



## Exceptional Family Member Program (EFMP) Installation Respite Care Program Request Application

Please Print or Type:

Name:	Rank:	SSN: (last four)	EAS:
		Home E-mail address:	
Unit Address:		Unit Telephone:	
		Home Telephone:	
Home Address:		Alternate Telephone:	
Number of Children/Dependants:	Name(s) and Age(s) of children:		
Number of EFMP Family Members:			
EFMP Enrollment Date: (YYYYMMDD)			
<input type="checkbox"/> USMC <input type="checkbox"/> NAVY <input type="checkbox"/> OTHER			
<p>Families may receive up to 40 clock hours per month; per family, this includes age-typical siblings if needed. Hours counts do not vary if more than one child is supported at the same time.</p> <p>EFMP enrollment and/or update must be current and the EFM must legally reside full time with the sponsor.</p> <p>The Marine Corps Installation Respite Care formula is determined by CMC (MRY-1) using the Installation CDC hourly rate. In some cases, this may not cover costs expended by the family and therefore should be considered as a subsidy for care and not an entitlement. (See Installation Respite Care Reimbursement Chart)</p> <p>Families must provide the medical necessity and the provider documentation of qualifications for level three or level four reimbursement. Level three and level four providers must be at least 18 years of age.</p> <p>National Respite Care Programs are designed to support level three and four members only. National Respite Care Program cannot be used in conjunction with the Installation Respite Care Program.</p>			

**Reminder:** Prior to your child attending a Child Care Development Center (CDC) for Respite Care; please schedule a "Special Needs Evaluation Review Team" (SNERT) assessment at the CDC, to ensure that your child's accommodations can be met. (Note: Installation Respite Care cannot be used to subsidize full-time childcare.)

Need for Nursing Care? (check one)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Enrolled in Medi-caid Program? (check one) <i>Example: SSI Supplemental Security Income</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
Enrolled at the States Developmental Disability Services? (check one) <i>Example: Dept of Disability &amp; Special Needs</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, indicate number of hours of Respite care approved.	_____ Hours per _____

Signature:	Date: (YYYYMMDD)
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Referred by: (please print or type)		
Agency Name:	Staff Name:	Phone Number:

### Official Use Only

Application Processing:

1. Current EFMP Enrollment Verification	4. Educational Eligibility
2. Medi-caid Eligibility	Copy of signed DD2792-1
3. Hold Harmless Release	5. Copy of Payment Procedures to family

EFMP administrative signature upon request:	Date:
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