DIVISION OF ALCOHOL AND SUBSTANCE ABUSE
INTERPRETER SERVICE REQUEST/APPROVAL
FOR SPOKEN OR SIGN LANGUAGE

Program Index G2421
Allocation Code 0010
DASA Org Index G700

CONFIDENTIALITY REMINDER: Treatment Provider – <u>REMOVE CLIENTS NAME</u> BEFORE faxing this form to Interpreter vendor agency or broker (per Alcohol/Drug Federal Confidentiality Regulations, CFR 42, Part 2).	DASA APPROVAL NUMBER

INTERPRETER VENDOR NAME: If applicable, FAX Number: ( ) -

Treatment Provider Name:	Phone Number: ( ) -
Treatment Provider Address:	Fax Number: ( ) -
Contact Person:	

CLIENT INFORMATION

Client Name: _____ _____ _____ _____ _____ _____
(Please print clearly) ***Last*** ***First*** ***MI***

Client Date of Birth _____

Who referred this patient to you?	Language:

TREATMENT

Service Type/Modality: _____ What hrs. will treatment begin and end? _____

How many times each week? _____ Dates of Interpreters Svc: Begin_____ Thru _____

What is the source of payment for client's treatment?

☐ DASA Direct Residential Contract
☐ DASA/County Contract (Low Income) Contract Type: _____
☐ DASA/County Medicaid Contract (TXIX) - ***MUST include client's Medicaid Coupon when faxing this form***
☐ Other, explain: _____
☐ Private Pay, or Insurance

DASA USE ONLY

☐ APPROVED
☐ <u>Not</u> yet approved - Still needs the following information:
☐ Denied - Reason: _____

DASA Approval: _____ (Date)

DASA Approval: _____ (Signature)

DASA faxed to treatment provider: _____

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