

## LANGUAGE CAPABILITY DISCLOSURE FORM FOR PARTICIPATING CALIFORNIA DENTAL OFFICES

Please fax the completed form to Provider Data Management at (866) 223-2770

### SECTION 1

No one on our current staff employed at the address reflected below is fluent in any language other than English.

— OR —

At least one dental office staff member employed at the address reflected below is fluent in one or more of the following non-English languages. Please check all that apply.

- |                                 |                                       |                                  |             |
|---------------------------------|---------------------------------------|----------------------------------|-------------|
| <input type="radio"/> Armenian  | <input type="radio"/> Hmong           | <input type="radio"/> Portuguese | Other _____ |
| <input type="radio"/> Cambodian | <input type="radio"/> Korean          | <input type="radio"/> Russian    | Other _____ |
| <input type="radio"/> Chinese   | <input type="radio"/> Miao            | <input type="radio"/> Spanish    | Other _____ |
| <input type="radio"/> French    | <input type="radio"/> Mon-Khmer       | <input type="radio"/> Tagalog    | Other _____ |
| <input type="radio"/> German    | <input type="radio"/> Persian (Farsi) | <input type="radio"/> Vietnamese | Other _____ |

### SECTION 2

By indicating a foreign language capability above, you certify that at least one member of the office staff is proficient in the foreign language(s) indicated, as well as English and has a fundamental knowledge of dental terminology and the concepts relevant to dental treatment in all language(s) indicated and will comply with the NCIHC National Standards of Practice for Interpreters in Healthcare. By signing below, an authorized representative of the dental practice certifies that the preceding response is true, complete and accurate to the best of his/her belief.

### SECTION 3

UNITED CONCORDIA  
DENTAL PROVIDER #: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRINT NAME: \_\_\_\_\_

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

TITLE: \_\_\_\_\_

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

**IMPORTANT NOTICE:** DMHC Regulation SB 853 requires all contracting offices to submit a Language Capability Disclosure Form. The submission of this disclosure form allows the Plan to oversee the availability of interpreter services and update its provider directory consistent with Section 1367.26 of the Act.

Refer to [www.ncihc.org](http://www.ncihc.org) for more information.