Michigan Office
139 W. Lake Lansing Rd., Suite 120 • East Lansing, MI 48823
Telephone: (800) 234-3287 • FAX: (517) 332-5543

Illinois Office
4415 W. Harrison St., Suite 535 • Hillside, IL 60162
Telephone: (800) 284-5273 • FAX: (708) 236-0872

www.acdkids.org

CACFP REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

For fluid milk substitutions due to preference and not a disability or medical condition please see the reverse side.

1. Provider Name:	2. Provider ACD Number:	3. Provider Telephone:
4. Name of Child:		5. Child Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. (To be completed by the appropriate medical professional) Check One:

☐ Participant has a **disability** and **requires** a special meal, fluid milk substitute, or accommodation. Agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP) MUST sign this form.**

☐ Participant **DOES NOT have a disability**, but is requesting a special meal or accommodation due non-disability medical reasons. Food preferences are not an appropriate use of this form. Agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP) or speech pathologist MUST sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (please describe in detail to ensure proper implementation- use extra pages as needed)

12. Foods to be omitted and substitutions: (please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed.)

A. Food(s) To Be Omitted:	B. Suggested Substitution(s)

13. Indicate Texture: (if applicable)	Regular	Chopped	Ground	Pureed
	☐	☐	☐	☐

14. Adaptive Equipment: (if applicable)

15. Signature of Provider:	16. Printed Name:	17. Telephone:	18. Date:
19. Signature of Medical Authority:	**20. Printed Name: (include credentials)**	**21. Telephone:**	**22. Date:**

Sponsor Use Only

Supervisor ____________ Date ____________ ☐ Approved ☐ Denied

9/2018

FLUID MILK SUBSTITUTIONS DUE TO PREFERENCE

Participant/Parent/Guardian Section - Please Complete

All milk substitutes for participants without a disability must be nutritionally equivalent to cow's milk and meet the following USDA nutrient standards. Please enter your requested product's nutritional requirements in the table below and submit this form to your provider. It should be compared to the nutritional standards listed to show the nutritional equivalence is met or exceeded.

(Participant's Name) **(Age)** **(Substitute Requested)**

Required Nutrients	Required Amounts Per Cup	% DV	Per Cup or %DV in Substitute Product
Calcium	276 mg	28%	
Protein	8 g	16%	
Vitamin A	500 IU	10%	
Vitamin D	100 IU	25%	
Magnesium	24 mg	6%	
Phosphorus	222 mg	22%	
Potassium	349 mg	10%	
Riboflavin	0.44 mg	26%	
Vitamin B-12	1.1 mcg	18%	

☐ I choose to provide the substitute product to my provider. By providing a creditable milk substitute, I understand that the provider may receive meal reimbursement for the meal/snack served.

☐ I choose to not provide the substitute requested. I understand that the provider is not required, but has the discretion to, purchase and provide ____________________ as requested.
(Name of Substitute)

Parent/Guardian Signature **Date**

Provider Section- Review the nutrient analysis and food label of the milk substitute requested by the parent/guardian. Keep a copy of this form on file. I have determined the nutritional quality of the non-dairy milk substitute requested by comparing the requested substitute's nutritional values to the approved values. The substitution requested is (circle one): **CREDITABLE** **NOT CREDITABLE**

I understand that I have the discretion to purchase and provide a creditable substitute as requested, if the participant/parent/guardian does not provide the non-diary milk substitute beverage. I understand I may only claim meal reimbursement for eligible meals.

Provider Signature **Date**

Sponsor Use Only

Supervisor Date ☐ Approved ☐ Denied

This project is funded at least in part by USDA funds through the Michigan Department of Education and/or the Illinois State Board of Education.

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 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. (11/2015)