Rhode Island Commission on the Deaf and Hard of Hearing
Sign Language Interpreter or CART Request Form

INSTRUCTIONS: Download the pdf form on the desktop. Fill-in (type-in) the request. Save as pdf file. Email with attachment (pdf form) to cdhh.interpreter@cdhh.ri.gov or fax to (401) 222-5736. *Please complete one request form for each assignment*. Incomplete form will not be processed.

Job ID
(Office Use Only)

Requester Contact

Name:		**Today Date:**
Company/Business:	**Doctor's Name:**	
Street Address:		
City:	**State:**	**Zip:**
Phone: Home ☐ Work ☐ Cell/Text ☐		**Fax:**
Email:		

On-Site Contact

Name:	**Same Contact as above** ☐
Company/Business:	
Phone: Home ☐ Work ☐ Cell/Text ☐	**Fax:**
Email:	

Assignment/Consumer Information

Date of Assignment:	**One time basis** ☐	**Ongoing basis** ☐ (weekly, monthly, etc)
Start and End Time of Assignment:	**If known:** Deaf ☐ Deafblind ☐ Hard of Hearing ☐	
Name of Consumer or Patient:		**DOB:**

Consumer's role: Patient/Client ☐ Presenter ☐ Parent(s) ☐ Student ☐ Facilitator ☐ Employee ☐ Service Provider ☐ Participant ☐ *For other, please be specific:*

Has Consumer Requested for a Specific Interpreter(s)? Yes ☐ No ☐ Male ☐ Female ☐	**Name of Specific Interpreter(s):**

Communication Preference, if known (ASL, Signed English, tactile, CDI, etc)**:**

Location/Address of Assignment:

Building:	**Room:**	**Floor:**
City:	**State:**	**Zip:**
How many Interpreters and/or CART Providers are Needed: **Interpreter(s) =** **CART =**		**CART Projector and Screen Needed:** Yes ☐ No ☐

Description of Situation or Nature of Assignment: Emergency ☐ Group Meeting ☐ One-on-One Meeting ☐ Educational ☐ Legal ☐ Police ☐ Court ☐ Employment ☐ Event ☐ Training ☐ Counseling ☐ Surgery ☐ Medical ☐ Mental Health ☐ Presentation ☐ PLEASE EXPLAIN: _____
For other, please be specific:

Billing Information

Name		**Same Contact as above** ☐
Company/Business		
Street Address		
City	**State**	**Zip**
Phone Home ☐ Work ☐ Cell/Text ☐		**Fax**
Email	**Medicaid Patient**? Yes ☐ No ☐	

Please note: request will NOT be processed without completed information.

OFFICE USE ONLY

Received By:	Date of Confirmation:
☐ Follow-up (72-96 hours notice) ☐ Filled within less than 72 hours ☐ Filled within more than 72 hours ☐ Canceled: B ☐ C ☐ A ☐ _____	Interpreter and/or CART Provider Name(s) Confirmed:

DATABASE ☐ DETAILS FOR INTERPRETER/CART ☐ REQUESTER ☐

Revised December 2016