

# MICHIGAN WIC SPECIAL FORMULA/FOOD REQUEST

Michigan Department of Health and Human Services

Client Name	Date of Birth	Parent/Guardian Name			
<b>Please specify the underlying qualifying condition below.</b> Conditions such as rash, non-specific intolerance, underweight fussiness, colic, spitting-up, vomiting, gas and constipation will <b>NOT</b> be considered indications for a special formula.					
<b>1. QUALIFYING MEDICAL CONDITION(S):</b> <input type="checkbox"/> Premature birth < 37 weeks gestation <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) _____					
<b>2. FORMULA:</b> _____ <b>Select Amount Requested:</b> _____ Ounces/day or <input type="checkbox"/> Maximum Allowable* <small>*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: <a href="http://www.michigan.gov/wic">www.michigan.gov/wic</a>. <b>click on Medical Providers</b></small>					
<b>3. SUPPLEMENTAL WIC FOODS: (<u>CHECK ONE</u>; MUST BE COMPLETED FOR <u>ALL</u> FORMULA REQUESTS)</b> <input type="checkbox"/> <b>All</b> (issue all allowed age appropriate WIC Foods starting at six months) <input type="checkbox"/> <b>Restriction (check foods to be OMITTED):</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> <b>Infant (6-12 months)</b>  <input type="checkbox"/> All (issue formula only)  <input type="checkbox"/> Infant cereal  <input type="checkbox"/> Infant fruits/vegetables         </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <b>Child (1-5 years) and Woman</b>  <input type="checkbox"/> All (issue formula only)  <input type="checkbox"/> Milk  <input type="checkbox"/> Yogurt  <input type="checkbox"/> Cheese  <input type="checkbox"/> Eggs  <input type="checkbox"/> Legumes  <input type="checkbox"/> Peanut butter  <input type="checkbox"/> Breakfast cereal  <input type="checkbox"/> Bread, rice, tortilla, oatmeal, pasta  <input type="checkbox"/> Fresh fruits/vegetables  <input type="checkbox"/> 100% fruit/vegetable juice  <input type="checkbox"/> Canned fish (women only)         </td> <td style="width: 34%; vertical-align: top; padding: 5px;"> <b>Special Instructions/Comments:</b>            _____            _____            _____            _____            _____            _____         </td> </tr> </table>			<b>Infant (6-12 months)</b> <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant fruits/vegetables	<b>Child (1-5 years) and Woman</b> <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Milk <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> Legumes <input type="checkbox"/> Peanut butter <input type="checkbox"/> Breakfast cereal <input type="checkbox"/> Bread, rice, tortilla, oatmeal, pasta <input type="checkbox"/> Fresh fruits/vegetables <input type="checkbox"/> 100% fruit/vegetable juice <input type="checkbox"/> Canned fish (women only)	<b>Special Instructions/Comments:</b> _____ _____ _____ _____ _____ _____
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<b>4. MILK SUBSTITUTIONS (optional): Medical Reason for Milkfat Change:</b> _____ <input type="checkbox"/> <b>2% milk</b> (in place of ≤ 1% milkfat, woman/child ≥ 2 years; or whole milk, child 12-23 months). Honored only if medically indicated. <input type="checkbox"/> <b>Whole milk</b> (in place of ≤ 1% milkfat, woman/child ≥ 2 years). Honored only if medically indicated formula prescribed above. <input type="checkbox"/> <b>Soy Beverage in place of milk for child:</b> <input type="checkbox"/> Milk allergy <input type="checkbox"/> Lactose intolerance <input type="checkbox"/> Vegetarian/Vegan diet <input type="checkbox"/> Cultural practice <input type="checkbox"/> Other _____					
<b>5. DURATION:</b> <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 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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