THE ARC OF THE CENTRAL CHESAPEAKE REGION
RESPITE CARE PROGRAM
PROGRAMA PARA CUIDADO Y RESPIRO
ANNUAL REGISTRATION FORM
FORMA DE REGISTRACIÓN ANUAL

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 disabilidad*:_____

Medical Condition/*Condicion Medica:* _____

_____

Medications/*Medicamentos*: _____

Diet/*Dieta:* _____

Personal Care/*Cuido Personal:* _____

Do you receive services from any other providers? _____
Day Program/School/*Programa Diurno/Escuela:* _____

Other/*Otros:* _____

Parent(s)/ Guardian(s)/Caregiver (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*: _____

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, 2017 – June 30, 2018

Name/*Nombre*:_____

Projected Days/Dates: *Estimados de dias/fechas:*	Projected Hours Of Care: *Estimados de horas de cuido:*

Total Hours:
Total de horas:

OFFICE USE ONLY/Uso de Oficina Solamente
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, 2017 – June 30, 2018

RESPITE CARE SUBSIDY

Amount and Source of Total Income
Cantidad y Origen del Ingreso Total

Name:/*Nombre*:_____

Person w/developmental disability
Persona con incapacidad de desarollo

	Parent/Guardian of child under 18 with disability *Padres/Guardianas De ninos menores de 18 con incapacidad*	**Adult with disability (over 18 years old)** *Adulto con disabilidad (sobre 18 años)*	
Salary or wages (gross) *Salario o Sueldo (bruto*)			
Social Security or SSI *Seguro Social o SSI*			
Public Assistance *Asistencia Pública*			
Unemployment Compensation *Compensación de desempleo*			
Alimony*/Pensión de Divorcio*			
Child Support *Mantenimiento del niño*			
Pension*/Pension*			
Interest*/Interés*			
Other Income*/Otro Ingreso*			
Total Income*/Ingreso Total* **Please attach proof of income**/*Por favor adhiera prueba de ingreso*			

Please attach documentation/proof of income./*Favor Adherir documentación y 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 parsona 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)** *Ninós (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*____

African American/*Americanos de Color*____

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:*

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!!!!!!!