## GOVERNMENT OF THE DISTRICT OF COLUMBIA Department of Health Care Finance



## Interpreter/Communication Access Real-Time Translation (CART) Services Request Form

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 should an interpreter be available. Authorization is required from an approved Department of Health Care Finance (DHCF) representative.

Please reply to this email/fax with the requested information.

Please complete this form with the correct information and send it to:

Email: Antonio.lacey@dc.gov

Phone: 202-442-5847 | Fax: 202-722-5685

Request Submis		WIDED DEL		Jew Appointment			☐ Follow-up Appointment ☐ HOSPITAL REFERRAL			
☐ TELEPHONE REFERRAL ☐ PROVIDER REFERRAL ☐ DOCTOR'S OFFICE REFERRAL ☐ HOSPITAL REFERRAL										
Beneficiary's Information	First Name:				Last Name:					
	Medicaid Number:		Beneficiary's Primary Telephone #:		Alternate Telephone #		e # (if any):	Beneficiary's Date of Birth:		
Appointment/ Requested Language	Urgent Appointment Date:  Please explain in below  'Comments' section why it is urgent.			Appointment Time :		Appointment with the Do		octor	Maximum 2 hours. Special approval is needed beyond 2 hours assignment.	
	Service Requested: Face-to-Face Interpreter ASL Interpreter Other (Specify):									
	Facility / Doctor Name:			Department:			Doctor's Office Phone:			
	Address (Please ensure the address is correct for the Interpreter to reach the location on time): Please include, Street, Bldg., Floor, Suite etc.									
	Assignment	City:			State:		Zip:			
	Requested Language:									
	Spanish			Vietnamese			☐ Chinese ☐ Sign Language (ASL)			
	French			Mandarin			☐ Korean			
	☐ Cantonese ☐ A			☐ Amharic	Amharic 🔲 Italian					
	Comments:									
Requester Information	Agency/Division: Requester F			Full Name: Relationship to		ip to the 1	to the Beneficiary:		Phone Number:( ) Email:	
	Full Address:				City: State:				Zip Code:	
DHCF Authorization	Method Used For St				ıbmission and Approval					
	APPROVED DENIED			Email		lline	Approved or Denied by:			
	Notes:									
	Signature/Electi	roval:		Date:						

Confidentiality Notice: The information contained in this transmission is confidential, proprietary, or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the message is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error, please contact the sender immediately by replying to this email or fax and delete the material from any computer.

\*Revised 3/29/2022\*\*