



**Child and Adult Care Food Program
Special Diet Statement/Special Accommodation Form
for Adult Day Care Participants**

(Food preferences are not an appropriate use of this form)

1. Name of Participant (Last, First)		2. Age									
3. Name of Guardian (If applicable)		4. Telephone Number									
5. Institution		6. Telephone Number									
<p>7. Check One:</p> <p><input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> a special meal or accommodation. (Refer to instructions below). Adult Day Care programs participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. A licensed physician, advance practice nurse, dentist, or physician assistant must sign this form.</p> <p><input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Adult Day Care programs participating in federal nutrition programs are encouraged to accommodate reasonable requests. In order to serve a reimbursable meal or snack, sites are required to purchase and provide the recommended substitute food(s) indicated by the medical authority. If the recommended substitute is difficult to obtain or presents a financial hardship, an Institution representative may contact the CDPHE-CACFP office to request approval to claim the participant's meals although the participant/guardian provides the food item. A licensed physician, dentist, physician's assistant, registered dietitian, or advance practice nurse must sign this form.</p>											
<p>8. Disability* or medical condition requiring a special meal or accommodation: Describe the medical condition that requires a special meal or accommodation. For example: "Juvenile diabetes, allergy to peanuts, etc.</p>											
<p>9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability: Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."</p>											
<p>10. Diet prescription and/or accommodation: Please describe in detail to ensure proper implementation. Use extra pages as needed. Describe a specific diet or accommodation prescribed by a physician, advance practice nurse, dentist, or physician assistant; or describe diet modification requested for a non-disabling condition.</p>											
<p>11. Foods to be omitted and substitutions: List specific foods to be omitted and suggested substitutions. An additional sheet may be attached with additional information as needed. List specific foods that must be omitted. For example: "Exclude fluid milk and soy milk or soy products."</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">A. Foods To Be Omitted</th> <th style="width:50%;">B. Suggested Substitutions</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> </tbody> </table>				A. Foods To Be Omitted	B. Suggested Substitutions						
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<p>12. If texture accommodations are needed, indicate texture needed by checking one of the boxes below: Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Liquid <input type="checkbox"/></p>											
<p>13. Adaptive Equipment: Describe specific equipment required to assist the participant with dining. Examples may include a sippy cup, a large handled spoon, wheel chair accessible furniture, etc.</p>											
14. Signature of Participant/Guardian		Date Signed									
15. Signature of Medical Authority**	16. Printed Name of Medical Authority	17. Telephone Number	18. Date								
19. Medical Office Name and Address											

*Refer to the CDPHE-CACFP Adult Day Care Manual for the federal definition of disability.

**Physician, advance practice nurse, dentist, or physician assistant signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, registered dietitian, or nurse practitioner must sign the form.

This form must be updated annually.



USDA Nondiscrimination Statement

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, 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 complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide all the information requested in the form.

To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to the 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
- (2) Fax: 202-690-7442
- (3) Email: Program.Intake@usda.gov.

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