Child and Adult Care Food Program
Participant Menu Modification

This facility participates in the Child and Adult Care Food Program (CACFP) and serves meals and snacks in accordance with CACFP regulation. Menu modifications are *required* for any participant who discloses a food allergy, intolerance, medical condition, or any major bodily function affected by a food item. All required menu modifications must reasonably accommodate a participant's need. Menu modifications are *optional* for any participant who has a non-medical personal preference, and an accommodation may be made at the customer service discretion of the facility.

Section 1. Documentation – To Be Completed by Parent/Guardian			
Participant's First & Last Name		**Date of Birth**	
List the food(s) to be omitted from the diet and the food(s) that should be provided instead:			
Food(s) to be avoided	Allowable Modification(s)	Additional instructions, requirements, or modifications such as special equipment, texture, thickness, etc.	
Explain how exposure to the food(s) affects the participant:			
Parent/Guardian Name		**Date**	
Parent/Guardian Signature			

Section 2. Assessment – To Be Completed by the CACFP Facility			
Discuss the modification request with the parent/guardian. Assess if an accommodation meets the meal pattern & if it is required.			
☐ Modification meets the CACFP Meal Pattern		☐ Modification does <u>not</u> meet the CACFP Meal Pattern	
Required Accommodation *or* Optional Accommodation		**Required Accommodation *or* Optional Accommodation**	
☐ Reported Food Allergy	☐ Non-Medical Personal Preference *No medical reason for the request. Accommodating this preference request is a facility's customer service decision*	☐ Reported Food Allergy	☐ Non-Medical Personal Preference *Participant Meals and Snacks may not be eligible for reimbursement if a facility chooses to accommodate this request.*
☐ Reported Food Intolerance		☐ Reported Food Intolerance	
☐ Reported Major Bodily Function Affected	☐ *Facility will provide modification* ☐ *Facility will <u>not</u> provide modification*	☐ Reported Major Bodily Function Affected	☐ *Facility will provide modification* ☐ *Facility will <u>not</u> provide modification*
Documentation Required: Sections 1 & 2		**Documentation Required: Sections 1 & 2 <u>and</u> request Medical Authority Documentation**	
Facility Representative Name		**Date**	

Section 3. Negotiation of Accommodation(s)			
Negotiation: Facility-Provided Reasonable Accommodation (Menu Modification) *Note: Required Reasonable Accommodations are not necessarily the accommodation requested (e.g. a preferred brand)*			
The facility will provide:		Indicate Specific Brand *if applicable*:	
☐ Parent/Guardian accepts accommodation. *The facility is purchasing the reasonable menu modification that is being provided.*		☐ Parent/Guardian does not accept accommodation. *The parent/guardian is requesting an accommodation beyond the reasonable accommodation provided by the facility. The parent/guardian is incurring the cost of the menu modification and will bring this item from home.*	
Notes:			
The facility acknowledges that if one component or less is provided from home, meals and snacks can continue to be claimed for reimbursement. Meals and snacks with two or more components provided from home cannot be claimed for reimbursement.			
Facility Representative Name		**Signature**	
Parent/Guardian Name		**Signature**	

Supplement A. Timeline – Medical Authority Documentation Requests		
This section should be used by a facility when a required accommodation is being made that does not meet the meal pattern and the facility is waiting for Medical Authority Documentation to be completed and returned. Completion of this section allows a facility to claim for up to 6 months while waiting for Medical Authority Documentation.		
☐ Initial Request for Medical Authority Documentation	Date:	Staff Initials:
☐ 1-Month Request for Medical Authority Documentation	Date:	Staff Initials:
☐ 3-Month Request for Medical Authority Documentation	Date:	Staff Initials:
☐ 6-Month Request for Medical Authority Documentation	Date:	Staff Initials:
☐ Medical Authority Documentation has not been provided within 6 months. The meals and snacks that do not meet the meal pattern, provided to this participant to accommodate a disability, can no longer be claimed for reimbursement.		

Facility Representative Name		**Signature**	

Arizona Department of Education - Child and Adult Care Food Program

Medical Authority Documentation | Participant Menu Modification

A facility participating in the Child and Adult Care Food Program has requested documentation from a medical authority for requested menu modifications that do not meet the CACFP Meal Pattern.

Patient First & Last Name		**Date of Birth**	

List the food(s) to be omitted from the diet and the food(s) that should be provided instead:

Food(s) to be avoided	Allowable Modification(s)	Additional instructions, requirements, or modifications such as special equipment, texture, thickness, etc.

Explain how exposure to the food(s) affects the patient:

The following recognized medical authorities can sign this document:
Dentist, Homeopathic Physician, Naturopathic Physician, Nurse Practitioner, Osteopathic Physician, Physician Assistant, Physician

Medical Authority Name		Date	
Medical Authority Signature			

This institution is an equal opportunity provider.

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Medical Authority Documentation | Participant Menu Modification

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Dentist, Homeopathic Physician, Naturopathic Physician, Nurse Practitioner, Osteopathic Physician, Physician Assistant, Physician

Medical Authority Name		Date	
Medical Authority Signature			