



EFMP Respite Care Attendance Sheet

Submit to: EFMattendance@usa.childcareaware.org

LOCATION:

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	Sub-Total # of Hours in Care
		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
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

	CHILD'S FIRST/LAST NAME	Day	Day	Day	Day	Day	Day	Day	Day	Day	Total # of Hours in Care
		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
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

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

☒ 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.

☒ 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.

☒ Quality Assurance Confirmation
Date (MMDDYYYY)