Navy EFMP Respite Care Attendance Sheet

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

_____ _____

FAMILY ID # **SPONSOR NAME**

_____ _____

PROVIDER ID # **PROVIDER'S NAME**

CHILD INFORMATION

1) _____ Child's Name	_____ age	□ IV □ V □ n/a EFM Category	_____ Provider rate for this child
2) _____ Child's Name	_____ age	□ IV □ V □ n/a EFM Category	_____ Provider rate for this child
3) _____ Child's Name	_____ age	□ IV □ V □ n/a EFM Category	_____ Provider rate for this child
4) _____ Child's Name	_____ age	□ IV □ V □ n/a EFM Category	_____ Provider rate for this child
5) _____ Child's Name	_____ age	□ IV □ V □ n/a EFM Category	_____ Provider rate for this child
6) _____ Child's Name	_____ age	□ IV □ V □ n/a EFM Category	_____ Provider rate for this child

THE MAXIMUM COMBINED FAMILY RATE IS $45 PER HOUR

Service member/spouse/legal guardian and provider must sign below each month for payment to be issued. Incomplete attendance sheets will be returned.

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 NACCRRA staff. I further understand that any misrepresentation of information may result in legal action.

X_____ _____

Sponsor /Legal Guardian Signature Date

I certify that the Sponsor 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 subsidy department. I further understand that any misrepresentation of information may result in legal action.

X_____ _____

Agency Verification Date

Version 6 (10/1/2014)
Supersedes previous versions

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_____ _____

FAMILY ID # **SPONSOR NAME**

_____ _____

PROVIDER ID # **PROVIDER'S NAME**

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

	Attendance: 1st – 30/31st of the Month (fill in the # of hours each day care was provided)															
Child's Name	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
1)																
2)																
3)																
4)																
5)																
6)																
Child's Name	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
1)																
2)																
3)																
4)																
5)																
6)																

THE PROGRAM WILL PAY FOR ONLY 40 HOURS PER MONTH

Parent: I verify that I received _____* hours of respite care on _____ days.

_____ / _____ (*the highest # of hours any 1 child received)
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)
		$