



Exceptional Family Member Program – Respite Care: Provider Intake

Provider Name: _____ Intake Date: _____

Primary Provider Site: _____

Contact Information

Street Address: _____

City: _____, State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

E-mail: _____ Provider's Tax ID #: _____

Provider Type: Child Care Center
 Licensed family child care home provider In children's home care provider
 Special care

Experience and Capacity

1. How long have you been a child care provider?

_____ years _____ months

2. Have you ever been a caregiver for children with special needs?

Yes → How long? _____ years _____ months
 No

3. Have you ever been a child care provider on a military installation either in a center or a family child care home?

Yes → How long? _____ years _____ months
 No

4a. Please tell us how many total spaces you have for full-time, year-round care for children. (Leave blank if not applicable, e.g., for in-home providers)

TOTAL LICENSED CAPACITY FOR ALL AGE GROUPS: _____

4b. The EFMP project is seeking respite care for children from Marine Corp/Navy families, who are enrolled in the EFMP, for **up to 40 hours per month per child**. Some of this care may be provided during non-traditional hours. What is the maximum number of children you anticipate you could serve at this level, per month?

TOTAL EFMP SLOTS FOR ALL AGE GROUPS (birth through age 18 years): _____

4c. What is the total number of hours per month you can make available for Marine Corp/Navy parents for EFMP respite care?

TOTAL HOURS PER MONTHS: _____



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Education and Training

5. Are you/caregiver working with special needs children in your center certified to administer any of the following? (CHECK ALL THAT APPLY)
- a First Aid → Expiration date (mm/dd/yyyy): ____/____/____
- b CPR → Expiration date (mm/dd/yyyy): ____/____/____
- c Dispensing Medication
- c No, am not certified in of the above
6. Do you have any training in working with children with special needs?
- No
- Yes (please describe) _____
7. Are you/caregiver working with special needs children in your center a licensed medical professional, such as LPN, RN, MD, EMT etc. (nursing aide or other aides are not considered to be medical professionals)?
- No
- Yes (please describe) _____

About You

8. Please give us your top **two** reasons why you chose to participate in this program? (CHECK TWO)
- a Training and professional development opportunities
- b Helping the specific family/child
- c Providing help to military families in general
- d Having a stable source of income
- e Staying at home with own children
- f Other (specify) _____
9. How did you find out about this program? (CHECK ALL THAT APPLY)
- | | |
|---|--|
| <input type="checkbox"/> a Letter from CCR&R/Outreach Specialist | <input type="checkbox"/> g Marine Corp/Navy family |
| <input type="checkbox"/> b Posters | <input type="checkbox"/> h Friends/Family |
| <input type="checkbox"/> c Brochures | <input type="checkbox"/> i Word of mouth |
| <input type="checkbox"/> d Newspaper article | <input type="checkbox"/> j At CCR&R office |
| <input type="checkbox"/> e Website on Marine Corp/Navy Respite Care Program | <input type="checkbox"/> k At another training session |
| <input type="checkbox"/> f Military installation | <input type="checkbox"/> l Other (specify) _____ |
10. Were you already providing care to a child with special needs from a Marine Corp/Navy family?
- Yes No
11. What is your hourly rate, i.e., how much do you charge per hour? \$_____/hour

OFFICE USE ONLY:

Background check status: Not Yet In Process In Process Passed Failed