

**DEPARTMENT OF HEALTH AND SENIOR SERVICES
LIMITED ENGLISH PROFICIENCY (LEP) CONSUMER REPORT**

USAGE DATA SHEET

****Complete this form each time an LEP individual is served—one form per person****

NOTE: This is for contact when DHSS will be responsible for providing and paying for the interpreter service. Be sure the interpreter service is offered to the LEP individual free of charge. If the individual wishes to use another person over the age of 18 years as his/her interpreter, document this choice and let the LEP individual know he/she can change at any time to the free interpreter service. Attach a copy of any invoice received for the payment of the service. Please keep this document in the client's file.

- 1) Date this form was filled out: _____
- 2) Division/Center/Office: _____
- 3) Bureau/Section: _____
- 4) Program in Bureau/Section (if applicable): _____
- 5) Address/Phone: _____
- 6) Name and position of employee making LEP contact: _____
- 7) Date contact was made: _____
- 8) Was an Interpreter Offered Free of Charge? Yes ____ No ____
- 9) Accepted? Yes ____ No ____ If "no", give reason: _____
- 10) Source of Interpreter Used (Example: Language Line, relative, friend, etc.): _____
- 11) Name of Interpreter (if available): _____
- 12) Relationship to LEP individual (None, spouse, mother, etc): _____
- 13) If an interpreter was not used, explain why and document attempts made to obtain an interpreter (Language Line is available by telephone 365 days, 24/7): _____
- 14) During this contact, please report the language used by the LEP individual:
Language used: _____

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The Missouri Department of Health and Senior Services will be the leader in promoting, protecting and partnering for Health.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.
Date: 10-03-2014