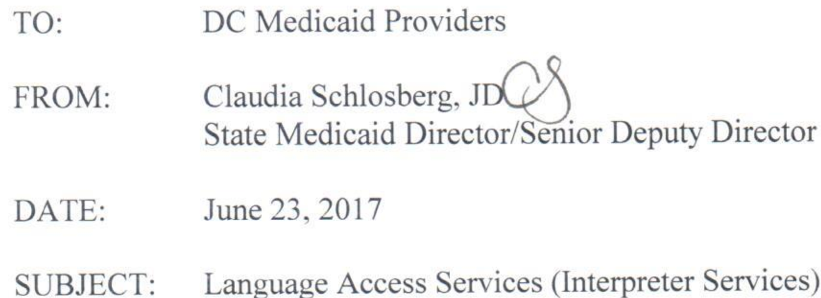
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director **TRANSMITTAL #17-15**

TO: DC Medicaid Providers



FROM: Claudia Schlosberg, JD
State Medicaid Director/Senior Deputy Director

DATE: June 23, 2017

SUBJECT: Language Access Services (Interpreter Services)

The purpose of this Transmittal is to give guidance to District of Columbia health care providers on how to access Language Access Services for Medicaid beneficiaries enrolled in the Medicaid fee-for-service (FFS) program. The Department of Health Care Finance (DHCF) contracts with two (2) entities to provide interpretation services, Allworld Language Consultant, Incorporated (ALC) and Geneva Worldwide, Incorporated (Geneva).

Face-to-Face Interpretation Services

ALC is the designated contractor for face-to-face interpretation services for FFS beneficiaries. All requests for these services may be requested by email to dhcf@alcinc.com or by phone at 301-881-8884. All requests must include the following information:

- Appointment Date, Time, and Address
- Requesting Provider Name
- Requesting Provider Phone Number
- Requesting provider DC provider number
- Beneficiary Name and DOB
- Beneficiary Medicaid Number
- Beneficiary Contact Number and Address

Please allow 5-7 business days for approval. If your request is outside of this timeframe there is no guarantee that an interpreter will be available however, urgent requests may be fulfilled pending availability of an interpreter.

American Sign Language Interpretation Services (ASL)

Geneva Worldwide, Incorporated is the contractor for ASL services. The attached Interpreter Request Form must be completed in its entirety and faxed to Geneva directly at 212-255-8409, or emailed to interpretingstaff@genevaworldwide.com.

441 4th Street, N.W., Washington DC 20011 (202) 442-5988 Fax number (202) 722-5686

Request through Department of Health Care Finance

To request an interpreter for either service through DHCF, please email the request information to dhcfinterpreter@dc.gov.

If you have any questions about this transmittal, please contact Cavella Bishop, Program Manager, Division of Clinician, Pharmacy, and Acute Provider Services at (202) 724-8936, or cavella.bishop@dc.gov. You may also contact Pamela Hodge, Management Analyst at (202) 442-4622 or pamela.hodge@dc.gov.

172 ROLLINS AVENUE, ROCKVILLE, MD 20852

Interpreter/CART Services Request Form

1. Date Request is Submitted to ALC:
2. **Type of Service Requested:**
3. **Number of Interpreters:**
4. **Contract number:**
5. **Name of Agency:**
6. **Individual Requiring Service:**
7. **Phone Number:**
8. **Address**
9. **DOB:**
10. **Medicaid Number:**
11. **Provider Number:**
12. Requester Information:

    Name: Agency/Division:
    E-Mail: Phone Number:

13. **Date Service is Required:** Time Service is Required (start-to-end):
14. Brief Description of Assignment:
15. ☐ Staff Meeting ☐ All Hands ☐ Training ☐ Ceremony
    ☐ Other (please give explaination)

Will informational materials be provided in advance to ALC to share with the assigned interpreter(s)?

☐ YES ☐ NO

If so, please email request@alcinc.com , so they are shared appropriately.

16. **Location of Assignment** (including suite or room numbers):
17. Point of Contact:

    Name:
    Email: Phone Number:

18. Special Needs (if applicable):

    ☐ Secret Clearance ☐ Top Secret Clearance

    ☐ Other: requesting at least advanced certification or equivalent

TEL: (301) 881-8884 x1210 | FAX: (301) 881-6877 | EMAIL: JBALAS@ALCINC.COM | WEB: WWW.ALCINC.COM

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If there are any further questions, comments, or concerns, please contact request@alcinc.com. Any and all input or feedback is requested and encouraged.

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GENEVAWORLDWIDE

PLEASE SIGN AND FAX TO 212-255-8409 OR EMAIL TO Interpretingstaff@genevaworldwide.com

Interpreter Request Form for DC Medicaid Fee-for-Service Beneficiaries

ASSIGNMENT INFORMATION	
DATE REQUESTED:	LANGUAGE: ASL ONLY
ASSIGNMENT DATE AND TIME:	PROVIDER NAME:
PROVIDER ID:	PROVIDER ADDRESS:
PROVIDER PHONE:	PROVIDER FAX:
PATIENT INFORMATION	
NAME:	MEDICAID ID NUMBER:
TELEPHONE NUMBER:	DOB:
PATIENT ADDRESS:	

THE ABOVE MENTIONED SERVICE WILL BE BILLED AT THE CONTRACTUAL RATE ESTABLISHED BY DHCF WITH A ONE HOUR MINIMUM CHARGE BILLED IN 15 MINUTE INCREMENTS THEREAFTER.

CANCELLATION POLICY: GWW REQUIRES 24 HOURS NOTICE. IF CANCELLED IN LESS THAN 24 HOURS, ASSIGNMENT WILL BE BILLED FOR A ONE HOUR MINIMUM.

IF YOU HAVE QUESTIONS ABOUT DC MEDICAID LANGUAGE ACCESS BENEFITS, OR HAVE TROUBLE ACCESSING SERVICES, PLEASE CONTACT PAMELA HODGE, DC DEPARTMENT OF HEALTH CARE FINANCE, DELIVERY MANAGEMENT ADMINISTRATION AT 202.442.4622 OR PAMELA.HODGE@DC.GOV.

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