Navy EFM Respite Care Attendance Sheet

MONTH OF CARE: Select Month

YEAR OF CARE: Select Year

Family ID #:

Sponsor Name:

Provider ID #:

Provider Name:

Indicate below the day of the month care occurred and number of hours provided that day for each child. Once all care is recorded for the month, draw a line through the next blank day column or indicate n/a. List each child's full legal name. CCAoA will reimburse the independent contractor for no more than 40 hours per month per family. A qualifying EFM child must be in care at all times.

	CHILD'S FIRST/LAST NAME	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Sub-Total # of Hours in Care
1												0
2												0
3												0
4												0
5												0
6												0
7												0
	Daily Care Total	0	0	0	0	0	0	0	0	0	0	0

	CHILD'S FIRST/LAST NAME	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Day n/a	Total # of Hours in Care
1												0
2												0
3												0
4												0
5												0
6												0
7												0
	Daily Care Total	0	0	0	0	0	0	0	0	0	0	0

Parent: I verify that I received 0 total hours of respite care on ____ days.

X Provider Signature

Date (MMDDYYYY)

I, the independent contractor, 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 complete voucher once received by Child Care Aware® of America staff. I further understand that any misrepresentation of information may result in legal action.

X Sponsor/Legal Guardian Signature

Date (MMDDYYYY)

I certify that the parent or legal guardian information and 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 Child Care Aware ® of America staff. I further understand that any misrepresentation of information may result in legal action.

X Agency Quality Assurance Confirmed

Date (MMDDYYYY)

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