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

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