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

Use this form to request a meal modification for adult participants in adult day care centers that participate in the U.S. Department of Agriculture's (USDA) CACFP. For instructions, refer to the Connecticut State Department of Education's (CSDE) *Instructions for the Medical Statement for Meal Modifications for Adult Participants in the Child and Adult Care Food Program (CACFP)*.

Section A: Completed by Participant or Guardian/Caregiver

Name of participant: _____ Birth date: _____

Name of responsible family member (if applicable): _____

Phone number (with area code): _____ Email address: _____

Address: _____ City: _____ State: ____ Zip: _____

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I hereby authorize my state licensed healthcare professional or registered dietitian listed below to release such protected health information as is necessary for the specific purpose of special diet information to the adult day care center listed below and to freely exchange the information listed on this form and in my records with the adult day care center as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a meal modification. I understand that I may rescind permission to release this information at any time, except when the information has already been released.

Name of participant's state licensed healthcare professional or registered dietitian:

_____

Name of participant's adult day care center: _____

Signature of participant or responsible family member: _____ Date: _____

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

This section must be completed 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:** Does the participant have a physical or mental impairment that restricts their diet?

   ☐ **No** ☐ **Yes:** Describe how the participant's physical or mental impairment restricts their diet.

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2. **Diet plan:** Explain the meal modification for the participant. Attach a specific diet plan, if needed.

3. **Food omissions and substitutions:** List foods to be omitted from the participant's diet and foods to be substituted.

4. **Food texture:** List foods that require a change in texture and describe below. Indicate if all foods should be prepared in this manner.

   ☐ Cut up or chopped into bite-size pieces ☐ Finely ground ☐ Pureed

5. **Equipment:** List any special equipment or utensils needed.

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

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

Name:_____ Office stamp:

Signature: _____

Phone number (with area code):_____

Date:_____

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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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