

**ALIGNSTAFFING  
RESPITE CARE NETWORK (RCN)  
REQUEST FOR SERVICES**

**SECTION A: EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)  
MANAGER/DESIGNEE INFORMATION**

Date/Time Received by RCN: \_\_\_\_\_ Date/Time of Request: \_\_\_\_\_

Military Installation: \_\_\_\_\_

EFMP Manager/Designee: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**SECTION B: EFM INFORMATION**

Case File: \_\_\_\_\_  
(Sponsor Last Name, Installation Code, EFM Initials)

Sponsor's Name: \_\_\_\_\_  
Last First Middle

EFM Member's Name: \_\_\_\_\_ EFM DOB: \_\_\_\_\_  
Last First Middle

Hours Authorized: \_\_\_\_\_ Date of Service Delivery Plan: \_\_\_\_\_

EFM's Primary Language: \_\_\_\_\_ Does the Family speak English? \_\_\_\_\_

**SECTION C: RESPITE CARE PROVIDER**

(To be completed by Alignstaffing personnel)

Date of initial contact by RCN: \_\_\_\_\_ Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

**SECTION D: Document Checklist**

	Requested:	Received:
_____	Respite Care Provider Information Form	_____
_____	DA Form 4700 (Respite Care Eligibility Review)	_____
_____	DA Form 5189 (Application for Respite Care)	_____
_____	Individual Family Respite Care Plan	_____
_____	Family Needs Assessment	_____
_____	Family Services Needs Matrix	_____

**Fax Document: 1-866-565-9307 or 1-866-550-8278 or 1-866-789-6918**