



**Exceptional Family Member Program
Installation Reimbursement Respite Care Program-Request Application
MCO 1754.4B**

Name:		Rank:	SSN:	EAS:
		Home E-Mail address		
Unit Address:		Unit Telephone:		
		Home Telephone:		
Home Address:		Alternate Telephone:		
Number of Dependents:		EFM Name/Age/Respite Level		
Children:		1. _____		
Spouse:		2. _____		
Parents:		3. _____		
Total Number of EFMs enrolled:		4. _____		
EFMP Eligibility for Enrollment Date: (DD/MM/YEAR)		5. _____		
		USMC	NAVY	OTHER
"I undersigned, understand the intended purpose of respite care support and that these funds are not intended for related childcare expenses. I also understand that requesting use of respite funds for other than the intended purpose constitutes fraud and may result, at a minimum, in ineligibility for future use of respite care funds up to prosecution"				

Need for Skilled Nursing Care? (check one)	
Enrolled in Medi-Caid Program? (check one)	
Enrolled in the state's Developmental Disability Services? (check one)	
If yes, indicate number of hours of Respite care approved.	_____ Hours per _____

Signature:		Date: (DD/MM/YEAR)
Agency Name:	Staff Name:	Phone Number:

***** Official Use Only*****

1. Current EFMP Enrollment Verification		5. Hold Harmless Agreement	
2. Medicaid Eligibility		6. EFT Account Election Form	
3. Copy of DD Form 2792/2792-1		7. Provider Timesheet	
4. Respite Provider Care Level		8. Form 1164 for Reimbursement	

EFMP administrative signature upon request:	Date:
---	-------