

DEAF COMMUNITY SERVICES OF SAN DIEGO, INC.

3930 Fourth Avenue, Suite 300
San Diego, CA 92103

Phone: (Voice) 619-398-2488 (Video): 866-948-9817

Fax: 619-398-2490

Email: scheduler@dcsofsd.org

Web: www.dcssofsd.org

(DCS Only)

Job #:

Interpreter(s) Assigned:

SIGN LANGUAGE INTERPRETER REQUEST FORM

Service Date: _____

Start Time: _____ am/pm

Day of the Week: _____

Medical Check-In Time: _____ am/pm

End Time: _____ am/pm

Name of Deaf Person(s): _____

Nature of Appointment: _____

Medical Record #: _____

Case/Code #: _____

Check here if requesting service for a COUNTY funded program.

Please Indicate # of Participants:		
	Deaf/ Hard-of-Hearing:	Hearing:
Adults:		
Minors (17 & Under):		

Appointment Location: _____

(Please include: Business Name, Full Address, Bldg #, Room #, etc...)

Site Contact Information:

Name: _____

E-mail: _____

Phone: _____

Fax: _____

Requestor Information: Same As Site Contact

Name: _____

E-mail: _____

Phone: _____

Fax: _____

Number of Interpreters Needed: _____ Preferred Interpreter(s): _____ Male / Female

Additional Information: _____

Mail Invoices to the Address Below:

Company Name: Molina Healthcare Attn: Health Education

Address: 200 Oceangate, Suite 100

City: Long Beach State: CA Zip Code: 90802

Phone: 562-499-6191 ext.127421 Fax: 562-499-6187 E-mail: jill.mcgougan@molinahealthcare.com

PO #: _____ (If Applicable)

Credit Card #: _____ EXP.: _____ CVC: _____

Signature: _____

(Only If Applicable – Signature Required When Paying By Credit Card)

Preferred Method of Billing: Mail E-mail Fax