Interpretation Vendor List

Please use the contact information provided when filling out the Notice to Proceed form. To promote equitable utilization of our contracted vendors, it is encouraged to rotate among them when possible.

In Person / Remote Interpretation Services:

- **Four Corners Translation**
  - Contact: Omid Jafarzadeh, omid@fourcornerstranslation.com (email preferred), 646-761-1493
  - Languages: Spanish, Chinese, Vietnamese, Russian, Arabic, Somali, and others
  - Contract No.: 28531, Expires: 2/3/2025
  - Billing address: P.O. Box 520151, Flushing, NY 11352 US
- **Passport To Languages**
  - Contact: Erik Lawson, erik@passporttolanguages.com, 503-297-2707
  - Languages: Spanish, Chinese, Vietnamese, Russian, Arabic, Somali, and others
  - Contract No.: 28610, Expires: 2/3/2025
  - Billing address: 3912 SW 43rd Ave, Portland, OR 97221 US

Remote Only Interpretation Services:

- **TransPerfect**
  - Contact: Fatema Sachak, fsachak@transperfect.com, 917-864-5233.
  - Secondary Phone Number: 202-347-2300
  - Languages: Spanish, Chinese, Vietnamese, Russian, Arabic, Somali, and others
  - Contract No.: 28609, Expires: 2/3/2025
  - Billing Address: 1250 Broadway, 32nd Floor, New York, NY 10001 US

Oregon Department of Human Services

ODHS/ODDS

Interpreting Services - NOTICE TO PROCEED

Purpose: This Interpreting Services – NOTICE TO PROCEED (NTP) form is used to request Interpreting Services for approved Individuals and their families, guardians, or caregivers by Oregon Department of Human Services (ODHS) Office of Developmental Disability Services (ODDS) and Case Management Entities (CME) Authorized Representative(s) or Appointee(s) from approved contractors holding active Interpreting Services Contracts with ODDS.

Form Instructions:
All Sections and boxes need to be completed as described below. If a box is not applicable to the request, please write N/A. Where signatures are required, electronic is acceptable or an attached email from the authorized signer indicating the section approved.

- ☐ Section 1 – to be filled out by ODDS/CME Authorized Representative or Appointee
- ☐ Section 2 – to be filled out by Requestor
- ☐ Section 3 – to be filled out by Requestor
- ☐ Section 4 – to be filled out by Interpreter
- ☐ Section 5 – to be filled out by ODDS/CME Authorized Representative or Appointee
- ☐ Section 6 – to be completed by Contractor

Attachments:
1. Approved Contractor List
2. Language List

Section 1: ODDS / CME Information			
Agency:	Contact Name:		
Address: Street	City	State	Zip
Contact Phone:	Contact Email:		

Section 2: Interpreting Services Contractor Information			
Contractor Legal Name:		Contract No.:	
Contact Name:		Contract Exp.:	
Physical Address: (For in-person assignments): Street	City	State	Zip
Billing Address: Street/PO Box	City	State	Zip
Office Phone:	Email:	Fax:	
Interpreter Phone:	Interpreter Email:		

Section 3: Service Requirements	
Client Name:	Client Prime:
Service Category: *(NOTE: Use Government Conversational unless a heavy medical focus is requested; if needed, the Interpreting Services Contractor can provide guidance on which box to check.)* ☐ Government Conversational ☐ Health Care Certified ☐ Health Care Qualified	
Requested language:	
Requested delivery format: ☐ Remote preferred ☐ In-Person preferred, flexible ☐ In-Person	

Oregon Department of Human Services

ODHS/ODDS

Interpreting Services - NOTICE TO PROCEED

Brief description of purpose for service *(i.e. medical appointment, etc.)*:			
Appointment Date(s):	Start Time:		
Interpreter Arrival Time *(15 min. prior to start time)*:	Anticipated End Time:		
Appointment Address: Street	City	State	Zip
Contact Name:	Contact Phone:		
Special Instructions: *(equipment needed, etc.)*			

Section 4: Interpreter's Validation – *To be filled out by Interpreter*

Interpreter's Name:	Cert. #	Exp. Date:
Miles Traveled to Appointment Address:	Roundtrip Total:	

By signing below, interpreter attests interpreting services were offered in accordance with the above request.

_____ _____

Interpreter's Signature Date

Section 5: Services Validation – *To be filled out at time of appointment*

ODDS/CME Authorized Representative Name:	
Date of Service:	Provider Number (when applicable):

☐ Service Provided as Requested ☐Client No Show ☐ Short Notice Service ☐ Cancellation

_____ _____

Authorized Representative's Signature Date

Section 6: Submit Form with Invoice – *To be completed by Contractor*

☐ Email invoice referencing associated contract number and completed NTP form to cau.invoice@odhs.oregon.gov. Allow 45 days for payment processing.