1&2)** 96 - 8 oz. cans RTF **(Mo. 3)** 114 - 8 oz. cans RTF	PEA 1 PEB 1		PEC 1 PEE 1 PEH 1
PediaSure with fiber (C) 30 cal / oz	Ross Lab	Nutritionally complete, virtually lactose-free, gluten-free. Liquid food with added fiber Above standard package	100 - 8 oz. cans RTF 114 – 8 oz cans	PED 1		PEF 1 PEG 1
Portagen (I,C,W)	Mead Johnson Direct purchase / state	Nutritionally complete, casein-based, powered formula with MCT oil	8 - 1 lb cans powder	POA 1	POB 1	POC 1

Product **I = Infant** **C = Children** **W = Women**	**Manufacturer**	**Description**	**Pack**	**0-5 months or Formula Only**	**6-12 months Formula & 96 oz. Juice 24 oz. Infant Cereal**	**Child/Women Formula & 144 oz. Juice 36 oz. Adult Cereal**
Pregestamil (I,C)	Mead Johnson	Nutritionaly complete, lactose-free protein (casein) hydrolysate formula with MCT oil	8 - 1 lb cans powder	PSA 1	PSB 1	PSC 1
Similac with iron or Isomil (C,W)	Ross Lab	Iron fortified standard formula	31 - 13 oz cans conc 9 - 14 oz cans powder 24 - 32 oz cans RTF			SIB 1 SID 1 SIF 1
		Above standard package	35 – 13 oz cans concentrate 10 – 14 cans powder 28 – 32 oz RTF			SIG 1 SIH 1 SIL 1
Similac (low iron) (C,W)	Ross Lab	Low iron infant formula	31 - 13 oz. cans conc 9 - 14 oz. cans powder 25 - 32 oz. cans RTF			SIK 1 SIM 1 SIO 1
Sustacal (C, W)	Mead Johnson	Nutritionally complete, lactose-free, low-residue, fiber-free liquid food	2 - 3.8 lb. cans powder 100 - 8 oz. can RTF	STA 1 STD 1		STC 1 STF 1
Sustagen (C,W)	Mead Johnson	High calorie, high protein, low residue nutritional supplement	2 - 5 lb cans powder	SUA 1		SUC 1

Level 5

Issuance requires physician's order, review and approval by local agency nutritionist and review and approval of state agency nutritionist

RHODE ISLAND WIC PROGRAM SPECIAL NON-CONTRACT FORMULAS

These formulas are special ordered through the State WIC Office. Checks should not be given to participant until approval given by State WIC Office.

Contact State Agency Nutritionist for additional unlisted formulas

Product I = Infant C = Child W = Women	Manufacturer	Description	Pack	CODES 0-5 onths or Formula Only	CODES 6-12 months Formula & 96 oz. Juice 24 oz. Infant Cereal	CODES Child/Women Formula & 144 oz. Juice 36 oz. Adult Cereal
Casec (C, W)	Mead Johnson	Concentrated protein preparation with negligible fat and Carbohydrates	2 - 10 cans powder			CAA 1
Enfamil AR (20 cal./oz) (I, C)	Mead Johnson	Complete infant formula that is thickened with added rice starch	8- 14.3 oz. cans powder 25 - 32 oz. cans RTF	CALL	FOR	CODES
Enfamil with iron (24 cal./ oz.) (I, C)	Mead Johnson direct purchase by state WIC nutritionist	Iron fortified infant formula 24 calories/oz. RTF	267 - 3 oz. bottles RTF	EFR 1	EFS 1	EFT 1
Enfamil Premature (20 cal./oz.) (I)	Mead Johnson direct purchase by state WIC nutritionist	Low iron formula for LBW infants, 20 cal./oz RTF	267 - 3 oz. bottles RTF	EFP 1	EFQ 1	
Enfamil Premature (24 cal./oz.) (I)	Mead Johnson direct purchase by state WIC nutritionist	Low iron formula for LBW infants 24 cal./oz. RTF	267 - 3 oz. bottles RTF	EFU 1	EFV 1	
Enfamil Premature with iron (20 cal./oz.) (I)	Mead Johnson direct purchase by state WIC nutritionist	Iron fortified formula for LBW infants 20 cal./oz. RTF	267 - 3 oz. bottles RTF	ERC 1	ERD 1	
Enfamil Premature with iron (24 cal./oz.) (I)	Mead Johnson direct purchase by state WIC nutritionist	Iron fortified formula for LBW infants, 24 cal./oz. RTF	267 - 3 oz. RTF	EFW 1	EFX 1	

Product I = Infant C = Child W = Women	Manufacturer	Description	Pack	0-5 months or Formula Only	6-12 months Formula & 96 oz. Juice 24 oz. nfant Cereal	Child/Women Formula & 144 oz. Juice 36 oz. Adult Cereal
Lipisorb, powder	Mead Johnson direct purchase by state WIC nutritionist	Nutritionally complete formula with MCT oil for fat malabsorption	8 – 1 lb cans powder	LIA 1	LIB 1	LIC 1
Lofenalac	Mead Johnson provided only through the CDC at RIH	formulation for PKU	8 – 1 lb cans powder	CALL	FOR	CODES
Neocate infant formula	Scientific Hospital Supplies direct purchase by state WIC nutritionist	Complete elemental formula for infants 20 cal / oz	9 – 14.2 oz cans powder	NEA 1	NEB 1	NEC 1
Neocate One+	Scientific Hopsital Supples direct purchase by state WIC nutritionist	Complete elemental formula for children	101 - 8 oz RTF boxes 37 - 100 gm packets			NED 1 NEE 1
Peptamen Jr.	Nestle direct purchase by state WIC nutritionist	Complete elemental diet for children	100 - 8 oz cans RTF vanilla flavored	PPA 1		PPC 1
Periflex, powder	Scientific Hospital Supplies (SHS) provided only through the CDC at RIH	formulation for PKU	8 – 1 lb cans powder	CALL	FOR	CODES
Phenyl-free powder	Mead Johnson provided only through the CDC at RIH	formulation for PKU	8 – 1 lb cans powder	CALL	FOR	CODES

Product **I = Infant** **C = Child** **W = Women**	**Manufacturer**	**Description**	**Pack**	**0-5 months** **or** **Formula Only**	**6-12 months** **Formula &** **96 oz. Juice** **24 oz. nfant** **Cereal**	**Child/Women** **Formula &** **144 oz. Juice** **36 oz. Adult** **Cereal**
Scandishake (C, W)	Scandipharm Direct purchase by state nutritionist	Calorically dense, gluten-free, high fat, high carbohydrate, low-protein powdered product	43 - 3 oz. pkts.	SNA 1		SNB 1
Similac PM 60/40 (I)	Ross Lab	Low iron, lower level of NA + K	8 - 1 lb. cans powder	SIU 1	SIV 1	SIW 1
Similac Special Care (24) (I)	Ross Lab direct purchase by state nutritionist	Low iron premature infant formula, 24 cal./oz.	201 - 4 oz. bottles RTF	SIP 1	SIQ 1	
Vital High Nitrogen (I, C, W)	Ross	Complete,partially hydrolyzed,powdered formula.	46 - 2.79 oz.pkts. powder	VIA 1	VIB 1	VIC 1
Vivonex (C)	Novartis	Nutritionally complete elemental formula for children.	75 - 1.7 oz.pkts. powder	VID 1		VIE 1
Special Need Formula	only use with prior approval of State WIC nutritionist	2 - cans powder		XXX 1	XXY 1	XXZ 1

Rhode Island WIC Program
Super Checks

Infant

	31-13 oz cans conc. Enfamil	8-14.3 oz. cans Enfamil powder	31 –13 oz cans conc. Prosobee	8-14.3 oz cans Prosobee Powder
Full Package	730A	732A	780A	782A
With 2 cans juice 24 oz infant cereal	731A	733A	781A	783A

Child 1-2

Food Package	**With 1 lb beans/peas**	**With 18 oz peanut butter**
36 oz WIC cereal 1 lb WIC cheese 192 oz juice 2 dozen eggs 4 gallons milk	958A	959A

Child 2-3

Food Package	With 1 lb beans/peas	With 18 oz peanut butter
36 oz WIC cereal 1 lb WIC cheese 192 oz juice 2 dozen eggs 4 gallons milk 1 quart milk	960A	961A

Child 3-5

Food Package	With 1 lb beans/peas	With 18 oz peanut butter
36 oz WIC cereal 2 lbs WIC cheese 192 oz juice 2 dozen eggs 4 & 1/2 gallons milk	962A	963A

Preg/non-exclusively BF

Food Package	With 1 lb beans/peas	With 18 oz peanut butter
36 oz WIC cereal 2 lbs WIC cheese 6 cans WIC juice 2 dozen eggs 5 & 1/2 gallons milk	159A	160A

Exclusively BF

Food Package	With 1 lb beans/peas	With 18oz peanut butter
36 oz WIC cereal 8 cans WIC juice 5 & 1/2 gallons milk 4-6 1/2 oz cans tuna 2 lbs carrots 18 oz peanut butter 2 dozen eggs 3 lbs WIC cheese	240A	241A

Postpartum Woman

Food Package	Milk/ Cheese Choices
4 & 1/2 gallons milk 2 lbs WIC cheese 2 dozen eggs 4 cans WIC juice 36 oz WIC cereal	359A

RHODE ISLAND DEPARTMENT OF HEALTH

WIC PROGRAM

WIC FEDERAL INCOME GUIDELINES

In Effect from April 1,2002 to June 30, 2003

Based on Income before Deductions or Gross

Family Size	Annual	*Monthly	*Weekly
1	$16,391	$1,366	$316
2	22,089	1,841	425
3	27,787	2,316	535
4	33,485	2,791	644
5	39,183	3,266	754
6	44,881	3,741	864
7	50,579	4,215	973
8	56,277	4,690	1,083
Each additional family member	+5,698	+475	+110

* Figures are rounded upward to the nearest dollar

Effect on Family Size with a Pregnancy
An applicant pregnant woman who does not meet income eligibility requirements on the basis of her current family size and income shall be reassessed for eligibility based on a family size increased by one, or by the number of expected multiple births.

Note: Proof of multiple births is required following standard procedure.

In situations where the family size has been increased for a pregnant woman, the same increased family size should also be used for any of the categorically eligible family members.

Apps 200-53

Section 500
Coordination and Outreach
RI WIC Procedure Manual

Revisions and / or Additions

Addition of the referral and coordination process with the Kidsnet Program, as allowed with parental / caregiver consent.

SECTION 500

OUTREACH AND COORDINATION
(Goals - V)

510 - Outreach

Local agencies have a crucial responsibility for the outreach effort in their respective areas. Each agency has some valuable unique local relationships with referral and service sources. The local agency should seek methods of cooperating with these resources in order to both maintain its caseload and to reach a greater proportion of high risk individuals.

Local Agency Outreach Plan

A. In order to assess the local outreach needs, the local agency should monitor its caseload in terms of the total number served and the proportion of high priority participants enrolled.

B. State and locally developed outreach materials can be provided for dissemination through the outreach network. It is particularly helpful to increase dissemination of multilingual outreach materials.

C. When contacts are arranged on the local level, the state agency can provide written or audiovisual materials and, as much as possible, state agency staff to assist in public presentations.

D. All public information materials must bear the nondiscrimination statement (Sec. 810, H.).

E. A written plan should be developed and present in the state and local agencies which contains at least:

1. The assessment of outreach sources in the area, noting the potential of high risk clients of each. Describe the relationship and contacts with each.

2. Attach copies of outreach materials about the Program which will be provided to these agencies.

3. Identification of staff and other agency resources available to conduct outreach activities.

4. Steps which can be taken to publicize the availability of the Program.

5. Plans to coordinate services with other programs.

6. Steps which will be taken to reach potentially eligible pregnant women, or high risk children, with emphasis on early intervention and on reaching migrants, if appropriate.

7. Steps the agency will take to ensure that pregnant women and infants receive an appointment promptly.

8. Measures the agency can take to fill available openings, in addition to the usual schedule of certification contacts (ex: "Open House" and "Health Fairs", special certification days, additional staff or clinic hours).

9. A log or other record of outreach activities and results.

10. The agency should list in its outreach plan those local organizations that have contact with sizable numbers of potential WIC applicants. Local contacts may also supplement state activities. Primary emphasis should be given to those organizations serving potentially high priority persons or underserved groups in the population. Contacts with such sources can be established through direct initiation by the WIC Program, or affiliated health agency, or through attendance at local professional or civic gatherings.

11. Local health care providers should be contacted (by mail or visit) to provide information about the Program at least once yearly. These efforts will be most productive when combined with a demonstrated interest in coordination of care and cooperation.

12. Local offices of financial aid programs should be contacted yearly to secure referrals. Through such contacts, changes in the availability of openings, waiting list requirements, and referral procedures can be communicated.

13. The agency, at least once a year, should mail outreach materials to local health and social service agencies in the area, including any shelters for homeless women and children in the area. WIC posters and outreach pads should be displayed and maintained in at least three area locations. Locations may include local grocery stores, churches, resale shops, laundromats, day care centers, etc. State printed flyers are available in bulk. Agencies can ask grocers and pharmacies to place a flyer in shopping bags.

14. Local media should be contacted in an effort to obtain news and/or feature publicity. Such publicity can focus both on the nutritional benefits of the WIC Program, and the services offered by the local agency. Such media efforts often provide far more detail about eligibility requirements, agency hours, and application procedures than do features in broader statewide media. The agency should issue radio public service announcements to local radio

stations each year and issue at least one press release to a local newspaper.

520 - COORDINATION

Related to their economic and health status, WIC participants are likely to be in need of additional services provided by other health or human resource programs. Coordination between WIC and other programs can reinforce the effectiveness of the WIC benefits. The health status and quality of life can be enhanced. Coordination of services and referrals can provide additional support and encouragement to participants to begin, or continue, to receive a broad range of health related services. Expensive duplication of services can also be minimized, and frustration and discouragement avoided. In order to assure service to those most in need WIC must be accessible to all those in need. Part of that involves cooperation with other helping agencies serving the same population. The intent is to ensure referral between programs and facilitate application for several programs at once. This will avoid duplication of effort on both the agency and client side.

Health Services

Local agencies should establish effective procedures for referral of appropriate agency clients to the WIC Program. WIC is intended to be an adjunct to needed health care. WIC procedures should be designed to reinforce health care visits. Local agencies should be careful to avoid procedures which encourage participants to choose between health and WIC visits because of physical or chronological separation of services.

Whenever possible, WIC and health care visits should be combined. WIC and other agency health care staff should encourage participants to make maximum use of services. Patient care recommendations should be mutually agreed upon where there is a relationship (ex: WIC food package, desirable weight and diet recommendations).

When participants receive health care from a private provider, WIC staff should be aware of the provider's identity. Participant utilization of health care should be encouraged and inquired about. Constructive and cooperative relationships between the local agency and other health providers are recommended. Informal agreements concerning referrals, coordination of care, and communication of questions or concerns are potentially effective.

Medical Assistance and RIte Care

During certification, special effort should be made to identify potential Medical Assistance and RIte Care recipients, to give them information on Medical Assistance and to make referrals where appropriate. A pregnant woman, as soon as pregnancy is confirmed, can be considered for Medical Assistance. If possible,

have the person call for an application on the spot (See Appendix for information). All pregnant women who have no health insurance should be referred to RIte Care for assistance.

Family and Child Services

In some instances, it may become apparent that the participant lacks the capacity to effectively obtain or utilize the WIC food benefits. Referrals to, or discussions with, family or child service or homemaker help agencies should be explored. When it is known that the Department of Children, Youth and Families is providing services to a participant family, appropriate use of WIC food benefits should be carefully monitored. Direct contact with other agencies without the client's participation, however, should be carefully evaluated for its implications on confidentiality requirements.

Economic Aid Programs

Local agencies are required by regulation to have available informational materials describing such programs as FIP, Medical Assistance/ Rite Care, Child Support Enforcement and FSP and to coordinate with other programs, such as Fuel Aid. Specific addresses and telephone numbers of such programs should be offered to WIC participants or applicants who appear to be eligible for these programs (See Appendix for information).

Protective Services for Children

WIC local agency staff may be in a situation where they have reasonable cause to know or suspect (observation, complaints received) that a child (WIC participants and non-participants as well) is being abused or neglected. Under Rhode Island law, all complaints, suspicions or knowledge however received (mail, telephone, or in person) must be immediately telephoned to the Child Abuse and Neglect Tracking System (CANTS) at Department of Children, Youth and Families (DCYF). The telephone number of the DCYF **Division of Protective Services, CANTS, is: 1-800-RI-CHILD.** The WIC staff person (all levels of staff) who receives the information will record all of the appropriate information and telephone CANTS at DCYF about the situation. Refer to the WIC brochure "WIC - Child Abuse and the Law" for detailed information regarding WIC personnel responsibilities under the law.

Any person making a report required by the law is immune from any liability.

Abused and/or neglected child means a child whose physical or mental health or welfare is harmed or threatened with harm by his parent or other person responsible for his welfare.

Drug and Other Harmful Substance Abuse Counseling Services

During certification, effort should be made by questioning to determine if the applicant is taking any drugs

or alcohol or other
substances which could be harmful to the health of the
applicant or her fetus. If such use is evident, WIC staff should refer the applicant to appropriate counseling services, if available, by giving the applicant a list of such services. A list has been distributed to local agencies by the State agency and should be kept and made available to WIC adult participants and applicants. The local agency annual nutrition education plan should include a plan to coordinate services with local drug and other harmful substance abuse counseling and treatment services.

Breastfeeding Promotion Programs

Applicants will be referred to appropriate local breastfeeding support programs. A list of such services has been distributed to local agencies and should be kept for reference.

Other Special Services or Programs

Added 10/02
If parents / guardians give permission, the WIC Program will share medical / nutritional / demographic information with the KIDSNET Program. Kidnset is the RI Dept of Health's information system that tracks children's immunization, lead screening, home visits and other preventive services. Kidsnet information is viewed by authorized health care providers and used to coordinate care, assuring preventive health services are provided and for quality assurance. (WIC – 101)

Participants may sometimes reveal specific health or social problems or needs during discussions with WIC staff. In such cases, WIC staff should explore the availability of resources within the programs of the local agency. Additionally, other known local programs or agencies providing health or social services can be referred to. Local programs such as food assistance agencies, nutrition education services like EFNEP, teen pregnancy programs, parenting and family stress intervention services and shelters for homeless women and children should be considered. Additional information about available services can be obtained from:

12/99
Travelers' Aid Help Line – Providence - 351-6500, elsewhere (800) 367-2700
Department of Human Services - 462-1000
WIC State Agency Liaison Staff - 222-3940, (800) 942-7434

Documentation

Referrals discussed or made should be documented in the participant record. The Income Determination Worksheet, progress notes, or a checklist may be utilized.

Financial Aid Programs / Food Stamp Programs

Refer WIC Applicant to Family Resource Counselors, or directly to FIP Food Stamps, Child Support Enforcement. See WIC Brochure WIC -44

SERVE NEW ENGLAND HOST SITES

RHODE ISLAND

Barrington

COMMUNITY SERVE
Deidre Walton, 437-1569

Chapel of the Nativity
Dee McGurty, 664-5513
Sally Ferulo, 664,2520

Central Falls

Serve ST GEORGE'S
Donald Griffin, 786-3525
Ruth and Mark Thomas, 727-0420

Coventry

Church of St. Andrew & St. Phillip
Jackie Paquette, 397-9964

Cranston

ANSA Serve
Gail Leoni, 943-0776
Frank Agresti, 942-1351

Cumberland

St John Vianney Church
Rev. Michael A. Brown, 334-8956
Grace Chartaier, 333-6977

Divine Harvest Church
Beverly Camper, 725-2556
Audrey Wigginton, 725-2556

East Greenwich

East Greenwich Rotary Club SERVE (Services North Kingstown also)
Bill McHale, 434-1746
Charles Saven, 884-8362

North Providence

St. James Church, Providence
Kate Sternberg, 232-7524

Providence

Olney St. Baptist-Children-Women's Ministries
Rosia Whetstone, 461-2236
Cleo Nobles, 334-0116

Smith Hill Center
Venus Jones, 351-2595

South Providence Neighborhood Ministries
Grace Wilcox, 785-0974
Wanda Michaelson, 785-0974

Warwick

Hillsgrove United Methodist Church
Ed Rhind, 885-4135
Donald Gothberg, 781-3695

First Congregational Church
Vi Moody, 739-8046

Faith Baptist Church
Diane Makin, 494-0039
Joan Battey, 737-7075

West Warwick

Emanuel Lutheran
Carol Caswell, 823-8892

Echo Valley Seve
Doris Nunes, 828-6187

Revised 10/02