Local 2/Hospitality Industry
Child & Elder
Care Plan
209 Golden Gate Avenue, San Francisco, CA 94102 • 415/864-0506
ChildElderPlan@local2benefits.org • www.local2benefits.org

日期:	计划年度 2018 – 2019	*Plan Year 2018-2019*
致以:	Local 2 会员和他们的看护	*Local 2 Members and Their Caregivers*
发出人:	Louise Rush, 计划主任	*Louise Rush, Plan Director*
标题:	长者/残障亲属看护福利付款手续	*Elder/Disabled Care Benefit Payment Procedures*

长者/残障看护福利的目的是为了 Local 2 会员需要工作的时候，帮助会员支付一名看护来照顾他们的亲属。这项福利**并非**用于补充你的收入而且必须实际用于支付你家庭的看护。

The purpose of the Elder/Disabled Care benefit is to help Local 2 workers pay someone to care for their relative while they work. These benefits are not intended to supplement the income of Local 2 workers and must actually be paid to the family's caregivers.

儿童和长者看护计划制订了相关手续来确保可以准确支付看护。以下是需要留意的一些关键信息。

The Child & Elder Care Plan has procedures to ensure correct payment to caregivers. Below are some key points that require agreement from you and your caregiver.

看护 —— 请阅读并草签 ***Caregivers – Please read and initial***

如果来自 Local2 儿童和长者看护计划的职员联络我，我会回答关于本人在看护责任方面的问题。_____

If someone from the Local 2 Child & Elder Care Plan contacts me, I will answer their questions about my caregiving responsibilities.

我**每月收到 160 美元或以上**来照顾背面所提到的人士_____

*I receive **$160 or more per month** to care for the person referenced on the other side of this paper.*

我本人填写了背面的护理部分。_____

I am the person who completed the caregiver section on the other side of this paper.

Local 2 会员 —— 请阅读并草签 ***Local 2 Members – Please read and initial***

如果我更换我**所支付**负责照顾我亲属的**看护**，我会在 30 天之内通知本计划办公室。

_____ *I will notify the Plan office within 30 days if the person I pay to take care of my relative changes.*

我向看护**每月支付 160 美元或以上**来照顾我的亲属。_____

I pay my caregiver $160 or more a month to care for my relative.

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计划年度：2018 年 9 月至 2019 年 8 月
Plan Year: September 2018 - August 2019

提供为长者和残障亲属看护的付款证明
PROOF OF PAYMENT FOR CARE OF ELDER OR DISABLED RELATIVES

本地 2 号工会会员：请填写 ***LOCAL 2 MEMBER: PLEASE COMPLETE***

_____ _____ _____
2 号工会会员姓名（正楷） 签名 日期
Name of Local 2 Member (Print) ***Signature*** ***Date***

* * *

看护者: 请由你填写 ***CAREGIVERS: PLEASE COMPLETE THE SECTION BELOW***

看护者姓名_____电话_____
Name of Paid Caregiver ***Phone***

你可以讲: 英文_____ 广东话_____ 其他_____
Languages You Speak: ***English*** ***Cantonese*** ***Other***

每个月你获支付的时数 # _____
NUMBER of Hours You Are Paid Each Month

你的看护对象姓名 _____
Name of PERSON You Care For

每个月 2 号工会会员所支付你的看护费用 $_____
Amount EACH MONTH You Are Paid by Local 2 Worker

你是否与支付你费用的 2 号工会会员有亲属关系？ 是 _____ 否 _____
Are you related to the Local 2 worker who pays you? ***Yes*** ***No***

如果是的话，你们的关系？_____
If yes, how are you related?

_____ _____ _____
看护者姓名（正楷） 看护者签名 日期
Provider Name (Print) ***Provider Signature*** ***Date***