COMMUNICATION SERVICES REQUEST FORM

NorCal Services for Deaf and Hard of Hearing
Voice/TTY (916) 349-7525 ● FAX (916) 349-7578

AFTER HOURS EMERGENCY INTERPRETING SERVICES ● 800-504-3009

Billing is based on a 1 hour minimum. Please be accurate when indicating START and END times.
Subject to the availability of staff and subcontractors, communication services are provided on request.
This form must be filled out LEGIBLY and COMPLETELY. Illegible and incomplete forms will be returned.

Appointment Date: _____ **Start Time:** _____ AM/PM

Day of the Week: M T W TH F SAT SUN **(circle)** **End Time:** _____ AM/PM

Name of Requesting Agency: _____

Name of Requestor: _____ Phone: ( )

E-Mail Address: _____ FAX: ( )

TYPE OF SERVICES REQUESTED: (PLEASE CHECK)

- ❑ Sign Language Interpreter
- ❑ Oral Interpreter
- ❑ Real-Time Captioning—Transcription **yes** ❑ **no** ❑
- ❑ Specific Gender Required —**Female** ❑ **Male** ❑
- ❑ Tactile Interpreter (Deaf/Blind)
- ❑ Video Remote Interpreting
- ❑ Deaf-Intermediary Interpreter

Official Use Only:
Appointment Number:

Interpreter Name:

ASSIGNMENT INFORMATION:

Name of Deaf/Hard of Hearing Consumer: _____

Case Name/Case No.: _____

Consumer Identification: (MRN/last 4 of SSN/DOB/P.O. No.): _____

Name of Facility/Agency/Location: _____

Appointment Address/Location:

Street: City: Zip:

Dept:/Floor: Cross Street:

Doctor/Provider's Name: _____

Specific Reason for Appointment: _____

Site Contact Person: _____ Phone: ( )

BILLING INFORMATION:

BILL TO: Attn:

COST CODE/Division/Dept. Name: _____

Street: City: Zip:

REQUIRED SIGNATURE:

By signing this request, you are agreeing to the terms and conditions in the Service Agreement and to pay for services requested/provided.

Authorizing Signature **Print Name** **Date**

Email Address **Phone Number:**

CANCELLATIONS MUST BE IN WRITING.

NorCal Services for Deaf and Hard of Hearing does not bill third parties or the Deaf or hard of hearing consumer. Rev. 9/14