



EFMP RESPITE CARE REIMBURSEMENT FORM

Payee/Sponsor Name _____ SSN _____

Child(ren) Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Dates and Hours of EFMP Respite Care provided:

FOR EFMP OFFICE USE ONLY

| Date of Care | Total Number of Hours | Hourly Fee Amount | DCP Amount \$\$ | # Hours | DCP PERIOD TOTAL |
|--------------|-----------------------|-----------------------------------|---------------------------|---------|------------------|
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| | | | | | |
| Comments: | | LIST WEEKLY CLAIMS ON ONE INVOICE | TOTAL CLAIM AMOUNT | | |
| | | | \$ _____ | | |

I attest that the information provided on this form is correct to the best of my knowledge.

Payee/Sponsor Signature _____ Date _____

Please enclose receipts for care described above and fax or mail the completed form to the EFMP office at (703) 614-7209. Should you have any questions, please contact: EFMP Manager at (703) 614-7200/01.

| | |
|--|-------------|
| FOR EFMP USE ONLY | |
| I certify that the amount of reimbursement due to the Sponsor is correct. | |
| EFMP Manager's Signature _____ | |
| Amount: _____ | Date: _____ |