

Family Case Worker:print: _____ Signature: _____

Family hourly rate of care: _____

SPONSOR INFORMATION

Sponsor Name/Rank					Email			SS# (last 4)	
Address			City/State		Zip		Phone		

EFM's & SIBLINGS NAMES/AGES/RESPITE CARE LEVEL OF NEED

Name	EFM Y/N	Age	Respite Level		Name	EFM Y/N	Age	Respite Level
Name	EFM Y/N	Age	Respite Level		Name	EFM Y/N	Age	Respite Level
Name	EFM Y/N	Age	Respite Level		Name	EFM Y/N	Age	Respite Level

RESPITE CARE HOURLY LOG (Use one form per care provider)

Date of Care	Military Time In	Military Time Out	Hours in Care	Location of Care (CDC, FCC, Home)	CARE PROVIDED FOR	Total Paid to Provider	Hourly Reimburse	Total Reimburse
TOTAL				TOTAL				

Respite reimbursement funds are U.S. Government funds made available to me as a benefit through the Exceptional Family Member Program. I certify that the above information is true and correct. I understand that providing false information in support of this request may result in ineligibility for future participation in the respite reimbursement program and notification to my command for appropriate action which may include adverse administrative or disciplinary action. .

Provider's Name (Print) _____ Telephone # _____

Military Sponsor/Designee w/POA Name (Print) _____

Provider's Signature _____ Date _____

Military Sponsor/Designee w/POA Signature _____ Date _____

For Official Use	
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Total	

New	
Update	

Provider's Title: _____