



**1a. SERVICE MEMBER'S SPOUSE/LEGAL GUARDIAN CONTACT INFORMATION:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name M.I. Date of Birth  
\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Grade Duty Telephone #: Home Telephone #: Cell #  
\_\_\_\_\_  
Street Name and Number (if different from Service Member)  
\_\_\_\_\_  
City State Zip Code  
Email Address: \_\_\_\_\_

**CHILD CARE PROVIDER INFORMATION:**

Date Care Begins: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider/Program Name: \_\_\_\_\_  
(As is appears on license/registration)

Provider/Program Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code

Provider rate for EFM child: \_\_\_\_\_ per hour; provider rate for EFM child's sibling: \_\_\_\_\_

**(to be completed by the EFMP Respite care partner agency)**

Provider/Program telephone number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Email Address: \_\_\_\_\_

Provider Point of Contact: \_\_\_\_\_

**Second Provider (if needed)**

Date Care Begins: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider/Program Name: \_\_\_\_\_  
(As is appears on license/registration)

Provider/Program Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code

Provider rate for EFM child: \_\_\_\_\_ per hour; provider rate for EFM child's sibling: \_\_\_\_\_

**(to be completed by the EFMP Respite care partner agency)**

Provider/Program telephone number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Email Address: \_\_\_\_\_

Provider Point of Contact: \_\_\_\_\_

**NAMES OF CHILD(REN) TO BE CARED FOR THROUGH EFMP RESPITE CARE PROGRAM**

Name of Child(ren)	Date of Birth	Gender (M/F)	Exceptional Family Member (EFM) status & Category
1.			<input type="checkbox"/> Yes (Category ____ ) <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes (Category ____ ) <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes (Category ____ ) <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes (Category ____ ) <input type="checkbox"/> No
5.			<input type="checkbox"/> Yes (Category ____ ) <input type="checkbox"/> No

**PARENT/LEGAL GUARDIAN CERTIFICATION:** *(Please read carefully; check all boxes, sign and date in designated area)*

**I CERTIFY THAT:**

- I am the parent or legal guardian of the child(ren) listed and I may be required to submit proof of such, in order to receive EFMP Respite Care services.
- All information submitted in this application is true and correct.

**I UNDERSTAND THAT:**

- This information is being given in order to establish eligibility for EFMP Respite Care.
- This information is being given in connection with military funds used to pay for the cost of respite care.
- Military and EFMP Respite Care officials may verify any information on this application at any time they deem necessary.
- Deliberate misrepresentation of this information may result in prosecution under applicable State and Federal laws. See 18 U.S.C/ Section 1001.
- Any misrepresentation or falsification of information that is in any way related to respite care fees, may result in reclaiming any money paid for respite care and may be punishable under criminal law.
- NO** respite care provider/program will be paid who does not meet the qualifications necessary to participate in EFMP Respite Care
- I may use more than one provider/program; however, EFMP Respite Care will not reimburse more than one provider/program for the same period of time, for the same child.
- EFMP Respite Care will only make payments directly to the respite care provider/program, and not to me.
- I have read all of the above and understand its content. I also understand that non-compliance with any of the above may result in termination of my participation in EFMP Respite Care and that I may be required to re-pay any money paid on my behalf.*

**PARENT/LEGAL GUARDIAN RESPONSIBILITIES AND CERTIFICATION:**

I [parent or legal guardian] understand/agree *(Please check all boxes):*

- That EFMP Respite Care for which I am eligible is based on my eligibility for the Navy Exceptional Family Member Program (EFMP), the provider/program’s location, and the type of respite care I select; if there are any changes to my situation, **I must make EFMP Respite Care team aware of those changes.**
- To authorize attendance records on a timely basis, to ensure the provider/program may receive timely reimbursement.
- To submit proof of my continued eligibility for this program when requested.
- To notify **EFMP Respite Care team** at least fifteen (15) calendar days before ending respite care services. In cases of emergency please notify **EFMP Respite Care team** immediately (1-800-424-2246).
- That the provider/program indicated on this form must meet all requirements to provide EFMP Respite Care, and that no payments will begin before the provider/program has been determined qualified.
- I have read all of the above and understand its content. I also understand that non-compliance with any of the above may result in termination with EFMP Respite Care.*

\_\_\_\_\_  
Parent/Legal Guardian (please print)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date