Updated 02/2019

Alabama Department of Mental Health
Office of Deaf Services

Notification of Right to Free Language Assistance

for Individuals Who Utilize a Spoken Language Other Than English

(This form must be presented in a format the consumer can easily understand. This usually means the consumer's preferred language)

Verbiage should not be changed below this line.

Case #_____ Provider/Center Name_____

I, _____, have been informed that it is important for my care to receive the services in the language that I understand best (my language of preference) and/or in a communication modality which is most readily understandable.

My language of preference is: _____

I have been advised that the agency is willing and can provide, at no cost to me, a clinical service provider who is fluent in my language of preference, a qualified professional interpreter, and/or appropriate accommodations. I have decided:

☐ I want to work with a clinical service provider fluent in my language of preference for direct clinical services. I understand that a qualified interpreter may be utilized when a clinical service provider fluent in my language of preference is not available.

☐ I want to work with a qualified interpreter. Vetting will be completed by the agency and documentation of the interpreter's qualification will be included in my permanent file.

☐ I prefer to use the following person to interpret for me: _____. I agree not to hold my clinical service providers, ADMH or its contract programs responsible for any adverse results that may arise from using this person as my interpreter. (This person cannot be a family member or other person younger than 18 years old.) The agency or the ADMH may determine that the person is not able or appropriate to perform this function. In such cases, the person mentioned above may remain as a support system.

☐ Other, please specify: _____

☐ I do not want free language/communication assistance provided by ADMH or its contract providers as mentioned above. I agree not to hold my clinical service provider or any other personnel at ADMH or its contract programs responsible for any adverse consequences that may arise as a result of my decision.

I understand that if my treatment team requests an accessibility accommodation provided by the ADMH or contract provider, it will be provided for them. I also understand that I can change my mind at any time. This waiver will expire one (1) year from the date signed. I understand that I may change my selection at any time by completing a new waiver.

_____	_____	_____
Signature of Consumer	Signature of Parent or Guardian (if applicable)	Date

_____	_____
Signature of Provider	Signature of Staff or Interpreter fluent in preferred language of consumer. (if consumer's preferred language is not English)

If the staff or interpreter providing the explanation of this document is in a remote location, their name or ID number, contact information, and language credentials are listed below:

Name/ID #: _____ Contact information: _____

Language and/or Interpreting Credentials: _____

Note: If the consumer has indicated that he or she does not wish to take advantage of free language assistance, this refusal is to be documented in writing. Every effort should be made to assure that the consumer fully understands his or her right to accessible communication in their language of preference through a clinical service provider, fluent in their preferred language, an interpreter or other appropriate provider and that such assistance will be provided at no charge. A provider who does not share the preferred language of the consumer does not meet the standards of this notification. Pursuant to Title VI requirements this document is to be filed in the consumer's permanent file and a copy given to the consumer.