

# 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):**

Premature birth < 37 weeks gestation

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](http://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: |
|---|--|--------------------------------|
| <input type="checkbox"/> All (issue formula only) | <input type="checkbox"/> All (issue formula only)              | _____                          |
| <input type="checkbox"/> Infant cereal            | <input type="checkbox"/> Milk                                  | _____                          |
| <input type="checkbox"/> Infant fruits/vegetables | <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)              | _____                          |

**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 |      | <b>WIC Use Only</b>         | 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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