UNITED STATES MARINE CORPS EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) RESPITE CARE REIMBURSEMENT LOG

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, U.S. Marine Corps; MCO 1754.4, Exceptional Family Member Program, E.O. 9397 (SSN), as amended, and SORN M01754-6.

PURPOSE: To manage the EFMP Respite Care Reimbursement Program. Information will be used to evaluate eligibility and reimburse families for authorized respite care.

ROUTINE USES: Information will be accessed by EFMP personnel with a need to know in order to meet the purpose. Information may be disclosed to individuals or organizations authorized to provide services to the individual patron. A complete list and explanation of the available routine uses is published in the authorizing SORN available at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570631/m01754-6/.

DISCLOSURE: Providing information on this form is voluntary, but failure to provide the information will result in ineligibility for respite care reimbursement program benefits.

RECORD MANAGEMENT: This form shall be managed in accordance with record schedule 1000-39, “Family Support Programs (Temporary)” of SECNAV M-5210.1.

Sponsor is required to complete blocks 1 through 7 prior to provider certification.

1. Sponsor Name:	2. Rank:	3. Preferred Telephone:
4. EFM Name:	5. Case ID#:	6. LoN:

7. Instructions: a. Always record hours in military time. b. Enter times in 15 minute increments (e.g., 1300-1415). c. Use one form per care provider

Date(s) of Care	Location of Care (F) Family Home (P) Provider's Home (O) Other (Approved)	Hours of Care		Children Present During Care (Eligible EFM(s) Only)	Age	Number of Hours Used (cannot exceed 6 hrs)	Hourly Rate	Total
		From	To					
If other for location of care, please describe:					Total:		Total Payment:	

8. I CERTIFY that I am 18 years of age or older and provided respite care services to the above named EFM(s) on the dates and times listed. I understand that I may be contacted by USMC EFMP personnel to verify provision of care.

Provider Signature:	Date:
Provider Name (print):	Phone Number:

9. I CERTIFY I have paid the total amount listed above to the above named provider(s) for respite services. I understand the USMC EFMP retains the right to verify provision of EFMP Respite Care Reimbursement Program, and that suspected fraudulent use will be reported for investigation.

Signature of Sponsor/Agent authorized to act pursuant to Power of Attorney: Date:

Non-sponsor signature is authorized only when a copy of a valid Power of Attorney is on file

*****OFFICE USE ONLY*****

Date Log was Received:	Are all EFM's Enrollments current: ☐ Yes ☐ No	Total Amount Due to Sponsor:

I have reviewed and verified the eligibility for respite care reimbursement, LoN, rate per hour, and total reimbursement amount is accurate.

EFMP Staff Signature:	Date:
EFMP Program Manager Signature:	Date:

Administrative Comments: