

**DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
OFFICE OF MULTICULTURAL & HEALTHCARE EQUALITY (OMHE)
410 Capitol Avenue Hartford, CT 06134**

AMERICAN SIGN LANGUAGE INTERPRETER REQUEST FORM

Date Service was Requested: Requestor's Name: Facility/or Division's Name:

Date Service is Needed: Time – from: to: Duration:

Staff Requesting Interpreter: Title Phone #: email

Name of Person Requiring Interpreter Service: Activity For Which Interpreting Is Needed:

Location /Address/ Floor/Room Number: City:

Person to Contact @ Location: Phone #: Extension #:

Interpreting Needed: Meeting (up to 3) Group (more than 3) Training Testing Counseling Medical
Legal (Court Appearance; Pre-Trial Intervention, etc.) Other (Please Specify)

Specific Interpreter (s) Requested: M F Number of Interpreter (s) Required:

Single Event Repeated Event: Please indicate: Start Date End Date Frequency

Other Special Interpreter Requirements:
(e.g., Spanish, deaf interpreter, male, female, etc.).

PLEASE DO NOT WRITE BELOW THIS LINE.

Protection of Confidential Information: In accordance with State of CT and Federal (HIPAA) regulations, do not e-mail Personal Health Information (PHI), *unless* e-mail correspondence is password protected. If it is password protected, you must contact the intended recipient by telephone to provide password separately. Please do **NOT** email password.

PLEASE FAX YOUR REQUEST TO:
Marlene Jacques, RN, MSN, MPH, LMSW, DMHAS Behavioral Health Clinical Manager
FAX #: (860) 418-6780
TEL #: (860) 418-6974

AUTHORIZED/APPROVED BY:

Date:

Signature and Title