NEW YORK STATE DEPARTMENT OF HEALTH
WIC Program

WIC Medical Documentation

For WIC approved formula, nutritionals and supplemental foods

NEW YORK STATE | WIC Program

INSTRUCTIONS: Complete sections A-D for WIC participants requiring exempt formula, nutritionals and supplemental foods (NYS WIC Formulary: https://www.health.ny.gov/prevention/nutrition/wic/approved_formulas.htm). Incomplete forms will cause delays in issuance of prescribed products. The provision of formula/food is subject to WIC policies and procedures. Multiple formulas may be listed to allow for alternative options based on product availability. (Details on back)

A. Patient Information

Patient Name: Date of Birth: / /

B. Formula

1. Formula/Nutritional Requested: _____
2. Product Form: ☐ Powder ☐ Concentrate ☐ Other: _____
3. Prescribed Amount: ☐ 20-32 oz/day (WIC Max) OR _____ oz/day (see back for additional details)
4. Length of Use: ☐ Until Age 1 OR _____ months (max of 12 for children/women)
5. Special Instructions/Comments: _____
6. WIC Qualifying Medical Condition (choose at least one):

☐ Developmental delay
☐ Dysphagia
☐ Failure to thrive
☐ Gastrointestinal diseases
☐ Immune system disorder
☐ Low birth weight (< 24 months only)
☐ Malabsorption syndromes
☐ Metabolic disorders
☐ Premature birth (< 24 months only)
☐ Severe food allergies
☐ *Other: _____

***Note:** The following non-specific symptoms and conditions are **not** acceptable: dermatitis, formula/food intolerance, fussiness, gas, spitting up, constipation, diarrhea, vomiting, colic, underweight, overweight.

C. WIC Supplemental Food Restrictions, if applicable

Infants 6-11 months:

NOT allowed:

☐ Solids, provide formula only
☐ Infant Cereal
☐ Fruits/Vegetables

Children ≥ 12 months & Women:

NOT allowed:

☐ Solids, provide infant fruits and vegetables and infant cereal
☐ Solids, provide formula only
☐ Cheese/Milk/Yogurt ☐ Eggs ☐ Soymilk/Tofu
☐ Canned Fish ☐ Peanut Butter ☐ Other: _____

D. Prescribing Health Care Provider Information (MD, NP, PA)

Provider's Signature Date / /

Provider Stamp

Provider's Printed Name Phone Number Fax Number

Street Address City, State, Zip Code

E. Participant 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 Printed Name Date / /

F. WIC Staff Use Only

WIC ID # ☐ Consent on file at WIC Date Obtained: / /

Date and Initial: ☐ Approved ☐ Pending ☐ Disapproved

Comments:

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, higher amount of standard formulas for infants ≥ 6 months who are unable to tolerate solid foods, standard formulas for children ≥ 12 months 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 State WIC agencies can be found at: https://www.health.ny.gov/prevention/nutrition/wic/local_agencies.htm

WIC nutrition staff will review and fill requests for formulas and supplemental foods according to federal regulations and New York State 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 nutrition staff may contact you if further clarification is needed.

Sections A-D Must Be Completed by Health Care Provider to Request WIC Formula and Foods

A. Patient Information (Complete for ALL patients.)

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

B. Formula (Complete for ALL patients.)

1. **Formula/Nutritional Requested:** Write the name of the prescribed formula or WIC-eligible nutritional. WIC can only provide products on the NYS WIC Formulary: https://www.health.ny.gov/prevention/nutrition/wic/approved_formulas.htm
2. **Product Form:** Specify the form - powder, concentrate or ready-to-use. RTU issuance is limited to certain conditions.
3. **Prescribed Amount:** Specify amount required in ounces/day or check WIC Formula Max. WIC provides a maximum amount of 20-32 oz/day for formula. (Ranges are allowed. Ad lib or as tolerated are not acceptable).
4. **Length of Use:**

   Infants: Specify the number of months for which the prescription is valid or check Until Age 1.

   Children and Women: Specify the number of months for which the prescription is valid. A new prescription is required for each certification, usually every 12 months.
5. **Special Instructions/Comments:** Include details of relevant medical condition, allergies, formula history, etc.
6. **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.)

C. WIC Supplemental Food Restrictions: (Complete for patients if applicable.)

If this section is left blank, WIC nutrition staff will determine if WIC supplemental foods should be issued or not.

Infant 6-11 months: WIC will provide higher amounts of formula to infants who cannot tolerate solid foods.

Children ≥ 12 months and Women: WIC will provide infant foods (infant cereal and infant fruits and vegetables) to children and women who cannot tolerate regular solid foods.

D. Prescribing Health Care Provider Information (Complete for ALL patients.)

Health care provider with prescriptive privileges must sign and date. Contact information may be stamped and must be legible.

E. Will Be Completed By Participant/Parent/Caregiver – Please sign, date, and print name.

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 State WIC population.