DEPARTMENT OF CORRECTIONS

INCARCERATED PERSON/RESIDENT REQUEST FOR LANGUAGE TRANSLATION SERVICES

Instructions: Please fully complete form, attaching additional pages if necessary, and send this form to the Facility AWA. If you need help completing or submitting this form, please ask the facility AWA coordinator or another staff person.

Name:	OID:
Facility:	

1. What is your preferred language?
2. What language assistance or tools do you need to fully access and benefit from DOC programs or services?

By submitting this form, you agree to communicate with DOC staff as needed to address your request. Providing this information helps the Minnesota DOC assess your language needs. Sharing it is voluntary, but not doing so may limit the DOC's ability to support you. Only authorized staff or individuals allowed by law will have access to this information.

_____ _____

Incarcerated Person's/Resident's (or Guardian's) Signature Date

DEPARTMENT OF CORRECTIONS

Received by:

_____ _____

Employee Signature/Printed Name Date

Facility LEP coordinator:

Date(s) of meeting with requestor: _____

Temporarily approved request: _____

_____

_____ _____

Signature/Printed Name Date

Copies: COMS, requestor, and unit securing language services.