EFMP Respite Care Reimbursement Receipt

Sponsor:

Name (last, first, middle initial)	
Social Security Number	xxx-xx-____________
Home Mailing address of where to mail reimbursement check	
Phone Number	

Provider:

Name (last, first, middle initial)	
Social Security Number	xxx-xx-_____________
Address where care is taking place	
Respite Provider phone number	

Time Sheet:

Date	Time In	Time Out	Total Hrs	EFM Name & Names of all children cared for	Cost/Hr	Total Cost
					Total:	

Signatures:

I, the undersigned, understand the intended purpose of respite care support and that these funds are not intended for work-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, ineligibility for future use of respite care funds up to prosecution. USMC EFMP retains the right to verify the provision of EFMP respite care claims.

Sponsor Signature: ____Date: ____________________

Provider Signature: ____Date: ____________________

Is this a new provider? ______Yes ______No

Please fax or mail the completed form to the EFMP office at (703) 614-7209 or mail the completed forms to Marine Corps Community Services, H&S Bn, HQMC Henderson Hall, ATTN: EFMP Office, 1555 Southgate Road Arlington, VA 22214. Please contact the EFMP Manager at (703) 693-6368 if you have any questions.

FOR EFMP OFFICE USE ONLY

I certify that the amount of reimbursement due to the Sponsor is correct.

EFMP Manager's Signature: ________________________________ Amount:_________________ Date: ______________