



LIMITED ENGLISH PROFICIENCY/ HEARING IMPAIRED

Interpreter Reimbursement Request

(Relatives or friends of the client are not eligible for reimbursement)

NOTE: Forms to be submitted to the CCC within seven (7) days.

Program Requesting _____ Contact Person _____

Program Phone _____ Program Fax _____

Date Requested: _____

Client's Name: _____ DOB _____ ID # _____

Source of Funds (i.e. BG, Medicaid, MI Child, Other) _____

Dates of Service: _____

Interpreter's Name/Credentials: _____

Interpreter's Address: _____ Phone: _____

Relationship to Client: _____

Hourly Rate: _____ Maximum Hours Anticipated: _____

Other Costs Associated: Mileage: _____ Parking: _____ Other: _____

Comments: _____

CCC Approved Denied

Authorizations: Level of Care _____ Number of Sessions _____

Comments: _____

CCC Staff Signature: _____ Date: _____

CCC Manager Signature: _____ Date: _____

Finance Department Approved Denied

Maximum Dollar Amount Approved: _____

Finance Manager Signature _____ Date: _____

Please fax this form to: Luann LeVeck, Care Coordination Secretary, at (517) 853-0496