State of Connecticut
Department of Mental Health and Addiction Services
Office of the Commissioner
Deaf, Deafblind, Hard of Hearing (DHOH) Services
Interpreter Request Form

Date of request: _____ Date Needed _____

Type of DHOH service: ASL ____ CART ____ CDI ____ VRI ____ Other (Specify) _____

Time: From: _____ To: _____ Anticipated duration: Hours _____ Minutes _____

Number of interpreters needed _____ (Two interpreters are required for events over 90 minutes)

Venue or Location: Online: Yes ____ No ____

Address/Apt Number: _____

City: _____ Room/Floor: _____

Contact person at location: _____ Telephone: _____

DMHAS Staff submitting this request: _____

Telephone number: _____ Email: _____

PNP staff requesting DHOH services: _____

Telephone Number: _____ Email: _____

Activity/Purpose (Check one) Meeting (up to 3 persons): ____ Group (more than 3 persons): ____

Community: ____ Counseling: ____ Educational: ____ Employment: _____

Legal (IE: Court, Pretrial intervention): ___ Medical: _____ Training: _____ Testing: _____

Specify Setting: _____

Frequency (check one): Single Event: ___ Repeated Event*: ___ Start date: _____ End date: _____

If a repeated event describe how often (IE: "Every week on a Monday"): _____

* Separate request forms must be submitted when events are held repeatedly for more than one month.

IF DHOH SERVICES ARE FOR AN INDIVIDUAL

Name or initials: _____

Person's gender preference of interpreter(s) *leave blank if no preference*: Male ____ Female ___

Other preferences: _____

Other requirements IE: Spanish or other spoken languages, Directions, Parking, Seating arrangements.
If an event, include an agenda with this request form:

_____

_____

Submit completed request forms to DMHAS OOC DHOH Services

- Forms are sent using ZIX encryption to: **William.Pierce@ct.gov** or by fax to 860-418-6690.
- Requests from DMHAS funded providers are submitted by a DMHAS manager.
- For more information contact William Pierce Voice 860-418-6933, TTY Relay 7-1-1 **William.Pierce@ct.gov**

DMHAS OFFICE OF THE COMMISSIONER DHOH SERVICES APPROVAL

Approved by: _____ **Date:** _____

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