



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