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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02425 (06/2023) | |  | | **STATE OF WISCONSIN** | | |
| **WISCONSIN ALZHEIMER’S FAMILY CAREGIVER SUPPORT PROGRAM (AFCSP)**  **HOME-DELIVERED MEALS CONTRIBUTION AUTHORIZATION** | | | | | | |
| This form authorizes contributions to Home-Delivered Meals or Senior Dining Meals to be reimbursed with an AFCSP allocation approved for: | | | | | | |
| Name | | | | | | |
|  | | | | | | |
| Street Address | City | | | | State | Zip |
|  |  | | | |  |  |
| Amount of Money to be Contributed per Meal | | | | | | |
| $ | | | | | | |
| This authorization begins with the meal served on | | |  | | and will continue until | |
|  | | | Date | |  | |
| the signed authorizer gives notice to stop. The AFCSP caregiver and program participant | | | | | | |
|  | | | | | | |
| understand that qualified OAA meal participants are not required to make a contribution in order to | | | | | | |
|  | | | | | | |
| receive meals, and that authorizing a contribution to Home-Delivered Meals or Senior Dining Meals | | | | | | |
|  | | | | | | |
| reduces the amount of AFCSP funds available for other caregiver support services. | | | | | | |
| **SIGNATURE** – Participant or Authorized Representative | | | | | Date Signed | |
|  | | | | |  | |
| **Submit** this completed form to the AFCSP coordinator and appropriate fiscal staff. Nutrition program staff will retain a copy of this completed form and also provide a copy to the primary caregiver of the AFCSP participant. | | | | | | |