



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 until further notice.

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 licensed medical provider 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 _____