Request for Meal Accommodation

This form maybe used to request meal modifications for participants of the Child and Adult Care Food Program (CACFP) who have a physical or medical impairment. The care provider will work collaboratively with parents/guardians to ensure equal opportunity to participate in the CACFP and receive program benefits. However, if the care provider is unable to accommodate your participant's meal modification within the meal pattern requirements, a *Medical Statement* completed by a State licensed Medical Professional will be needed (CACFP 17-2016).

Parent/Guardian:

Completing the *Request for Meal Accommodation* form helps the care provider accommodate meal modifications within the meal pattern requirements for participants with a mental or physical impairment. Your participation in this process is important and allows for advanced planning and preparation needed to provide the accommodation. The care provider is not required to provide a specific substitution (such as a particular brand name), but must offer a reasonable modification that effectively accommodates your participant's needs.

Name of Participant:		Date of Birth:
Name of Parent/Guardian:		Telephone:
Address:	City:	State/Zip:
Email Address:		
Specify any dietary restrictions or special instructions for meals:		
Describe the participant's physical or mental impairment:		

IMPORTANT: *Reimbursable milks for children two years old and older and adults include low-fat or fat-free milk, low-fat or fat-free lactose reduced milk, low-fat or fat-free lactose free milk, low-fat or fat-free buttermilk, or low-fat or fat-free acidified milk (7 CFR 226.20(a)(1)). Milk must be pasteurized fluid milk that meets State and local standards. Non-dairy beverages must be nutritionally equivalent to milk and meet the nutritional standards for fortification of calcium, protein, vitamin A, vitamin D, and other nutrients to levels found in cow's milk. The nutrient standards for non-dairy beverages are outlined in the CACFP regulations at 7 CFR 226.20(g)(3). To see the non-dairy beverages that meet the this requirement visit https://www.education.ne.gov/ns/forms-resources/child-and-adult-care-food-program/*

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. Individual 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 in the letter all of 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 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; or

(3) Email: program.intake@usda.gov

This institution is an equal opportunity provider.

Internal Use – Child Care Provider Information

Return to: ___

Phone number: _____

Date form received by child care provider: _____

Follow-up: _____

NEBRASKA
DEPARTMENT OF EDUCATION

Nutrition Services
Revised: April 2018

MEDICAL STATEMENT

Parent/Guardian: You have requested a meal accommodation for your participant of the Child and Adult Care Food Program (CACFP) that cannot be achieved within the federal meal pattern requirements. Therefore, in order to meet your participant's needs, this form must be completed and returned to the care provider. The form must be completed by a State Licensed Health Care Professional (Physician (MD or DO), Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor. A Licensed Medical Nutrition Therapist (LMNT) may also complete and sign when acting under the consultation of the licensed physician.

Name of Participant:		Date of Birth:
Name of Parent/Guardian:		Telephone:
Address:	City:	State/Zip:
Email Address:		
Description of participant's physical or mental impairment that restricts the diet:		
Specify any dietary restrictions or special instructions for meals:		
If applicable, list foods to omit:	If applicable, list foods to substitute:	
Texture Modifications:	Thickness Modifications:	
Signature of State Licensed Health Care Professional:	Name of referring physician working with LMNT *(if applicable)*:	
Printed Name and Title:	Phone Number:	Date:

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Internal Use – Care Provider's Information

Return to: _____

Phone number: _____

Date form received by providers: _____

Follow-up: _____

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DEPARTMENT OF EDUCATION

Nutrition Services
Revised: January 2018