

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



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

Open Door Family Medical Centers, Inc.  
WIC Program  
344 E. Main St.  
Ste. 105  
Mount Kisco, NY 10549  
Tel: (914) 269-0784  
Fax: (914) 241-0341

### A. PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### B. FORMULA

Formula Requested: \_\_\_\_\_ Length of Use:  1 month  6 months  \_\_\_\_\_ months

Prescribed Amount: \_\_\_\_\_ ounces/day  3 months  12 months

Special Instructions/Comments: \_\_\_\_\_

### WIC Qualifying Medical Conditions:

<input type="checkbox"/> Premature Birth	<input type="checkbox"/> Metabolic Disorders	<input type="checkbox"/> Failure to Thrive <i>(Must meet at least one of the criteria on back)</i>	<i>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.</i>
<input type="checkbox"/> Low Birth Weight	<input type="checkbox"/> Immune System Disorders	<input type="checkbox"/> Severe Food Allergies	
<input type="checkbox"/> GI Disorders	<input type="checkbox"/> Malabsorption Syndromes	<input type="checkbox"/> 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):	<input type="checkbox"/> Infant Cereal	<input type="checkbox"/> Baby Food Fruits/Vegetables	<input type="checkbox"/> Fresh Fruits/Vegetables (9-11 months)
Children (≥ 12 months) & Women:	<input type="checkbox"/> Peanut Butter	<input type="checkbox"/> Milk	<input type="checkbox"/> Whole Grains
	<input type="checkbox"/> Cereal	<input type="checkbox"/> Canned Fish	<input type="checkbox"/> Vegetables/Fruits
		<input type="checkbox"/> Beans	<input type="checkbox"/> Yogurt
			<input type="checkbox"/> 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?
- Signature: \_\_\_\_\_ Pending Date & Initial \_\_\_\_\_  
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](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](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.**