

Dear Parents and Guardians,

You are receiving this letter because the staff at your child's afterschool program have informed us that your child brings their own meal or meal component due to dietary restrictions. If you prefer to continue to provide this substitution for your child, you are certainly able to do so. However, we wanted to make you aware of alternative options.

Greater Pittsburgh Community Food Bank provides meals to your child's afterschool program through the federally-funded Child and Adult Care Food Program (CACFP). Federal regulations require that sponsors of CACFP meals provide appropriate substitutions to accommodate a medically indicated dietary need. Every child enrolled in the program is entitled to a meal that meets their dietary needs. Greater Pittsburgh Community Food Bank is committed to working with your child's medical providers and our food suppliers to ensure your child receives a meal that meets USDA nutritional requirements and special dietary needs.

If your child has a medically indicated dietary need, you need to submit the PA Department of Education Medical Plan of Care form (**attached**) completed by a state licensed health care provider. If you need time to obtain a Medical Plan of Care form or you would like to request a substitution related to a dietary preference, you can complete the Parent/Guardian Dietary Accommodation Request Form (**attached**) and return it to your child's afterschool program leadership team.

Please be sure to list all dietary allergies/restrictions on the form so that we can make any needed substitutions for your child. Please note that sponsors are only required to make medically necessary substitutions. However, we will do what we can to accommodate dietary preferences related to general health concerns or personal beliefs as long as they still meet USDA nutritional requirements. Substitutions will not be made for the child's preference for certain foods over others.

If, instead, you would like to continue to provide your child with an appropriate substitution from home, please sign the attached confirmation statement and return to your child's afterschool program leadership team. Thank you for your support in these efforts. We are happy to serve you and your child. If you have any questions, please call us at 412-745-6508.

Sincerely,

Dana Launius

Child Nutrition Programs Supervisor

Office: 412-460-3663 ext. 552 | dlaunius@pittsburghfoodbank.org

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CONFIRMATION OF REFUSAL OF DIETARY ACCOMMODATION

I confirm that the CACFP Sponsor at my child's afterschool program, Greater Pittsburgh Community Food Bank, informed me of my child's rights to receive a meal substitution for all medically indicated special dietary needs. I confirm that I have opted, instead, to provide an appropriate substitution from home at this time.

Afterschool Program Name (Printed)

Child/Participant Name (Printed)

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date of Signature

Children and Adults with Disabilities and Special Dietary Needs

Operators of the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP) are required to make reasonable modifications to Program meals or the meal service to accommodate children or adults (Program participants) with disabilities that restrict the diet.

1. Licensed Medical Authority's Statement for Participants with Disabilities

U.S. Department of Agriculture (USDA) regulations at [7 CFR Part 15b](#) require substitutions or modifications in Program meals for participants whose disabilities restrict their diets. Sponsors, centers, and day care homes must provide modifications for participants on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for Child Nutrition Programs") may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in Pennsylvania includes a:

- Physician,
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the participant's physical or mental impairment restricts the diet;
- An explanation of what must be done to accommodate the participant; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs

Program operators may make food substitutions for individual participants who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Program operators are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary needs and requests such as those related to general health concerns and personal preferences are not disabilities and are optional for Program operators to accommodate. Meal modifications for non-disability reasons are reimbursable provided that these meals adhere to Program regulations.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008*, a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Children and Adults with Disabilities and Special Dietary Needs

4. Individuals with Disabilities Education Act

Preschool children, infants, and toddlers with disabilities have additional rights under the *Individuals with Disabilities Education Act* (IDEA). Questions regarding the IDEA's requirements should be directed to the U.S. Department of Education, which is the federal agency responsible for the administration and enforcement of the IDEA.

Child Nutrition Program (CACFP/SFSP) Contact

For more information about requesting accommodations to Program meals and the meal service for participants with disabilities please contact:

USDA Nondiscrimination Statement

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, 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](https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint), (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, 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.

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Medical Plan of Care for Child Nutrition Programs (CACFP and SFSP)

Please read pages 1 and 2 before completing this form.

Participant's Name	Date of Birth	Age/Classroom
Name of Center/Program/Site		
Name of Parent/Guardian or Participant's Representative	Phone Number of Parent/Guardian/Representative	
Signature of Parent/Guardian or Participant's Representative	Date	
1. Provide an explanation below of how the participant's physical or mental impairment restricts the participant's diet:		
2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the participant's needs:		
3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. <u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable: <input type="checkbox"/> Chopped/Cut into bite-sized pieces <input type="checkbox"/> Diced/Finely Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Other:		
5. List any required special adaptive equipment:		
Name of Physician/Medical Authority & Title (Please Print)		Provider Phone Number
Signature of Physician/Medical Authority		Date
<p><i>Signing the following section is optional but may prevent delays by allowing the Program to speak with the physician/medical authority.</i></p> <p>Health Insurance Portability and Accountability Act Waiver In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of the participant as is necessary for the specific purpose of Special Diet information to _____ (center/program/site) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning the participant with the childcare/adult care/summer food 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 for the participant. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.</p> <p>The undersigned certifies that he/she is (circle one): Parent Guardian Adult participant or Representative of participant listed on this document and has the legal authority to sign on behalf of that person.</p> <p>Signature: _____ Date: _____</p>		

Parent or Guardian Requested Dietary Substitution

Participant's Name	Date of Birth	Age/Classroom
Name of Center/Program/Site		
Name of Parent/Guardian	Phone Number of Parent/Guardian/Representative	
Signature of Parent/Guardian	Date	
<p>This requested dietary substitution is due to a:</p> <p><input type="checkbox"/> Disability-related restriction <input type="checkbox"/> Dietary preference (skip Question #1 below)</p> <p>Note: A disability-related restriction is in response to a physical or mental impairment that substantially limits one or more major life activities or major bodily functions. Special dietary needs and requests such as those related to general health concerns and personal preferences are not disabilities unless.</p>		
1. Provide an explanation below of how the participant's physical or mental impairment restricts the participant's diet:		
2. Describe the specific diet or necessary modifications to accommodate the participant's needs/preferences:		
3. List the food(s) or beverage to be omitted (please be specific) and recommended alternatives, if appropriate.		
<u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable:		
<input type="checkbox"/> Chopped/Cut into bite-sized pieces <input type="checkbox"/> Diced/Finely Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Other: _____		
5. List any required special adaptive equipment:		

Name of Center Representative	Phone Number of Center
Center Representative Signature	Date

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