MICHIGAN WIC SPECIAL FORMULA/FOOD REQUEST

Michigan Department of Health and Human Services

Client Name	Date of Birth	Parent/Guardian Name

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):

- ☐ Pre term birth < 37 weeks gestation ☐ Low birth weight (<5 lbs 8 oz) ☐ Failure to thrive
- ☐ Severe food allergies (specify) _____
- ☐ Immune system disorder (specify) _____
- ☐ Metabolic disorder/inborn errors of metabolism (specify) _____
- ☐ Medical condition that impairs nutrition status (specify) _____
- ☐ 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)	**Child (1-5 years) and Woman**	**Special Instructions/Comments:**
☐ All (issue formula only)	☐ All (issue formula only)	
☐ Infant cereal	☐ Milk	
☐ Infant fruits/vegetables	☐ Yogurt	_____
	☐ Cheese	
	☐ Eggs	_____
	☐ Legumes	
	☐ Peanut butter	_____
	☐ Breakfast cereal	
	☐ Bread, rice, tortilla, oatmeal, pasta	_____
	☐ Fresh fruits/vegetables	
	☐ 100% fruit/vegetable juice	_____
	☐ Canned fish (women only)	

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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