Language Assistance Acknowledgement Form

Patient Name: _____ Date: _____

Health Plan

☐ **Commercial**	☐ Aetna	☐ Care 1st	☐ Health Net	☐ Molina
☐ **Duals**	☐ Alignment	☐ Central Health	☐ Heritage	☐ SCAN
☐ **Medi-Cal**	☐ Blue Cross	☐ Cigna	☐ Inland Empire	☐ United
☐ **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**

☐ **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: _____

GREATER Covina MEDICAL GROUP inc.