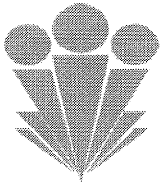

People For People
302 W. Lincoln Ave
Yakima, WA 98902
509-248-6793
1-800-233-1624
Fax: 509-853-2151

Interpreter Agency	The Language Exchange, Inc.
Authorization Number	

Appointment Record
Spoken Language Interpreter Service

APPOINTMENT INFORMATION TO BE COMPLETED PRIOR TO THE APPOINTMENT

1. **Client Full Name or DASA Approval Number (Last Name, First Name, Middle Initial)**			2. Gender ☐ Male ☐ Female
3. Date of Birth	4. Client Phone Number (Include Area Code)	5. Language Requested	6. Request Date
7. **Location of Appointment** Place (e.g. Clinic Name, Home Visit, etc.)	Street Address		8. Requester Phone
City	Zip		9. Requester Name

COMPLETE EITHER LINE 10 OR 11 BELOW. DO NOT COMPLETE BOTH.

10. Individual Appointment Date	Service Type Requested: ☐ Social Service ☐ Medical Scheduled Start Time:	Anticipated End Time:
11. Block of Time Appointment Date	Service Type Requested: ☐ Social Service ☐ Medical Scheduled Start Time:	Anticipated End Time:

THE SECTION BELOW TO BE COMPLETED BY THE INTERPRETER

12. Print Full Name of Interpreter Providing Service (Last Name, First Name, Middle Initial)		
13. Origin (Address, City, Zip)	14. Destination (If Different Than Box 7, Location of Appointment)	
15. Final Destination Address (If different than Box 13, Origin)		18. Total Reimbursable Mileage *(rounded up to the nearest full mile)*
16. Mileage to Appointment (If over 10 Miles 1 Way)	17. Mileage From Appointment (If over 10 Miles 1 Way)	
19. Date of Service	**20. Total Billing Time**	

21. Interpreter's Certification

I hereby certify *under penalty of perjury* that the information and charges listed herein for services rendered are accurate and have been provided as authorized and without discrimination on the grounds of race, creed, color, national origin, or sex.

Interpreter Signature **DSHS Cert #** **Date**

THE SECTION BELOW *MUST* BE COMPLETED BY THE REQUESTOR – DSHS OR MEDICAL PROVIDER

22. Service Date	**23. Interpreter Arrival Time / Staff Initials**	**24. Interpreter Picture ID Verified / Staff Initials**
25. Service Start Time / Staff Initials	**26. Service Completion Time / Staff Initials**	

27. Was the interpreter service completed? ☐Yes ☐No **If No; was appt. Cancel** ☐ **No Show** ☐

Who was responsible for the Cancellation or No Show?
☐Client ☐Interpreter ☐Requester ☐Other (If other, explain in the comments section below.)

28. For Medical Appointments, was the medical service? ☐ Inpatient ☐ Outpatient

29. Requestor - DSHS Staff/Medical Provider Certification
DO NOT SIGN BELOW UNTIL ALL ITEMS ABOVE ARE COMPLETED AND REVIEWED FOR ACCURACY.
Be sure to double check the Interpreter's name (Box 12) and Interpreter's signature (Box 21) for accuracy. Use Box 32 as needed.

I hereby certify that the service information provided herein is accurate and has been provided as specified. The service has also been provided without discrimination on the grounds of race, creed, color, national origin, or sex.

Signature **Date**

30. PRINT NAME HERE	**31. TITLE/POSITION**

32. COMMENTS