

Nutrition Risk Factor

Mini Manual

WIC is different than SNAP or other food assistance programs. Income eligibility is not the only reason participants qualify for WIC. WIC participants must also have a nutrition need or risk to qualify for WIC services.

A nutrition risk factor (NRF) is a condition or set of circumstances that indicate a person is either **more likely to have** or **already has** a nutrition-related problem. These are used to show what nutrition need or risk a WIC participant has. WIC uses nutritious food and nutrition education to improve the participant's health and growth once we know their nutrition risk factor.

Nutrition risk factors are key to personalizing WIC services.

Nutrition risk factors are used to:

- certify that the participant is eligible for WIC.
- focus nutrition education to a participant's needs.
- identify which WIC foods best meet the participant's needs.
- determine the participant's risk level.
- identify referrals that may be helpful for the participant.

The nutrition risk factors are represented by **codes** and are divided into 5 groups in VISION.

Grouping	Description	Examples
Anthropometric Risks (codes 101-153)	Refer to a person's physical size. Weight classification (derived from the growth chart) should be integrated with the growth pattern, familial obesity, medical risks, and dietary and physical habits before providing education.	• Height • Weight • Rate of growth
Biochemical Risks (codes 201, 211)	Refer to blood tests.	• Hematocrit/hemoglobin • Blood lead level
Clinical/Health/Medical Risks (codes 301-383)	Refer to a person's health and medical history.	• Genetic conditions • Chronic illness • Birth complications
Nutrition Practice Risks (codes 401-428)	Refer to feeding behaviors.	• Inappropriate or inadequate nutrition practices
Other Risks (codes 501-904)	Refer to conditions that present a risk.	• Homelessness • Foster care • Breastfeeding complications

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
101 p. 4	Underweight Women BMI <18.5 Pregnant women are at higher risk for delivery of low-birth weight infants and other complications. Being underweight could indicate poor nutrition, low intake, or underlying medical conditions.	Yes		- Weight - Lifestyle changes
103 a-b p. 9	A. At risk for underweight / infant or child >2.3rd and ≤5th %ile weight-for-length for infants and children <24 months >5th and ≤10th %ile BMI for children >24 months Early detection and prompt intervention for infants and children with low weight-for-length or BMI can prevent growth stunting.	Yes		- Length/height/weight - Head circumference (<12 months) - Child behavior changes
	B. Underweight / infant or child ≤2.3rd %ile weight-for-length for infants and children <24 months ≤5th %ile BMI for children ≥24 months Many infants and children meeting these descriptions are in need of nutritional intervention to prevent growth stunting, increased infection rates, and slower development—especially for infants and children <2 years old.	Yes	Infants	- Length/height/weight - Head circumference (<12 months) - Child behavior changes
111 p. 14	Overweight Women - Pregnant, NBF, BF women <6 months PP based on pre-pregnancy BMI ≥ 25 - BF women >6 months PP based on current BMI ≥25 Maternal overweight and obesity are associated with higher rates of C-section delivery, gestational diabetes mellitus, preeclampsia, and other complications. Encourage modest changes in diet and activity for the whole family.	Yes		- Weight - Lifestyle changes
113 p. 18	Obese (2-5 Years of Age) ≥ 95%ile BMI or weight-for-stature. The rapid increase in the prevalence of obesity in children and adolescents is one of the most important public health issues in the U.S. Obesity can result from excessive energy intake, low energy expenditure, or a medical condition affecting metabolism. The first step in weight control for most overweight children is not weight loss. Encourage modest changes in diet and activity for the whole family. Refer to medical providers when necessary.	Yes		- Height/weight - Child behavior changes

*Auto-assigns in some cases. See complete risk factor explanation for more details.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

ANTHROPOMETRIC	NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
	114 p. 22	Overweight or At Risk of Overweight - Overweight: 2-5 yr olds: $\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ %ile BMI < 12-month infant of a biological mother with a BMI ≥ 30 at the time of conception or at any point in the first trimester of pregnancy. - At Risk of Overweight: - Child (> 12 months) of a biological mother with a BMI ≥ 30 at the time of the child's certification. - Birth to 5 years: having a biological father with a BMI ≥ 30 at the time of certification. *BMI of biological mother or father is based on self-reported weight and height or measurements taken in clinic at time of certification. The first step in weight control for most overweight children is not weight loss. Encourage modest changes in diet and activity for the whole family. Refer to medical providers when necessary.	Yes		- Height/weight - Child behavior changes
	115 p. 28	High Weight for Length (Infants/Children < 24 months) Birth to < 24 months: $\geq 97.7^{\text{th}}$ %ile weight-for-length This risk may put the infant or young child at risk of overweight/obesity later in life. It is important to communicate with parents/caregivers in a way that is supportive and nonjudgmental. Growth charts are a screening tool and show only one aspect of overall growth assessment.	Yes		- Length/height/weight - Head circumference (< 12 months) - Child behavior changes
	121 a-b p. 32	A. At Risk of Short Stature (Infants/Children) - At risk of short stature: - Birth to 24 months: $> 2.3^{\text{rd}}$ %ile and $\leq 5^{\text{th}}$ %ile length for-for-age 2-5 yr olds: $> 5^{\text{th}}$ %ile and $\leq 10^{\text{th}}$ %ile stature-for-age B. Short Stature (Infants/Children) - Short stature: - Birth to 24 months: $\leq 2.3^{\text{rd}}$ %ile length-for-age 2-5 yr olds: $\leq 5^{\text{th}}$ %ile stature-for-age This indicator can help identify children whose growth is stunted due to prolonged undernutrition or repeated illness. Short stature may also result from disease conditions, inborn errors of metabolism, bone diseases, chromosomal defects, fetal alcohol syndrome, and chronic systemic diseases.	Yes		- Length/height weight - Head circumference (< 12 months)

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NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
135 p. 53	Slowed/Faltering Growth Pattern - Infants birth to 2 weeks of age: weight loss $\geq$ 7% of birth weight. - Infants 2 weeks to 6 months of age: any weight loss using two separate weight measurements taken at least 8 weeks apart. Normal growth is steady and predictable but still has periods of rapid growth followed by periods of slower growth. Slowed/faltering growth occurs when catch-up growth does not occur as expected. Appropriate intervention can help prevent short stature, delayed development, poor cognition, and nutrition-related chronic diseases.	Yes	Infants $\leq$ 6 months of age	- Length/Height - Weight - Head circumference (<12 months) - Feeding patterns (i.e. number of feedings, proper mixing of formula, spit up, etc.) - Medical follow-up if weight loss is >10% of birth weight for infants birth to 2 weeks.
141 a-b p. 61	A. Low Birth Weight (LBW) - birth weight $\leq$ 5lbs 8oz ($\leq$ 2500g) B. Very Low Birth Weight (VLBW) - birth weight $\leq$ 3lbs 5oz ($\leq$ 1500g) Infants and children born with LBW/VLBW need optimal nutrient intake to meet the needs of an extended period of relatively rapid postnatal growth and to develop normally. Breastfeeding reduces the risk of NEC (necrotizing enterocolitis) and many other diseases.	Yes	Infants	- Length/height/weight - Head circumference (<12 months) - Feeding patterns - Medical follow-up if necessary
142 a-b p. 64	A. Preterm Delivery - Infant born $\leq$ 36 6/7 weeks gestation A typical pregnancy lasts about 40 weeks. Babies that are born too early may have a number of health conditions (see list in NRM, p.65). Breastfeeding has been associated with improved motor maturity and cognitive ability, reduced risk of NEC and reduced risk of retinal detachment among preterm/early term infants. The effects of preterm birth can continue beyond infancy. B. Early Term Delivery - Infant born $\geq$ 37 0/7 to $\leq$ 38 6/7 weeks gestation	Yes	142a only- infants	- Length/weight - Head circumference - Feeding practices - Medical follow-up if necessary
151 p. 71	Small for Gestational Age Small for gestational age (SGA) diagnosed by a physician as self-reported or documented by a physician, or someone working under physicians' orders. Infants who are SGA are more likely to develop cardiovascular disease, metabolic syndrome, and other health problems later in life. SGA infants with rapid weight gain after birth have reduced insulin sensitivity and may even become insulin dependent by age 1. The exact timing of rapid weight gain contributing to poor health outcomes is still being debated.	No - Manually assign risk to infants and children <24 mo old fitting the criteria.	Infants *Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/height/weight - Head circumference (<12 months) - Feeding practices - Medical follow-up

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NRF # NRM p.		Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
ANTHROPOMETRIC	152 p. 74	Low Head Circumference (LHC) Birth to < 24 months having $\leq 2.3^{\text{rd}}$ percentile head circumference-for-age as plotted on the CDC birth to 24 months gender specific growth charts. LHC alone does not necessarily indicate abnormal head size. Diagnosis of LHC must also be based on presence of other evidence (malnutrition during early fetal life through ~3 months past delivery, low maternal weight gain during pregnancy, cocaine and alcohol use during pregnancy, etc.) and knowledge of the causes of LHC. Poor nutrition affects weight first, then height, then head circumference; thus LHC may indicate advanced malnutrition.	Auto assigned for infants Manually assign for children (≤ 12 months to <24 months)		- Length/height weight - Head circumference (<12 months) - Feeding patterns - Medical follow-up if applicable
	153 p. 77	Large for Gestational Age - Birth weight $\geq 9\text{lbs}$ ($\geq 4000\text{g}$); or - Diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or someone working under physician's orders. Very large infants, regardless of their gestational age, have a higher incidence of birth injuries and congenital anomalies (especially congenital heart disease) and slowed development.	No – Manually assign to infants fitting criteria.		- Length/height/ weight - Head circumference (<12 months) - Feeding patterns - Medical follow-up if applicable
BIOCHEMICAL	201 p. 79	Low Hematocrit/Low Hemoglobin - Cut off values dependent on age, smoking status, pregnancy trimester, and altitude levels. See p. 89 in NRM for clinic area altitude levels; See p. 90 in NRM for hematocrit/hemoglobin cut-off values. - High risk if hemoglobin is $>1\text{ gm/dL}$ below cut off value or hematocrit is $>3\%$ below anemia cutoff. Measurements of Hb and Hct reflect the amount of functional iron in the body; changes in levels occur at the late stages of iron deficiency. Hb/Hct tests are not direct measures of iron status and are useful indicators of iron deficiency anemia only. WIC staff cannot diagnose iron deficiency anemia. Iron deficiency and iron deficiency anemia have adverse effects on childhood cognitive and behavioral development, and can lead to complications during pregnancy and delivery.	Yes	Participants meeting high risk criteria - hemoglobin $>1\text{ gm/dL}$ below cut off value or hematocrit $>3\%$ below anemia cutoff Manually assign HR	- Hematocrit/ hemoglobin level (whichever was tested to determine risk status initially) - Dietary patterns – particularly intake of iron, milk/dairy, vitamin C foods - Supplementation if applicable - Medical follow-up (if high-risk)
	211 p. 96	Elevated Blood Lead Levels - Blood lead level of $\geq 5\text{ }\mu\text{g/deciliter}$ within the past 12 months (women and infants). - Blood lead level of $\geq 3.5\text{ }\mu\text{g/deciliter}$ within the past 12 months (children). There is no safe blood lead level, however the CDC has identified the above reference values to be used to determine this risk factor. Avoidance of lead exposure remains the primary preventive strategy for reducing adverse health effects.	Yes – designated based on information entered in the blood screen		- Dietary patterns – particularly intake of iron, milk/dairy, vitamin C foods - Medical follow-up

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301 p. 105	Hyperemesis Gravidarum - Diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or someone working under physician's orders - Based on a chronic condition, not single episodes. Severe and persistent nausea and vomiting during pregnancy which may cause >5% weight loss and fluid and electrolyte imbalances. Women diagnosed are more likely to give premature birth, have LBW and SGA children, spontaneous preterm birth, and additional physical symptoms such as cognitive, behavioral and emotional dysfunction.	No - Manually assign	Pregnant * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Weight - Lifestyle – particularly food, liquid, supplement intake - Medical follow-up if necessary
302 p. 112	Gestational Diabetes - Any degree of glucose/carbohydrate intolerance with onset or first recognition occurring during pregnancy. - Diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or someone working under physician's orders Infants of women with GDM are at increased risk of developing obesity, impaired glucose tolerance or diabetes as children or young adults. GDM is a risk factor for the mother developing type 2 diabetes after delivery. Breastfeeding and lifestyle modifications should be strongly encouraged; they are associated with maternal weight loss and reduced insulin resistance for both mother and infant.	No - Manually assign	Pregnant * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Weight - Lifestyle changes - Medical follow-up if necessary
303 p. 118	History of Gestational Diabetes History of GDM diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or someone working under physician's orders. ~30-50% of the women with a history of GDM will develop GDM in a subsequent pregnancy. A pre-pregnancy consultation with a medical provider, diet/lifestyle changes and increased physical activity can be beneficial to help prevent subsequent GDM development. An early glucose screening can also be requested once pregnant.	No - Manually assign		- Weight - Lifestyle changes - Medical follow-up if necessary
304 p. 122	History of Preeclampsia History of preeclampsia diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or someone working under physician's orders. *See risk 345 for overview & definition of preeclampsia. Women with history of preeclampsia are at greater risk for future hypertension, heart attack, metabolic disease, PPD, etc. Encourage regular BP checks, DASH diet, regular exercise.	No - Manually assign		- Weight - Lifestyle – particularly dietary patterns (DASH diet or equivalent can be helpful) - Medical follow-up if necessary

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311 p. 127	History of Preterm or Early Term Delivery - Preterm: delivery of an infant born ≤ 36 6/7 weeks - Early term: delivery of an infant born ≥ 37 0/7 and ≤ 38 6/7 weeks Severe and persistent nausea and vomiting during pregnancy which may cause $>5\%$ weight loss and fluid and electrolyte imbalances. Women diagnosed are more likely to give premature birth, have LBW and SGA children, spontaneous preterm birth, and additional physical symptoms such as cognitive, behavioral and emotional dysfunction.	No - Manually assign		- Weight - Lifestyle - Medical follow-up if necessary
312 p. 133	History of Low Birth Weight - Birth of an infant weighting ≤ 5lb 8oz (≤ 2500g) BF/non-BF participants: Based on infant birth weight from most recent pregnancy. Pregnant participants: Based on any history of low birth weight. History of a delivery of a low birth weight (LBW) baby is the most reliable predictor for LBW in a subsequent pregnancy. Risk for LBW is 2-5x higher than average among women who have had previous LBW deliveries and increases with the number of previous LBW deliveries.	Auto assigned for BF/non-BF women Manually assign for pregnant women		- Weight - Lifestyle - Medical follow-up if necessary
321A-C p. 135	History of Spontaneous Abortion, Fetal or Neonatal Loss - Spontaneous abortion (SAB): spontaneous termination of a gestation at <20 weeks or <500 grams. - Fetal death: spontaneous termination of a gestation at ≥ 20 weeks. - Neonatal death: death of an infant within 0-28 days of life. <i>Assigned to: criteria</i> 321A – Pregnant women: any history of fetal or neonatal loss OR 2+ spontaneous abortions. 321B – BF women: most recent pregnancy resulted in 1+ fetal or neonatal deaths but 1+ infants still living. 321C – Non-BF women: most recent pregnancy	No – Manually assign		- Emotional/mental health and support - Lifestyle - Medical follow-up if necessary
331 a-b p. 138	Pregnancy at a Young Age - Pregnant women: current pregnancy - BF/non-BF women: most recent pregnancy 331a – Last menstrual period (LMP) minus birth date is <16 years. 331b – LMP minus birth date is ≥ 16 years to ≤ 20 years (up to 21 st birthday) Pregnancy before growth is complete is a nutritional risk because of the potential competition for nutrients for the pregnancy needs and the woman's growth.	Yes	Pregnant (both a and b)	- Weight - Lifestyle - Medical follow-ups as needed

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332 p. 142	Short Interpregnancy Interval - Short Interpregnancy Interval (IPI): less than 18 months from the date of a live birth to the conception of a subsequent pregnancy. - Pregnant women: current pregnancy - BF/non-BF women: most recent pregnancy An interval of at least 24 months after a live birth is recommended to reduce the risk of adverse maternal, perinatal, and infant outcomes. Short IPI does increase the risk of maternal, perinatal, and neonatal complications.	Yes	Pregnant if IPI <6 months. Manually assign HR	- Weight - Lifestyle – particularly supplement/prenatal vitamin intake - Medical follow-up if necessary
334 p. 148	Lack of Prenatal Care prenatal care beginning after the 1st trimester (after 13th week) of pregnancy Women who do not receive early and adequate prenatal care are more likely to deliver premature, growth retarded, or LBW infants.	Yes* *if question 1f marked as “No” in Nutrition Interview	Pregnant	- Weight - Lifestyle – particularly supplement/prenatal vitamin intake - Medical follow-up if necessary
335 p. 151	Multifetal Gestation >1 fetus - Pregnant women: current pregnancy - BF/non-BF women: most recent pregnancy Associated with LBW, fetal growth restriction, placental/cord abnormalities, preeclampsia, anemia, other pregnancy complications and increased risk of infant mortality. Small, frequent, energy-dense meals should be recommended due to reduced stomach capacity	Yes* *if “Multifetal Gestation” checkbox in the pregnancy screen is checked.	- Pregnant - Breastfeeding	- Weight - Medical follow-up if necessary
336 p. 155	Fetal Growth Restriction (FGR) Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician’s orders. FGR replaces the term Intrauterine Growth Retardation (IUGR). Usually leads to LBW. FGR may be caused by conditions affecting the fetus such as infections and chromosomal and congenital anomalies. Associated with maternal height, pre-pregnancy weight, birth interval, maternal smoking, and other factors.	No – Manually assign	Pregnant * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Weight - Lifestyle – specifically eating a balanced diet with protein supplementation, smoking cessation, and avoiding alcohol - Medical follow-ups as needed
337 p. 158	History of Birth of a Large for Gestational Age Infant - Pregnant women: any history of giving birth to an infant weighing ≥ 9 lbs. (4,000 g) - BF/non-BF women: most recent pregnancy, or history of giving birth to an infant weighing ≥ 9 lbs. (4,000 g). Risk auto assigned if associated infant is marked as LGA on anthro screen. Women with a previous delivery of an infant weighing ≥ 9 lbs are at an increased risk of giving birth to a LGA infant. The incidence of maternal, fetal, and neonatal complications is high for neonates weighing ≥ 9 lbs.	Auto assigned for BF/non-BF women Manually assign for pregnant women		- Weight - Lifestyle

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338 p. 160	Pregnant Woman Currently Breastfeeding Pregnant woman who is currently breastfeeding. It's generally considered safe for most women to continue BF while pregnant. This risk is not intended to discourage women from continuing BF during pregnancy, but to emphasize the need to review medical history, diet, and BF goals. Pregnant women currently BFing have a higher need for calories and certain vitamins/minerals. It may be helpful to provide anticipatory guidance on tandem nursing. It's the mother's decision whether or not to continue BF through or after a pregnancy.	No – Manually assign		- Weight - Lifestyle – especially adequate caloric intake and rest. - Medical follow-up if necessary; refer to health care provider if they have a history of premature labor, miscarriage, or are concerned about contractions.
339 p. 165	History of Birth with Nutrition Related Congenital or Birth Defect - Pregnant women: any history of giving birth to an infant who has a congenital or birth defect linked to inappropriate nutrition intake, e.g., inadequate zinc, folic acid, excess vitamin A. - BF/non-BF women: most recent pregnancy history of giving birth to an infant who has a congenital or birth defect linked to inappropriate nutrition intake, e.g., inadequate zinc, folic acid, excess vitamin A. This single greatest risk factor for a pregnancy with a neural tube defect is a personal or family history of such a defect. More than 50% of recurrences can be prevented by taking folic acid before conception.	No – Manually assign		- Weight - Lifestyle – especially adequate folic acid intake. - Medical follow-up if necessary; refer to health care provider if they have a history of birth with nutrition related congenital or birth defect.
341 p. 167	Nutrient Deficiency or Disease - Any currently treated or untreated deficiency or disease. - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders Nutrient deficiencies or diseases can be the result of poor intake, chronic or acute health conditions, medications, altered nutrient metabolism, or a combination of these. Intake of vitamin E, iron, and calcium are commonly inadequate in children between 2 and 5 years. See p. 170 in NRM for signs and symptoms of various nutrient deficiencies.	No – Manually assign	Pregnant, BF, non-BF, infants, children * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary
342	Gastro-Intestinal (GI) Disorders - Diagnosis of disease and/or condition that interferes with the intake, digestion, and/or absorption of nutrients. - Disorders include, but are not limited to: GERD, peptic ulcer, post-bariatric surgery, short bowel syndrome, inflammatory bowel disease, Crohn's, liver disease, pancreatitis, biliary tract diseases. See p. 177 in NRM for definitions and more information for these diseases/conditions.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary

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345 (continued) p. 195	Hypertension is either primary/essential (no identifiable cause) or secondary (identifiable cause). Sleep apnea, kidney and/or thyroid problems, diabetes, some tumors, inflammation, blood vessel defects, and some medications/illegal substances significantly raise blood pressure (BP). Weight can affect BP as well. Encourage a healthy low-sodium diet and appropriate physical activity to help manage hypertension/pre-hypertension.			
346 p. 206	Renal Disease - Any renal disease including persistent proteinuria; excludes urinary tract infections (UTIs) involving the bladder. - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Renal disease can result in growth failure in children and infants. Pregnant women can experience limited fetal growth and have a high risk of developing preeclampsia-like syndrome.	No – Manually assign	Pregnant, BF, non-BF, infants, children * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/height/weight - Behavior/Lifestyle – adherence to dietary recommendations - Medical follow-up if necessary; encourage them to follow their health care provider's diet and food and restrictions.
347 p. 209	Cancer - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. - Current condition, or treatment for the condition, must be severe enough to affect nutritional status. Participants are at medical and nutritional risk depending on the stage of disease, form of cancer, and type of treatment. The most common nutritional risk is Protein Energy Malnutrition (PEM) and wasting. Assist with meal planning and meet nutrition needs-particularly protein and energy needs.	No – Manually assign	Pregnant, BF, non-BF, infants, children * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/height/weight - Behavior/Lifestyle – protein and energy intake - Medical follow-up if necessary
348 p. 212	Central Nervous System Disorders - Conditions which affect energy requirements, ability to feed self, or alter nutritional status metabolically, mechanically, or both (i.e. epilepsy, cerebral palsy, neural tube defects such as spina bifida, Parkinson's disease, multiple sclerosis). - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Individuals with these disorders are at nutrition risk due to alterations in nutritional status from prolonged anti-convulsion therapy, inadequate growth, and physical injuries from seizures. Oral motor dysfunction associated with these disorders may also impact nutritional status.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle – appropriate folic acid intake during pregnancy can help prevent neural tube defects - Medical follow-up if necessary

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349 p. 217	Genetic and Congenital Disorders - Hereditary or congenital condition at birth that causes physical or metabolic abnormality (i.e. cleft lip or palate, down's syndrome, thalassemia major, sickle cell anemia (not sickle cell trait), muscular dystrophy). Current condition must alter nutrition status metabolically, mechanically, or both. - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Nutrition needs will vary depending on the specific genetic and/or congenital disorder. See p. 218 in the NRM for counseling guidelines specific to each disorder.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary
351 p. 223	Inborn Errors of Metabolism (IEM) - IEM generally refers to gene mutations or gene deletions that alter metabolism of protein, carbohydrate, or fat in the body. - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. All states screen newborns for IEM, although the type and number of IEM screened for varies state to state. Infants are most commonly screened for amino acid, urea cycle, organic acid, and fatty acid oxidation disorders. Nutrition therapy is integral to the treatment of IEM. Encourage the participant to follow the prescribed dietary regimen.	No – Manually assign	Pregnant, BF, non-BF, infants, children * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary
352 a-b p. 232	A. Infectious Diseases - Acute - Single or repeated episode of relatively rapid onset and short duration. Must be present within the past 6 months and diagnosed by a physician. - Common acute infectious diseases: Hepatitis A, Hepatitis E, Listeriosis, Pneumonia, Meningitis, Bronchitis (3 episodes in last 6 mo.), parasitic infections. B. Infectious Diseases – Chronic - Conditions likely lasting a lifetime and require long-term management of symptoms. - Common chronic infectious diseases: HIV, AIDS, Hepatitis B, Hepatitis C, Hepatitis D Both chronic and acute infectious diseases can lead to poor appetite, low nutrient absorption, accelerated nutrient utilization and/or rapid nutrient loss.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary See p. 231 in the NRM for recommendations specific to individual diseases.

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NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
353 p. 251	Food Allergies Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Food allergies can cause serious illness and life-threatening reactions. Food intolerances are not the same as food allergies, even though symptoms are similar. Food allergies involve the immune system; food intolerances do not. Help educate participants on reading food labels and ingredient lists. Encourage participants to talk with their healthcare provider as well.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary
354 p. 259	Celiac Disease Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Autoimmune disease that results in damage to the small intestine and malabsorption of nutrients from food when gluten is ingested. Gluten is a protein in wheat, rye, and barley. Treatment requires strict adherence to a gluten-free diet for life. Help participants identify which WIC food benefits are gluten free.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle – understanding of and strict adherence to gluten-free diet - Medical follow-up if necessary
355 p. 265	Lactose Intolerance Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Occurs due to a lactase enzyme deficiency. The lactase enzyme digests lactose (found mainly in milk, milk-based formula, and other dairy products). Lactose intolerance can be temporary and correct itself. Some people can tolerate various quantities of lactose without symptoms.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle
356 p. 269	Hypoglycemia Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. Occurs as a complication of diabetes, on its own, or along with other disorders or conditions. SGA infants and some pregnant women often show symptoms of hypoglycemia (sweating, weakness, blurred vision, etc.).	No – Manually assign		- Length/height/weight - Behavior/Lifestyle – frequent feedings for infants and children; balanced diet, exercise and low carbohydrate snacks for women.
357	Drug Nutrient Interactions Use of prescription or over-the-counter (OTC) drugs or medicine that can interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to the extent that nutritional status is compromised. OTC and prescription medications can impact nutritional status directly or indirectly. They may	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary – possibly consider alternative medication options.

*Auto-assigns in some cases. See complete risk factor explanation for more details.

Adult lifestyle may include: dietary intake, physical activity, medical care, sleep habits, stressors, tobacco use, etc.

Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
357 (continued) p. 271	affect the absorption of the nutrient, or symptoms of the medication may impact nutrition intake (changes to appetite, taste, smell, nausea, etc.). Common medications and their possible impacts on nutritional status can be found on p. 270 in the NRM.			
358 p. 276	Eating Disorders - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. - Anorexia nervosa, bulimia nervosa, binge eating disorder. Other common eating disorders: avoidant/restrictive food intake disorder (ARFID), orthorexia nervosa, other specified feeding or eating disorder (OSFED) Eating disorders are complex and can have serious physical and psychological consequences. Eating disorders result in general malnutrition, may cause life-threatening fluid and electrolyte imbalances, and/or lead to pregnancy complications. Some women may experience less eating disorder symptoms during pregnancy but regress or relapse after delivery. Be sensitive when talking about weight and weight gain/loss with participants who have or have had an eating disorder. Always ask if they would like to know or discuss their weight at the beginning of the appointment.	No – Manually assign	- Pregnant - Breastfeeding - Non-breastfeeding * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Weight – be sensitive when talking about weight. Always ask if they would like to know or discuss their weight at the beginning of the appt. - Behavior/Lifestyle – be sensitive when talking about exercise and food intake. - Medical follow-up if necessary.
359 p. 286	Recent major surgery, physical trauma, burns - Major surgery (including cesarean sections), physical trauma, or burns severe enough to compromise nutritional status. - Any occurrence ≤ 2 months ago may be self-reported. - Any occurrence > 2 months ago must have need for nutritional support diagnosed by a physician or healthcare provider. The body needs increased calories, protein, and other nutrients to respond to these injuries. Women may need additional help finding a comfortable position to breastfeed in after a C-section.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary
360 p. 292	Other Medical Conditions - Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. - Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.	No – Manually assign		- Length/height/weight - Behavior/Lifestyle - Medical follow-up if necessary

*Auto-assigns in some cases. See complete risk factor explanation for more details.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
371 (continued) p. 322	utero exposure is associated with reduced lung function in infants. The requirement for vitamin C is higher for women who smoke due to increased oxidative stress and metabolic turnover.	Nutrition Interview		Always offer referral to the Tobacco Quitline www.waytoquit.org
372A p. 324	Alcohol use - Pregnant women: any alcohol use - BF/non-BF women: - High risk drinking: routine consumption of ≥ 8 drinks per week or ≥ 4 drinks in one day. - Binge drinking: routine consumption of ≥ 4 drinks within 2 hours. Substance use and misuse during pregnancy and postpartum may have mild to severe physical and mental health consequences. Substance use is known to lead to vitamin and mineral deficiencies. This threatens physical and mental health, damages vital organs and the nervous system, and decreases immunity. People with substance addiction may suffer from calorie and protein malnutrition. There is no safe consumption of alcohol during pregnancy. BF women should minimize alcohol use and avoid the use of other substances.	Auto assigned for: Pregnant women if "alcohol per week now" is >0 in the Nutrition Interview. BF and non-BF women if "alcohol per week now" is >5 in the Nutrition Interview.	Pregnant	- Weight - Lifestyle (encourage reduction/avoidance of alcohol use) - Contact with any referrals provided.
372B p. 336	Substance Use - Pregnant/BF women: any illegal substance use and/or abuse of prescription medications; any marijuana use in any form. - Non-BF women: any illegal substance use and/or abuse of prescription medications. Illegal drugs have the potential to damage the fetus (i.e. inhibiting growth and neurodevelopment) at every stage of pregnancy. Drugs also increase the risk for LBW, head circumference, and premature birth. Illegal drugs are transmitted through breast milk. They also impair the ability to care for infants and other children.	No – Manually assign	- Pregnant * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Weight - Lifestyle (encourage avoidance of illegal drug use or abuse of substances) - Contact with any referrals provided.
381 p. 339	Oral Health Conditions Diagnosed by a physician or dentist as self-reported by applicant/participant/caregiver; or as reported or documented by a physician or someone working under physician's orders Oral health conditions include, but are not limited to: dental caries (cavities), periodontal diseases, tooth loss. Oral health reflects and influences general health and well-being. Infants that consume sugary foods, are of low socioeconomic status, and whose mothers have a low education level are 32x more likely to have caries at the age of 3 years than children who don't have those risk factors. The frequency of sugar consumption is the main dietary variable in tooth decay/cavities.	No – Manually assign		- Behaviors/Lifestyle - Contact with any referrals provided.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
CLINICAL/HEALTH/MEDICAL RISKS	Fetal Alcohol Spectrum Disorders Diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician or someone working under physician's orders Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother consumed alcohol during pregnancy. FASDs is an overarching phrase and encompasses fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol related birth defects (ARBD), alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE). These include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. p. 349	No – Manually assign	Pregnant, BF, non-BF, infants, children * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/height/weight - Behavior/Lifestyle - Contact with any referrals provided. (www.fasdunited.org)
	Neonatal Abstinence Syndrome (NAS) Condition must be present within the first 6 months of birth and diagnosed by a physician as self-reported by the infant's caregiver. NAS is a drug withdrawal syndrome that occurs among drug-exposed (primarily opioid-exposed) infants as a result of the mother's use of drugs during pregnancy. NAS is a combination of physiologic and neurologic symptoms that can be identified immediately after birth and can last up to 6 months after birth. See p. 358 in NRM for list of symptoms. Breastfeeding protects against the development/severity of NAS. p. 359			- Length/weight - Feeding practices - Medical follow-up if necessary
NUTRITION PRACTICE RISKS	Failure to Meet Dietary Guidelines for Americans Can only be used when a complete nutrition assessment has been completed and no other risk criteria have been identified. Defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans). Evidence exists that nearly all low-income women in the childbearing years and children ages 2-5 years are at dietary risk. p. 365	No – Manually assign		- Length/height/weight - Behavior/Lifestyle
	Inappropriate Nutrition Practices for Infants Routine use of these feeding practices may result in impaired nutrient status, disease, or health problems. See NRM for examples of each. 411a: Routinely using a substitute(s) for breast milk or for FDA approved iron-fortified formula as the primary nutrient source during the first year of life. 411b: Routine using nursing bottles or cups improperly. p. 369			- Length/weight - Nutrition practices

*Auto-assigns in some cases. See complete risk factor explanation for more details.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
NUTRITION PRACTICE RISKS 411 a-k (continued) p. 369	Inappropriate Nutrition Practices for Infants (continued) ○ 411c: Routinely offering complementary foods* or other substances that are inappropriate in type or timing. *complementary foods are any foods or beverages other than human milk or infant formula. ○ 411d: Routinely using feeding practices that disregard the developmental needs or stage of the infant. ○ 411e: Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins. ○ 411f: Routinely feeding inappropriately diluted formula. ○ 411g: Routinely limiting the frequency of nursing of the exclusively breastfed infant when human milk is the sole source of nutrients. ○ 411h: Routinely feeding a diet very low in calories and/or essential nutrients. ○ 411i: Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breast milk or formula. ○ 411j: Feeding dietary supplements with potentially harmful consequences. ○ 411k: Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements.	No – Manually assign		• Length/weight • Nutrition practices
	Inappropriate Nutrition Practices for Children Routine use of these feeding practices may result in impaired nutrient status, disease, or health problems. See NRM for examples of each. ○ 425a: Routinely feeding inappropriate beverages as the primary milk source. ○ 425b: Routinely feeding a child any sugar-containing fluids. ○ 425c: Routinely using nursing bottles, cups, or pacifiers improperly. ○ 425d: Routinely using feeding practices that disregard the developmental needs or stages of the child. ○ 425e: Feeding foods to a child that could be contaminated with harmful microorganisms. ○ 425f: Routinely feeding a diet very low in calories and/or essential nutrients. ○ 425g: Feeding dietary supplements with potentially harmful consequences. ○ 425h: Routinely not providing dietary supplements recognized as essential by national public health policy when a child's			• Height/weight • Nutrition practices

*Auto-assigns in some cases. See complete risk factor explanation for more details.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

	NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
NUTRITION PRACTICE RISKS	425 a-i (continued) p. 386	diet alone cannot meet nutrient requirements. o 425i : Routine ingestion of non-food items (pica).			
	427 a-e p. 398	Inappropriate Nutrition Practices for Women Routine use of these feeding practices may result in impaired nutrient status, disease, or health problems. See NRM for examples of each. o 427a : Consuming dietary supplements with potentially harmful consequences. o 427b : Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery. o 427c : Compulsively ingesting non-food items (pica). o 427d : Inadequate vitamin/mineral supplementation recognized as essential by national public health policy. (<27mg iron supplement per day by pregnant woman; <150mcg iodine supplement per day by pregnant and BF women; <400mcg folic acid from fortified foods and/or supplements daily by non-pregnant women) o 427e : Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms. (e.g., raw fish, unpasteurized dairy products, etc.)	No – Manually assign		- Height/weight - Nutrition practices
	428 p. 409	Dietary Risk Associated with Complementary Feeding Practices - Assess for risk 411 (Inappropriate Nutrition Practices for Infants) and risk 425 (Inappropriate Nutrition Practices for Children) prior to assigning this risk. An infant or child is at dietary risk of inappropriate complementary feeding if they have started or are expected to: - consume complementary foods and beverages. - eat independently. - be weaned from breast milk or infant formula. - transition from a diet based on infant/toddler foods to a diet based on the Dietary Guidelines for Americans.	No – Manually assign		- Length/height/weight - Feeding practices
	501	Possibility of Regression This risk may only be used once and cannot be used for consecutive certification periods. A participant who has previously been certified eligible for WIC may be considered to be at nutritional risk in the next certification period if you determine there is a possibility of regression	No – Manually assign		- Length/height/weight - Behavior/Lifestyle
OTHER RISKS					

*Auto-assigns in some cases. See complete risk factor explanation for more details.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
p. 418	in nutritional status without the benefits that the WIC Program provides.			
502	Transfer of Certification Person with current valid Verification of Certification (VOC) document from another State or local agency. The VOC is valid through the end of the current certification period, even if the participant does not meet the Utah WIC Program's nutritional risk, priority or income criteria, or the cert period extends beyond the Utah WIC Program's certification period for that category. Use this risk when the VOC document doesn't reflect another (more specific) nutrition risk or the participant was certified based on a nutrition risk not used in Utah's WIC Program.	Auto assigned if current Application record is marked as Out-of-State VOC		- Contact with any referrals provided. - Establishment of medical doctor and dentist for well child check-ups in Utah.
p. 420				
601	Breastfeeding Mother of Infant at Nutritional Risk BF woman whose breastfed infant has been determined to be at nutritional risk. Special attention should be given to the health and nutritional status of the BF woman. Inadequate maternal nutrition may result in decreased nutrient content in her breast milk. Lactation requires an additional 500 calories per day (approximately) as increased protein, calcium, and other vitamins and minerals.	Auto assigned once risk records have been created for mother and infant.		- Length/weight of breastfeeding infant. - Nutrition intake of BF woman. - Breastfeeding (i.e. complications, amount of feedings per 24 hrs, wet/dirty diapers)
p. 422				
602 a-h	Breastfeeding Complications or Potential Complications (Women) A woman with any of the following complications or potential complications for breastfeeding: 602a: Severe breast engorgement 602b: Recurrent plugged ducts 602c: Mastitis (fever or flu-like symptoms with localized breast tenderness) 602d: Flat or inverted nipples 602e: Cracked, bleeding or severely sore nipples 602f: Age ≥40 years 602g: Failure of milk to come in by 4 days postpartum 602h: Tandem nursing (breastfeeding 2 siblings who are not twins) See NRM for counseling guidelines specific to each complication.	No – Manually assign	- BF (all except 602f and 602h) * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk factor is assigned.	- Length/weight of breastfeeding infant. - Breastfeeding complication that has been identified.
p. 424				
603 a-d	Breastfeeding Complications or Potential Complications (Infants) A breastfed infant with any of the following complications or potential complications for breastfeeding: 603a: Jaundice ("Breast milk jaundice" vs. "Breastfeeding jaundice" is explained on p. 430 in NRM) 603b: Weak or ineffective suck 603c: Difficulty latching onto mother's breast	No – Manually assign	- Infants * Risk must be manually assigned, but the high-risk designation will automatically activate when this risk	- Length/weight of breastfeeding infant. - Breastfeeding complication that has been identified.

*Auto-assigns in some cases. See complete risk factor explanation for more details.

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Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
603 a-d (continued) p. 429	603d: Inadequate stooling (for age, as determined by a physician or other health care professional), and/or less than 6 wet diapers per day See NRM for counseling guidelines specific to each complication.			
701 p. 434	Mom on WIC/Mom Not on WIC during Pregnancy An infant <6 months of age whose mother was: - A WIC Program participant during pregnancy or whose mother's medical records document that the woman was at nutritional risk during pregnancy. - Not on the WIC Program during pregnancy but would have qualified. CPA must document what the mother would have qualified for. WIC participant during pregnancy is associated with improved pregnancy outcomes and infant nutritional status.	No – Manually assign or answer “Yes” to the question “Was mother on WIC during her pregnancy.”		Length/weight
702 p. 436	Breastfeeding Infant of Woman at Nutritional Risk Infant who is breastfed by a woman who has been determined to be at nutritional risk. A breastfed infant is dependent on the mother's milk as the primary source of nutrition. Special attention should be given to the health and nutritional status of the BF woman and her infant. Lactation requires an additional 500 calories per day (approximately) as increased protein, calcium, and other vitamins and minerals.	Auto assigned once risk records have been created for mother and infant.		- Length/weight - Nutrition intake of BF woman. - Breastfeeding (i.e. complications, amount of feedings per 24 hrs, wet/dirty diapers)
801 p. 438	Homelessness - A woman, infant or child who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is one of the following: - supervised publicly or privately operated shelter designed to provide temporary living accommodations. (e.g., group shelters, rescue missions, shelters for victims of domestic violence, motels. etc.) - public or private place not ordinarily used as a regular sleeping accommodation for human beings (e.g., tents, cars, parks, hallways, sidewalks, abandoned buildings, doorsteps, etc.) - temporary residence for persons intended to be institutionalized. A person experiencing homelessness no longer meets this risk code when they have lived in a temporary accommodation of another individual for more than 365 days.	Auto assigned if “homeless” is marked on the current Family Address record (Contact/ Address screen)		- Length/height/ weight - Behavior/Lifestyle - Contact with any referrals provided. - Food preparation and safety techniques to avoid foodborne illness.

OTHER RISKS

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NRF # NRM p.	Risk Definition/Cut-off value	Risk is auto assigned	High Risk for (will auto assign unless otherwise stated)	Follow-up on
802 p. 440	Migrancy Individuals who are members of a family which contain at least 1 individual whose principal employment is in agriculture on a seasonal basis (within the last 24 months), and who establishes a temporary residence for the purpose of such employment. There are significantly higher rates or incidence of infant mortality, malnutrition, and parasitic disease (among migrant children) than among the general U.S. population.	Auto assigned if "migrant" is marked on current Family Address record (Contact/ Address screen)		- Length/height/ weight - Behavior/Lifestyle - Contact with any referrals provided. - Food preparation and safety techniques to avoid foodborne illness
901 p. 442	Environmental Risk Violent physical assault on women (battering) or child abuse/neglect as self-reported, or as documented by a social worker, healthcare provider, or other appropriate personnel. Child abuse/neglect is defined as any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of an infant or child by a parent or caretaker. Utah state law requires the reporting of known or suspected child abuse or neglect to Child Protective Services (1-855-323-3237). Utah state law does not require WIC to report suspected battering; however, extensive referrals must be given. See NRM for counseling guidance for victims of domestic violence and child abuse.	No – Manually assign		Contact with any referrals provided.
902 p. 451	Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions - A woman or an infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. - Examples include: misuse of alcohol, drugs, mental illness, diagnosed intellectual or physical disability that impairs abilities, <17 years of age. A responsive feeding relationship is critical for supporting healthy dietary habits, food preferences, and weight outcomes in children. Responsive feeding means the caregiver recognizes infant/child cues and responds appropriately in a warm and nurturing environment.	No – Manually assign		- Length/height/ weight - Behavior/Lifestyle - Medical follow-up if necessary. - Contact with any referrals provided.

OTHER RISKS

*Auto-assigns in some cases. See complete risk factor explanation for more details.

Adult lifestyle may include: dietary intake, physical activity, medical care, sleep habits, stressors, tobacco use, etc.

Child behavior may include: dietary intake, physical activity, medical care, screen time, or sleep habits.

