Record of Care Provider

Name of provider and / or agency: Relationship to Sponsor:

Phone Number: _____

Address: _____

_____

And has the following specialized training: (LON 3 Must Complete) _____

_____

_____

And has the following certifications: (LON 4 Must Complete) _____

_____

_____

And has the following license: _____

_____

IF PROVIDING CARE FOR LON 3 OR 4, I CERTIFY PROVIDER IS OVER 18 YEARS OLD.

_____ _____

Provider Signature and Date Sponsor Signature and Date

_____ _____

Provider Printed Name Sponsor Printed Name

** A copy of the training certificates and / or licenses must be attached to this form **

and must be submitted BEFORE respite can be reimbursed.

Initials of EFMP staff member who received & verified info: _____ Date: _____

LON of EFM is: _____ Update Due Date: _____