



**ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES**  
**County Office Building 800 Park Avenue Utica, NY 13501**

**TO:** All Employees  
**FROM:** Lucille Soldato, Commissioner  
**RE:** Interpreter Services for Limited English Proficient and Hearing Impaired Clients  
**DATE:** 11/30/11 (revised 8/10/16)

**POLICY AND PROCEDURES**

The Oneida County Department of Social Services is committed to providing effective, efficient and equitable service to the public we serve. The public has access to our services regardless of their ability to speak, read or write English. Policies and procedures for ensuring that our Limited English Proficient (LEP) and hearing impaired clients can communicate effectively with us are as follows and effective immediately. By definition, LEP persons are those who do not speak English as their primary language and have limited ability to read, speak, write or understand English. Not all Limited English Proficient clients, (i.e. the Hispanic population), are refugees. This procedure defines the plans and processes and ensures that communication assistance is provided as needed to all Limited English Proficient clients, including those who are not refugees.

- Signs advising “Free Interpretation Services Are Available” shall be generated in the languages of primary non-English population groups and posted at all points of client access. The signs shall include other appropriate information such as how to file a complaint.
- All other routinely posted signs regarding agency procedures shall be reviewed on a regular basis and, when deemed appropriate, versions translated in the primary languages shall be posted with, or included in, the English version.
- Key client documents such as consents and letters explaining agency actions shall be translated and provided in the primary language.
- Each department will designate a staff member who will be responsible for coordinating language communication assistance as needed and maintaining a supply of forms. A log must be kept each time interpreter services are requested on behalf of a client. The log must be turned in to the Contract Administrator at the end of each month. A copy of the log is part of this document.

- All staff must assess the proficiency needs of any client whose primary language is not English. An assessment tool with suggestions for assessing English proficiency is attached to this policy as Attachment A.
- To ensure access to and coordination of services, documentation of LEP must be kept in the front cover of each case record under the alert card and/or noted by a special coding on the 3209 in the area designated for local data. A form for this purpose titled LEP Client Need for Interpreting Services is included in this policy as Attachment B.
- The Language Identification Tool is available for all staff to assist in identifying specific language assistance needs. Copies are to be kept in all DSS interview rooms.
- We have a responsibility to obtain a qualified interpreter, but may not deny access to an application for benefits, programs or services based on the inability to provide adequate interpretation services.
- The use of minor children, other family members and friends is discouraged and should **only** occur during emergency and/or initial CPS contact situations when there is no other choice. However, it is recognized at times a client may designate a person and/or relative to act as their interpreter. In any of these situations to promote confidentiality and verify the clients consent the Consent/Confidentiality Form (Attachment C), available in several major languages, must be signed by both the LEP client and the client's chosen interpreter. But note if at all possible it is best practice to encourage the use of a qualified interpreter.
- The Waiver Form (Attachment D) must be signed by a client refusing interpreter services and it must be attached to the front of the case record. It must also be documented in the case narration that interpreter services were offered and refused.
- All Department of Social Services staff members including employees, contract personnel, summer employees and student interns shall be trained on this Interpreter Services Policy and Procedures. Staff shall be re-trained on a yearly basis.

### **INTERPRETER SERVICES ARE AS FOLLOWS:**

1. **Compass Interpreters: (Mohawk Valley Resource Center for Refugees)**  
Office Address: 309 Genesee Street Utica, New York 13501  
Interpreter services can be coordinated by calling the 24-hour interpreter service line at **315-749-7080**.
2. **LLE – LINK:** This service is a phone based option available for short term and immediate translation needs as well as for longer interviews and conferences or meetings. Please use the **Telephone Interpreter Service Users Guide** for reference and code numbers. The designees listed on page 10 have the necessary information.  
**General Instructions:**
  - Place the LEP person on Conference while you contact LLE if they are calling by phone or use the speaker phone if they are present.
  - Dial **800-234-0780**.

- Enter the access code assigned to your department on the telephone key pad followed by the **# key**. Check with your designee or supervisor for the number.
  - Enter the request code of the language on your keypad to be connected directly to the interpreter. If you do not know what language the client is speaking, there is a code to enter on the key pad.
  - If you need additional assistance, press “0” at the request prompt and a Customer Care Representative will assist you.
  - Add the LEP person to the conference call. Once connected to the interpreter, instruct him/her to proceed.
3. **MAMI** – (Multicultural Association of Medical Interpreters) provides on-site, face-to-face or telephone interpreter service in many languages. MAMI is available every day, 24 hours a day.

Utica Office: 287 Genesee St. Suite 101, Utica, NY 13501

Utica Phone Number: **(315) 732-2271**

Fax Number: **(315) 732-2360**

Syracuse Phone Number: (315) 241-5003

Syracuse Fax Number: (315) 218-5288

Syracuse Office: 404 Oak Street, Syracuse, NY 13203

MAMI Office hours: Weekdays, Monday – Friday 5 pm – 8:30 am; Friday 5 pm - Monday 8:30 am.

#### **HOW TO ACCESS MAMI DURING OFF-HOURS**

- Call MAMI at **(315) 624-0953**
  - Give your organization’s name, address and your name
  - Give the name and language of the LEP person
  - Indicate when/where an interpreter is needed
  - The MAMI Off-Hour Dispatcher will call back within 10 minutes to indicate the name of the interpreter and estimated time of arrival or availability by phone.
4. **Language and Cultural Services, Inc.** – P.O. Box 58, New Hartford, NY. 13413 **(315) 542-7226.**
5. **Techno-Logic Solutions, Inc.** – **32 Auburn Ave., Utica, NY 13501. (315) 733-1399**
6. **Hearing Impaired Interpreter Services:**  
Empire Interpreting provides interpreting services for the deaf. Services can be accessed by contacting either Jay Slater or Susan Urben at 315-472-8032.

Additionally, Compass Interpreters also have limited capacity to provide deaf interpretation week days till 2 pm. They request advance notice if at all possible due to the limited availability. To request these services contact the 24 hour interpreter service line at **315-749-7080.**

**Please note:**

Please be sure to notify the provider that the services are being used for a county program so services will be billed at the established County rate.

Compass is the first choice for interpreting services as they offer the county a more affordable rate.

It is important to note that whenever possible appointments should be canceled in advance as the county is charged for client or worker “no-show” appointments.

The interpreter service logs are monitored by the Contract Administrator and maintained as a file. The Contract Administrator should be advised if there is an identified language that interpreting services are not available or difficult to access so that efforts can be made to identify alternate resources.

Confidentiality requirements must be adhered to and interpreting services must be conducted in confidential location(s) whether provided in person or through a phone service.

**Protocols for use of Language Forms**

These forms are to be completed at all face to face TA, MA, SNAP, Services, HEAP and Day Care Interviews in which it is determined that the head of household’s primary language is other than English. This includes all intakes completed at Facilitated Enrollers or Community Based Organizations. The head of household must either accept or refuse an interpreter.

These form(s) are to be kept in the case file and made part of IEDR as documentation that the client was asked if an interpreter was needed. If a client rescinds their request, it must be documented, preferably with written verification from client, and made part of the case file.

A copy of these form(s) must be sent with all TA transfers to MA or SNAP as well as all referrals to Employment, Daycare, IV-D, and Resources (including Validations, fraud referrals and complaints).

## Attachment A

# Language Assessment Tool

## **Suggestions to identify a Limited English Proficient (LEP) who may need language assistance:**

- Examine case records to see if requests for language assistance have been received in the past.
- Informally engage clients in conversation to gauge their ability to understand and speak English. Use simple language and speak slowly.
- Some basic questions that can be asked are:
  - What is your name?
  - What is your address?
  - Where do you live?
  - Where were you born?
  - What language do you speak, read and write?
  - What is your birthday?
  - What are your children's names and how old are they?
  - Do you speak, read or write in English?
  - What kind of work do you do?
- If the client indicates they do not understand use the Language Identification Guide (pg. 8) available in all DSS Interview Rooms (pg. 8) to assist in identifying the primary language.

**Attachment B**

Anthony J. Picente Jr.  
County Executive

Lucille A. Soldato  
Commissioner



**ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES**  
County Office Building 800 Park Avenue Utica, NY 13501

**LIMITED ENGLISH PROFICIENT CLIENT  
NEED FOR INTERPRETER SERVICES**

I attest that \_\_\_\_\_ is limited in English  
**(Client's Name – Print Legibly)**  
Proficiency and requires an interpreter in \_\_\_\_\_.  
**(Primary Language)**

Interpreter Services were offered on \_\_\_\_\_.  
**(Date)**

DSS employee's name: \_\_\_\_\_  
**(Print)**

DSS employee's signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

**Attachment C**

County Executive  
**Anthony J. Picente Jr.**

Commissioner  
**Lucille A. Soldato**



**ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES**

County Office Building 800 Park Avenue Utica, NY 13501

**WAIVER OF INTERPRETER SERVICES/CONFIDENTIALITY FORM**

I \_\_\_\_\_ am declining an Interpreter Service

*(Client's Printed Name)*

arranged by the Oneida County Department of Social Services. I designate

\_\_\_\_\_, relationship \_\_\_\_\_

*(Printed Client Designated Interpreter's Name)*

to act as my interpreter. I understand that I may request an Interpreter Service at a future time.

\_\_\_\_\_  
Date: \_\_\_\_\_

*(Client's Signature)*

**I have been advised of confidentiality rules and I agree that I will hold in strict confidence anything that is said while I am acting as an interpreter.**

\_\_\_\_\_  
Date: \_\_\_\_\_

*(Designated Interpreter's Signature)*

\_\_\_\_\_

*(Agency/Representative Witness Name Printed)*

\_\_\_\_\_  
Date: \_\_\_\_\_

*(Agency Representative Witness Signature)*

**Attachment D**

**ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES  
WAIVER OF RIGHT TO FREE ORAL INTERPRETATION SERVICES**

APPLICANT/CLIENT NAME:

\_\_\_\_\_

I have been told of my right to a free interpreter from the Oneida County Department of Social Services.

I understand that I can have an interpreter at no cost to me or my family members.

I understand that I am allowed to change my mind at any time and accept a free interpreter.

I choose not to use a free interpreter at this time.

\_\_\_\_\_  
(Please **PRINT** Applicant/Client Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant/Client Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(**PRINT – NAME & UNIT** of Local District Representative)

\_\_\_\_\_  
(**Ext. #**)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Local District Representative)

\_\_\_\_\_  
(Date)

***Whenever applicable:* the interpreter named below has read this form to the Applicant/Client in his/her primary language.**

\_\_\_\_\_  
(**PRINT** - Name of Interpreter)

\_\_\_\_\_  
(Agency or Relationship to Client)

\_\_\_\_\_  
(Signature of Interpreter)

\_\_\_\_\_  
(Telephone No.)

\_\_\_\_\_  
(Date)

# REQUEST TO SCHEDULE AN INTERPRETER

COMPLETE IN FULL

DATE: \_\_\_\_\_

TO: \_\_\_\_\_ Department: \_\_\_\_\_  
(Department Designee)

FROM: \_\_\_\_\_

**PLEASE SCHEDULE:**

\_\_\_\_\_ Language Interpreter Services    **\*\*Language Spoken by Client:** \_\_\_\_\_

\_\_\_\_\_ Hearing Impaired Interpreter Services

NAME OF CLIENT: \_\_\_\_\_  
(Print Legibly)

DATE(S) SERVICE NEEDED: \_\_\_\_\_

TIME(S) NEEDED: \_\_\_\_\_

WHERE: \_\_\_\_\_  
DSS Office/Floor, Court (which one and address), other location (be specific as to entrance/floor)

SPECIAL REQUESTS: \_\_\_\_\_  
(Be Specific)

\_\_\_\_\_

\*\*\*\*\*

**THIS SECTION IS TO BE COMPLETED BY THE DESIGNATED PERSON SCHEDULING THE SERVICE AND RETURNED TO THE STAFF PERSON REQUESTING THE SERVICE**

An interpreter has been arranged on the date(s) and time(s) requested above.

PROVIDER CONTACTED: \_\_\_\_\_ Phone: \_\_\_\_\_

NAME OF INTERPRETER: \_\_\_\_\_ Phone: \_\_\_\_\_  
(if known)

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## DEPARTMENT DESIGNEES FOR COORDINATION OF LEP AND HEARING IMPAIRED LANGUAGE ASSISTANCE AND MAINTAINING LOGS AND SUPPLIES

Child Support	Fran (Marie) Sierak	793-6011
Employment	Lorraine Getman Janine Roberts	798-5464 798-3691
SNAP	Michelle Wadas (Utica) Candace Hammon (Rome)	798-3658 338-0214
Medicaid	Carrie Block (Utica Office)	798-5957
Resources/Fraud Investigations	Karen Karas	798-5746
Services (Child Welfare & Adult Protective)	Julie Drake	798-5738

A log will be kept in the Emergency Duty kit. An entry must be made each time an interpreter service is requested listing the service used and the date of service. The log must be submitted to Julie Drake on the last working day of the month.

Temporary Assistance	Donna Peroni (Utica)	798-3682
	Joanne Frick (Utica)	798-3439
	Sue Holland (Rome- will coordinate language assistance and maintain logs)	338-0223
	Norma Robinson (Rome - will maintain the supply of forms).	338-0216

Legal Department/The client's caseworker or examiner will utilize their departments' Fair Hearings designee to arrange for an interpreter.

NOTE: The unit designee must submit a copy of the log to Vicky Conover, Contract Administration, on the last working day of the month.



## **NOTICE OF NONDISCRIMINATION IN SERVICE DELIVERY**

IN ACCORDANCE WITH FEDERAL LAW AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) POLICY, THIS INSTITUTION IS PROHIBITED FROM DISCRIMINATING ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, OR DISABILITY.

### **DISCRIMINATION COMPLAINT INFORMATION**

**If you believe you have been discriminated against because of your Limited English Proficiency, you may file a written complaint with:**

**John Herbowy, Chief Attorney  
Oneida County Department of Social Services – 9<sup>th</sup> floor  
800 Park Ave., Utica, NY 13501**

### **ADDITIONAL DISCRIMINATION COMPLAINT INFORMATION**

You may also contact the U.S. Department of Health and Human Services, Office of Civil Rights:

**Office of Civil Rights, DHHS  
25 Federal Plaza – Suite 3313  
New York, NY 10278  
Telephone: (212) 264-3313  
Fax: (212)861-4431  
TDD: (212)264-2355**

**Should you wish to file a complaint, Complaint Forms are at the front desk**

## Process for Clients Who Wish to File a Complaint with the LDSS

You may file a complaint with your LDSS using the LDSS Complaint Form (C-2a). However, if you prefer to submit a written complaint in your own words, be sure to include the following information:

1. Your full name and address
2. Home and work telephone numbers
3. E-mail address
4. Name, full address and phone number of the person, agency or organization you believe discriminated against you
5. Brief description of what happened: how, why, and when you believe your (or someone else's) civil rights were violated
6. Any other relevant information
7. Your signature and date of complaint
8. Please mail your complaint to:

John Herbowy, Chief Attorney  
Oneida County Department of Social Services – 9<sup>th</sup> floor  
800 Park Ave.  
Utica, NY 13501

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If someone else is filing a complaint on your behalf, please provide their name.

ONEIDA COUNTY DEPARTMENT OF SOCIAL SERVICES  
LIMITED ENGLISH PROFICIENT (LEP)  
**DISCRIMINATION COMPLAINT FORM**

COMPLAINANT'S FIRST NAME \_\_\_\_\_ COMPLAINANT'S LAST NAME \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ALTERNATE PHONE \_\_\_\_\_  
( ) ( )

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ E-MAIL ADDRESS ( If available) \_\_\_\_\_

Is someone else filing this complaint for you? YES NO  
If Yes, include their name below

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

I believe that I have been (or the person named above has been) discriminated against on the basis of :  
Limited English Proficiency / National Origin

Who do you think discriminated against you (or the person named above)? Be specific  
PERSON/ AGENCY / ORGANIZATION

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

When and where do you believe that the discrimination took place? Be Specific  
LIST DATE(S) AND LOCATION(S)

Describe briefly what happened. How and why do you believe you (or the person named above) were  
discriminated against? Please be as specific as possible. (Attach additional pages as needed)

Please sign and date this complaint.  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Please type or print, and return completed complaint form to:**  
John Herbowy, Chief Attorney  
Oneida County Department of Social Services – 9<sup>th</sup> floor  
800 Park Ave.  
Utica, NY 13501