

The Arc of the Central Chesapeake Region Respite Care Program
Programas del Condado de Anne Arundel de Cuido para respirar

ANNUAL UPDATE

Informacion Annual Actualizada

Name/Nombre: _____

Date/Fecha: ____/____/____

Date of Birth/Fecha de Nacimiento: ____/____/____ Male/Hombre ____ Female/Mujer ____

Address/Direccion: _____

Social Security Number/Numero de Seguro Social: ____/____/____

Type of Disability/Tipo de discapacidad: _____
—

Parent(s)/ Guardian(s)

Padre(s) o Guardian(es)

Name/Nombre: _____

Name/Nombre: _____

Day Phone/Tel. Diamo: () _____ Day Phone/Tel Diamo: () _____

Home Phone/Tel. Casa: () _____ Home Phone/Tel. Casa: () _____

Emergency Contact/Contacto en Caso de Emergencia: _____ Phone/Tel.: () _____

Physician/Doctor: _____ Phone/Tel.: () _____

Address/Direccion: _____

PLEASE DESCRIBE ANY CHANGES, OVER THE PAST YEAR, IN THE FOLLOWING AREAS/Favor describir cualquier cambio ocurrido el ano pasado en las areas siguientes:

Medical Condition/Condicion Medica:

Medications/Medicamentos: _____

Diet/Dieta: _____

Personal Care/Cuido Personal:

Day Program/School/Programa Diurno/Escuela:

Other/Otros:

Signature/Firma:

*In order to expedite processing, please make sure all three (3) forms are filled out completely, and send documentation of your gross income. Please remember to sign the bottom of the first page. THANK YOU.
En Orden De Acelerar El Proceso, Favor De Cercionarse Que Los Tres (3) Formularios Estan Completamente Llenos, Y Tienen Que Enviar La Documentacion De Su Ingreso Bruto. Favor De Acordarse De Firmar Al Fondo De La Primera Pagina. GRACIAS.*

The Arc of the Central Chesapeake Region
Respite Care Program
Programa Para Cuidado Y Respiro
Projected Respite Needs
July 1, 2008 – June 30, 2009

Name/*Nombre*: _____

Projected Days/Dates:
Estimados de dias/fechas:

Projected Hours Of Care:
Estimados de horas de cuidado:

Total Hours:
Total de horas:

<small>OFFICE USE ONLY/Usó de Oficina Solamente</small> Date received/Fecha Recibido: ____/____/____ Hours/Days approved/Contidad aprobada: _____ Date family notified/Fecha de notificación a las familias: ____/____/____ Approved by/Aprobado por: _____

The Arc of the Central Chesapeake Region
931 Spa Road
Annapolis, MD 21401
(410) 269-1883
Fax: (410) 269-0091
July 1, 2008 – June 30, 2009
RESPIRE CARE SUBSIDY
Amount and Source of Total Income
Cantidad y Origen del Ingreso Total

Name:/Nombre: _____

Person w/developmental disability
Persona con incapacidad de desarrollo

**Parent/Guardian
of child under 18 with disability**
*Padres/Guardianas
De niños menores de 18 con incapacidad*

**Adult with disability
(over 18 years old)**
*Adulto con discapacidad
(sobre 18 a os)*

Salary or wages (gross) <i>Salario o Sueldo (bruto)</i>			
Social Security or SSI <i>Seguro Social o SSI</i>			
Public Assistance <i>Asistencia Pública</i>			
Unemployment Compensation <i>Compensación de desempleo</i>			
Alimony/Pensión de Divorcio			
Child Support <i>Mantenimiento del niño</i>			
Pension/Pension			
Interest/Interés			
Other Income/Otro Ingreso			
Total Income/Ingreso Total Please attach proof of income/Por favor adhiera prueba de ingreso			

MEDICAL EXPENSES

GASTOS MÉDICOS

Medical expenses for the person with the disability must be related to the disability and not covered by any insurance or other coverage and incurred in the past 12 months. Please attach receipts.

Gastos médicos para la persona con incapacidad deben de relacionarse con la incapacidad y no cubierto por ningún otro seguro o protección e incurrido en los últimos 12 meses. Favor incluir los recibos.

Type of expense/Tipo de gasto	Cost/Costo	Date/Fecha
1.		
2.		
3.		

Application for Subsidy
Aplicación para Subsidio

Number of persons in household
Número de personas en el hogar

Adult/Adultos

Children (under 18) Niños (menores de 18)

Female/Femenino _____

Male/Masculino _____

Signature/Firma

Date/Fecha

Please check one (for statistical purposes only)
Favor de marcar uno (para propósito de estadísticas solamente)

White/Blanco _____

Black/Negro _____

Hispanic/Hispano _____

Asian/Asiático _____

Native American/Nativo Americano _____

Other/Otro _____

For office use only:/Para uso de la oficina solamente:
Income:/Ingreso:
Medical Deductions:/Deducciones médicas:
Adjusted Income:/Ingreso Ajustado:
Eligibility:/Elegibilidad:

Please attach documentation/proof of income./Favor Adherir documentación y prueba de ingreso.

The Arc of the Central Chesapeake Region
Respite Care Program
Family Survey

We appreciate your assistance in improving our services by providing your feedback.

1) Have you received respite services or reimbursement for respite in the past year ?

_____ yes _____ no

2) How would you rate your satisfaction with our respite services?

_____ great _____ good _____ OK _____ poor

3) Did having respite afford you the opportunity to spend time with other family members or attend to your needs (ie:medical appts. shopping, relaxation, etc.) ?

4) Do you feel that having respite available lessens your stress?

5) Did our respite services or reimbursement for respite meet your families' needs? Or provide the flexibility you need?

Comments: _____

Suggestions or
recommendations: _____

OPTIONAL – Name _____

THANK YOU!!!!!!!