

Medical Statement for Meal Modifications in Child and Adult Care Food Program (CACFP) Adult Day Care Centers

This form applies to requests for meal modifications for adult participants in adult day care centers participating in the U.S. Department of Agriculture's (USDA) [CACFP](#). CACFP adult day care centers are required to make reasonable meal modifications for participants whose physical or mental impairment restricts their diet. For guidance on meal modifications and instructions for completing this form, see the Connecticut State Department of Education's (CSDE) document, [Guidance and Instructions for the Medical Statement for Meal Modifications in CACFP Adult Day Care Centers](#).

Note: The USDA requires that the medical statement includes: 1) information about the participant's physical or mental impairment that is sufficient to allow the adult day care center to understand how the impairment restricts the participant's diet; 2) an explanation of what must be done to accommodate the participant's disability; and 3) if appropriate, the food or foods to be omitted and recommended alternatives. **CACFP adult day care centers should not deny or delay a requested meal modification because the medical statement does not provide sufficient information.** When necessary, the adult day care center should work with the participant or responsible family member to obtain the required information. While obtaining additional information, the CACFP adult day care center should follow the portion of the medical statement that is clear and unambiguous to the greatest extent possible.

Section A – Completed by participant or responsible family member

1. Name of participant: _____ 2. Birth date: _____
3. Name of responsible family member (if applicable): _____
4. Phone number (with area code): _____ 5. Email address: _____
6. Address: _____ City: _____ State: _____ Zip: _____
7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
name of participant's recognized medical authority
to release such protected health information as is necessary for the specific purpose of special diet information to _____
name of CACFP adult day care center
and I consent to allow the recognized medical authority to freely
freely exchange the information listed on this form and in my records with the adult day care program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet. I understand that I may rescind permission to release this information at any time except when the information has already been released.
8. Signature of participant or responsible family member: _____ 9. Date: _____

Section B – Completed by participant's recognized medical authority

This section must be completed by the participant's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment:** Does the participant have a physical or mental impairment that restricts the participant's diet?
 No Yes: Describe how the participant's physical or mental impairment restricts the participant's diet.

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

Medical Statement for Meal Modifications in CACFP Adult Day Care Centers

Section B – Completed by participant’s recognized medical authority, *continued*

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

13. **Food texture:** List foods that require a change in texture. Indicate “all” if all foods should be prepared in this manner.

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

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

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

16. Name of recognized medical authority: _____

17. Phone number (with area code): _____

18. Signature of recognized medical authority: _____

19. Date: _____

20. Office stamp:

This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/SpecDiet/Adult_Medical_Statement_CACFP.pdf.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

The Connecticut State Department of Education is committed to a policy of equal opportunity/affirmative action for all qualified persons. The Connecticut Department of Education does not discriminate in any employment practice, education program, or educational activity on the basis of race; color; religious creed; age; sex; pregnancy; sexual orientation; workplace hazards to reproductive systems, gender identity or expression; marital status; national origin; ancestry; retaliation for previously opposed discrimination or coercion, intellectual disability; genetic information; learning disability; physical disability (including, but not limited to, blindness); mental disability (past/present history thereof); military or veteran status; status as a victim of domestic violence; or criminal record in state employment, unless there is a bona fide occupational excluding persons in any of the aforementioned protected classes. Inquiries regarding the Connecticut State Department of Education’s nondiscrimination policies should be directed to: Attorney Louis Todisco, Connecticut State Department of Education, by mail 450 Columbus Boulevard, Hartford, CT 06103-1841; or by telephone 860-713-6594; or by email louis.todisco@ct.gov.

This institution is an equal opportunity provider.