Washington State WIC Nutrition Program

WIC/Medicaid Nutrition Form

If a client requests a WIC/Medicaid Nutrition Form to be completed:

1. WIC staff are required to complete this form (or use another form for documentation) to provide the information below. All WIC staff (clerk, certifier, nutritionist, etc.) are authorized to complete this form.
2. WIC staff provide the original copy to the Medicaid client and keep one copy on file for four years at the WIC clinic for documentation.
3. WIC staff inform the client/caregiver to take this form as proof they have consulted with the WIC Nutrition Program, the medical provider's prescription form, and the client's ProviderOne Services Card to:
   - A pharmacy/Durable Medical Equipment provider (DME) if the client is a Medicaid Fee-for-Service client. They will verify whether the client is eligible to receive formula and/or enteral nutrition products* from Medicaid.
   - The client's prescribing medical provider if the client is a Medicaid managed care client. They will verify whether they will provide formula and/or enteral nutrition products.
4. WIC staff may complete this form for another entity (e.g., hospital, medical provider, pharmacy/DME) with the client/caregiver's permission. WIC staff are not required to have a signed release from the client to complete and send this form. A request for this form can be made in person or by phone. This form was developed by the WIC Nutrition Program to provide the necessary written documentation that Medicaid requires the pharmacy/DME provider to keep on file.

   *Note: Medicaid requires that the client first seek formulas and/or enteral nutrition products from WIC; and that WIC provide the information below. Medicaid defines enteral nutrition products as nutrition formulas and/or products that are consumed orally or by feeding tube. The standard and therapeutic formulas provided by WIC are enteral nutrition products.

Complete the following:

1. Client's name: _____ DOB: _____
2. Caregiver's name and phone number (if applicable): _____
3. Name and address of the WIC clinic: _____
4. WIC clinic phone #: _____
5. Signature of WIC staff person: _____ Date: _____

Check the box below that applies to the client:

☐ Client is not eligible for the Washington State WIC Nutrition Program.

☐ The requested formula and/or nutrition product is not offered on the Washington State WIC Approved Formulas form.

- Name of the requested formula and/or nutrition product _____

☐ Client is eligible for the Washington State WIC Nutrition Program; the formula and/or nutrition product is available as a Washington State WIC Approved Formula; and the need for the formula and/or nutrition product exceeds WIC's allowed amount.

- Name of the formulas and/or nutrition product which is WIC approved: _____

_____ Number of cans requested

_____ Maximum number of cans allowed by WIC

_____ Number of cans requested that WIC cannot provide