NEW YORK STATE DEPARTMENT OF HEALTH
Division of Nutrition

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

New York State WIC — Together Growing Stronger Families

Instructions: Providers, please complete sections A and D for all WIC participants.
- **To request exempt formula and prescribe supplemental foods, complete section B.**
- **To request soy beverage or tofu for milk protein allergy, complete section C.**

A. PATIENT INFORMATION (Further instructions on reverse.)

Patient's Name: _____ **Date of Birth:** _____

B. EXEMPT FORMULA AND WIC SUPPLEMENTAL FOODS

Formula Requested: _____ **Length of Use:** ☐ 1 month ☐ 6 months ☐ _____ months ☐ 3 months ☐ 12 months

Prescribed Amount: _____ **ounces/day**

Special Instructions/Comments: _____

WIC Qualifying Medical Conditions:

☐ Premature Birth	☐ Metabolic Disorders	☐ Failure to Thrive *(Must meet at least one of the criteria on back)*
☐ Low Birth Weight	☐ Immune System Disorders	☐ Severe Food Allergies
☐ GI Disorders	☐ Malabsorption Syndromes	☐ Other

Note: *These non-specific symptoms/conditions are not acceptable: formula/food intolerance, fussiness, gas, spitting up, constipation, diarrhea, vomiting, colic, or to enhance or manage body weight without an underlying medical condition.*

WIC Supplemental Foods:

☐ No Restrictions
☐ Patient cannot tolerate foods: provide formula only.
☐ Issue modified food package omitting foods checked below.

WIC Category	Check the foods that should **NOT** be issued to the patient.
Infants (6 - 11 mos.)	☐ Infant Cereal ☐ Baby Food Fruits ☐ Baby Food Vegetables
Children (≥ 12 mos.) and Women	☐ Milk ☐ Cheese ☐ Cereal ☐ Whole Grains ☐ Eggs ☐ Juice ☐ Beans ☐ Peanut Butter ☐ Vegetables/Fruit ☐ Canned Fish* **Only for Exclusive Breastfeeding Women*

C. SOY BEVERAGE AND/OR TOFU (No cow's milk or cheese will be issued.)

Check box(es) for requested item(s) for **Milk Protein Allergy** diagnosis for women and children. *Federal regulations state an allergy that can be treated with soy beverage/contract soy formula does not qualify for exempt formula.*

☐ Soy beverage ☐ Calcium-set tofu

D. HEALTH CARE PROVIDER INFORMATION (Provision of exempt formula/food subject to WIC policies and procedures.)

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 Program staff to disclose/discuss information regarding this request. I understand that I may cancel this permission at any time with my written request to my health care provider, and that this 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 in WICSIS)

☐ Acceptable qualifying condition indicated? ☐ Approved ☐ Pending ☐ Disapproved WIC ID# _____

☐ Formula consistent with qualifying condition? Signature: _____

☐ Is amount and length appropriate? Printed Name: _____ Date: _____

 The WIC Program is an equal opportunity provider.

NEW YORK STATE DEPARTMENT OF HEALTH
Instructions and Resources for WIC Formula Medical Documentation

Federal policy limits the issuance of exempt formulas to medically fragile participants with qualifying medical conditions.

Use this form to request exempt formulas and/or supplemental foods for patients with qualifying medical conditions. If you have questions or need additional clarification, please contact the local 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**.

Local agency WIC staff will review and fill requests for exempt formulas and supplemental foods according to federal regulations and New York WIC program policies and procedures. Denial of a request does not imply that WIC Program staff question the health care provider's clinical judgment.

RENEWAL OF THIS FORM REQUIRED PERIODICALLY

SECTIONS A-D ARE COMPLETED BY HEALTH CARE PROVIDER

A. PATIENT INFORMATION *(Complete for ALL WIC participants.)*

Patient Name and Date of Birth: Print WIC participant name and date of birth.

B. EXEMPT FORMULA AND WIC SUPPLEMENTAL FOODS *(Complete if exempt formula is requested.)*

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 acceptable.)

Severe food allergies: *Select for severe or multiple food allergies that require a* ***formula other than soy beverage.***

Failure to Thrive (FTT) is a severe condition that the NYS WIC Program takes seriously.
Below are the criteria 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.

Copies of CDC growth charts used by WIC can be found at: **http://www.cdc.gov/growthcharts.**

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**
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.
Special Instructions:	Include any special instructions or comments, as appropriate.
WIC Supplemental Foods:	Check (√) to indicate no restrictions, formula only, or a modified package. To modify package, check (√) the foods that should NOT be issued.

C. SOY BEVERAGE AND/OR TOFU *(Complete if soy beverage/tofu for milk protein allergy is requested.)*
Check (√) the appropriate box to substitute soy beverage and/or calcium-set tofu for a milk protein allergy diagnosis.

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.

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.

The New York WIC Program may require additional documentation for prescription approval if diagnoses are missing, incomplete, non-specific, or inconsistent with anthropometric data. Local WIC agency staff will contact you if further clarification is needed.

We appreciate your cooperation and partnership in serving the New York WIC population.