



**U. S. AIR FORCE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)
RESPIRE CARE FOR ACTIVE DUTY AIRMEN
PARENT ELIGIBILITY APPLICATION**

To complete an online application go to: <https://fap.americasteamforchildcare.org>
or fax to 571-255-4881 or email to AFEFMPrespite@naccrra.org

Active Component Air Force stationed at one of the following Air Force Bases (AFB) or Joint Bases (JB):
Please check one.

State	Air Force Bases	State	Air Force Bases
Alaska	<input type="checkbox"/> JB Elmendorf-Richardson	Nebraska	<input type="checkbox"/> Offutt AFB
Arizona	<input type="checkbox"/> Davis-Monthan AFB	Nevada	<input type="checkbox"/> Creech AFB <input type="checkbox"/> Nellis AFB
California	<input type="checkbox"/> Travis AFB	North Dakota	<input type="checkbox"/> Minot AFB
Colorado	<input type="checkbox"/> AF Academy <input type="checkbox"/> Peterson AFB <input type="checkbox"/> Schriever AFB	Ohio	<input type="checkbox"/> Wright-Patterson AFB
Florida	<input type="checkbox"/> Hurlburt Field <input type="checkbox"/> Eglin AFB	Oklahoma	<input type="checkbox"/> Tinker AFB
Georgia	<input type="checkbox"/> Warner-Robins AFB <input type="checkbox"/> Moody AFB	South Carolina	<input type="checkbox"/> Charleston AFB <input type="checkbox"/> Shaw AFB
Hawaii	<input type="checkbox"/> JB Pearl Harbor-Hickam	Texas	<input type="checkbox"/> JB San Antonio
Missouri	<input type="checkbox"/> Scott FAB	Virginia	<input type="checkbox"/> JB Langley-Eustis
National Capital Region	<input type="checkbox"/> JB Andrews <input type="checkbox"/> JB Anacostia-Bolling <input type="checkbox"/> Fort Meade <input type="checkbox"/> Pentagon	Washington	<input type="checkbox"/> JB Lewis-McChord <input type="checkbox"/> Fairchild AFB

TYPE OF APPLICATION (CHECK ONE):

- ☐ Initial Application
- ☐ Change of information, eligibility criteria, status, etc.

SECTION A. HOUSEHOLD INFORMATION

1. AIRMAN'S CONTACT INFORMATION: NOTE: EFM CHILD AND SIBLINGS MUST RESIDE WITH AIRMAN

_____-_____-_____/_____/_____
Last Name First Name M.I. Social Security # Date of Birth

_____(____)-_____(____)-_____(____)-_____
Rank Duty Telephone # Home Telephone # Cell #

AIRMAN'S CONTACT INFORMATION, CONTINUED:

Mailing Address		

City	State	Zip Code
Military Email Address: _____@_____		
Home Email Address: _____@_____		

1a. AIRMAN'S SPOUSE/LEGAL GUARDIAN CONTACT INFORMATION:

_____	_____	_____	_____/_____/_____
Last Name	First Name	M.I.	Date of Birth
_____ (_____) _____ - _____	_____ (_____) _____ - _____	_____ (_____) _____ - _____	
Rank	Duty Telephone #:	Home Telephone #:	Cell #

Street Name and Number (if different from Service Member)			

City	State	Zip Code	
Home Email Address: _____@_____			

CHILD CARE PROVIDER INFORMATION: Date Care Begins: ____/____/____ Date Care Ended: ____/____/____

Provider/Program Name: _____ (As it appears on license/registration)			
Provider/Program Mailing Address: _____			

City	State	Zip Code	
Provider rates: 1st EFM child: _____ 2nd EFM child: _____ 3rd EFM child: _____ 4th EFM child: _____			
Sibling rate: _____			
Provider/Program telephone number: (_____) _____ - _____ Email Address: _____			
Provider Point of Contact: _____			

Second Provider (if needed)

Date Care Begins: ____/____/____

Date Care Ended: ____/____/____

Provider/Program Name: _____
(As it appears on license/registration)

Provider/Program Mailing Address: _____

City _____ State _____ Zip Code _____

Provider rates: 1st EFM child: _____ 2nd EFM child: _____ 3rd EFM child: _____ 4th EFM child: _____

Sibling rate: _____

Provider/Program telephone number: (_____) _____ - _____ Email Address: _____

Provider Point of Contact: _____

CHILDREN'S INFORMATION:

Name of Child(ren)	Date of Birth (mm/dd/yr)	Gender (M/F)	Exceptional Family Member Severity of Diagnosis	For Agency Use Only - Confirm Family Priority*
1.			<input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sibling	
2.			<input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sibling	
3.			<input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sibling	
4.			<input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sibling	
5.			<input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sibling	
6.			<input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sibling	

*Priority 1 - EFM is diagnosed with severe special needs with deployed or Wounded Airman.
Priority 2 - EFM is diagnosed with moderate special needs with deployed or Wounded Airman.
Priority 3 - EFM is diagnosed with severe special needs.
Priority 4 - EFM is diagnosed with moderate special needs.

PARENT/LEGAL GUARDIAN CERTIFICATION: (Please read carefully; check all boxes, sign and date in designated area)

I CERTIFY THAT:

- ☐ I am the parent or legal guardian of the child(ren) listed and I may be required to submit proof of such, in order to receive EFMP Respite Care.
- ☐ All information submitted in this application is true and correct.

I UNDERSTAND THAT:

- ☐ This information is being given in order to establish eligibility for the EFMP Respite Care program.
- ☐ This information is being given in connection with military funds used to pay for the cost of respite care.
- ☐ Military and NACCRRRA officials may verify any information on this application at any time they deem necessary.
- ☐ Deliberate misrepresentation of this information may result in prosecution under applicable State and Federal laws. See 18 U.S.C/ Section 1001.
- ☐ Any misrepresentation or falsification of information that is in any way related to respite care fees, may result in reclaiming any money paid for respite care and may be punishable under criminal law.
- ☐ NACCRRRA will not reimburse any respite care provider/program that does not meet the qualifications necessary to participate in EFMP Respite Care.

- ☐ I may use more than one provider/program; however, NACCRRRA will not reimburse more than one provider/program for the same period of time, for the same child.
 - ☐ NACCRRRA MILITARY PROGRAMS will only make payments directly to the respite care provider/program, and not to me.
 - ☐ *I have read all of the above and understand its content. I also understand that non-compliance with any of the above may result in termination of my participation in the NACCRRRA MILITARY PROGRAMS and that I may be required to re-pay any money paid on my behalf.*
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PARENT/LEGAL GUARDIAN RESPONSIBILITIES AND CERTIFICATION:

I [parent or legal guardian] understand/agree (*Please check all boxes*):

- ☐ That EFMP Respite Care for which I am eligible is based on my eligibility for the Air Force Exceptional Family Member Program (EFMP), the provider/program's location, and the type of child care I select; if there are any changes to my situation, **I must make NACCRRRA MILITARY PROGRAMS aware of those changes.**
- ☐ To authorize attendance records on a timely basis, to ensure the provider/program may receive timely reimbursement.
- ☐ To submit proof of my continued eligibility for this program when requested.
- ☐ To notify NACCRRRA at least fifteen (15) calendar days before ending respite services. In cases of emergency please notify NACCRRRA immediately (1-800-793-0324).
- ☐ That the provider/program indicated on this form must meet all requirements to provide respite care, and that NACCRRRA is under no obligation to begin reimbursements before the provider/program has been determined qualified.
- ☐ *I have read all of the above and understand its content. I also understand that non-compliance with any of the above may result in termination with the EFMP respite care program.*

Parent/Legal Guardian (please print)

Parent/Legal Guardian Signature

Date