Exceptional Family Member Program (EFMP)
Respite Care Reimbursement Log

In accordance with the Privacy Act of 1974, as amended, this notice informs you of the purpose for collection of information on this form. Please read it before completing the form. Authority: 10 U.S.C. 5013; 10 U.S.C. 5041; MCO 1754.4B, Exceptional Family Member Program (EFMP). **Principal Purpose:** To manage the EFMP Respite Care Reimbursement Program. Collected information will be filed pursuant to the Privacy Act System of Records Notice M01754-6 Exceptional Family Member Program Records, which may be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/usmc/M01754-6.html. **Retention and Safeguards:** Paper and electronic records are restricted to authorized personnel with an official need-to-know. Electronic data is maintained in a password restricted case management system and encrypted while at rest and during transmission. **Routine Uses:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, these records may specifically be disclosed outside the DoD as a routine use pursuant to the DoD Blanket Routine Uses that appear at http://privacy.defense.gov/notices/blanket_uses.shtml. **Disclosure:** Providing information on this form is voluntary, but failure to provide the information will result ineligibility for respite care reimbursement program benefits.

Sponsor's Full Name: _____ **Rank:** _____

Case #: _____ **Preferred Phone:** _____

INSTRUCTIONS:

1. Always record hours in MILITARY TIME. 2. Enter times in 15 minute increments (e.g. 1300-1415). 3. Use one form per care provide

DATE(S) of Care	Location of Care (F) Family Home (P) Provider's Home (O) Other (Approved)	HOURS of Care From	To	Children Present During Care (Eligible EFM(s) Only)	AGE	Level of Need	*No. of Hours Used (cannot exceed 6 hrs)	Hourly Rate	Total
If other for location of care, please describe:						**Total:**			

I CERTIFY that I am 18 years of age or older, and provided respite care services to the above named EFM(s) on the dates and times listed. I understand that I may be contacted by USMC EFMP personnel to verify provision of care.

Provider Signature: _____ **Date:** _____

Provider Name (print): _____ **Phone number:** _____

I CERTIFY I have paid the total amount listed above to the above named provider(s) for respite services. I understand the USMC EFMP retains the right to verify provision of EFMP Respite Care Reimbursement Program, and that suspected fraudulent use will be reported for investigation.

_____ _____

SPONSOR/AGENT AUTHORIZED TO ACT PURSUANT TO POWER OF ATTORNEY SIGNATURE **DATE**

Non-sponsor signature is authorized only when a copy of a valid Power of Attorney is on file

****OFFICE USE ONLY****			
Date Log was Received: _____ **Respite Level:** _____	**Are all EFM's Enrollments current:**	**YES**	**NO**
I have reviewed and verified the eligibility for respite care reimbursement, the rate per hour, and total reimbursement amount is accurate.			
EFMP Staff Signature:	**Date:**		
EFMP Program Manager Signature:	**Date:**		
Total Amount Due to Sponsor:			