|  |  |
| --- | --- |
| *Autorización y Factura por Servicios de Alivio del Programa* |  |

#### *Infantes-Niños Menores de Tres Años de Carolina del Norte*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 1: General Information – to be Completed by Early Intervention Service Coordinator (EISC ) and Parent/Guardian:**  ***Sección 1: Información general – debe ser completado por la Coordinador de Servicios de Intervención Temprana (EISC) y los padres de familia o tutor legal:*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Autorizado por CDSA: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Dirección: | | | |  | | | | | | | | | | | | | | | | | | | | |
| Dirección: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre del niño: | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | Fecha de nacimiento: | | |  | | | | | | HIS ID #: | | | | |  |
|  | | | Apellido paterno | | | | | | | | | | | | | | | | | | Nombre | | | | | | | | | | Inicial 2º nombre | | | | | | | | | | MM / DD / YY | | | | | |  | | |  | | |
| Nombre del padre o tutor legal: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | |  | |
|  | | | | | | | | | | | Apellido paterno | | | | | | | | | | | | | | | | | | | | | Nombre | | | | | | | | | | | | | | | | Inicial 2º nombre | | | | |
| Número de teléfono: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Dirección: |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |  | |  | | | | | | | | | | |
|  | | Calle y No. | | | | | | | | | | | | | | | | | | | | | | Ciudad | | | | | | | | | | | Estado | | | | | Código Postal | | Condado de residencia | | | | | | | | | | |
| Nombre del Coordinador de Servicios (EISC): | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Teléfono de Coordinador de Servicios: | | | | | | | | | | |  | | | | | | |
|  | | | | | | | Apellido paterno | | | | | | | | | | | | | | | | | Nombre | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | |
| Fecha de Inicio del IFSP: | | | | | | | |  | | | | | | a | |  | | | | | | | Fecha Final | | | | | | | | | | | | Resultado #: | | | | | | | | | |  | | | | | | | |
| (\*see instructions for date to use) | | | | | | | | MM / DD / YY | | | | | |  | | MM / DD / YY | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 2: Respite Authorization Approval – to be Completed by EISC and Approved by Finance Officer**  ***Sección 2: Autorización de Servicios de Alivio – debe ser completado por EISC y aprobado por el agente financiero*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | $5.00 | | **x** | | | |  | | | | | | | | **=** |  | | | | | | **x** | | | |  | | | | | **=** | | | | | $ | | | |  | | | | | | | | | |
|  | | | | Base Rate / *Tarifa Básica* | | | | | Annual Family Service Percentage / *Porcentaje anual de servicio familiar* / AFSP | | | | | | | | |  | Family’s Hourly Rate / *Tarifa por hora de la familia* | | | | | | | | | | Respite Hours Authorized / *Horas de Servicios de Alivio aprobadas* | | | | | | | | | | Maximum Amount of Reimbursement / *Reembolso Máximo* | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Firma del coordinador de servicios y Fecha | | | | | | | | | | | | | | | | | | | | | | | | | |  | Firma del agente financiero y Fecha | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 3: Invoice for Respite Services – to be Completed Monthly by Parent/Guardian**  ***Sección 3: Factura por Servicios de Alivio – debe ser completado mensualmente por los padres/tutor legal*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Para fines de reembolso, anote toda la información completa en la sección 3 y entrégala al EISC en el CDSA (dirección anotado anteriormente) ***antes el día 20 del mes cuando ocurrió los servicios. (Para los servicios que ocurrieran después del día 20,  entrega la factura el mes siguiente.)*** Puede obtener más formularios con su coordinador de servicios cuando sea necesario. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nombre del Proveedor de Servicios de Alivio**  **(Favor de escribir legible y precisa)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Fecha de Servicio** | | | | | | | **Hora de Empezar**  (circule am o pm) | | | | | | | **Hora de Terminar**  (circule am o pm) | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | am / pm | | | | | | | am / pm | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | am / pm | | | | | | | am / pm | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | am / pm | | | | | | | am / pm | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | am / pm | | | | | | | am / pm | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | am / pm | | | | | | | am / pm | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | am / pm | | | | | | | am / pm | | | | | | | | |
| **Certifico que mi niño ha recibido servicios de alivio en las fechas y las horas que aparecen anteriormente.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Firma del padre o tutor legal | | | | | | | | | | | | | | | | | | | |  | | Fecha enviada al EISC para el reembolso | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4: Reimbursement Authorization – to be Completed by Finance Officer**  ***Sección 4: Autorización de Reembolso – debe ser completado por el agente financiero*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | **x** |  | | **=** | | $ | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Total Hours | | | | | | |  | Hourly Rate | |  | | Total Reimbursement | | | | | | | | | |  | Finance Officer Signature Authorizing Reimbursement and Date | | | | | | | | | | | | | | | | | | | | | | | | |