Navy EFMP Respite Care Attendance Sheet

MONTH OF CARE:_____ **YEAR OF CARE:** _____

_____ _____

FAMILY ID # **SPONSOR'S* FULL NAME**

_____ _____

PROVIDER ID # **PROVIDER'S FULL NAME**

CHILD INFORMATION**

1) _____ |_____ 2) _____ |_____
Child's Name age Child's Name age

3) _____ |_____ 4) _____ |_____
Child's Name age Child's Name age

5)_____ |_____ 6) _____ |_____
Child's Name age Child's Name age

EFMs are cared for up to age 19 (19th birthday). Siblings are cared for up to age 13 (13th birthday).

Parent/Legal Guardian and provider must sign to authorize payment. Incomplete attendance sheets will be returned. All attendance sheets must be received within 60 days of the month care occurred.

X _____ _____
Provider Signature Date

I certify that the provider information and attendance record entered on this voucher are true and accurate. I understand that my payment will be based on this completed voucher once received by Child Care Aware® of America staff. I further understand that any misrepresentation of information may result in legal action.

X_____ _____
Parent /Legal Guardian Signature Date

I certify that the parent or legal guardian information and the attendance record entered on this voucher are true and accurate. I understand that payment to the provider will be based on this completed voucher once received by the Child Care Aware® of America staff. I further understand that any misrepresentation of information may result in legal action.

X_____ _____
Agency Verification Date

Name of the Service Member
****Child's Name MUST be full legal first name***

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_____ _____

FAMILY ID # **SPONSOR'S* FULL NAME**

_____ _____

PROVIDER ID # **PROVIDER'S FULL NAME**

Indicate the # of hours of care provided for each child, on the day of the month care was provided.

Fill in the number of hours each day care was provided, total hours for each child																
Child's Name	**EFM Status**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**

Fill in the number of hours each day care was provided, total hours for each child																	Total hours per child this month
Child's Name	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	
																	= 0.00
																	= 0.00
																	= 0.00
																	= 0.00
																	= 0.00
																	= 0.00

THE PROGRAM WILL PAY FOR ONLY 40 HOURS PER MONTH
THE MAXIMUM COMBINED FAMILY RATE IS $45 PER HOUR

Parent: I verify that I received _____ hours of respite care (highest # of hours any 1 child received from "Total hours per child this month" column) on _____ days.

_____ / _____
Parent initials Date

If the one-way trips to this family are 24 miles or under, there is no monthly travel reimbursement.
If the one-way trips to this family are 25+ miles, each round trip is $25.

Monthly Travel Reimbursement		
Agency Verified # of miles each way	**# of round trips**	**Total mileage reimbursement** (25+ miles = $25 per round trip)