Instructions for the Medical Statement for Meal Modifications for Adult Participants in the Child and Adult Care Food Program (CACFP)

Please print all information and submit the completed *Medical Statement for Meal Modifications for Adult Participants in the Child and Adult Care Food Care Program (CACFP)* form to the participant's CACFP adult day care center.

- The adult participant or responsible family member and signs section A.
- The participant's state licensed healthcare professional or registered dietitian completes and signs section B.

Any changes to the participant's special dietary needs require the submission of a new medical statement signed by the participant's state licensed healthcare professional or registered dietitian.

Section A: Completed by Participant or Responsible Family Member

- **Name of participant:** Print the participant's name.
- **Birth date:** Print the participant's birth date (month, day, and year).
- **Name of responsible family member (if applicable):** Print the name of the family member who is responsible for the participant, if applicable.
- **Phone number (with area code):** Print the telephone number of the participant or responsible family member, including area code.
- **Email address:** Print the email address of the participant or responsible family member.
- **Address:** Print the address of the participant or responsible family member, including street, city, state, and zip code.
- **Authorization for Health Insurance Portability and Accountability Act (HIPPA) and Family Educational Rights and Privacy Act (FERPA):** Print the name of the state licensed healthcare professional or registered dietitian who will be allowed to release the participant's health information for the specific purpose of special diet information. Print the name of the adult day care center that will receive the participant's health information.
- **Signature of parent or guardian:** Signature of the participant or responsible family member who is completing the participant's medical statement.
- **Date:** Print the date the participant or responsible family member signs the form.

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Section B: Completed by State Licensed Healthcare Professional or Registered Dietitian

This section must be completed and signed by the participant's physician (MD), physician assistant (PA or PAC), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or registered dietitian (RD or RDN).

1. **Physical or mental impairment:** Check (☑) the appropriate box to indicate if the participant has a physical or mental impairment that restricts their diet. If "Yes," describe how the participant's physical or mental impairment restricts the participant's diet.

2. **Diet plan:** Explain the meal modification for the participant. Provide detailed information to ensure proper implementation. For food allergies, identify the foods to be omitted and recommended alternatives. For other medical conditions, more information may be required. For example, if the participant requires caloric modifications or the substitution of a liquid nutritive formula to accommodate a disability, the statement must include this information. Attach a specific diet plan, if needed.

3. **Food omissions and substitutions:** Provide specific information on what foods must be omitted from the participant's diet and what foods are appropriate alternatives for substitutions.

4. **Food texture:** Check (☑) the appropriate box for any texture modifications and list any foods that require a change in texture, e.g., cut up or chopped into bite-size pieces, finely ground, or pureed. Describe any specific requirements for texture modifications. Indicate if all foods should be prepared in this manner.

5. **Equipment:** List any special equipment or utensils needed to assist the participant with dining, e.g., sippy cup, large-handled spoon, and wheel-chair accessible furniture.

6. **Additional information:** Indicate any other information about the participant's eating or feeding patterns that will assist in providing the requested meal modification.

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Signature and Office Stamp of State Licensed Healthcare Professional or Registered Dietitian

- **Name:** Print the name of the state licensed healthcare professional or registered dietitian.
- **Signature:** Signature of the state licensed healthcare professional or registered dietitian who is completing the participant's medical statement.
- **Phone number (with area code):** Print the office telephone number of the state licensed healthcare professional or registered dietitian, including area code.
- **Date:** Print the date the state licensed healthcare professional or registered dietitian signs the form.
- **Office stamp, if available:** Stamp the form with the state licensed healthcare professional or registered dietitian's office stamp.

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For more information, visit the CSDE's Special Diets in the Child and Adult Care Food Program webpage or contact the CACFP staff at the Connecticut State Department of Education, Bureau of Child Nutrition Programs, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841. This document is available at https://portal.ct.gov/-/media/sde/nutrition/cacfp/specdiet/adult_medical_statement_cacfp_instructions.pdf.

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Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

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