Exceptional Family Member Program
Respite Child Care
Verification Statement

I am an Active Duty Airman or Activated Guard or Reserve Member who has a family member with special needs. I understand EFMP respite child care is based on the severity of the disability. I understand I am required to be enrolled in the Air Force Exceptional Family Member Program and provide verification of disability category. I am aware there will be no fee charged to me for this service <u>until further notice.</u>

EFMP CHILD'S NAME: _____ BIRTHDATE: _____
(MM/DD/YYYY)

SPONSOR'S NAME: _____ RANK: _____

STATUS: AD (requires Q-code verification) Guard/Reserve (requires a copy of Active Duty Orders)

INSTALLATION: _____UNIT: _____

PARENT'S EMAIL/TELEPHONE NUMBERS

PRIMARY EMAIL: _____SECONDARY EMAIL:_____

WORK: _____ HOME: _____ CELL: _____

PARENT SIGNATURE **DATE** **PRINT NAME**

The verification below must be filled out and signed by a <u>licensed medical provider</u> familiar with the family member for which respite care is being requested.

☐ Intellectual Disability ☐ Hearing impairment ☐ Vision impairment

☐ Deaf/blindness ☐ Speech-language impairment ☐ Emotional Disturbance

☐ Autism Spectrum Disorders ☐ Traumatic Brain Injury ☐ Orthopedic Impairments

☐ Specific Learning Disabilities ☐ Developmental Delays

☐ Multiple Disabilities ☐ Other Health Impairments, specify:_____

SEVERITY OF SPECIAL NEED: *(select only one)* ☐ SEVERE ☐ MODERATE ☐ MILD

MEDICAL PROVIDER'S SIGNATURE **DATE**

_____

PRINTED NAME AND TITLE OR OFFICIAL STAMP