EFMP RESPITE CARE REIMBURSEMENT FORM

Sponsor's Name: _____

Mailing Address: _____

_____

FOR OFFICE USE ONLY

CW Verifying eligibility/level_____

NACCRRA_____

DATE OF CARE	EFM/SIBLINGS	AGE	RESPITE LEVEL	COST/HR	*TOTAL HRS	*TOTAL COST
*Please **include receipts** for all care being submitted for reimbursement. If you have any questions or concerns please contact the EFMP Admin. Assistant at 910-451-4394.*				**TOTAL:**		

PROVIDER:	***Name** (Last, first, MI)*	***Phone number:***
	***Address** (include Zip Code)*	

***I understand that by signing this form I attest that the information provided is true, and that any false information submitted could result in future suspended respite care services. Reimbursements will not be processed without the original provider's signature**(no photocopies).*

SIGNATURE:	***Sponsor:***	***Date:***
	Provider:	***Date:***

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I certify that 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 Program Manager's Signature_____.

Amount: _____. Date: _____.