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#### *برنامه نوزادان - اطفال نوپای کارولینای شمالی*

#### *مجوز و بل بازپرداخت هزینه استراحت (وقفه)*

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| **بخش 1: معلومات عمومی - توسط هماهنگ‌کننده خدمات مداخله زودهنگام (EISC) و والدین/سرپرست تکمیل خواهد شد:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Authorizing CDSA: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Address: | | | | | | | | | | |  | | | | | | | | | | | |
| Mailing Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | |
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| Mailing Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | |  | | |  | | | | | | |
|  | | | Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | State | | | | | | Zip Code | | | County of Residence | | | | | | |
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| EISC’s Name: | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | EISC Phone Number: | | | | | | | | | | |  | | | | | |
|  | | تخلص | | | | | | | | | | | | | | | | | | | | | | | | | نام | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | |
| تاریخ شروع مجاز IFSP: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | تا | | | | |  | | | | | | | تاریخ ختم | | | | | | IFSP Outcome Number: | | | | | | | | | | |  | |
| (\*برای تاریخ استفاده به دستورالعمل‌ها مراجعه کنید) | | | | | | | | | | | | | | | | | | | | | | سال / روز / ماه | | | | | | | |  | | | | | سال / روز / ماه | | | | | | |  | | | | | | | | | |  | | | | | | |  | |
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| **Section 2: Respite Authorization Approval – to be Completed by EISC and Approved by Finance Officer** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Base Rate | | | | | | | Annual Family Service Percentage (AFSP) | | | | | | |  | Family’s Hourly Rate | | | | | | | |  | | Respite Hours Authorized | | | | | | | |  | | | Maximum Reimbursement | | | | | | | |  | | | | | | | | | | | | | | | |
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| EISC Signature and Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Finance Officer Signature and Date | | | | | | | | | | | | | | | | | | | | | | | | |
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| **بخش 3: بل برای خدمات استراحت (وقفه) - که باید ماهانه توسط ولی/سرپرست تکمیل شود** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| برای بازپرداخت، تمام بخش 3 را تکمیل نموده و این فورم را ***حداکثر تا 20 ماهی که خدمات در آن ارائه شده است،*** *به EISC خود در CDSA (آدرس بالا)* ارسال کنید. ***(برای خدماتی که پس از تاریخ 20 ارائه می‌شوند، بل را در ماه بعد ارسال کنید.)*** در صورت نیاز می‌توانید فورم‌های اضافی را از EISC خود دریافت کنید. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **نام فراهم کننده خدمات استراحت (وقفه)** (لطفاً به حروف واضح چاپ/بنويسيد) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **تاریخ خدمات** | | | **تاریخ شروع**  (am (قبل از ظهر) یا pm  (بعد از ظهر) را حلقه کنید) | | | | | | | | | | | | | **تاریخ ختم**  (am (قبل از ظهر) یا pm (بعد از ظهر) را حلقه کنید) | | | | |
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| **تصدیق میکنم که طفلم در تاریخ‌ها و ساعات فوق خدمات استراحت (وقفه) دریافت نموده است.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| امضای ولی/سرپرست | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | تاریخ ارسال به EISC برای بازپرداخت | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Section 4: Reimbursement Authorization – to be Completed by Finance Officer** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | Total Hours | | | |  | | | | Hourly Rate | | |  | | | | Total Reimbursement | | | | | | |  | | | | | Finance Officer Signature Authorizing Reimbursement and Date | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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