



MCB CAMP LEJEUNE EFMP RESPITE PROGRAM REIMBURSEMENT FORM

REMINDER: Child care reimbursement is only authorized for up to 40 hours per calendar month and not to exceed 6 hours daily per family. USMC EFMP retains the right to verify the information and provision of respite care services. There is legal recourse for fraudulent reporting per MCO 1754.4B. Respite care is intended to reduce stress on families by providing temporary rest periods for family members who care for those with special needs.

DIRECTIONS: PLEASE FILL OUT ONLY WHITE AREAS

Sponsor's Name:		SSN (Last 4):
Contact Phone #	Is this (cell) (home) (work)	
Mailing Address:		

Family Member's Name To Include Spouse:	Date of Birth	Age	Respite Level	Is family member the EFM?	Rate: (cost per hour)
				Y N	
				Y N	
				Y N	
				Y N	
				Y N	
				NTE:	

Please list **dates** and **hours** and **ages of children** service was provided for the **month of:** _____

Date	Hours	Ages of children receiving care	Date	Hours	Ages of children receiving care

Total hours for the month (not to exceed 40):	
RATE _____ times HOURS _____ equals REIMBURSEMENT AMOUNT: _____	Total:
RATE _____ times HOURS _____ equals REIMBURSEMENT AMOUNT: _____	

PROVIDER NAME:	PHONE:
PROVIDER ADDRESS:	
<i>I CERTIFY that I received \$ _____ for the care provided as stated above.</i>	
<i>I CERTIFY THE ABOVE CARE WAS PROVIDED AS STATED.</i>	
PROVIDER SIGNATURE:	DATE:
<i>I CERTIFY THAT THE ABOVE CARE WAS USED FOR RESPITE PURPOSES ONLY AND NOT AS A SUBSIDY FOR LONG TERM CHILD CARE.</i>	
<i>I CERTIFY THAT MY EFMP ENROLLMENT IS CURRENT AND MY NEXT UPDATE IS DUE : _____.</i>	
SPONSOR SIGNATURE:	DATE:

VERIFICATION OF ELIGIBILITY

I certify that the children listed above are authorized to receive EFMP Respite Care and the amount due to the sponsor is correct.

GL Account Number	6100-01-6720
AP Voucher Number	

Tracey Sosa
Program Manager