Navy EFMP Respite Care Attendance Sheet

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

_____ _____

FAMILY ID # **SPONSOR NAME**

_____ _____

PROVIDER ID # **PROVIDER'S NAME**

CHILD INFORMATION

1) _____ |_____ | □ IV □ V □ n/a |_____
Child's Name age EFM Category Provider rate for this child

2) _____ |_____ | □ IV □ V □ n/a |_____
Child's Name age EFM Category Provider rate for this child

3) _____ |_____ | □ IV □ V □ n/a |_____
Child's Name age EFM Category Provider rate for this child

4) _____ |_____ | □ IV □ V □ n/a |_____
Child's Name age EFM Category Provider rate for this child

5) _____ |_____ | □ IV □ V □ n/a |_____
Child's Name age 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 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_____ _____
CCR&R Verification Date

Version 5 (2/17/2011) Revised version by KShelby for San Diego ~ permission granted by BStorm 2/22/2011
Supersedes previous versions (only for San Diego EFM Respite)

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

_____ _____

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)																
Child's Name	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
1)																
2)																
3)																
4)																
5)																

THE PROGRAM WILL PAY FOR ONLY 40 HOURS PER MONTH

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

_____ / _____
Parent initials Date

Monthly Travel Reimbursement			
# of one-way trips	**Verified # of miles each way**	**Total Mileage (# of trips * # of miles)**	**Total mileage reimbursement** (see calculation method below)*

***Calculation per one way trip**

If the one way trips to this family are 10 miles or under, there is no monthly travel reimbursement.
One way trips of 11-24 miles are reimbursed @.51 per mile
One way trips of 25+ miles are reimbursed @ .51 per mile, capped at $12.50 one way/$25 round trip.

Example 1: Mary travels 12 miles one way to the Jones home. She works 10 days in January. 20 one way trips x 12 miles = 240 miles x .51 = $122.40 mileage reimbursement.

Example 2: Tim travels 30 miles one way to the Tran home. Mileage is capped at 25 miles. He works 5 days in March. 10 one way trips x $12.50 one way cap = $125

Example 3: Ann travels 8 miles one way to the Santos home. Mileage is 0-10 miles, therefore not claimed or reimbursed.

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