Washington State Department of CHILDREN, YOUTH & FAMILIES

LIMITED ENGLISH PROFICIENT (LEP) / DEAF/HARD OF HEARING SERVICE RECORD

CASE/PROVIDER NAME	CASE/PROVIDER NUMBER	INTERPRETER/TRANSLATOR SERVICES NEEDED ☐ Yes ☐ No LANGUAGE:

LIST NAME, ROLE (e.g., child, parent, caregiver, etc.) AND PRIMARY (PREFERRED) LANGUAGE:

NAME	ROLE	LANGUAGE

COMMENTS/ADDITIONAL INFORMATION:

Record all interpreter/translation services provided to each LEP and Deaf/Hard of Hearing client/provider, indicating the date, the name of the person served, and the name of the interpreter/vendor.

Attach a copy of each translation to a copy of the original document and file in the (paper or electronic) case record.

DATE	CLIENT/PROVIDER NAME	SERVICE PROVIDED (SEE CODES BELOW)	NAME OF INTERPRETER/VENDOR	STAFF FIRST & LAST NAME

SIGNATURE OF EMPLOYEE | PRINT NAME | DATE

SERVICE CODES:

1. Telephone/Video Remote Interpreter
2. American Sign Language/Certified Deaf Interpreter
3. Translated Document
4. Approved Dual Language Employees
5. Contracted Interpreter
6. Other (specify)