



PROCEDURE: Must be strictly adhered to for successful submission. All previous forms are obsolete.

1. Form provided to member by Work Life office.
2. Member completes section 1 and returns to Family Resource Specialist (FRS) or Family Advocacy Specialist (FAS) for endorsements in Section 2.
3. The FRS or FAS will send the Approved form back to the member.
4. Member provides completed form to their local CGMA Representative.
5. CGMA Representative enters case into netFORUM for CGMA HQ Approval.
6. CGMA HQ reviews and approves.
7. Local CGMA Representative disburses funds.

Note 1: Checks may be made out to the member or the care provider, as determined by the member.

Note 2: If this is for services rendered (reimbursement), a copy of the invoice or receipt should be provided with the application for inclusion in the netFORUM case.

Note 3: If this is for services yet to provided, a copy of an agreement or letter between the member and the provider should be provided with the application for inclusion in the netFORUM case.

SECTION 1 – Member Information

* Name: Last	*First	M.I.	* Social Security Number	Employee ID Number
			XXX-XX-	
* Home Address Line 1	Line 2	*City	*State	*Zip Code
* Home Phone Number	Cell Phone Number	Home E-mail Address		
* Rank/Rate/Grade:	Current Duty Station (if applicable)		Work Phone Number	
Year of Member's Birth (YYYY)	Year Member Joined CG (YYYY)			
*Amount Requested \$ _____		Amounts previously received under this program \$ _____		
Total number of hours used/needed (including previous application) _____				
*Make Check Payable to: [] Member [] Care provider (use checks only)				
* I Prefer to Receive Funds by: Check Electronic Disbursement (for members only) Apply to my CGMA loan				
E-mail address for electronic disbursement				

I certify that I have attached a receipt or invoice for services rendered.

OR

I certify that I have attached an agreement or letter certifying services to be provided.

*Applicant's Signature _____

Date _____

SECTION 2 – Verification for Respite Care from servicing FRS or FAS :

Total Hours: _____	Hourly Rate: \$ _____
Verified by:	
Title	
Signature	Date