

**RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS  
Letter of Medical Necessity for Supplementation in CHILDREN**

Date: \_\_\_\_\_

As the primary medical caretaker for \_\_\_\_\_, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every \_\_\_\_\_. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

\_\_\_\_\_, M. D./ D.O./ ARNP/ PA-C

SIGNATURE

(Physician, Nurse Practitioner or Physician Assistant)

\_\_\_\_\_  
PRINT NAME

(Physician, Nurse Practitioner or Physician Assistant)

\_\_\_\_\_  
Florida Medical License #

\_\_\_\_\_  
SIGNATURE

(Registered Dietitian/Nutritionist)

\_\_\_\_\_  
PRINT NAME

(Registered Dietitian/Nutritionist)

\_\_\_\_\_  
Dietitian/Nutritionist Florida License #

**Nutrition Products Available Through the Ryan White Program**

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/ Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: \_\_\_\_\_ Weight: \_\_\_\_\_  Lbs  Kgs      IBW/UBW: \_\_\_\_\_  Lbs  Kgs

**NOTE: 1 Serving = 1 Can (8 fluid ounces)**

**Boost Liquid is restricted to Children 18 years and under**

- Boost Liquid- \_\_\_\_\_ No. of **SERVINGS per DAY**  
Number of Refills Authorized \_\_\_\_\_  
*(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above.)* Please indicate FLAVOR preference:  Vanilla  Chocolate  Strawberry

**Resource Just for Kids is restricted to Children 1 - 10 years of age**

- Resource Just for Kids- \_\_\_\_\_ No. of **SERVINGS per DAY**  
Number of Refills Authorized \_\_\_\_\_

**Please note:** If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.  
Patient's 10 digit MEDICAID Number: \_\_\_\_\_

**Please note:** All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.