



EFMP 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 eligible 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 the family's authorized hours per month per family.

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)