SAMPLE WIC REFERRAL FORM

PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation.

Name of Person Being Referred: _____

Address: _____

Telephone Number: _____

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

- ☐ Pregnant woman
- ☐ Woman who is breast-feeding her infant(s) up to one year postpartum
- ☐ Woman who is not breast feeding up to six months postpartum
- ☐ Infant (age 0-1)
- ☐ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

Send completed form to: