



**Exceptional Family Member Program
Respite Care Program
Application Request
MCAGCC Twentynine Palms**

Please Print or Type:

Name:		Rank:	SSN: (last four)
EAS:		DCTB:	
Unit Address:		Unit Telephone:	
Home Address:		Home Telephone:	
		Alternate Phone:	
Number of Children/Dependants:		Number of EFMP family members:	
Name(s) and Age(s):			
EFMP Enrollment Date: (YYYYMMDD)		<input type="checkbox"/> USMC <input type="checkbox"/> NAVY <input type="checkbox"/> OTHER	
Total Number of Hours Requested: _____ (40 hours a month is maximum)			

State reason/circumstances for request (How deployment cycles impact your need for this care):



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(cont.)

Need for Nursing Level care: (check one)	YES		NO	
Enrolled in Medi-Cal program? (check one) <i>Examples: SSI – Supplemental Security Income and IHSS – In Home Support Services</i>	YES		NO	
Enrolled at Regional Center? (check one)	YES		NO	
If yes, indicate number of hours of Respite care approved.	_____ Hours per _____			

*Please note that the intent of the Marine & Family Services EFMP Respite Program is to provide respite hours to families that are impacted by deployment cycles.

I certify that my family does not receive any respite care or pediatric health day care from any agency beyond what has been documented in this application.

Signature:	Date: (YYYYMMDD)
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Referred by: (please print or type)

Agency Name:	Staff Name:	Phone Number:
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Official Use Only

Application Processing:

1. Current EFMP Enrollment verification	
2. Medical Eligibility	
Copy of Respite Care Medical Review	
3. Educational Eligibility	
Copy of signed DD2792-1	
4. Copy of Payment Procedures to family	

EFMP administrative signature upon receipt:	Date:
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EFMP Respite Care Program

Step 1:

The Family completes the Application Request pages 1 and 2 with the Service Member's information. The number of dependants is the total number of children in the household along with their names and ages. At the bottom of page 1 write a brief summary of why respite is beneficial to your family.

Step 2:

The Family then returns the Application Request to the Exceptional Family Member Program Office for verification of enrollment. A valid home email address is to be submitted at this time. It is very important to maintain a valid home email address, and if you need to change addresses please contact the Exceptional Family Member Program Office at (760)830-7740.

Step 3:

Family needs to fill out an 1199(Direct Deposit Form.) Turn the 1199 in along with a voided check to the EFMP Office. All EFMP families enrolled in respite must sign up for direct deposit.

Step 4:

The Family then finds their own respite provider/caregiver. A list of respite providers will be available at the EFMP Office in the Village Center Bldg 1551.

- The Family tracks all hours on Monthly Respite Log (reimbursed for up to 40 hours per month)
- Complete Monthly Respite Voucher and return along with the monthly log to the EFMP Office by hand carrying, email, or fax. If you email the form please remember to sign all necessary fields.
- The current month's Respite Vouchers and Logs will be available online.
- Please check the EFMP website to see when Respite information is due.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A)** Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C)** Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F)** Type of payment is printed to the left of the amount.

United States Treasury		15-51 000	Check No. 0000 415785
	Month Day Year 08 31 84	AUSTIN, TEXAS	
	00	28 28	
Pay to the order of			DOLLARS CTS \$****100 00
			NOT NEGOTIABLE
:00000518: 041571926*			

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.