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

耆英或残障亲属护理

付款证明

耆英/残障护理福利的目的是为了二号工会工人们需要工作的时候，帮助他们支付一名护理人员来照顾他们的亲属。这项福利并非用于补充二号工会工人们的收入而是必须实际用于支付家庭成员的护理。

*The purpose of the **Elder/Disabled Care** benefit is to help Local 2 workers pay a caregiver 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 caregiver.*

儿童和耆英护理计划制订了相关手续来确保可以准确支付护理。为了获得计划福利而提交虚假信息不仅违反了计划条款，而且此类行为也是非法的。

The Child & Elder Care Plan has procedures to ensure correct payment to caregivers. The submission of false information for purposes of obtaining Plan benefits is not only a violation of the terms of the Plan, such conduct is unlawful.

此表格，正面与反面，包含需要阁下本人和看护者承诺的重点事项。

This form, front and back, contains key points that require agreement from you and your caregiver.

Local 2 会员 - 请阅读并签名

1. 如果我更换我所支付负责护理我亲属的护理人员，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 **caregiver** I pay to take care of my relative changes.*

2. 我向护理人员每月支付 200 美元或以上来照顾我的**亲属**。
   *I pay my caregiver $200 or more a month to care for my **relative**.*

填写并签名确认我本人同意以上第一和第二条款。

Printing and signing my name below confirm my agreement to #1 and #2 above.

二号工会会员姓名（正楷） 签名 日期

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护理人员：请由你手写，非打印

护理人员姓名_____ 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

你的护理**耆英或残障**对象姓名 _____
*Name of **Elder Disabled** Person You Care For*

每个月二号工会工人支付给你的护理费用 $$_____
Amount EACH MONTH You Are Paid by Local 2 Worker

你是否与支付你费用的二号工会工人有亲属关系? 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?

护理人员 - 请由你填写

1. **如果来自 Local 2 儿童和耆英护理计划的职员联络我，我会回答关于本人在护理责任方面的问题。**
   If someone from the Local 2 Child & Elder Care Plan contacts me, I will answer their questions about my caregiving responsibilities.

2. 我每个月收到 200 美元或更多，用于护理本页提及的**耆英或残障人士**。 *I receive $200 or more per month to care for the **elder or disabled** person referenced on this page.*

填写并签名确认我本人同意以上第一和第二条款以及其他所有我在此表格上填写的信息。
Printing and signing my name below confirm my agreement to #1 and #2 above and to all the information written on this page.

看护者姓名（正楷） 看护者签名 日期