NEW YORK STATE DEPARTMENT OF HEALTH
Division of Nutrition

Medical Documentation for WIC Formula and Approved WIC Foods for Women, Infants and Children

WIC **Instructions: Providers, please complete sections A-D for ALL WIC participants to request formula and supplemental foods. The provision of formula/food is subject to WIC policies and procedures. (Detailed instructions and resources on back)**

WIC Stamp

A. PATIENT INFORMATION

Patient's Name: _____ Date of Birth: ____/____/____

B. FORMULA

Formula Requested: _____ Length of Use: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ _____ months

Prescribed Amount: _____ ounces/day

Special Instructions/Comments: _____

WIC Qualifying Medical Conditions:

☐ Premature Birth	☐ Metabolic Disorders	☐ Failure to Thrive *(Must meet at least one of the criteria on back)*	***Note: These non-specific symptoms/ conditions are <u>not</u> acceptable: dermatitis, formula/food intolerance, fussiness, gas, spitting up, constipation, diarrhea, vomiting, colic, or to enhance or manage body weight without an underlying medical condition.***
☐ Low Birth Weight	☐ Immune System Disorders	☐ Severe Food Allergies	
☐ GI Disorders	☐ Malabsorption Syndromes	☐ Other (Specify):	

C. WIC SUPPLEMENTAL FOODS (WIC does not provide supplemental foods to infants < 6 months old)

☐ YES ☐ NO I authorize qualified WIC staff to determine supplemental foods and amounts based on the patient's medical condition.

If NO, select ONE of the following options:

☐ No food restrictions; provide full amount of age-appropriate foods

☐ Infant <6 months; provide formula only

☐ Patient requires food restrictions based on medical condition (provider MUST complete the following):

☐ ≥ 6 months cannot tolerate solid food: provide formula only

☐ ≥ 12 months cannot tolerate solid food: provide jarred baby fruits & vegetables in lieu of fruit & vegetable voucher

☐ OMIT the following food(s) based on medical condition:

Infants (6-11 months):	☐ Infant Cereal	☐ Baby Food Fruits/Vegetables			☐ Fresh Fruits/Vegetables (9-11 months)	
Children (≥ 12 months) & Women:	☐ Peanut Butter	☐ Milk	☐ Whole Grains	☐ Cheese	☐ Yogurt	
	☐ Cereal	☐ Canned Fish	☐ Vegetables/Fruits	☐ Beans	☐ Juice	

D. HEALTH CARE PROVIDER INFORMATION (Contact information may be printed or stamped and must be legible)

Provider Stamp

Provider's Signature _____ Date _____

Street _____ City, State, Zip Code _____

Provider's Printed Name _____ Telephone Number _____ Fax Number _____

E. RELEASE OF INFORMATION

I authorize the above health care provider and NYS WIC agency staff to disclose/discuss information regarding feeding needs. This permission is good for the length of this certification. I understand that I may cancel this permission at any time by request to my health care provider and WIC. This release is not a condition of WIC eligibility.

Participant/Parent/Caregiver Signature _____ Date _____

Printed Name _____

F. WIC STAFF USE ONLY (WIC staff must complete section in its entirety and note comments/actions) ☐ Consent on file at WIC

Check box next to question if the answer is yes:

☐ Acceptable qualifying condition indicated?

☐ Formula consistent with qualifying condition?

☐ Amount and length appropriate?

☐ Med Doc Foods note written?

☐ Approved ☐ Disapproved ☐ Pending Pending Date & Initial _____

Signature: _____

Printed Name: _____ Date: _____

Comments: _____ WIC ID # _____

NEW YORK STATE DEPARTMENT OF HEALTH
Instructions and Resources for WIC Medical Documentation Form

Federal policy limits the issuance of certain formulas to medically fragile participants with qualifying medical conditions.

Use this form to request exempt formulas, WIC-Eligible Nutritionals, standard formulas for infants unable to tolerate solid foods, and supplemental foods for patients with qualifying medical conditions. If you have questions or need additional clarification, please contact the WIC agency where your patient is receiving WIC benefits. A directory of New York WIC agencies can be found at: **http://www.health.ny.gov/prevention/nutrition/wic/local_agencies.htm.**

WIC agency staff will review and fill requests for formulas and supplemental foods according to federal regulations and New York WIC program policies and procedures. WIC may require additional documentation for prescription approval if diagnoses are missing, incomplete, non-specific, or inconsistent with anthropometric data. WIC agency staff may contact you if further clarification is needed.

RENEWAL OF THIS FORM REQUIRED PERIODICALLY

SECTIONS A-D ARE COMPLETED BY HEALTH CARE PROVIDER TO REQUEST WIC FORMULA AND FOODS

A. PATIENT INFORMATION *(Complete for ALL WIC participants.)*

Patient's Name and Date of Birth: Print WIC participant name and date of birth.

B. FORMULA *(Complete for ALL WIC participants.)*

Formula Requested: Write the prescribed formula name and/or brand. See approved NYS WIC formulas at: **http://www.health.ny.gov/prevention/nutrition/wic/approved_formulas.htm**

Prescribed Amount: Specify amount required in ounces/day. (**Ranges allowed.** WIC max, ad lib, as tolerated are not acceptable.)

Length of Use: Check (√) the number of months for which the prescription is valid, or enter number of months up to 12.

Special Instructions/Comments: Include details of relevant medical condition, allergies, formula history, etc.

WIC Qualifying Medical Conditions: Check (√) beside one or more of the described medical diagnoses or check (√)"Other" and specify the medical diagnosis. (ICD Codes are not required.)

Severe food allergies: *Select for severe or multiple food allergies that require a formula.*

Failure to Thrive (FTT) is a severe condition that the NYS WIC Program takes seriously. The patient must meet at least one of the criteria below that WIC uses to define Failure to Thrive:

- Weight consistently below the 3rd percentile for age;
- Weight less than 80% of ideal weight for height/age;
- Progressive fall-off in weight to below the 3rd percentile; or
- A decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile.

WIC measures heights and weights on participants to monitor their growth. Copies of CDC growth charts used by WIC can be found at: **http://www.cdc.gov/growthcharts.**

C. WIC SUPPLEMENTAL FOODS: Complete for all patients. Check (√) Yes or No to indicate referral to WIC for supplemental foods and amounts. If a patient requires restrictions select one of the options listed within the section.

D. HEALTH CARE PROVIDER INFORMATION *(Complete for ALL WIC participants.)*

Licensed health care provider must sign and date. Contact information may be printed or stamped and must be legible.

SECTION E WILL BE COMPLETED BY PARTICIPANT/PARENT/CAREGIVER – Please sign, date, and print name.

SECTION F WILL BE COMPLETED BY WIC STAFF – Please follow WIC program procedure when completing this form.

We appreciate your cooperation and partnership in serving the New York WIC population.