Exceptional Family Member Program – Respite Care: FAMILY ENROLLMENT

Family Name: ____ Enrollment Date: ____________________

Primary Site: ____

Service Branch: ☐ Navy ☐ Marine Corp ☐ Other

Contact Information

Street Address: ____

City: ______________________________, State: __________________ Zip: _______________

Home Phone: (_____)________________ Work: (____)_____________ Cell: (___)_________

E-mail: ____________________________

Children

List the names of all children in the family eligible to receive care, their date of birth and if they are an EFM child.

Name	Date of Birth	EFM Child?
1.		☐ Yes ☐ No
2.		☐ Yes ☐ No
3.		☐ Yes ☐ No
4.		☐ Yes ☐ No
5.		☐ Yes ☐ No
6.		☐ Yes ☐ No
7.		☐ Yes ☐ No

KT ID: ____________________________