|  |
| --- |
|  |

#### *ﺑرﻧﺎﻣﺞ ولاية كارولينا الشمالية ﻟﻸطﻔﺎل اﻟرﺿﻊ واﻷطﻔﺎل اﻟﺻﻐﺎر*

#### تفويض وفاتورة سداد تكاليف الرعاية المؤقتة

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **القسم 1: المعلومات العامة - يتم تعبئتها من قبل منسق خدمة التدخل المبكر (EISC) والوالد/الوصي:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Authorizing CDSA: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | Address: | | | | | |  | | | | | | | | | | | | |
| Mailing Address:: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Child's Name: |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | DOB: | | | |  | | | | | HSIS ID #: | | | | |  | | |
|  | Last | | | | | | | | | | | | | | | | | | | | | | | First | | | | | | | | | M.I. | |  | | | | MM / DD / YY | | | | | | | | | | | |
| Parent/Guardian Authorized for Payment: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | |  |
|  | | | | | | | | | | | | | | | | Last | | | | | | | | | | | | | | | | | | | | | First | | | | | | | | | | M.I. | | |  |
| Parent/Guardian Phone Number: | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | |  | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | |  | | | |  | | | | | |
| Mailing Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | |  | | | |  | | | | | |
|  | | | Street | | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | State | | Zip Code | | | | County of Residence | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| EISC’s Name: | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | EISC Phone Number: | | | | | | | |  | | | | |
|  | | Last | | | | | | | | | | | | | | | | | | | | | First | | | | | | | | | | | | | | |  | | | | | |  | | | | | | |
| تاريخ بدء تفويض خطة الخدمة الأسرية الفردية (IFSP): | | | | | | | | | | | | | | | | | | | | |  | | | | إلى |  | | | | | | | | تاريخ الانتهاء | | | | | | IFSP Outcome Number: | | | | | | | |  | | |
| (\*راجع التعليمات لمعرفة تاريخ الاستخدام) | | | | | | | | | | | | | | | | | | | | | MM / DD / YY | | | |  | | MM / DD / YY | | | | | | |  | | | | | | | |  | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 2: Respite Authorization Approval – to be Completed by EISC and Approved by Finance Officer** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | $5.00 | | | | x | | | |  | | | | | | = | |  | | | | | x | |  | | | | | = | | $ | | | | |  | | | | | | | | | | | | | | | | |
|  | Base Rate | | | | | | | Annual Family Service Percentage (AFSP) | | | | | | |  | | Family’s Hourly Rate | | | | |  | | Respite Hours Authorized | | | | |  | | Maximum Reimbursement | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | |
| EISC Signature and Date | | | | | | | | | | | | | | | | | | | | | | | | |  | | Finance Officer Signature and Date | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **القسم 3: فاتورة خدمات الرعاية المؤقتة – يتم إكمالها شهريًا بواسطة الوالد/الوصي** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| للحصول على المبلغ المسترد، أكمل القسم 3 بالكامل وأرسِل هذا النموذج إلى EISC الخاص بك في CDSA (العنوان أعلاه) في موعد أقصاه اليوم العشرين من الشهر الذي تم فيه تقديم الخدمة. (بالنسبة للخدمات التي قُدِّمت بعد اليوم العشرين، يُرجى تقديم الفاتورة في الشهر التالي).  يمكنك الحصول على نماذج إضافية من EISC حسب الحاجة. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **اسم مقدم الرعاية المؤقتة** (يرجى الكتابة بخط واضح) | | | | | | | | | | | | | | | | | | | | | | | | **تاريخ الخدمة** | | | | | | | **وقت البدء**  (ضع دائرة حول الصباح أو المساء) | | | | | | | | | | | | وقت النهاية  (ضع دائرة حول الصباح أو المساء) | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | صباحًا / مساءً | | | | | | | | | | | | صباحًا / مساءً | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | صباحًا / مساءً | | | | | | | | | | | | صباحًا / مساءً | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | صباحًا / مساءً | | | | | | | | | | | | صباحًا / مساءً | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | صباحًا / مساءً | | | | | | | | | | | | صباحًا / مساءً | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | صباحًا / مساءً | | | | | | | | | | | | صباحًا / مساءً | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | صباحًا / مساءً | | | | | | | | | | | | صباحًا / مساءً | | | | | | | |
| **أُقر بأن طفلي قد حصل على خدمات الرعاية المؤقتة في التواريخ والأوقات المذكورة أعلاه.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | |
| توقيع الوالد/الوصي | | | | | | | | | | | | | | | | | | | | | | | | |  | | تاريخ الإرسال إلى EISC لسداد المبلغ | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4: Reimbursement Authorization – to be Completed by Finance Officer** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | |  | | | | x | |  | | | | | = | | | $ | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Total Hours | | | |  | | | | Hourly Rate | | | | |  | Total Reimbursement | | | | |  | | | Finance Officer Signature Authorizing Reimbursement and Date | | | | | | | | | | | | | | | | | | | | | | |