Los Angeles County Department of Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

# Sign Language Interpreter Request Form

| **Section 1: General Information** (this section to be completed by SAPC staff only) | | |
|---|---|---|
| 1. Today's Date: | 2. Time: | 3. PO# |
| **Section 2: Information about the Requestor** | | |
| 4. **Name of Agency**: | 5. **Name of Person Completing Form**: | |
| 6. Phone Number: | 7. Email: | |
| 8. Name of Requestor (**to be complete by SAPC only**) | | |

**Section 3: Sign Language Appointment Information**

**9. Dates, Types and times of Service requested (no more than 2-weeks)**

| Day: | Date(s) | Type of Service** | Start Time | End Time |
|---|---|---|---|---|
| Monday | | | | |
| | | | | |
| Tuesday | | | | |
| | | | | |
| Wednesday | | | | |
| | | | | |
| Thursday | | | | |
| | | | | |
| Friday | | | | |
| | | | | |
| Saturday | | | | |
| | | | | |
| Sunday | | | | |
| | | | | |

If a break is required between sessions, please list the duration (e.g.15 min):__ ___

**Group Counseling, Patient Education, Individual Counseling, Assessment, Case Management, Family Therapy, Collateral Services, Crisis Intervention, Treatment Plan, and Discharge Services **ONLY**.

| | |
|---|---|
| 10. **Patient Name**: | 11. **Language Needed**: |

**12. Covered Benefit** (select one)**: ☐ Medi-Cal enrolled #**_____ **☐ Medi-Cal eligible**

**MHLA-enrolled #**_____ **☐ MHLA-eligible** **☐ other:**_____

13. Location (Address where interpreter is needed, include room, floor, suite, etc.):

14. **Parking** (cross street, special instructions, lot or street):

| | |
|---|---|
| 15. **Onsite Contact** (**if different from above**): | 16. **Phone**: |

**SAPC Approval**

| | |
|---|---|
| ☐ Approved ☐ Denied | Reason for denial: |
| Date: | SAPC Signature: |