Valle del Sol
COMMUNITY HEALTH

Language Assistance Request Form

This form is used to identify a patient's preferred language and any requested language assistance services. Please complete all sections. This information enables us to provide interpreter and translation services as required by Title VI, HRSA, ADHS, and Joint Commission standards.

Patient Information

Patient Name: ________________________ Date of Birth: ___/___/_____

Medical Record #: ________________________ Phone: ________________________

Preferred Language

Preferred spoken language for health care discussions: ________________________

Preferred written language for documents: ________________________

Interpreter Needed

☐ Yes, I need an interpreter for my visits.
☐ No, I do not need an interpreter.
If yes, specify type of interpreter requested: ________________________ (e.g., in-person, phone, sign language)

Written Materials Translation

☐ Yes, I need my written materials translated into my preferred language.
☐ No, I do not need translated written materials.

Special Accommodations

☐ Deaf/Hard of Hearing
☐ Blind/Low Vision
☐ Other auxiliary aids requested: ___________________________

Signatures

Patient/Guardian Signature: ___________________________ Date: ____/____/______

Staff Signature: ___________________________ Date: ____/____/______