Navy EFM Respite Care Attendance Sheet

MONTH OF CARE: _____ YEAR OF CARE: _____

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	Day	Day	Day	Day	Day	Day	Day	Day	Day	Sub-Total # of Hours in Care
1												
2												
3												
4												
5												
6												
7												
	Daily Care Total											

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

Parent: I verify that I received _____ 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)