



**OFFICE OF LANGUAGE ACCESS
STATEMENT FOR SERVICES**

FOR INTERNAL USE ONLY

Date Received by OLA: _____
Time Period of Invoice:
From _____ to _____
Page _____ of _____

**INVOICE(S) SHALL BE SUBMITTED WITHIN 7 DAYS OF THE SERVICE BEING PROVIDED.
FAILURE TO COMPLY WITH THIS REQUIREMENT MAY RESULT IN DELAY.**

Contract #: _____ Invoice #: _____ Assignment ID #: _____

Name of Interpreter: _____ Language or Dialect Interpreted: _____

Mailing Address: _____ Phone Number: _____

_____ Email Address: _____

_____ County of Residence/Business: _____

Total Interpreting Time: _____ hours X \$ _____ (See Contract Rate) = \$ _____

Total Travel Time: _____ hours X \$ _____ (See Contract Rate) = \$ _____

Total Reimbursable Lodging Expenses: (OLA Pre-Approval and Receipt Required) = \$ _____

Total # of Cases Included in this Invoice: _____ (enter "0" if none) **INVOICE TOTAL: \$** _____

I hereby state the information provided on this form and the payment requested is true to the best of my knowledge. Each charge is supported by relevant orders and receipts. **NO OTHER INVOICE HAS BEEN SUBMITTED FOR THESE SERVICES.**

_____, 2_____
Date

Interpreter Signature

VERIFICATION OF APPOINTING/REQUESTING AUTHORITY

Printed Name of Appointing/Requesting Authority

Signature of Appointing/Requesting Authority

County

_____, 2_____
Date

Title of Appointing/Requesting Authority

Submit by mail to: Administrative Office of the Courts
Manager, Office of Language Access
1001 Vandalay Drive, Frankfort, KY 40601
or by e-mail to: FreelanceInterpreterInvoices@kycourts.net.

Name of Interpreter: _____

Invoice #: _____

Time Period of Invoice: From _____ to _____ Contract #: _____

Page _____ of _____

Use as many page 2 of 2 pages as necessary

15 min. = .25; 30 min. = .5; 45 min. = .75

Date of Service	County of Service	Travel Time (If Any)			Interpreting Time			Total Time (round to nearest 1/4 hour)	Case Information (or Description of Direct Service Provided)			Name of Person Requiring Services
		Start	End	Subtotal	Start	End	Subtotal or 2 hr min.		Case #	Judge's Last Name	Court Level*	

* Court Level: CC = Circuit Court; DC= District Court; FC = Family Court; SC = Specialty Court; PS = Pretrial Services; CDW = Court Designated Worker; OT = Other

CANCELLATIONS/NO SHOWS

Date Service Scheduled	Type of Service Scheduled	Length of Scheduled Service	County of Service	Date of Cancellation	Compensation			Check if No-Show <i>(click spacebar, or press enter)</i>	Name of No-Show Party
					Hours	Rate	Total		

Submit by mail to: Administrative Office of the Courts
 Manager, Office of Language Access
 1001 Vandalay Drive, Frankfort, KY 40601
 or by e-mail to: FreelanceInterpreterInvoices@kycourts.net.