Attachment A (IN FINAL FORM WILL BE IN PDF)

Bilingual/Multilingual Temporary Salary Supplement Test Request Form

*Please see "POL 2002-Bilingual/Multilingual Temporary Salary Supplement Testing Policy" before submitting the request form

☐ New Request ☐ Renewal Request (Date of last test: ___/____/___) ☐ Retest (retest may need to be paid by employee)

Date of Request:	**Employee First Name:**	**Employee Last Name:**	
Position / Title:		**Is this position client facing?**	
Employee Email:		**Best Contact Phone Number:**	
DHS Division:			
DFCS ONLY:	**Program/ Unit:**	**County / Office:**	**Region:**
Office Address:			
City:	**State:** Georgia	**Zip Code:**	

Language Test to be taken:

Language:

Supervisor / County Director (DFCS) Name:
Supervisor Position/Title:
Supervisor / County Director (DFCS) Email:
Best Supervisor Contact Phone Number:

By signing below, approval is given to employee to take the language test for a temporary salary supplement as language assistance is needed in the employee's county. This determination is supported by county data collected on constituents with Limited English Proficiency (LEP) through:

DHS Only:

☐ Census Data

☐ Other Source: _____

_____ _____

Supervisor / County Director Signature Date

Please submit completed Request Form to: lepsi@dhs.ga.gov
Once request form is received, it will be sent to the testing vendor for processing.
Testing vendor will send email to employee with all testing information which includes call in information and testing code.

(FOR DHS LEP/SI OFFICE USE ONLY)

Date Received _____ Date of Test _____ P/F_____

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