



MASSACHUSETTS WIC NUTRITION PROGRAM REQUEST FOR SPECIAL FORMULA AND FOOD

Participant's Name: _____

Date of Birth (DOB): ____ / ____ / ____

Guardian's Name: _____

Weeks Gestation (for premature infants): ____

Formula or medical food requested: _____

Prescribed oz per day: _____ ad lib or _____ oz per day ☐ Powder ☐ Concentrate ☐ RTF (restrictions apply)

Intended length of use: _____ months Caloric density (if applicable): _____

Comments/Instructions: _____

REQUIRED for requests for Similac Total Comfort, Similac Sensitive, and Similac For Spit-Up:

- ☐ I acknowledge that the caloric density of these formulas is 19 kcal/oz.
☐ I acknowledge that requests for Similac For Spit-Up must include documentation of an appropriate medical condition/ICD code below.

REQUIRED for all other special/metabolic formulas: Please check qualifying medical condition(s)/ICD code(s)

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergy, Food: _____ (K52.2) | <input type="checkbox"/> Delay, Developmental (R62) | <input type="checkbox"/> Gastroesophageal Reflux (K21.9) |
| <input type="checkbox"/> Autoimmune Disorder (M35.9) | <input type="checkbox"/> Diseases of the Digestive System (K00-K95); specify: _____ | <input type="checkbox"/> Lactose Intolerance (E73) |
| <input type="checkbox"/> Anomaly, Respiratory (Q34.9) | <input type="checkbox"/> Endocrine, Nutritional & Metabolic Diseases (E00-E89); specify: _____ | <input type="checkbox"/> Malnutrition (E43) |
| <input type="checkbox"/> Anomaly, GI (Q45.9) | | <input type="checkbox"/> Pregnancy, Multiple Gestation (O30) |
| <input type="checkbox"/> Conditions Originating in the Perinatal Period (P00-P96); specify: _____ | | <input type="checkbox"/> Prematurity (P07.3) |
| <input type="checkbox"/> Congenital Heart Disease (Q24.9) | <input type="checkbox"/> FTT/Inadequate Growth (R62.51) | <input type="checkbox"/> Other: specify nutrition-related condition and ICD code: _____ |

Additional WIC supplemental foods available: Please check foods that are **not allowed** based on medical diagnosis

- | | | | | |
|--|---|--|---|--------------------------------|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Eggs | <input type="checkbox"/> Cereal | <input type="checkbox"/> Fruits/vegetables | <input type="checkbox"/> Juice |
| <input type="checkbox"/> Soy Milk/Tofu | <input type="checkbox"/> Legumes (beans/peas) | <input type="checkbox"/> Whole wheat bread/whole grains | <input type="checkbox"/> Infant fruits/vegetables | |
| <input type="checkbox"/> Cheese/Yogurt | <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Canned fish (for fully breastfeeding women) | <input type="checkbox"/> Infant cereal | |

REQUIRED: I authorize the WIC Nutritionist to make future decisions about supplemental foods for this participant ☐ Yes ☐ No

Provider (MD, DO, PA, CNM, or NP) Signature: _____ Date: _____

Provider Printed Name: _____ Provider Stamp/Address: _____

Phone: _____

- Massachusetts WIC strongly endorses breastfeeding as the optimal way to feed most infants. For infants that consume formula, MA WIC standard contract formulas are Similac Advance and Similac Soy Isomil. Similac Total Comfort, Similac Sensitive, and Similac For Spit-Up can also be provided with a *Request for Special Formula and Food* form per USDA's requirement of medical documentation for any formula that is not 20 kcals/oz.
- WIC participants who carry MassHealth insurance will receive special formulas through MassHealth upon prior authorization. To obtain authorization, contact MassHealth or the member's Managed Care Organization. To assist families, WIC will provide 1 month of benefits in order to allow for the MassHealth Prior Approval process and will act as a safety net for families should the process take longer. **Similac Total Comfort, Similac Sensitive, and Similac For Spit-Up are not required to be provided through MassHealth;** WIC will issue these formulas throughout an infant's period of need.
- WIC does not provide whole cow's milk for infants. **Whole milk is ONLY provided to women and children over the age of 2 who have a documented medical condition that warrants the use of a high-calorie special formula or supplement.**
- The request for formula other than WIC contract formula will require thorough documentation of medical need (including an ICD code) which warrants its issuance. The request for a special formula is subject to WIC approval. A WIC Nutritionist will complete a thorough dietary assessment to verify the need for the requested formula. Significant findings will be communicated to you with the participant's permission. **It is WIC's policy to re-evaluate the participant's continued need for the formula on a periodic basis.**

WIC Use Only:

Date Received _____ ID# _____ Site _____ MH contacted? _____ MH approved? _____ Contacted MD? _____

Category: P B N I C Next Appointment _____ Comments _____

Nutritionist's Signature _____ Date _____

MA WIC forms and formula list can be downloaded from our website at www.mass.gov/wic.

For more information, please call WIC at 1-800-WIC-1007.

Revised WIC Form #67, 10/16

This institution is an equal opportunity provider.

AUTHORIZATION FOR RELEASE OF INFORMATION TO WIC

I _____ authorize _____ to release nutrition assessment information, related to the
(print name) (health center)

Request For Special Formula and Food Form, about me or my child, _____
(specify name and date of birth)

to the Massachusetts WIC Program and the _____ WIC Program for the purpose of establishing
eligibility for WIC benefits and/or for coordinating care.

- ☐ I understand that I do not have to give authorization to my healthcare provider to share health information about me and/or my child with WIC but I want to.
- ☐ I understand that I can change my mind and cancel this authorization at any time. To do this, I need to write a letter to my healthcare provider and send it or bring it to the place where I am now giving this authorization. Once the information has already been given out by my healthcare provider, I understand that it is too late for me to cancel the authorization.

Participant/Parent/Guardian Signature: _____ Date: ____/____/____

Relationship to Participant: _____

- This authorization is valid until the end of the WIC participant's certification period.
- WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law.

AUTHORIZATION FOR RELEASE OF INFORMATION FROM WIC

I _____ authorize _____ WIC Program to release the information, which
(print name)
appears on the other side of this form, from the WIC record of _____ to _____
(name of participant) (name of health center)
for the purpose of coordinating nutrition services.

- ☐ I understand that the person(s) or organization listed here may not be covered by federal or state privacy laws, and they may be able to further share the information WIC gives them.
- ☐ I am requesting that the WIC Program provide the information specified above even though I know that federal law gives me the right to obtain WIC benefits and to keep WIC participant records private.
- ☐ I understand that I can change my mind and cancel this authorization at any time. To do this, I need to write a letter to WIC and send it or bring it to the WIC Program where I am now giving this permission. Once the information has been given out by WIC, I understand that it is too late for me to cancel the authorization.

Participant/Parent/Guardian Signature: _____ Date: ____/____/____

Relationship to Participant: _____

- This authorization is valid until the end of the WIC participant's certification period.
- WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law.



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