Medical Statement for Adult Participants *without* Disabilities

Requiring Special Meals in the Child and Adult Care Food Program (CACFP) Adult Day Care Centers

This statement must be completed in its entirety and submitted to the CACFP facility before any meal substitutions can be made for participants with disabilities. The participant or responsible family member should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the participant's recognized medical authority.

PART 1 – TO BE COMPLETED BY PARTICIPANT OR RESPONSIBLE FAMILY MEMBER. *PLEASE PRINT.*

Participant's Name: ______________________ Birth Date: ____/____/____ *(month/day/year)* ☐ Male ☐ Female

Responsible Family Member's Name (if applicable): ______________________

Phone: (______) ______–______ Alternate Phone: (______) ______–______

Address: ______________________ City: __________ State: _____ Zip: ________

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 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 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. My permission to release this information will expire on

____
(Expiration Date)*

* **Note:** The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the participant's annual physical.

Signature of Participant or
Responsible Family Member: ______________________ Date: ______________

PART 2 – TO BE COMPLETED BY RECOGNIZED MEDICAL AUTHORITY. *PLEASE PRINT.*

The Connecticut State Department of Public Health defines a recognized medical authority as a physician, physician assistant, doctor of osteopathy or advanced practice registered nurse (APRN). This includes nurse practitioners, clinical nurse specialists and certified nurse anesthetists who are licensed as APRNs.

A. Describe the medical or other special dietary need that restricts the patient's diet:

Medical Statement for Participants *without* Disabilities, continued

B. List foods to be **omitted** from the diet and foods to be **substituted** (attach specific diet plan):
*Note: A specific diet plan **must** be provided before the CACFP adult day care center can make any meal substitutions.*

C. List foods that require a change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up or chopped to bite-size pieces:

Finely ground:

Pureed:

D. List any special equipment or utensils needed:

E. Indicate any other comments about the patient's eating or feeding patterns:

Name of Recognized
Medical Authority: ______________________________ Office Phone Number: ( ) – ________

Signature of Recognized
Medical Authority: ______________________________ Date: ________________

Office Stamp:

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