Exceptional Family Member Program
RESPITE CARE REIMBURSEMENT RECEIPT

SPONSOR Name:			SSN:
Rank:			
EAS:	Date of Detachment:		Command Info:
HOME Phone number:		**ALTERNATE** Phone number:	
HOME Address:		**HOME** Email:	
		WORK Email:	
Number of Children:		Number of EFMP Family Members:	

	DATE of CARE	HOURS of Care		EFM or Sibling(s)	AGE	COST per Hour	*TOTAL Hours	*TOTAL COST
		From	To					
Example:	07/01/10	6 pm	9 pm	EFM, Sibling	5&7	$ 8.75	3	$ 26.25
Example:	07/06/10	6 pm	10 pm	EFM, Sibling	5&7	$ 8.75	4	$ 35.00
	07/10/10	10 am	4 pm	EFM, Sibling	5&7	$ 8.75	6	$ 52.50
	07/13/10	6 pm	9 pm	EFM, Sibling	5&7	$ 8.75	3	$ 26.25
	07/15/10	5 pm	9 pm	EFM, Sibling	5&7	$ 8.75	4	$ 35.00
	07/17/10	12 pm	6 pm	EFM, Sibling	5&7	$ 8.75	6	$ 52.50
	07/20/10	5 pm	9 pm	EFM, Sibling	5&7	$ 8.75	4	$ 35.00
	07/22/10	5 pm	9 pm	EFM, Sibling	5&7	$ 8.75	4	$ 35.00
	07/24/10	12 pm	6 pm	EFM, Sibling	5&7	$ 8.75	6	$ 52.50
						$		$
						$		$
						$		$
						$		$
						$		$
	*Please **include additional pages** for all care being submitted for reimbursement. If you have any questions or concerns please contact the EFMP Admin. Assistant at 843-228-2041.					**TOTAL:**	40 hrs	$350.00

PROVIDER:	**Name:** (Last, First, MI)	**Phone number:**
	SIGNATURE:	**Address:** (including Zip Code)

I, the undersigned, understand the intended purpose of respite care support and that these funds are not intended for work-related childcare expenses. I also understand that requesting use of respite funds for other that the intended purpose constitutes fraud and may result, at a minimum, in ineligibility for future use of respite care funds up to prosecution. I am also aware that National Respite Care cannot be used in conjunction with installation respite. Reimbursements will not be processed without the original provider's signature (NO photocopies). USMC EFMP retains the right to verify the provision of EFMP respite care claims.

SPONSOR Signature:		**DATE:**

**** FOR OFFICE USE ONLY ****

Date Receipt Received:	Is EFMP file current: ☐ YES ☐ NO
If EFMP file is not current, when was update due?	
Family has received a copy of the EFMP Respite Care Program Policy? ☐ YES ☐ NO	

I certify the child(ren) listed above is/are authorized to receive up to 40 hours of EFMP respite care and the amount due to the sponsor is correct.

EFMP Case Worker Signature:	Date:
EFMP Manager Signature:	Date: