



## LANGUAGE CAPABILITY VERIFICATION FORM

### FACE SHEET

**Instructions to Specialized Health Plans:** In accordance with the Department of Managed Health Care’s Language Assistance Program (“LAP”) Regulations (Section 1300.67.04 of the California Code of Regulations, Title 28), a specialized health plan – i.e., a specialized dental, vision, chiropractic, acupuncture or employee assistance program plan – may demonstrate to the Department:

“[...] adequate availability and accessibility of competent and qualified bilingual providers and office staff if:

(A) The plan identifies within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English;

(B) The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers and/or office staff by submitting new language capability disclosure forms, and the plan updates its provider directories accordingly, and consistent with Section 1367.26 of the [Knox-Keene] Act; and

(C) The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.” [Section 1300.67.04(d)(9) CCR]

ICE has developed the Language Capability Verification Form for specialized plans to consider using with their contracted provider network, if the specialized plan chooses to fulfill its obligations in accordance with the Department’s LAP Regulations as described above. This tool is not intended for full-service health plans or for any purpose other than what is described above.

Additionally, Section 1300.67.04(d)(9) of the Department’s LAP Regulations as described above is not an obligation of a provider, so ICE proposes that a specialized plan consider asking a provider to facilitate the specialized plan’s need to comply with this section of the LAP Regulations, as follows:

Dear **[ENTER NAME OF PROVIDER]**:

**[ENTER NAME OF SPECIALIZED HEALTH PLAN]** is asking for your assistance in fulfilling the requirements set forth in the Department of Managed Health Care’s Language Assistance Program (“LAP”) Regulations (Section 1300.67.04 of the California Code of Regulations, Title 28). Our Provider Directory has identified you and/or your staff as speaking a language other than English. Please complete the attached Language Capability Verification Form to attest that you and/or your office staff are bilingual and fluent in languages other than English.



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To ensure that patients will have accurate information on physician's and office staff language capability, please fill out this document and fax it back to [Plan's Fax Number]. Please make sure to SIGN this document. **This document will not be valid without a signature.** Language information will be printed in a provider directory.

<b>PROVIDER NAME:</b>	
<b>LICENSE:</b>	
<b>PRIMARY SPECIALTY:</b>	
<b>CLINIC NAME:</b>	
<b>OFFICE ADDRESS:</b>	
<b>PHONE:</b>	
<b>FAX:</b>	
<b>LANGUAGE(S) FLUENTLY SPOKEN BY PROVIDER:</b>	English,
<b>LANGUAGE(S) FLUENTLY SPOKEN BY OFFICE STAFF:</b>	English,

I certify that the information in this document and any attached documents is true and correct.

\_\_\_\_\_  
**Provider Signature/Provider Staff**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

**THANK YOU FOR YOUR PROMPT RESPONSE!**