



Request for Special Formula and Food

Medical documentation is required for the Iowa WIC Program to authorize special formulas and supplemental foods for WIC participants. This form must be filled out in its entirety to be valid. Approval is subject to USDA and WIC Program policies.

A. Participant Information

Participant Name: _____ Date of Birth (DOB): _____

Parent/Guardian Name: _____ Phone: _____

B. Medical Formula

Formula requested: _____ Powder Concentrate Ready to Use

Prescribed ounces per day: _____

Preparation/Feeding Instructions: _____

If not specified, up to the WIC maximum allowable may be provided. Maximum allowed might not meet participant's full needs.

Length of Use:

1 month 2 months 3 months 4 months 5 months 6 months

C. Qualifying Medical Condition (include ICD-10 Code)

Symptoms such as spitting up, milk/formula intolerance, constipation, fussiness, gas or picky eating are **not** considered acceptable medical diagnoses and will not be approved by WIC for issuance of a special formula. WIC **cannot** provide formula to enhance nutrient intake or manage body weight without underlying medical conditions.

Premature birth \leq 37 weeks gestation (P0710)

- Failure to thrive (specify underlying medical condition)
- Severe food allergies (Specify)
- Immune system disorder (Specify)
- Metabolic disorder/inborn errors of metabolism (Specify)
- Gastrointestinal disorder/malabsorption syndromes (Specify)
- Medical condition that impairs nutrition status (Specify)

D. Supplemental Foods

- I authorize the WIC RD/Nutritionist to determine supplemental foods and amounts based on medical needs.
- I do NOT authorize WIC RD/Nutritionists to make decisions about supplemental foods. Select any of the following that apply below:
 - Formula only-** No foods and increased amount of formula for those 6-12 months of age due to inability/delay consuming solid foods.
 - The foods checked below are allowed on the WIC food package for this person:

<input type="checkbox"/> All foods allowed			
<input type="checkbox"/> Infant cereal	<input type="checkbox"/> Infant Fruits/Vegetables		
<input type="checkbox"/> Milk	<input type="checkbox"/> Soy Beverage	<input type="checkbox"/> Cheese	<input type="checkbox"/> Yogurt
<input type="checkbox"/> Tofu	<input type="checkbox"/> Juice	<input type="checkbox"/> Peanut Butter	<input type="checkbox"/> Nut/Seed Butter
<input type="checkbox"/> Whole Wheat/Whole Grain Breads	<input type="checkbox"/> Oatmeal	<input type="checkbox"/> Whole Wheat Pasta	<input type="checkbox"/> Eggs
<input type="checkbox"/> Fish	<input type="checkbox"/> Cereal	<input type="checkbox"/> Beans	<input type="checkbox"/> Brown/Wild Rice
<input type="checkbox"/> Corn/Whole Wheat Tortillas	<input type="checkbox"/> Fruits/Vegetables		

Comments:

E. Healthcare Provider Information

Provider's Signature (MD, DO, PA, ARNP)	Date
Provider's Name (Print)	Medical Office
Phone	Fax

F. Release of Information

I give permission to the WIC Program to release confidential information from my WIC record to the healthcare provider listed above. I also give permission to the person or agency named above to share requested information. I understand the WIC Program will use this information to provide nutrition services to my family.

Autorizo al programa WIC a divulgar información confidencial de mi expediente de WIC al proveedor de atención médica mencionado anteriormente. También doy el permiso a la persona o a la agencia nombrada arriba compartir la información solicitada. Entiendo que el programa de WIC utilizará esta información para proporcionar servicios de la nutrición a mi familia.

Participant/Parent/Caregiver Signature	Date
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G. WIC Use Only

WIC Clinic	WIC Phone
WIC Fax	FID #:

Comments:

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

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