

MICHIGAN WIC SPECIAL FORMULA/FOOD REQUEST

Michigan Department of Health and Human Services

Client Name	Date of Birth	Parent/Guardian Name
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Please specify the underlying qualifying condition below. Conditions such as rash, non-specific intolerance, underweight fussiness, colic, spitting-up, vomiting, gas and constipation will **NOT** be considered indications for a special formula.

1. QUALIFYING MEDICAL CONDITION(S):

- | | | |
|--|---|--|
| <input type="checkbox"/> Premature birth < 37 weeks gestation | <input type="checkbox"/> Low birth weight (<5 lbs 8 oz) | <input type="checkbox"/> Failure to thrive |
| <input type="checkbox"/> Severe food allergies (specify) _____ | | |
| <input type="checkbox"/> Immune system disorder (specify) _____ | | |
| <input type="checkbox"/> Metabolic disorder/inborn errors of metabolism (specify) _____ | | |
| <input type="checkbox"/> Medical condition that impairs nutrition status (specify) _____ | | |
| <input type="checkbox"/> Gastrointestinal disorder/malabsorption syndromes (specify) _____ | | |

2. FORMULA: _____

Select Amount Requested: _____ Ounces/day or Maximum Allowable*

*Up to the WIC maximum allowable may be provided. Maximum allowable may not meet patient's full need.

A list of Michigan Authorized Formulas is available at: www.michigan.gov/wic. click on Medical Providers

3. SUPPLEMENTAL WIC FOODS: (CHECK ONE; MUST BE COMPLETED FOR ALL FORMULA REQUESTS)

All (issue all allowed age appropriate WIC Foods starting at six months)

Restriction (check foods to be OMITTED):

Infant (6-12 months)

- All (issue formula only)
- Infant cereal
- Infant fruits/vegetables

Child (1-5 years) and Woman

- All (issue formula only)
- Milk
- Yogurt
- Cheese
- Eggs
- Legumes
- Peanut butter
- Breakfast cereal
- Bread, rice, tortilla, oatmeal, pasta
- Fresh fruits/vegetables
- 100% fruit/vegetable juice
- Canned fish (women only)

Special Instructions/Comments:

4. MILK SUBSTITUTIONS (optional): Medical Reason for Milkfat Change: _____

2% milk (in place of ≤ 1% milkfat, woman/child ≥ 2 years; or whole milk, child 12-23 months). Honored only if medically indicated.

Whole milk (in place of ≤1% milkfat, woman/child ≥ 2 years). Honored only if medically indicated formula prescribed above.

Soy Beverage in place of milk for child:

- Milk allergy Lactose intolerance Vegetarian/Vegan diet Cultural practice Other _____

5. DURATION:

- 1 month 2 months 3 months 4 months 5 months 6 months (maximum approval)

Medical Provider Name		WIC Use Only	Client # (Optional)
Address		Approved Through (Optional)	
Phone Number	Fax	Reason (if denied)	
Signature	Date	Signature (if denied)	Date

WIC CLINIC: _____ Phone: _____ Fax: _____

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