MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

REQUEST TO DIRECT SHIP FORMULA TO LOCAL AGENCY (LA)

Complete LA, Participant and Formula Information and email this form to DSWICFormula@health.mo.gov.

TODAY'S DATE:

LA INFORMATION

LA NAME:	LA NUMBER:
NUTRITIONIST/CPA NAME:	
PHONE NUMBER:	EMAIL ADDRESS:

PARTICIPANT INFORMATION

NAME:	DATE OF BIRTH (DOB):
STATE WIC ID (SWID):	

LOCAL RETAILERS/PHARMACIES (INCLUDE NAMES AND LOCATIONS OF PLACES ALREADY CONTACTED AND REASON FORMULA WAS UNAVAILABLE IF PROVIDED):

AMOUNT PURCHASED AT RETAILER (IF APPLICABLE):

FORMULA INFORMATION - Complete a separate form for each month.

BENEFIT MONTH:	FORMULA:	☐ PWD ☐ RTU ☐ Concentrate
CAN SIZE:	FLAVOR PREFERENCES:	
WIC-27 END DATE:	TOTAL MONTHLY BENEFIT:	

AMOUNT ON HAND:

SECTIONS BELOW ARE FOR STATE AGENCY (SA) STAFF ONLY

SA NUTRITIONIST:

PRODUCT INFORMATION:

	PRODUCT CODE	AMOUNT PER CASE	NUMBER OF CASES TO ORDER
Formula			
2nd Formula			

LA ADDRESS:

COMMENTS:

MANUFACTURER CONTACTED:
☐ MJN ☐ Abbott ☐ Nestle ☐ Star Medical ☐ Nutricia

MANUFACTURER PHONE NUMBER:	SPOKE WITH?	EMAIL TO:
STATE ACCOUNT NUMBER:	LA ACCOUNT NUMBER:	
PO NUMBER (FIRST AND LAST INITIALS AND TODAY'S DATE):	REFERENCE NUMBER:	

COST PER CASE:	TOTAL COST:	SHIPPED DATE: