

4. Adult scales that do not agree within 1/4 pound with calibrated weights shall be repaired or replaced. Infant scales that do not agree within 1/2 ounce with calibrated weights shall be repaired or replaced.

5. Scales will be zeroed after each use to help maintain their accuracy.

6. Stature boards must be checked at least annually to determine if they are mounted correctly.

7. Assessment of measuring techniques will be included as part of the county health department/WIC quality assurance process.

(2) Biochemical - Hemoglobin or Hematocrit. Bloodwork must be obtained as described in the periodicity requirements of (f) below. (See Attachment 14 to Chapter 3, WIC CPA Guidebook, 2009 for a summary of bloodwork requirements.)

(a) Approved Equipment. Approved machines for hemoglobins or hematocrits are listed in Attachment 15 to Chapter 3, Approved Medical Equipment. Exceptions made to the use of these machines will need to be approved through the state WIC office.

(b) Equipment Calibration. The calibration of hematological equipment used to determine hematocrits or hemoglobins for WIC in the CHD clinics must be checked and results documented daily. However, if the agency is using a hemoglobin analyzer that internally self-tests calibration, additional testing of the calibration by staff is not needed, unless required to do so by the county health department lab director.

(c) Training on Hematological Measuring Techniques. Local agency WIC staff who conduct hemoglobins or hematocrits for WIC certifications and all Competent Professional Authorities (CPAs) must be trained on hematological measuring techniques and universal precautions as described in Chapter 12-8.e.

(d) Categorical Requirements for Women Participants. For women participants, the hemoglobin or hematocrit test must be reflective of her categorical status. A hemoglobin or hematocrit used for a pregnant woman must be obtained during the current pregnancy. A hemoglobin or hematocrit test used for a postpartum or breastfeeding woman must be obtained after the termination of the most recent pregnancy. For pregnant women assessment of the hemoglobin or hematocrit test for counseling and nutrition risk determination must be based on the trimester in which the hemoglobin or hematocrit test was obtained.

(e) Bloodwork Used For WIC Certification. Bloodwork used for WIC certifications must be according to the periodicity schedule described below and must be:

1. Obtained at the time of certification (except for infants); or

2. Obtained from a referral source, or

3. Deferred for up to 90 days from the date of certification as long as at least one qualifying nutrition risk factor is present at the time of certification.

(f) Periodicity Requirements

1. Pregnant Women - once during pregnancy.

2. Breastfeeding and Postpartum Women - once after delivery.

3. Infants - once between 9-13 months of age. However, regulations do allow the test to be obtained as early as 6 months of age (or less than 6 months of age for preterm and low birthweight infants who were not fed iron-fortified formula). This hemoglobin or hematocrit test does not have to occur within 90 days of the date of certification. Note: Infant assessments are still recommended at approximately six months of age for infants certified up to their first birthday. The infant assessment should include measurement and evaluation of the infant's length and weight, a nutrition assessment, a food package review, a nutrition education contact, immunization review, and the monitoring of the

adequacy of ongoing health care. A six-month hemoglobin or hematocrit test is no longer required for an infant assessment.

4. For children 12 months to 24 months of age - one hemoglobin or hematocrit test six months from the “infant” hemoglobin or hematocrit test, ideally around 15 - 18 months of age. However, the test can be obtained as early as 12 months of age or as late as 24 months of age.

Note: This requirement cannot be waived, even if the “infant” hemoglobin or hematocrit test was normal. Although a hemoglobin or hematocrit test obtained when an infant was between 9 and up to 13 months old may be used to certify a 12 month old as a child, such data cannot be used to fulfill the hemoglobin or hematocrit test that is required between 12 - 24 months.

5. For children ages two and older - once every 12 months unless the blood test result was low (<11.1 g/dl or <33%) at their last certification. If the blood test value was low at the last certification, a hemoglobin or hematocrit test is required at a six-month interval.

(g) Exceptions. The hemoglobin or hematocrit test may be omitted for any one of the following reasons, which must be documented in the participant’s file:

1. Special medical circumstances cause the Competent Professional Authority to feel there is greater than normal risk for the participant or laboratory technician.

2. Religious reasons.

3. Personal convictions.

4. Child who is in the Department of Children and Families shelter care or foster care status, because no bloodwork procedure is routinely allowed without parental consent or court ruling.

(h) Failure to Bring in Bloodwork (all client types). Recognizing WIC’s role in bloodwork screening, it is important that hemoglobin or hematocrit test data be obtained. Local agencies must put procedures in place to ensure that a hemoglobin or hematocrit test is obtained, if it is not available at the time of certification. This could include typing a reminder message in the WIC data system Client Comment Update screen and putting a CCU lock on the screen, making a reminder call or sending a reminder letter, or providing monthly issuance of checks for participants who have not provided the bloodwork data. Because the participant has a risk condition that makes the individual eligible for participation, it would not be appropriate to terminate the participant for failure to provide the hemoglobin or hematocrit test. A Notification of Ineligibility/Suspension form does not have to be completed, since the participant is not being terminated. However, the bloodwork data is required to support all certifications.

(i) Local Agency Provision of Bloodwork. In order to reduce barriers to participants and to facilitate easy access to WIC services, the local agency must be able to perform any bloodwork required for participant certification if there will be a cost or charge to the participant for them to obtain the bloodwork data elsewhere or if there will be a delay in getting the bloodwork done elsewhere. Local agencies must have a written procedure in place which describes the times and places where a participant may obtain a hemoglobin or hematocrit test free of charge.

(j) Monitoring of Bloodwork Guidelines. The state office will be monitoring a local WIC agency’s compliance with the bloodwork policy. If a local WIC agency exhibits low performance in obtaining/documenting the required bloodwork data in accordance with this policy, the state WIC office will require corrective action. The state WIC office reserves the right to deny a local agency the option of allowing the collection of bloodwork data up to 90 days after the date of certification for WIC if it fails to abide by the corrective action plan.

b. Nutrition Risk Criteria. Nutrition risk criteria are set by the state WIC office in accordance with federal rules and regulations and are listed in Attachment 13 to Chapter 3, WIC Nutrition Risk Criteria. Florida has adopted a modified version of the three digit national numbering system. The numbers for the risk categories are described below. The WIC CPA Guidebook, 2009 (Attachment 14 to Chapter 3) has been developed to clarify the risk criteria.

(1) High Risk Criteria. Medically high risk criteria and high risk criteria have been determined from the list of allowable nutrition risk criteria. The medically high risk criteria are specified with the letter “M” preceding a three-digit

agrees to make full restitution of the value of benefits obtained fraudulently. For further information, see Chapter 10, Participant Sanctions and Fair Hearings.

3-21. Authorized Representatives, Co-Caretakers and Proxies. See Chapter 4, Food Delivery, Section 4-11.

3-22. Caseload Management. Caseload is managed on a statewide basis. Managing caseload at the state level allows similar applicants to be treated the same regardless of their county of residency and does not require the constant readjustment of caseload assignments statewide. The caseload is monitored through the management information reporting system to ensure that maximum service levels are maintained. When the participation level reaches the maximum that funding will allow, the state WIC office will institute the priority system of caseload management. When caseload management is instituted, waiting lists must be maintained for applicants who request placement on the waiting list and transferring participants (including participants in the WIC Overseas Program) with valid VOC cards. See Attachment 22 to Chapter 3, Waiting List for WIC Program. Participants certified on the basis of VOC cards must be treated like other participants in terms of the order of disqualification.

a. Waiting Lists. When the state is serving a maximum caseload, a waiting list must be maintained of those individuals whose priorities, client types, or age categories are not being served. The WIC staff should always explain why placement on a waiting list is necessary and what it means in terms of realistic possibilities of receiving benefits. Referrals to other health or social service programs should be given as appropriate. Precertification of applicants is not required. See Attachment 22 to Chapter 3, Waiting List for WIC Program.

(1) In order for the local agency to contact the applicant when caseload space becomes available, the waiting list must include the following:

- (a) Date applicant was placed on waiting list.
- (b) Applicant's name.
- (c) Applicant's address and/or telephone number.
- (d) Client type, i.e., pregnant, breastfeeding.

(e) To aid in periodically purging the list for categorically ineligible applicants, local agencies may also want to include the date of birth for the infant and the child on the waiting list and the EDD or date of delivery for the woman on the waiting list.

(2) All persons must be notified of their placement on the waiting list within 20 days of their initial visit to the local agency during clinic office hours to request program benefits.

(3) Migrants and other transferring participants (including participants in the WIC Overseas Program) with a valid VOC/ID card must be served as long as new participants are being added. This applies even when the priority of the participant with the VOC/ID card is not being served. Participants with VOC/ID cards are waitlisted only when no new participants are being enrolled in any priority. In this situation, participants with valid VOC/ID cards are given priority placement on the waiting list.

(4) Those applicants placed on waiting lists are to be notified when caseload restraints have been lifted and service is possible. Those persons on the waiting list whose medical data are still valid for use as certification data will be contacted to come to the local agency immediately to be certified. All others will be informed that current medical data is required and must be evaluated before certification will be possible. Applicants may be contacted by phone or letter; however, documentation as well as the waiting list itself must be retained by the local agency for 3 years after the closeout of the fiscal year in which the client was put on the waiting list to verify attempts to contact persons on the waiting list. In the event the waiting list is for postpartum women (priorities 5 and 6), only those women who are currently less than 6 months postpartum need be contacted. All others may be periodically purged from the list although documentation should be retained for the appropriate retention period showing why a person was removed from the waiting list.

b. Caseload Management Steps.

- (1) Step 1. Eliminate Priority 6, postpartum women.
- (2) Step 2. Eliminate Priority 5, postpartum women.
- (3) Step 3.
 - a. Eliminate Priority 5, children ≥ 4 years of age.
 - b. Eliminate Priority 5, children ≥ 3 years of age.
 - c. Eliminate Priority 5, children ≥ 2 years of age.
 - d. Eliminate Priority 5, children >12 -24 months of age.
- (4) Step 4. Eliminate Priority 4, pregnant women and breastfeeding women
- (5) Step 5. Eliminate Priority 4, infants.
- (6) Step 6.
 - a. Eliminate Priority 3, children ≥ 4 years of age (except high risk and medically high risk).
 - b. Eliminate priority 3, children ≥ 3 years of age (except high risk and medically high risk).
 - c. Eliminate priority 3, children ≥ 2 years of age (except high risk and medically high risk).
 - d. Eliminate priority 3, children >12 -24 months (except high risk and medically high risk).
 - e. Eliminate priority 3, high risk and medically high risk children.
- (7) Step 7. Eliminate priority 2 infants.
- (8) Step 8. Discontinue benefits to a group of participants within a certification period. This action would be used only in extreme situations.
- (9) Step 9. Eliminate priority 1 pregnant women, breastfeeding women and infants (except high risk and medically high risk). This action would be used only in extreme situations.

c. Food Assistance Referrals When Agency is at Maximum Caseload. Local agencies are encouraged to provide information about other potential sources of food assistance in the local area to adult individuals applying or reapplying in person for the WIC Program for themselves or on behalf of others, when such applicants cannot be served because the program is operating at capacity. Examples of referral sources include food banks, food pantries, soup kitchens, or the Food Stamp Program.