MARINE & Family | Exceptional Family Member Program

Respite Care
Hold Harmless Agreement

The exceptional family members listed below are approved for respite care reimbursement with the Camp Pendleton Exceptional Family Member Program:

____DOB_________________________AGE_____________
____DOB_________________________AGE_____________
____DOB_________________________AGE_____________

I understand that if care is provided for siblings my respite care provider will not be reimbursed.

____DOB_________________________AGE_____________
____DOB_________________________AGE_____________
____DOB_________________________AGE_____________

Statement of Understanding and Agreement:

1. I have selected my own respite care provider who knows and understands the level of care necessary to keep my child(ren) or adult sponsored dependent safe.

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

3. I expressly release and discharge Camp Pendleton, its staff and employees, the United States Marine Corps and United States Government from any and all claims, demands, liability and damage of any nature whatsoever, arising from or in connection with the placement or medical/dental treatment of our children and EFM, other than that resulting from the negligence or intentional conduct of the above name persons and organizations.

4. *I understand that all suspected fraudulent activity will be reported to the Criminal Investigation Division on Camp Pendleton for investigation.*

5. As the parent or legal guardian, I hereby release my Exceptional Family Member(s) and/or sponsored adult exceptional family member into the full care of:

   Name of Respite Provider: ____
   Address: ____
   Phone Number: ______________________________ Email: ____________________________

6. I have read this document, understand, and concur with the terms within this agreement. I further agree that this document shall remain in full effect for as long as respite care is provided by this provider.

Signature of Sponsor: ____ Date: _______________________

Signature of Adult EFM: ____ Date: _______________________

Signature or Respite Provider: ____________________________________ Date: _______________________

Signature of EFMP Staff: ____ Date: _______________________

(Rev. 03/2018)