Washington State Department of Social & Health Services

Request for Sign Language Interpreter

Office of the Deaf and Hard of Hearing

Requester Information

COMPLETED BY REQUESTER

1. PERSON REQUESTING INTERPRETER FOR AN APPOINTMENT
2. DATE OF REQUEST
3. TELEPHONE NUMBER (INCLUDE AREA CODE)
4. AGENCY
☐ DSHS ☒ Other (specify):
5. DSHS ADMINISTRATION/DIVISION **OR** SERVICE/MEDICAL PROVIDER
6. BILLING ADDRESS
7. INTERPRETER REFERRAL AGENCY (IF APPLICABLE)

Appointment Information

1. APPOINTMENT DATE
2. SCHEDULED START TIME ☐ AM ☐ PM
3. SCHEDULED END TIME ☐ AM ☐ PM
4. APPOINTMENT ADDRESS (WHERE APPOINTMENT WILL BE HELD)
5. BUILDING FLOOR ROOM
6. APPOINTMENT CONTACT (IF OTHER THAN REQUESTER)
CONTACT TELEPHONE NUMBER
7. CLIENT/EMPLOYEE NAME (OR DASA APPROVAL NUMBER)
GENDER ☐ Male ☐ Female
8. CLIENT IDENTIFICATION NUMBER
PIC CODE (ON DSHS MEDICAL IDENTIFICATION CARD)

OR

9. CLIENT COMMUNICATION PREFERENCE
☐ American Sign Language ☐ Pidgin Signed English ☐ Signed Exact English ☐ Oral
☐ Minimal Language Skills (QDI/CDI) ☐ Other (specify):
DEAF BLIND ☐ Tactile OR ☐ Close Up
10. TYPE OF APPOINTMENT SETTING

11. Specific interpreter requested: ☐ Yes ☐ No If yes, name of interpreter requested:

Confirmation Information

COMPLETED BY INTERPRETER REFERRAL AGENCY/CONTRACTOR

1. INTERPRETER NAME
CERTIFICATION LEVEL
ADDITIONAL INTERPRETER(S) (IF APPLICABLE)
2. APPOINTMENT ☐ Filled ☐ Unfilled
3. CONFIRMATION NOTIFIED TO REQUESTER WITHIN 48 HOURS? ☐ Yes ☐ No
4. TRACKING NUMBER

Billing Information

COMPLETED BY INTERPRETER

1. ADDRESS OF ORGIN (HOME PLACE OF BUSINESS, PREVIOUS APPOINTMENT)
2. ADDRESS OF DESTINATION
3. CHECK IF DESTINATION IS ☐ Home ☐ Place of business For payment, address cannot be to a subsequent appointment.

4. SERVICE	5. MILEAGE
Start time:	Mileage to appointment:
End time:	Mileage from appointment (if applicable):
Total billing time:	Total mileage:

6. Other fees incurred (parking, ferry, etc.):

Verification Information

COMPLETED AT TIME OF APPONTMENT BY INTERPRETER AND STATE/PROVIDER EMPLOYEE

SERVICE:

1. Was this service completed? ☐ Yes, complete VERIFICATION section below
☐ No, check the correct reason why this service was not completed:

NO SHOW BY:
☐ Client
☐ DSHS/State Employee
☐ Service/Medical Provider
☐ Interpreter
☐ Other (specify):

CANCELLATION BY:
☐ Client
☐ DSHS/State Employee
☐ Service/Medical Provider
☐ Interpreter
☐ Other (specify):

CANCELLATION INFORMATION (REQUIRED FOR CANCELLATIONS):
Date: _____
Time: _____ ☐ AM ☐ PM
Name of person cancelling:
_____
* Only cancellations with less that 48 hours notice are billable

VERIFICATION:

2. INTERPRETER'S SIGNATURE
DATE

DO NOT SIGN unless sections above are completed. Be sure to check for accuracy and for the interpreter's signature above. Interpreter signature not required if cancelled. Use the comments section as needed.

3. SIGNATURE OF STATE OR PROVIDER EMPLOYEE CONFIRMING SERVICE DELIVERY
DATE
PRINT NAME HERE
TITLE/POSITION
4. COMMENTS