

**Bilingual Services Program
IMPLEMENTATION PLAN TRANSMITTAL
FORM**

AGENCY/DEPARTMENT NAME:

Our agency/department has completed its Implementation Plan and verified accuracy of the data prior to submitting to the California Department of Human Resources.

Submit copies of your corrective action plans with this transmittal.

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|-----------------------------------------------------|----------------------------|
| Director's Name: <input type="text"/> | Date: <input type="text"/> |
| Director's Signature: _____ | |
| LS Coordinator's Name: <input type="text"/> | |
| LS Coordinator's Email: <input type="text"/> | |
| LS Coordinator's Phone: <input type="text"/> | Date: <input type="text"/> |
| Language Survey (LS) Coordinator's Signature: _____ | |

| | |
|-------------------------------------------------------|-----------------------------|
| LS Coordinator's Manager's Name: <input type="text"/> | |
| Email: <input type="text"/> | Phone: <input type="text"/> |

Send completed form and attachments to:

California Department of Human Resources
Office of Civil Rights
1515 S Street North Building, Suite 400
Sacramento, CA 95811

Confirmation of receipt will be sent via email.