**Exceptional Family Member Program (EFMP)**
H&S BN, HQMC, Henderson Hall
1555 Southgate Rd. Bldg 12, Arlington, VA 22214-5000

Henderson Hall Exceptional Family Member Program

# RESPITE CARE REIMBURSEMENT PROGRAM

This packet contains information and forms needed to participate in the **Respite Care Reimbursement Program**.

- Enrollment Guidelines
- Privacy Act Statement
- Verification of Eligibility - NAVMC 1750/1 (Rev. 6-2021) (EF)
- Statement of Understanding – NAVMC 1750/2 (Rev. 6-2021) (EF)
- ACH Application Form (Direct Deposit)
- Hold Harmless Agreement
- Respite Care Reimbursement Log – NAVMC1750/3 (Rev. 6-2021) (EF)
- Reimbursement Rates (for your reference)
- 2021 & 2022 Respite Care Reimbursement Log Due Dates

Submit forms via:

* Email - efmphh@usmc-mccs.org (please encrypt emails to help protect your PII)
* Mail - EFMP, H&S BN, HQMC Henderson Hall, P.O. Box 4009, Arlington, VA 22204-0009
* Deliver - EFMP Office at Henderson Hall, Building 12.

For questions related to the Respite Care Reimbursement Program, please contact Henderson Hall EFMP at 703-693-6510.

Thank You

**Exceptional Family Member Program (EFMP)**
H&S BN, HQMC, Henderson Hall
1555 Southgate Rd. Bldg 12, Arlington, VA 22214-5000

# Henderson Hall EFMP Respite Care Reimbursement Program Enrollment Guidelines

Respite Care Reimbursement Program (usmc-mccs.org)

The Marine Corps recognizes that as an exceptional family, you may experience extra hardships in daily life–travelling to frequent therapy or doctor's appointments, missing work, and rarely having free time. In response to these increased demands, EFMP implemented a Respite Care Reimbursement Program that provides you reimbursement/subsidy, at a set rate, for **up to 20 hours per month** of respite care services. Each installation has its own respite care program, so it is essential that you register/apply with your new duty station's EFMP office each time you PCS.

The EFMP Respite Care Reimbursement Program is childcare or babysitting provided to your child with special needs. Families apply for this program by completing the following three forms:

- **Respite Care Program Verification of Eligibility Form**
- **Hold Harmless Agreement** is required for each respite care provider.
- **Respite Care Reimbursement Log** documents the dates and hours of respite care that was provided each month. Sponsors are responsible for paying the provider. The Henderson Hall EFMP office will arrange for reimbursement to the sponsor via direct deposit.

## Respite Care Enrollment Guidelines

- Marine families must be currently enrolled in EFMP and enrollment paperwork must be up-to-date (renewed every 3 years or earlier if there is a change in condition).
- Respite care Level of Need (LoN) 3 & 4 enrolled family members are eligible for up to 20 hours of respite care per month/per family with no more than 6 consecutive hours of respite care at one time.
- Respite care providers cannot transport children.
- Respite care should be provided in the sponsor's home or in the provider's home.

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Henderson Hall Exceptional Family Member Program

# Privacy Act Statement

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

**Authority:** 10 U.S.C. 5013; 10 U.S.C. 5041; MCO 1754.4C, Exceptional Family Member Program (EFMP) and E.O. 9397 (SSN).

**Principal Purpose:** To manage the EFMP Respite Care Reimbursement Program. Collected information will be filed pursuant to the Privacy Act System of Records Notice M01754-6 Exceptional Family Member Program Records, which may be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/usmc/M01754-6.html.

**Retention and Safeguards:** Paper and electronic records are restricted to authorized personnel with an official need-to-know. Electronic data is maintained in a password restricted case management system and encrypted while at rest and during transmission.

**Routine Uses:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, these records may specifically be disclosed outside the DoD as a routine use pursuant to the DoD Blanket Routine Uses that appear at http://privacy.defense.gov/notices/blanket_uses.shtml.

**Disclosure:** Providing information on this form is voluntary, but failure to provide the information will render you ineligible to participate in the EFMP Respite Care Reimbursement Program.

**DL1.14. Personally Identifiable Information (PII).** Information about an individual that identifies, links, relates, or is unique to, or describes him or her, e.g., a social security number; age; military rank; civilian grade; marital status; race; salary; home/office phone numbers; other demographic, biometric, personnel, medical, and financial information, etc. Such information is also known as personally identifiable information (i.e., information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, including any other personal information which is linked or linkable to a specified individual).

**To help protect your PII**, send us your documents as an encrypted email.

# UNITED STATES MARINE CORPS VERIFICATION OF ELIGIBILITY TO PARTICIPATE IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) RESPITE CARE REIMBURSEMENT PROGRAM

## PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read ii before completing the form.

**AUTHORITY:** 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, U.S. Marine Corps; MCO 1754.4, Exceptional Family Member Program, E.O. 9397 (SSN), as amended, and SORN M01754-6.

**PURPOSE:** To manage the EFMP Respite Care Reimbursement Program. Information will be used to evaluate eligibility and reimburse families for authorized respite care.

**ROUTINE USES:** Information will be accessed by EFMP personnel with a need to know in order to meet the purpose. Information may be disclosed to individuals or organizations authorized to provide services to the individual patron. A complete list and explanation of the available routine uses is published in the authorizing SORN available at: bl!Ql!:l/dgcld.deJe0:if.19Qll/Eril(ilCl(/SQ8_:il0l:le_QQQ-wige-SQR_-Artii::le-Vl_lAl:llclel5ZQeJ1l rn0175_-6l.

**DISCLOSURE:** Providing information on this form is voluntary, but failure to provide the information will result in ineligibility for respite care reimbursement program benefits.

**RECORD MANAGEMENT:** This form shall be managed in accordance with record schedule 1000-39, "Family Support Programs (Temporary)" of SECNAV M-5210.1.

**Sponsor Is required to complete blocks 1 through 7 prior to provider certification.**

| 1. Sponsor Name: | 2. Rank: 13, Preferred Telephone: | |
|---|---|---|
| 4. EFM Name: | 5. Case ID#: | 6. LoN: |

7. Instructions: a. Always record hours in military time. b. Enter times in 15 minute increments (e.g., 1300-1415). c. Use one form per care provider

| Date(s) of Care | Location of Care (F) Family Home (P) Provider's Home (0) Other (Approved) | Hours of Care | | Children Present During Care (Eligible EFM(s) Only) | Age | Number of Hours Used (cannot exceed 6 hrs) | Hourly Rate | Total |
|---|---|---|---|---|---|---|---|---|
| | | From | To | | | | | |
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| | | | | | | | | |
| If other for location of care, please describe: | | | | | Total: | | Total Payment: | |

18. I Cl::H 11t-r that I am 18 years or age or Older and provided respite care services to the above named EFM(s) on the dates and times used. I understand that I may be contacted bv USMC EFMP personnel to verify provision of care.

| Provider Signature: | Date: |
|---|---|
| Provider Name (print): | Phone Number: |

19. I"' " 111-r I nave paid the total amount listed above to the above named prov1der(s) for respite services. I understand the USMC EFMP retains the right to verify provision of EFMP Respite Care Reimbursement Program. and that suspected fraudulent use will be reported for investigation.

Signature of Sponsor/Agent authorized to act pursuant to Power of Attorney: Date:

***Non-sponsor signature is authorized only when a copy of a valid Power of Attorney is on file***

***""OFFICE USE ONLY••**

Date Log was Received: Are all EFM's Enrollments current: Yes No Total Amount Due to Sponsor:

I have reviewed and verified the eligibility for respite care reimbursement, LoN, rate per hour, and total reimbursement amount is accurate.

| EFMP Staff Signature: | Date: |
|---|---|
| EFMP Program Manager Signature: | Date: |

Administrative Comments:

# UNITED STATES MARINE CORPS EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) RESPITE CARE REIMBURSEMENT PROGRAM STATEMENT OF UNOERSTAN ING

## PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

**AUTHORITY:** 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, U.S. Marine Corps; MCO 1754.4, Exceptional Family Member Program, E.O. 9397 (SSN), as amended, and SORN M01754-6.

**PURPOSE:** To manage the EFMP Respite Care Reimbursement Program and obtain sponsor statement of understanding.

**ROUTINE USES:** Information will be accessed by EFMP personnel with a need to know in order to meet the purpose. Information may be disclosed to individuals or organizations authorized to provide services to the individual patron. A complete list and explanation of the available routine uses is published in the authorizing SORN available at: htlllli:lltll!Cld.def.e□lie.qQJl{ecillE!CYlSQBN::Jadex/DQO- ide-SQBN-Mlcle- iira;18r;liclel5;ZQ$J1fmQ]154-6|-

**DISCLOSURE:** Providing information on this form is voluntary, but failure to provide the information may limit respite care services.

**RECORD MANAGEMENT:** This form shall be managed in accordance with record schedule 1000-39, "Family Support Programs (Temporary)" of SECNAV M-5210.1.

I understand the Marine Corps EFMP Respite Care Reimbursement Program is intended to reduce the stress on sponsor families by providing temporary rest periods for family members who care for those who have special needs in accordance with MCO 1754.4.

I understand that respite care reimbursement hours are not authorized for medical, long term care (service for more than 6 hours consecutively) or custodial care of adults, to supplement, augment or substitute traditional childcare for work, or to allow a family member to attend school, or preschool programs. Respite care does not include the provider performing household chores or transportation.

I understand each family member enrolled in the EFMP will be assigned a Level of Need between 1 and **4,** and that the Respite Care Reimbursement Program will only reimburse for Level of Need 3 or **4.** The EFMP Level of Need is determined by Headquarters, Marine Corps EFMP, based upon the documentation received during the initial or updated enrollment review. I will be notified by the installation EFMP office of the date of Respite Care Reimbursement Program application approval, Level of Need for each eligible member, and the family's reimbursement rate for care. I am responsible for interviewing, hiring, and making payments to the respite care provider. If my family member is eligible (Level of Need 3 or **4)** and I choose to participate in the Respite Care Reimbursement Program, I must hire a provider who is 18 + years of age **with** the appropriate level of skill. If the EFM requires medication administration, I must hire a provider that possesses the appropriate level of skill and/or credentials as determined by the requirements of my physical state of residence. I am required to provide current documentation of respite care provider's qualifications for Level of Need 3 and 4 to the installation EFMP office prior to administration of care for reimbursement.

I understand that the Respite Care Reimbursement Program established reimbursed rate may not cover all costs expended by the family and therefore should be considered as a subsidy for respite care and not an entitlement. I understand that I am eligible to receive a maximum of 20 clocked respite hours per calendar month, per family. Other respite care programs funded by non-DoD agencies shall not be counted against the EFMP Respite Care Reimbursement hours. Respite care reimbursement does not impact Leave & Earning Statement or Basic Allowance for Housing.

I understand that respite care reimbursement funds are not considered taxable income to me, however by hiring respite care providers I may be liable for Federal or State taxes as a Household Employer and should consult with a tax professional or review IRS Publication 926 for more information about tax liability.

I understand I must utilize the Respite Care Reimbursement Log from the EFMP office. I will maintain the Respite Care Reimbursement Log each time care is provided. I will complete one log per care provider per month and submit the log(s) for reimbursement after care is provided and in accordance with the installation's EFMP due dates. I understand that the Respite Care Reimbursement Log must be filled out in its entirety. I understand that I am responsible for submitting and verifying that Respite Care Reimbursement Logs are submitted and received by the EFMP office within 60 days from last day of the month in which care was used. **Logs submitted after 60 calendar days will not be reimbursed.**

I understand that the **EFM must physically reside with me** in order to be eligible for the Respite Care Reimbursement Program. Exceptions include, if I am deployed, TAD, attending an official school, or approved Continuation on Location (Col), or serving an unaccompanied overseas tour where HQMC EFMP, or the overseas screening process, determines services are not available. These are the only cases in which an agent authorized to act pursuant of Power of Attorney may be used. The Sponsor's EFMP enrollment must be current **FOR ALL EFMs** in order to receive respite reimbursement. In all other instances, the Sponsor must sign the Respite Care Reimbursement Log.

I understand that USMC EFMP has the right to verify the provision of Respite Care.

**By signing this Statement of Understanding, I acknowledge my understanding of the terms listed above, and agree to the same. Suspected fraudulent activity will be reported to the appropriate authority for investigation.**

| Sponsor Name (print) | Date Received | Rank |
|---|---|---|
| Signature of Sponsor/Agent authorized to act pursuant to Power of Attorney | Agent Name (print) | |
| POA Expiration Date (If POA used) | EFMP Staff Signature | |

**US Marine Corps, Semper Fit & Exchange Services Division**
**Marine Corps Community Services**

# ACH Application Form

I hereby authorize the U.S. Marine Corps Semper Fit & Exchange Services Division, Marine Corps Community Services, hereinafter called MCCS-MRF, to initiate credit and debit entries to the account indicated below, with the financial institution named below, hereinafter called DEPOSITORY, to credit or debit the same to such account. All fees and charges that may be applied by the DEPOSITORY for the receipt and processing of transfers will be my sole responsibility. This authority is to remain in full force and effect until such time as MCCS-MRF has received written notification from me of its termination/change. Written notification shall be provided to MCCS-MRF at least thirty (30) working days prior to the effective date of termination/change.

**Check One:** I am not currently participating in the MCCS-MRF ACH Program.
**ADD** - Credit/Debit my payment to the account shown.

I am currently participating in the MCCS-MRF ACH Program.
**CHANGE** -Change financial institutions and/or account number.
**CANCEL** - Slop my participation in the program.

| | | |
|---|---|---|
| Name as shown on invoice: | | MCCS-MRF Vendor ID: |
| Address: | | |
| City: | State: | Zip: |
| Accounts Receivable (AR) Point of Contact (POC) Name: | | |
| AR POC Telephone Number: | AR POC Fax Number: | AR POC E-mail Address: |
| ACH Notification and Remittance Information Choice (Check one Box): | Via FAX | Via E-Mail |

| | | |
|---|---|---|
| **Depositor Account Number:** | | |
| Name of Financial Institution: | | |
| Street Address: | | Phone: |
| City: | State: | Zip: |
| **Routing Number:** | | |
| Depositor Account Title: | | |

Tax ID Number (TIN) for Business:

Signature:_____ Date:_____

Printed Name & Title:_____

| **To be completed by MCCS:** | | | |
|---|---|---|---|
| Date Received: | | MCCS-MRF Vendor ID: | |
| Date Completed: | | ACH Remit ID: | |
| Completed By: | | | |

**PRIVACY ACT STATEMENT** - The following information is provided to comply with the Privacy Act of 1974.
All information collected on this form is required under the provisions of the Federal Financial Management Act of 1994, Section 3332 of tiUe 31 of U.S.C.
This information **will** be used by the MCCS Financial Management Office to transmit payment data, by electronic means to vendor's financial institution.
Failure to provide the requested information may delay or prevent the receipt of payments through the ACH Program.

US Marine Corps, Semper Fit & Exchange Services Division
Marine Corps Community Services

# ACH Application Form

I hereby authorize the U.S. Marine Corps Semper Fit & Exchange Services Division, Marine Corps Community Services, hereinafter called MCCS-MRF, to Initiate credit and debit entries to the account Indicated below, with the financial institution named below, hereinafter called DEPOSITORY, to credit or debit the same to such account. All fees and charges that may **be** applied by the DEPOSITORY for the receipt and processing of transfers will be my sole responsibility. This authority Is to remain In full force and effect until such time as MCCS-MRF has received written notification from me of Its termination/change. Written notification shall be provided to MCCS-MRF at least thirty (30) working days prior to the effective date of termination/change.

**Check One:** I am not currently participating in the MCCS-MRF ACH Program.
**DADD** – Credit/Debit my payment to the account shown.

Bm currently participating in the MCCS-MRF ACH Program.
**CHANGE** - Change financial institutions and/or account number.
**CANCEL** - Stop my participation in the program.

| | |
|---|---|
| Name as shown on invoice: Smith, John *(Sponsor's Name) | MCCS-MRF Vendor ID: ***Leave Blank*** |
| Address: 12345 Rainbow Road | |
| City: Arlington | State: VA Zip: 22205 |
| Accounts Receivable (AR) Point of Contact (POC) Name: Smith, John *(Sponsor's Name) | |
| AR POC Telephone Number: (555) 555-5555 | AR POC Fax Number: AR POC E-mail Address: johnsmith21.mailme@mail.mil •sponsor's Email) |
| ACH Notification and Remittance Information Choice (Check one Box): | Via FAX Via E-Mail |

| | |
|---|---|
| **Depositor Account Number:** | 1 2 3 0 0 0 4 S 6 7 |
| Name of Financial Institution: My Financial Credit Union Bank | |
| street Address: 45573 Money Street | Phone: (111) 111-1111 |
| City: Arlington | State: VA Zip: 22205 |
| **Routing Number:** | 1 2 3 4 5 6 7 8 9 |
| Depositor Account Title: Checking / Savings *(choose () e) | |

TaxID Number (TIN) for Business: ***Leave Blank***

Date: 01/15/13

Signature: _7 !:!J-...-!.!;.lj :::A...Jb.....L.

Printed Name itle: Smith, John, Maj USMC

Leave Blank

To be completed by **MCCS:**

| | |
|---|---|
| Date Received: | Leave Blank |
| Date Completed: | Leave Blank |
| Completed By: | ***Leave Blank*** |

MCCS-MRF Vendor ID: I ...Leave Blank...
ACH Remit ID: I ...Leave Blank"..

PRIVACY ACT STATEMENT- The following Information is provided to comply with the Privacy Act of 1974.
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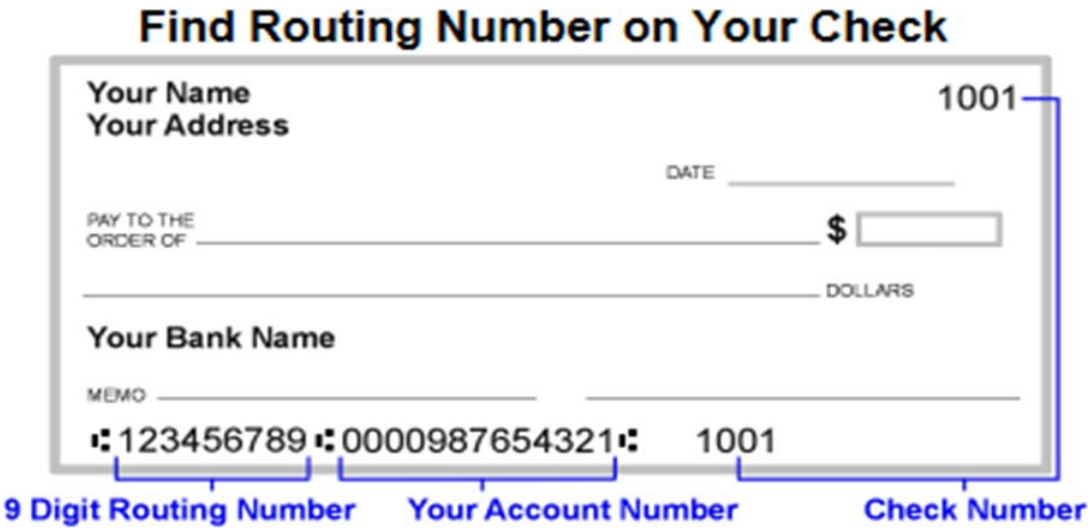
**Exceptional Family Member Program (EFMP)**
H&S BN, HQMC, Henderson Hall
1555 Southgate Rd. Bldg 12, Arlington, VA 22214-5000

Henderson Hall Exceptional Family Member Program
Respite Care Reimbursement Program

# How to Find Your Checking Account Number

Find your checking account number, then enter it where is says "Depositor Account Number" (one character per square) on the ACH Application Form (Direct Deposit Form)

You may also use your savings account number. Indicate which account you are using on the ACH Application Form where it says
"Depositor Account Title."




August 2023

**Exceptional Family Member Program (EFMP)**
H&S BN, HQMC, Henderson Hall
1555 Southgate Rd. Bldg 12, Arlington, VA 22214-5000

# Henderson Hall EFMP Respite Care Reimbursement Program
## Hold Harmless Agreement

We (I) _____ and _____ the legal parent(s) /custodian(s) of:

_____ DOB _____

_____ DOB _____

_____ DOB _____

hereby release our (my) Exceptional Family Member child (ren) and age-typical siblings and /or sponsored adult EFM into the full care of:

Name: _____ Phone Number: _____

Address: _____
for the purpose of providing Exceptional Family Member Program (EFMP) respite care.

We (I) further agree as follows:

1. While our children and EFM(s) is/are in the full care of the above named respite care provider, said respite care provider shall have full care over the siblings and EFM(s).

2. We (I) hereby authorize any licensed medical facility operated or sanctioned by the United States Government to provide our children and EFM named above emergency medical care. We (I) continue to be responsible for hospital and physician costs not covered by medical insurance.

3. We (I) expressly release and discharge Henderson Hall Marine Corps Base, Arlington, VA, its staff and employees, the United States Marine Corps, and United States Government from any and all claims, demands, liability, and damage of our children and EFM.

4. We (I) understand that EFMP retains the right to verify any information provided and certify that the information provided is accurate. We (I) understand that it is our (my) responsibility to report any changes of provider's information to local installation EFMP.

5. We (I) have read this document and expressly understand and concur with the terms within this agreement. We (I) further agree that this document shall remain in full effect for as long as respite care is provided by the above provider.

Signature of Parent(s):_____ Date:_____

Signature of Adult EFM: _____ Date:_____

Signature of POA Designee: _____ Date:_____

# UNITED STATES MARINE CORPS VERIFICATION OF ELIGIBILITY TO PARTICIPATE IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) RESPITE CARE REIMBURSEMENT PROGRAM

## PRIVACY ACT STATEMENT

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**AUTHORITY:** 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, U.S. Marine Corps; MCO 1754.4, Exceptional Family Member Program, E.O. 9397 (SSN), as amended, and SORN M01754-6.

**PURPOSE:** To manage the EFMP Respite Care Reimbursement Program. Information will be used to evaluate eligibility and reimburse families for authorized respite care.

**ROUTINE USES:** Information will be accessed by EFMP personnel with a need to know in order to meet the purpose. Information may be disclosed to individuals or organizations authorized to provide services to the individual patron. A complete list and explanation of the available routine uses is published in the authorizing SORN available at: tlllR illall!:ld defe□ e.gQ IPciv11cv/SOBN!!lni:lf:lx/DQO-Wii:l I:iORN-Mli::l1;1-V11;1wl8r1iC!e&ZQIiJ]l m01754-6/.

**DISCLOSURE:** Providing information on this form is voluntary, but failure to provide the information will result in ineligibility for respite care reimbursement program benefits.

**RECORD MANAGEMENT:** This form shall be managed in accordance with record schedule 1000-39, "Family Support Programs (Temporary)" of SECNAV M-5210.1.

| 1. Sponsor Name: | 2. Rank: | 3. EAS: | 4. Preferred Telephone: | 5. Alternate Telephone: |
|---|---|---|---|---|
| | | | | |

| 6. Home Address: | 7. UniUDuty Station Address: |
|---|---|
| | |
| 8. Official Government Email: | 9. Preferred Email: |
| | |

| | | *""OFFICE USE ONLY •• | | | | |
|---|---|---|---|---|---|---|
| 10. Exceptional Family Member Name | 11. Date of Birth | **12a.** Level of Need **(Per CMS)** | 12b. Eligible EFM **Case#** | 12c. Enrollment Date | 12d. Update Due Date | 12e. Reimbursement **Rate** |
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13. Does EFM physically reside with the sponsor? Yes No

13a. If you answered no, please specify: TAD School Approved Col Unaccompanied (Non-Voluntary)

14. USMC-MP retains the right to verify the 1mormat1on on me application is accurate. Verification of Eligibility Form must be submitted with a signed Statement of Understanding prior to initiation of participation in the USMC EFMP respite care reimbursement program.

Signature of Sponsor/Agent authorized to act pursuant to Power of Attorney: Date:

***OFFICE USE ONLY""*

15. Date Received: j16. EFMP Enrollment Current: Yes No , 11. Respite Enrollment Effective Date:

18. Family received copy of signed EFMP Respite Care Reimbursement Program Statement of Understanding: Yes No

19. Provider's Credentials Approved: Yes No 20. Approval Date: 21. Expiration Date:

| 22. EFMP Staff Signature: | Date: |
|---|---|
| 23. EFMP Program Manager Signature: | Date: |

**Exceptional Family Member Program (EFMP)**
H&S BN, HQMC, Henderson Hall
1555 Southgate Rd. Bldg 12, Arlington, VA 22214-5000

# Henderson Hall EFMP Respite Care Reimbursement Program

## Reimbursement Rates

| | 1 EFM | 2 EFMs or more |
|---|---|---|
| **Level of Need 1** | **N/A** | **N/A** |
| **Level of Need 2** | **N/A** | **N/A** |
| **Level of Need 3** | **Not to exceed** **$18.00/hr** | **Not to exceed** **$30.00/hr** |
| **Level of Need 4** | **Under no circumstances will reimbursement exceed** **$45.00 per hour** | **Under no circumstances will reimbursement exceed** **$60.00 per hour** |

MARINE & Family
Exceptional Family Member Program

**Exceptional Family Member Program (EFMP)**
H&S BN, HQMC, Henderson Hall
1555 Southgate Rd. Bldg 12, Arlington, VA 22214-5000

# Henderson Hall EFMP Respite Care Reimbursement Program

## Reimbursement Log (NAVMC 1750/3 Rev. 1-2015 EF) Due Dates

*** Respite Care Reimbursement Logs are submitted monthly to ensure prompt reimbursement. Families who elect to delay submissions of the NAVMC Form 1750/3 Respite Care Reimbursement Log for more than 60 days forfeit reimbursement. ***

| **2023 - 2024 EFMP Respite Care Reimbursement Program Due Dates** | | | | |
|---|---|---|---|---|
| **Month of Care** | **Submit By Date** | | **Month of Care** | **Submit By Date** |
| September 2023 | October 5th | | April 2024 | May 2nd |
| October 2023 | November 2nd | | May 2024 | June 6th |
| November 2023 | December 7th | | June 2024 | July 4th |
| December 2023 | January 4th | | July 2024 | August 1st |
| January 2024 | February 1st | | August 2024 | September 5th |
| February 2024 | March 7th | | September 2024 | October 3rd |
| March 2024 | April 4th | | | |

| **2024 - 2025 EFMP Respite Care Reimbursement Program Due Dates** | | | | |
|---|---|---|---|---|
| **Month of Care** | **Submit By Date** | | **Month of Care** | **Submit By Date** |
| October 2024 | November 7th | | May 2025 | June 5th |
| November 2024 | December 5th | | June 2025 | July 3rd |
| December 2024 | January 2nd | | July 2025 | August 7th |
| January 2025 | February 6th | | August 2025 | September 4th |
| February 2025 | March 6th | | September 2025 | October 2nd |
| March 2025 | April 3rd | | October 2025 | November 6th |
| April 2025 | May 1st | | | |