### MICHIGAN WIC SPECIAL FORMULA/FOOD REQUEST

**Michigan Department of Health and Human Services**

**Client**

**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
- [ ] 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

<table>
<thead>
<tr>
<th>Food Item</th>
<th>Infant (6-12 months)</th>
<th>Child (1-5 years) and Woman</th>
<th>Special Instructions/Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (issue formula only)</td>
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<td>All (issue formula only)</td>
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<tr>
<td>Infant cereal</td>
<td></td>
<td>Milk</td>
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<td>Infant fruits/vegetables</td>
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<td>Yogurt</td>
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<td>Cheese</td>
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<td>Eggs</td>
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<td>Legumes</td>
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<td>Peanut butter</td>
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<td>Breakfast cereal</td>
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<td>Bread, rice, tortilla, oatmeal, pasta</td>
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<td>Fresh fruits/vegetables</td>
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<td>100% fruit/vegetable juice</td>
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<td>Canned fish (women only)</td>
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</tbody>
</table>

#### 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)

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