

**NEW YORK STATE DEPARTMENT OF CORRECTIONS
 AND COMMUNITY SUPERVISION
 LANGUAGE ACCESS PLAN COMPLIANCE REPORT**

Please complete this form, monthly, for all interpretation or translation services provided to any inmate in your area. Note that contract vendors also need to be tracked, and should be included in the "Staff Providing Service" column. "Type of Service" examples may be a Disciplinary Hearing, Grievance, Medical/Mental Health encounter, etc.

Please return this form to the DSP's Office by the 5th of the following month.

Facility: _____ Reporting Month: _____ Year: _____

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|--|---|
| Date | |
| Inmate, Visitor | Name _____ DIN _____ Primary Language _____ |
| Staff Providing Service (Name & Title), Contract Vendor, Inmate | |
| Interpretation or Translation? | Interpretation (Spoken) _____ Translation (Written) _____ |
| Type of Service (Check) | D ___ G ___ Me ___ MH ___ CS ___ Other _____ Examples may be Disciplinary , Grievance , Medical/Mental Health , or Community Supervision . |

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| Interpretation or Translation? | Interpretation (Spoken) _____ Translation (Written) _____ |
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Person Completing Form _____
 (Must be Area Supervisor) (Name & Title, Print & Sign)

Attach additional sheets, as needed