

Staff Interpreter Billing Form

Staff Interpreter's Name:
Billing Address:

Consumer's Name:
Appointment Address/Department:

Job ID #	Reference Number	Service Date	Start Time	End Time

Quantity	Item	Description	Unit Price	Total
	Hour(s) (2 hrs minimum)	Sign Language Interpretation Service		
	Mileage	Odometer reading: _____ to _____		
	Travel Time	*		
	Other Fee	<input type="checkbox"/> Parking <input type="checkbox"/> Tolls <input type="checkbox"/> Public Transportation		
*Travel time formula – (total miles ÷ 50 = _____ X ½ of hourly rate = travel reimbursement) Note: Must travel a minimum of 20 miles each ways to be eligible for travel reimbursement			Total	

An invoice payable to MCDHH will be issued shortly

I certify that the above information is true and correct. Information will be kept strictly confidential.

Staff Interpreter Signature:
Consumer's Signature (verification of service rendered): X

For MCDHH Use Only									
<input type="checkbox"/> Job was cancelled	Date of Cancellation:			Time of Cancellation:			By:		
Vendor/Customer ID:									
MMARS Document ID#:									
Fund 0300	Sub-Fund 2697	Revenue 3500	Department MCD	Unit 0001	Description:				
Prepared By:							Date:		
Entered By:							Date:		
Submitted/Approved By:							Date:		

