WHITTIER PEDIATRIC GROUP

LANGUAGE ASSISTANCE ACKNOWLEDGEMENT FORM

Patient Name:_____ DOB:_____

Date:_____

Health Plan

☐ **Commercial**	☐ Aetna	☐ Blue Shield Promise (care 1ST)	☐ Health Net	☐ Molina
☐ **Duals**	☐ Alignment	☐ Central Health	☐ Heritage	☐ Scan
☐ **Medi-Cal**	☐ Blue Cross	☐ Cigna	☐ Inland Empire	☐ United Health
☐ **Senior**	☐ Blue shield	☐ Easy Choice	☐ Inter Valley	☐ Other (Specify)
	☐ Cal Optima	☐ Golden State	☐ LA Care	_____

Primary Language Spoken: _____

Member was informed of the availability of Medical Group and/or Health Plan Interpreter Service. (Must Document)

☐ **Yes – I was informed of interpreter Service availability, Health Plan Language assistance sheet given.**

☐ **No – I refused Interpreter Services.**

Patient signature**:** _____ Date**:**_____

Witness Signature**:** _____ Date**:**_____

FOR ADMINISTRATIVE USE ONLY

Documentation of Interpreter Service assistance.

Interpreter Agency**:** _____ Date**:** _____

Interpreter Name**:** _____ Date**:** _____

Staff Signature**:** _____ Date**:** _____
