Utah WIC Program Formula and Food Authorization

Children at 12 Months of Age or Older and Women

Please complete each section below or formula/foods cannot be issued. Only complete one row for formula amount.

If specific amount per day is not checked/indicated, then the formula cannot be provided.

A. Patient's Name: _____ Patient's DOB: _____

Parent/Guardian Name: _____ Today's Date: _____

Primary Care Physician : _____ Discharging Physician: _____

B. Medical Diagnosis – Check all that apply

❑Allergies ❑GERD ❑Feeding Difficulties ❑Prematurity
❑Cystic fibrosis ❑FTT ❑Malnutrition ❑Other ICD 10 Medical Dx: _____

C. Name of Formula/Product:	
Physical Form of Formula:	❑ powder ❑ concentrated liquid ❑ ready to feed (RTF)
Formula Amount (oz/day):	❑ 8 ❑ 16 ❑ 24 ❑ 27 ❑ 29 ❑ Other: ____oz/day **(no ranges)** ***The maximum allowance is 30 oz/day for a 30 day month and 29 oz/day for 31 day month.**
RTF/Single Serving Product (cans/day):	❑ 1 ❑ 2 ❑ 3 ❑ 3.5

D. WIC Supplemental Foods – **Age appropriate foods will be issued if nothing is marked.**

❑ No milk
❑ No cheese
❑ No yogurt
❑ No eggs
❑ No wheat bread/brown rice/tortillas/pasta
❑ No dry beans/canned beans
❑ No canned fish
❑ No peanut butter
❑ No cereal
❑ No juice
❑ No fresh fruits/vegetables

E. Whole Milk/Other

Please indicate medical reason/qualifying condition if prescribing whole milk.
Note: Personal preference is not a qualifying condition.

❑ Allow whole milk for a child ≥ 2 years or a woman. WIC participant must have a medical condition, requiring a medical formula, to receive whole milk. Medical reason: _____
❑For children, allow jarred infant fruits and vegetables.
❑Substitute infant cereal for breakfast cereal.

Skim, 1%, 2% Milk for a 12-23 month old with weight at or > 85th %:
❑ Skim milk
❑ 1% milk
❑ 2% milk

F. Months of Issuance
(6 months will be issued including current month if nothing is marked)

❑ 2 mo. ❑ 4 mo. ❑ 6 mo. ❑ 8 mo. ❑ 10 mo. ❑ 12 mo.

Order will continue through the end of the expired month.

G. Health Care Provider Information (A written or stamped signature is acceptable.)

State Licensed Prescriptive Authority ❑ MD ❑ DO ❑ NP ❑ PA

Signature _____ Clinic/Hospital _____

Fax# _____ Phone # _____

WIC USE ONLY	Approved by:	Received in Clinic Date: FAFAF Expiration Date:

See Instructions on Back

Instructions to Complete
Utah WIC Formula and Food Authorization Form
Children at 12 Months of Age or Older and Women

Step A: Complete patient information.

Step B: Indicate all medical diagnoses that apply to patient. If diagnosis is not listed, please write in the ICD 10 Medical Diagnosis that applies.

Step C: Formula/Product

- List name and brand of formula required.
  <u>Authorization should be based on medical need and not patient preference.</u>
- Specify if the requested formula is powder, concentrated liquid, or ready to feed.
- Indicate quantity of authorized food or formula needed per day. Please give specific amount needed -no ranges can be accepted.
  NOTE: Breastfeeding mothers may request less.

Step D: Please indicate if WIC supplemental foods are allowed or if there are any restrictions. Full provision of WIC food packages are listed below.

Step E: WIC can only give clients ≥ 2 years of age whole milk if they are receiving a medical specialty formula and require additional calories.

Step F: Specify the length of time this formula and food authorization will be valid.

Step G: Health Care Provider Information must be signed by a Utah state licensed prescriptive authority.

Full Provision of WIC Foods*	
Children and Women	
• **Eggs** - 1 dozen/month • **Fruits/Vegetables** - $9-$11 • **Cereal** - 36 oz/month • **Milk -** up to 4 gal/month (Children approximately 13 -17 oz/day)	• **Juice** - 1 gal/month (Children approximately 4 oz/day) • **Whole Grains** - 1-2 lbs/month • **Beans** - 1 lb/month • **Peanut Butter** - 16 - 18 oz/month
***If formula is needed, maximum allowance 29-30 oz/day based on number of days in month or no more than 910 oz per month.**	

UTAH | WOMEN, INFANTS & CHILDREN